This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-0015 Worksheet S Peri od: From 10/01/2022 Parts I-III AND SETTLEMENT SUMMARY 09/30/2023 Date/Time Prepared: 12/29/2023 3:54 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 12/29/2023 3:54 pm ] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 10. NPR Date: 11. Contractor's Vendor Code: 4
(2) Settled without Audit 8. [N] Initial Report for this Provider CCN 12. [0] If line 5, column 1 is 4: Enter 13. Settled with Audit 9. [N] Final Report for this Provider CCN 14. [N] Initial Report for this Provider CCN 15. [N] Final Report for this Provider CCN 16. NPR Date: 11. Contractor's Vendor Code: 4. In Contractor's V Contractor use only (3) Settled with Audit number of times reopened = 0-9.

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

(4) Reopened (5) Amended

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BLESSING HOSPITAL (14-0015) for the cost reporting period beginning 10/01/2022 and ending 09/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Patr	ick Gerveler	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	Patrick Gerveler			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

2. 00       SUBPROVI DER - I PF       0       0       0       0       2. 00         3. 00       SUBPROVI DER - I RF       0       10, 626       -173       0       3. 00         5. 00       SWI NG BED - SNF       0       0       0       0       0       5. 00         6. 00       SWI NG BED - NF       0       0       0       0       6. 00         7. 00       SKI LLED NURSI NG FACI LI TY       0       27, 488       -11, 228       0       7. 00         9. 00       HOME HEALTH AGENCY I       0       0       0       9. 00         10. 01       EAST ADAMS RHC I       0       23, 959       0       10. 00         10. 02       MT STERLI NG RHC III       0       3, 745       0       10. 01         10. 03       MAIN CAMPUS RHC IV       0       46, 600       0       10. 03         10. 04       BLESSI NG EXPRESS CLINIC V       0       384       0       10. 04         10. 06       HANNI BAL MAI N RHC VII       0       50, 993       0       10. 06         10. 07       PALMYRA RHC VIII       0       9, 140       0       10. 07								
1.00   2.00   3.00   4.00   5.00				Title	XVIII			
PART       SETTLEMENT SUMMARY			Title V	Part A	Part B	HIT	Title XIX	
1.00       HOSPITAL       0       -1,491,367       -177,753       0       0       1.00         2.00       SUBPROVI DER - I PF       0       0       0       0       0       2.00         3.00       SUBPROVI DER - I RF       0       10,626       -173       0       3.00         5.00       SWI NG BED - SNF       0       0       0       0       0       5.00         6.00       SWI NG BED - NF       0       0       0       0       6.00       7.00         7.00       SKI LLED NURSI NG FACILITY       0       27,488       -11,228       0       7.00         9.00       HOME HEALTH AGENCY I       0       0       0       0       9.00         10.00       EAST ADAMS RHC I       0       23,959       0       10.00         10.01       48TH AND MAINE RHC II       0       51,969       0       10.01         10.02       MT STERLING RHC III       0       3,745       0       10.02         10.03       MAIN CAMPUS RHC IV       0       46,600       0       10.03         10.04       BLESSI NG EXPRESS CLINIC V       0       384       0       10.06         10.06       HAN			1.00	2.00	3. 00	4. 00	5. 00	
2. 00       SUBPROVI DER - I PF       0       0       0       0       2. 00         3. 00       SUBPROVI DER - I RF       0       10, 626       -173       0       3. 00         5. 00       SWI NG BED - SNF       0       0       0       0       0       5. 00         6. 00       SWI NG BED - NF       0       0       0       0       6. 00         7. 00       SKI LLED NURSI NG FACI LI TY       0       27, 488       -11, 228       0       7. 00         9. 00       HOME HEALTH AGENCY I       0       0       0       9. 00         10. 01       EAST ADAMS RHC I       0       23, 959       0       10. 00         10. 02       MT STERLI NG RHC III       0       3, 745       0       10. 01         10. 03       MAIN CAMPUS RHC IV       0       46, 600       0       10. 03         10. 04       BLESSI NG EXPRESS CLINIC V       0       384       0       10. 04         10. 06       HANNI BAL MAI N RHC VII       0       50, 993       0       10. 06         10. 07       PALMYRA RHC VIII       0       9, 140       0       10. 07		PART III - SETTLEMENT SUMMARY						
3. 00   SUBPROVI DER - I RF   0   10, 626   -173   0   3. 00   5. 00   6. 00   5. 00   6. 00   5. 00   6. 00   6. 00   7. 00   SWI NG BED - NF   0   0   27, 488   -11, 228   0   7. 00   7. 00   HOME HEALTH AGENCY I   0   0   0   0   0. 00   0.	1.00	HOSPI TAL	0	-1, 491, 367	-177, 753	0	0	1.00
5. 00       SWI NG BED - SNF       0       0       0       0       5. 00         6. 00       SWI NG BED - NF       0       0       0       6. 00         7. 00       SKI LLED NURSI NG FACI LI TY       0       27, 488       -11, 228       0       7. 00         9. 00       HOME HEALTH AGENCY I       0       0       0       0       9. 00         10. 01       EAST ADAMS RHC I       0       23, 959       0       10. 00         10. 02       48TH AND MAI NE RHC II       0       51, 969       0       10. 01         10. 02       MAI N CAMPUS RHC IV       0       46, 600       0       10. 02         10. 04       BLESSI NG EXPRESS CLINIC V       0       48, 382       0       10. 04         10. 05       BLESSI NG WALK IN CLINIC VI       0       384       0       10. 05         10. 06       HANNI BAL MAI N RHC VII       0       50, 993       0       10. 06         10. 07       PALMYRA RHC VIII       0       9, 140       0       10. 07	2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
6. 00	3.00	SUBPROVI DER - I RF	0	10, 626	-173		0	3. 00
7. 00       SKILLED NURSING FACILITY       0       27, 488       -11, 228       0       7. 00         9. 00       HOME HEALTH AGENCY I       0       0       0       0       0       9. 00         10. 00       EAST ADAMS RHC I       0       23, 959       0       10. 00         10. 01       48TH AND MAINE RHC II       0       51, 969       0       10. 01         10. 02       MT STERLING RHC III       0       3, 745       0       10. 02         10. 03       MAIN CAMPUS RHC IV       0       46, 600       0       10. 02         10. 04       BLESSING EXPRESS CLINIC V       0       48, 382       0       10. 04         10. 05       BLESSING WALK IN CLINIC VI       0       384       0       10. 05         10. 06       HANNI BAL MAIN RHC VII       0       50, 993       0       10. 06         10. 07       PALMYRA RHC VIII       0       9, 140       0       10. 07	5.00	SWING BED - SNF	0	0	0		0	5. 00
9. 00     HOME HEALTH AGENCY I     0     0     0     0     9. 00       10. 00     EAST ADAMS RHC I     0     23, 959     0     10. 00       10. 01     48TH AND MAINE RHC II     0     51, 969     0     10. 01       10. 02     MT STERLING RHC III     0     3, 745     0     10. 02       10. 03     MAIN CAMPUS RHC IV     0     46, 600     0     10. 03       10. 04     BLESSING EXPRESS CLINIC V     0     48, 382     0     10. 04       10. 05     BLESSING WALK IN CLINIC VI     0     384     0     10. 05       10. 06     HANNI BAL MAIN RHC VII     0     50, 993     0     10. 06       10. 07     PALMYRA RHC VIII     0     9, 140     0     10. 07	6.00	SWING BED - NF	0				0	6. 00
10. 00     EAST ADAMS RHC I     0     23, 959     0     10. 00       10. 01     48TH AND MAINE RHC II     0     51, 969     0     10. 01       10. 02     MT STERLING RHC III     0     3, 745     0     10. 02       10. 03     MAIN CAMPUS RHC IV     0     46, 600     0     10. 03       10. 04     BLESSING EXPRESS CLINIC V     0     48, 382     0     10. 05       10. 05     BLESSING WALK IN CLINIC VI     0     384     0     10. 05       10. 06     HANNI BAL MAIN RHC VII     0     50, 993     0     10. 06       10. 07     PALMYRA RHC VIII     0     9, 140     0     10. 07	7.00	SKILLED NURSING FACILITY	0	27, 488	-11, 228		0	7. 00
10. 01     48TH AND MAINE RHC II     0     51, 969     0     10. 01       10. 02     MT STERLING RHC III     0     3, 745     0     10. 02       10. 03     MAIN CAMPUS RHC IV     0     46, 600     0     10. 03       10. 04     BLESSING EXPRESS CLINIC V     0     48, 382     0     10. 05       10. 05     BLESSING WALK IN CLINIC VI     0     384     0     10. 05       10. 06     HANNI BAL MAIN RHC VIII     0     50, 993     0     10. 06       10. 07     PALMYRA RHC VIII     0     9, 140     0     10. 07	9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10. 02       MT STERLING RHC III       0       3,745       0       10. 02         10. 03       MAIN CAMPUS RHC IV       0       46,600       0       10. 03         10. 04       BLESSING EXPRESS CLINIC V       0       48,382       0       10. 04         10. 05       BLESSING WALK IN CLINIC VI       0       384       0       10. 05         10. 06       HANNI BAL MAIN RHC VII       0       50,993       0       10. 06         10. 07       PALMYRA RHC VIII       0       9,140       0       10. 07	10.00	EAST ADAMS RHC I	0		23, 959		0	10.00
10. 03     MAIN CAMPUS RHC IV     0     46,600     0     10.03       10. 04     BLESSING EXPRESS CLINIC V     0     48,382     0     10.04       10. 05     BLESSING WALK IN CLINIC VI     0     384     0     10.05       10. 06     HANNI BAL MAIN RHC VII     0     50,993     0     10.06       10. 07     PALMYRA RHC VIII     0     9,140     0     10.07	10.01	48TH AND MAINE RHC II	0		51, 969		0	10. 01
10. 04     BLESSING EXPRESS CLINIC V     0     48, 382     0     10. 04       10. 05     BLESSING WALK IN CLINIC VI     0     384     0     10. 05       10. 06     HANNI BAL MAIN RHC VII     0     50, 993     0     10. 06       10. 07     PALMYRA RHC VIII     0     9, 140     0     10. 07	10.02	MT STERLING RHC III	0		3, 745		0	10. 02
10. 05     BLESSING WALK IN CLINIC VI     0     384     0     10. 05       10. 06     HANNI BAL MAIN RHC VII     0     50, 993     0     10. 06       10. 07     PALMYRA RHC VIII     0     9, 140     0     10. 07	10.03	MAIN CAMPUS RHC IV	0		46, 600		0	10. 03
10. 06     HANNI BAL MAIN RHC VIII     0     50, 993     0     10. 06       10. 07     PALMYRA RHC VIII     0     9, 140     0     10. 07	10.04	BLESSING EXPRESS CLINIC V	0		48, 382		0	10. 04
10. 07 PALMYRA RHC VIII 0 9, 140 0 10. 07	10.05	BLESSING WALK IN CLINIC VI	0		384		0	10. 05
	10.06	HANNIBAL MAIN RHC VII	0		50, 993		0	10.06
10 00 POWLING OPEN DIG IV	10.07	PALMYRA RHC VIII	0		9, 140		0	10. 07
10.08   BOWLING GREEN RHC 1X   0  0   0  10.08	10.08	BOWLING GREEN RHC IX	0		0		0	10. 08
200. 00 TOTAL 0 -1, 453, 253 46, 018 0 0 200. 00	200.00	TOTAL	0	-1, 453, 253	46, 018	0	0	200. 00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0015 Peri od: Worksheet S-2 From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 12/29/2023 3:54 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1005 BROADWAY 1.00 PO Box: 1.00 2.00 City: QUINCY State: IL Zip Code: 62301 County: ADAMS 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) 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 BLESSING HOSPITAL 140015 99914 07/01/1966 Ν Р 0 3.00 Hospi tal 1 Subprovider - IPF 4.00 4.00 5.00 Subprovider - IRF BLESSING REHAB UNLT 14T015 99914 5 10/01/1985 N Р 0 5 00 Subprovi der - (Other) 6.00 6.00 7 00 Swing Beds - SNF 7.00 Swing Beds - NF 8.00 8.00 Hospi tal -Based SNF BLESSING SKILLED CARE 145643 99914 06/20/1989 Ρ Ν 9.00 9.00 Ν UNI T Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA BLESSING HOME CARE 147031 99914 12/01/1984 Ν Ρ Ν 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 HOSPICE OF ADAMS COUNTY 141501 99914 14.00 06/01/1984 Hospital-Based Health Clinic - RHC 15 00 GOLDEN CLINIC 143422 99914 09/08/1996 N Λ N 15 00 Hospital-Based Health Clinic - RHC BLESSING HEALTH - 48TH 148629 99914 12/23/2021 15.01 0 15.01 Hospital-Based Health Clinic - RHC MT STERLING CLINIC 148630 99914 12/13/2021 0 Ν 15.02 15.02 Ν IIIIHospital-Based Health Clinic - RHC BLESSING HEALTH MAIN 99914 15.03 148631 12/23/2021 N 0 N 15.03 I V CAMPUS VBLESSING EXPRESS CLINIC 148634 99914 15.04 Hospital-Based Health Clinic - RHC 05/20/2022 0 Ν 15.04 Hospital-Based Health Clinic - RHC BLESSING WALK IN CLINIC 148635 99914 05/17/2022 15.05 15.05 Ν 0 N Hospital-Based Health Clinic - RHC BLESSING HANNIBAL MAIN 268800 99926 15.06 04/23/2023 N 0 N 15 06 VII CLINIC 15.07 Hospital-Based Health Clinic - RHC BLESSING PALMYRA CLINIC 268801 99926 07/24/2023 0 Ν 15.07 Ν 15.08 Hospital-Based Health Clinic - RHC BLESSING BOWLING GREEN 268802 99926 07/24/2023 Ν 0 Ν 15.08 CLINIC ΙX Hospital - Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2022 09/30/2023 20.00 21.00 Type of Control (see instructions) 2 21.00 1.00 2. 00 3.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for 22.00 Ν 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 22.01 Ν 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 22.02 Ν Ν 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

Ν

Ν

48.00

48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.

61.05

61.06

current cost reporting period (see instructions). Enter the difference between the baseline primary

61.04 minus line 61.03). (see instructions)
61.06 Enter the amount of ACA §5503 award that is being

and/or general surgery FTEs and the current year s primary care and/or general surgery FTE counts (line

used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)

Health Financial Systems BLESSING HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0015 Peri od: Worksheet S-2 From 10/01/2022 Part I Date/Time Prepared: 09/30/2023 12/29/2023 3:54 pm Program Name Program Code Unweighted IME Unwei ghted Direct ĞME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61. 20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 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 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Ν 63.00 for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs in **FTES** (col . 1 + col Nonprovi der Hospi tal 2)) 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 0.000000 64.00 0.00 n 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) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2,

the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

Health Financial Systems BLESSING HO		N 14 0015 F		u of Form CMS-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	F	eriod: rom 10/01/2022	Worksheet S-2 Part I	
		1	o 09/30/2023	Date/Time Pre 12/29/2023 3:	
			Approved for	Number of	
			Permanent Adjustment	Approved Permanent	
			(Y/N)	Adjustments	
			1. 00	2.00	00.00
88.00 Column 1: Is this hospital approved for a permanent adjustmer amount per discharge? Enter "Y" for yes or "N" for no. If yes 89. (see instructions)			N	C	88. 00
Column 2: Enter the number of approved permanent adjustments.		\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	TEE	A	
		No.	Effecti ve Date	Approved Permanent	
				Adjustment	
				Amount Per	
		1. 00	2.00	Di scharge 3.00	-
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A li	ne number	0.00			89.00
on which the per discharge permanent adjustment approval was Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA tar	based. peri od				
per discharge. Column 3: Enter the amount of the approved permanent adjustme TEFRA target amount per discharge.	ent to the				
TELLINA Lai get aillouitt pei ui schai ge.			V	XI X	
T: 11 V 1 V 1 V 1 V 1 V 1 V 1 V 1 V 1 V 1			1. 00	2. 00	
90.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	servi ces? Er	nter "Y" for	N	Y	90. 00
91.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the appli			N	N	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applications	al certificati			N	92. 00
93.00 Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.			N	N	93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a applicable column.			N	N	94. 00
95. 00 If line 94 is "Y", enter the reduction percentage in the appl 96. 00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N	0. 00 N	95. 00 96. 00
97.00   If line 96 is "Y", enter the reduction percentage in the appl			0. 00	0.00	97. 00
98.00 Does title V or XIX follow Medicare (title XVIII) for the interest stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for the interest of the step o			N	Y	98. 00
column 1 for title V, and in column 2 for title XIX.  98.01 Does title V or XIX follow Medicare (title XVIII) for the report of the column 1 for title XIX.  1. Page 1. Column 1 for title XIX.			N	Υ	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or			N	Y	98. 02
for title V, and in column 2 for title XIX.  98.03 Does title V or XIX follow Medicare (title XVIII) for a criti reimbursed 101% of inpatient services cost? Enter "Y" for yes			N	N	98. 03
for title V, and in column 2 for title XIX.  98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH routpatient services cost? Enter "Y" for yes or "N" for no in			N	N	98. 04
in column 2 for title XIX.  98.05 Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co	ck the RCE dis	sallowance on	N	Υ	98. 05
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost r	reimbursed for	· Wkst. D,	N	Υ	98. 06
Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.  Rural Providers	i for title \	r, and rh			
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-i	nclusive meth	nod of payment	N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cos	st reimburseme	ent for I&R			107. 00
training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do yapproved medical education program in the CAH's excluded IPF	ou train I&Rs	s in an			
Enter "Y" for yes or "N" for no in column 2. (see instruction 108.00 is this a rural hospital qualifying for an exception to the	ons)	• •	N.		100.00
	JANA LEE SCHEO	1111 E ( NEE 4)	N		108.00

128. 00

in column 1 and termination date, if applicable, in column 2.

Health Financial Systems		HOSPITAL				eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENIIFICATION DATA	Provi der CC	N: 14-0015	From 10	0/01/2022 9/30/2023	Worksheet S- Part I Date/Time Pr	
						12/29/2023 3	
20 00 f this is a Madisons contified to	una trananiant program	onton the contifi	aati aa da		1. 00	2. 00	129. 0
29.00 If this is a Medicare-certified I in column 1 and termination date, 30.00 If this is a Medicare-certified pa	if applicable, in columr ancreas transplant progra	n 2. am, enter the cer					130. 00
date in column 1 and termination of 31.00 If this is a Medicare-certified in date in column 1 and termination of	ntestinal transplant prog	gram, enter the c	erti fi cat	i on			131. 00
32.00 If this is a Medicare-certified in column 1 and termination date,			132. 0				
33.00 Removed and reserved 34.00  f this is a hospital-based organ in column 1 and termination date, All Providers			133. 00 134. 00				
40.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the	'N" for no in column 1. I e home office chain numbe	f yes, and home er. (see instruct	office co		Y	14H132	140. 00
1.00 If this facility is part of a cha		.00 n lines 141 throu	  ah 143 th	ne name and	3.00	of the	
home office and enter the home of 141.00 Name: BLESSING CORPORATE SERVICE	fice contractor name and S Contractor's Name:	contractor number	er.				141. 00
42.00 Street: BROADWAY AT 11TH STREET 43.00 City: QUINCY	PO Box:	SERVI CES	Zip C	ode:	6230	01	142. 00 143. 00
						1. 00	
44.00 Are provider based physicians' co	sts included in Worksheet	t A?				Y	144. 0
					1. 00	2.00	
45.00 If costs for renal services are c inpatient services only? Enter "Y" no, does the dialysis facility in period? Enter "Y" for yes or "N"	' for yes or "N" for no i clude Medicare utilizatio	n column 1. If c	olumn 1 i		Y		145. 00
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/	gy changed from the previ n column 1. (See CMS Pub.			lf	N		146. 0
						1. 00	
47.00 Was there a change in the statist 48.00 Was there a change in the order o						N N	147. 0 148. 0
49.00 Was there a change to the simplif		Enter "Y" for ye	s or "N"			N	149. 0
		Part A 1.00	Part 2.00		3.00	Title XIX 4.00	_
Does this facility contain a prov or charges? Enter "Y" for yes or 55.00Hospital		onent for Part A	the appl and Part	ication of	CFR §413	er of costs 3.13)	155. 0
56.00 Subprovi der – IPF		N N	N N		N N	N N	156. C
57. 00 Subprovi der – IRF 58. 00 SUBPROVI DER		N	N		N	N	157. 0 158. 0
59. 00 SNF		N	N		N	N	159. 0
60.00 HOME HEALTH AGENCY 61.00 CMHC		N	N N		N N	N N	160. 0 161. 0
OT. GO CIVILE			IV		IN .	14	101.0
Multicampus						1. 00	
65.00 Is this hospital part of a Multica	ampus hospital that has o	one or more campu	ses in di	fferent CB	SAs?	N	165. 0
Enter "Y" for yes or "N" for no.	Name	County	State	Zip Code	CBSA	FTE/Campus	
// 0015 line 1/5 is 5	0	1. 00	2. 00	3. 00	4. 00	5. 00	01// 2
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. 0	00 166. 0
						1. 00	
Health Information Technology (HI							4,7 -
67.00 s this provider a meaningful use 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the	05 is "Y") and is a meani	ngful user (line	N' for no 167 is "	Y"), enter	the	Y	167. 0 168. 0
68.01 If this provider is a CAH and is	not a meaningful user, do	oes this provider			shi p		168. 0
exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful	user (line 167 is "Y") ar	nd is not a CAH (	line 105	is "N"), e	nter the	0.0	00169.0
transition factor. (see instruction	פווע)					I	I

Health Financial Systems	BLESSING HOSPITAL				In Lieu of Form CMS-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CCN: 14-0015	Perio		Worksheet S-2 Part I	2	
						enared.	
				077 007 2020	12/29/2023 3:	54 pm	
		Begi nni ng	Endi ng				
				1. 00	2.00		
170.00 Enter in columns 1 and 2 the EHR bequence 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					(	171. 00	
1876 Medicare days in column 2. (see	e instructions)						

Health Financial Systems BLESSING HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-0015 Peri od: Worksheet S-2 From 10/01/2022 Part II Date/Time Prepared: 09/30/2023 12/29/2023 3:54 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 1.00 N reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν 2.00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Υ 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports
Column 1: Were the financial statements prepared by a Certified Public 4 00 Α 4 00 Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5 00 Are the cost report total expenses and total revenues different from 5 00 Ν those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper. 1.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 the legal operator of the program? 7 00 Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 Were nursing programs and/or allied health programs approved and/or renewed during the N 8.00 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 Υ 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions. Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting 13.00 Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part B Y/N Y/N Date Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? N N 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 17.00 Was the cost report prepared using the PS&R Report for Υ 11/30/2023 11/30/2023 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 Ν Ν 18.00 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 Ν Ν 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th	Financial Systems BLESSING	HOSPI TAL		In Lie	u of Form CMS-	2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 14-0015	Peri od: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part II Date/Time Pre 12/29/2023 3:	epared:		
		Descr	i pti on	Y/N	Y/N			
			0	1. 00	3. 00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00		
		Y/N	Date	Y/N	Date			
		1.00	2.00	3. 00	4. 00			
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	(OSPI TALS)		1,00			
	Capital Related Cost		,			1		
22. 00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22. 00		
23.00	Have changes occurred in the Medicare depreciation expense		sals made dur	ing the cost	N	23. 00		
	reporting period? If yes, see instructions.	• •		· ·				
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost re	porting period?	N	24. 00		
25. 00	Have there been new capitalized leases entered into during	the cost repor	rting period?	If yes, see	N	25. 00		
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost reporti	ng period? I	f yes, see	N	26. 00		
27.00	instructions.	. aaat mamamtir	a nonioda le	voo oubmi t	N	27.00		
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportir	ng period?ir	yes, submit	N	27. 00		
28. 00	Interest Expense  00 Were new Loans, mortgage agreements or Letters of credit entered into during the cost reporting							
29. 00	period? If yes, see instructions.	. 0	N	28. 00				
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see insti	IN	29.00					
30. 00								
31. 00								
	Purchased Services							
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru	ntractual	N	32. 00				
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app. no, see instructions.		ng to competi	tive bidding? If	N	33. 00		
	Provi der-Based Physi ci ans					1		
34. 00	Were services furnished at the provider facility under an a	arrangement wit	h provider-h	ased physicians?	Υ	34. 00		
	If yes, see instructions.	· ·	·	. 3				
35. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		nts with the		N	35. 00		
				Y/N	Date			
				1. 00	2. 00			
01	Home Office Costs			.,		1		
36. 00 37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	Y		36. 00 37. 00		
38. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of	N		38. 00		
	the provider? If yes, enter in column 2 the fiscal year end	d of the home o	offi ce.					
39. 00	If line 36 is yes, did the provider render services to othe see instructions.	er chain compor	lents? IF yes	, Y		39. 00		
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	Υ		40. 00		
	1.00 2							
	Cost Report Preparer Contact Information	1.		2.				
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	CONNI E		ZI EGLER		41. 00		
42.00	respecti vel y.	DI ECCLNO CORRO	DATE CEDULAT			42.00		
42. 00	Enter the employer/company name of the cost report preparer.	BLESSING CORPO	JKATE SERVICE			42. 00		
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400,	X4159	CONNI E. ZI EGLER H. ORG	@BLESSI NGHEALT	43. 00		

Health Financial Systems		BLESSING HOSPITAL				In Lieu of Form CMS-2552-1		
HOSPITAL AND HOSPITAL HE	ALTH CARE REIMBURSEMENT QUESTION	NNAI RE	Provi der 0		Peri od:	Worksheet S-2		
					From 10/01/2022 To 09/30/2023	Part II  Date/Time Pre	narod:	
					10 07/30/2023	12/29/2023 3:		
·								
			3.	.00				
Cost Report Prepa	rer Contact Information							
	ame, last name and the title/pos		REI MBURSEMENT	COORDI NATOR			41. 00	
	report preparer in columns 1, 2,	and 3,						
respecti vel y.								
42.00 Enter the employe	r/company name of the cost repor	t					42. 00	
preparer.								
	ne number and email address of t						43. 00	
report preparer i	n columns 1 and 2, respectively.							

Health Financial Systems BLE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-0015 

					1	0 09/30/2023	12/29/2023 3:	
							I/P Days / 0/P	от рііі
							Visits / Trips	
	Component	Worksheet A Line No.	No.	of Beds	Bed Days Available	CAH/REH Hours	Title V	
		1.00		2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA				•			
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		284	103, 660	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			284	103, 660	0.00	0	7. 00
0.00	beds) (see instructions)	21.00		٥٢	0.105	0.00	0	0.00
8. 00 9. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	31. 00		25	9, 125	0.00	0	8. 00 9. 00
10.00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)	43.00		309	112, 785	0.00	Ö	14. 00
15. 00	CAH visits			007	112,700	0.00	0	15. 00
15. 10	REH hours and visits						· ·	15. 10
16. 00	SUBPROVI DER - I PF							16. 00
17. 00	SUBPROVIDER - IRF	41. 00		18	6, 570		0	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							20.00
21.00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE	116. 00		0	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC						_	25. 00
26. 00	EAST ADAMS RHC	88. 00					0	26. 00
26. 01	48TH AND MAINE RHC	88. 01					0	26. 01
26. 02 26. 03	MT STERLING RHC	88. 02					0	26. 02 26. 03
26. 03	MAIN CAMPUS RHC BLESSING EXPRESS CLINIC	88. 03 88. 04					0	26. 03 26. 04
26. 04	BLESSING WALK IN CLINIC	88. 05					0	26. 04
26. 05	HANNIBAL MAIN RHC	88. 06					0	26. 05
26. 07	PALMYRA RHC	88. 07					0	26. 07
26. 08	BOWLING GREEN RHC	88. 08					0	26. 08
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)	07.00		347			· ·	27. 00
28. 00	Observation Bed Days			0.,			0	28. 00
29. 00	Ambul ance Trips						_	29. 00
30. 00	Employee discount days (see instruction)							30. 00
31.00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			0	0			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	l	0	0		0	34. 00

Provider CCN: 14-0015

| Period: | Worksheet S-3 | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared: | 12/29/2023 3:54 pm

	12/29/2023 3:54 pm							
		I/P Days	/ O/P Visits	/ Tri ps	Full Time 6	Equi val ents		
	C	T: +1 - \/\/\	T: +1 - VIV	T-+-1 All	T-4-1 1-4	F1 0		
	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	20, 926	1, 013	58, 470			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)	13, 522	15, 515				2. 00	
3. 00	HMO I PF Subprovi der	0	0				3. 00	
4.00	HMO I RF Subprovi der	858	0				4. 00	
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00	
6.00	Hospital Adults & Peds. Swing Bed NF	20.027	1 013	U F0 470			6. 00	
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	20, 926	1, 013	58, 470			7. 00	
8. 00	INTENSIVE CARE UNIT	2, 139	103	5, 809			8. 00	
9. 00	CORONARY CARE UNIT	2, 137	103	3,007			9. 00	
10.00	BURN INTENSIVE CARE UNIT						10. 00	
11. 00	SURGI CAL INTENSI VE CARE UNI T						11. 00	
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00	
13.00	NURSERY		37	2, 065			13. 00	
14.00	Total (see instructions)	23, 065	1, 153	66, 344	18. 25	2, 457. 02	14.00	
15.00	CAH visits	o	0	0			15.00	
15. 10	REH hours and visits						15. 10	
16.00	SUBPROVI DER - I PF						16. 00	
17. 00	SUBPROVI DER - I RF	2, 790	378	4, 630	0.00	22. 98	17. 00	
18. 00	SUBPROVI DER		_				18. 00	
19. 00	SKILLED NURSING FACILITY	3, 297	0	4, 765	0.00	23. 89	19. 00	
20.00	NURSING FACILITY						20. 00	
21. 00 22. 00	OTHER LONG TERM CARE	15 102	0	25 457	0.00	20.00	21. 00	
23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)	15, 193	U	35, 457	0.00	38. 88	22. 00 23. 00	
24. 00	HOSPICE	0	0	0	0.00	23. 07	24. 00	
24. 10	HOSPICE (non-distinct part)	١	J	0		25.07	24. 10	
25. 00	CMHC - CMHC						25. 00	
26. 00	EAST ADAMS RHC	1, 204	0	5, 513	0.00	7. 46		
26. 01	48TH AND MAINE RHC	2, 820	0			19. 17	26. 01	
26. 02	MT STERLING RHC	243	0	1, 954	0.00	6. 31	26. 02	
26. 03	MAIN CAMPUS RHC	7, 357	0	74, 475	0.00	120. 70	26. 03	
26. 04	BLESSING EXPRESS CLINIC	656	0	14, 991	0.00	15. 67	26. 04	
26. 05	BLESSING WALK IN CLINIC	1, 084	0			18. 41	26. 05	
26. 06	HANNIBAL MAIN RHC	7	0	,		24. 14	26. 06	
26. 07	PALMYRA RHC	0	0		0.00	2. 84		
26. 08	BOWLING GREEN RHC	0	0			0. 95		
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0.00	26. 25	
27. 00	Total (sum of lines 14-26)			F 440	18. 25	2, 781. 49	27. 00	
28. 00	Observation Bed Days		0	5, 148			28. 00	
29. 00 30. 00	Ambulance Trips Employee discount days (see instruction)	0		943			29. 00 30. 00	
31. 00	Employee discount days (see instruction)			124			30.00	
32. 00	Labor & delivery days (see instructions)	0	191	621			32. 00	
32. 00	Total ancillary labor & delivery room		171	021			32. 00	
52. 01	outpatient days (see instructions)			ĺ			02.01	
33.00	LTCH non-covered days	o					33. 00	
33. 01	LTCH site neutral days and discharges	o					33. 01	
34.00	Temporary Expansion COVID-19 PHE Acute Care	o	0	0			34. 00	

| Peri od: | Worksheet S-3 | From 10/01/2022 | Part I | To 09/30/2023 | Date/Time Prepared: Provider CCN: 14-0015

					10	09/30/2023	12/29/2023 3:	
		Full Time	_		Di sch	arges		
		Equi val ents						
	Component	Nonpai d	Title V		Title XVIII	Title XIX	Total All	
		Workers		$\perp$			Pati ents	
		11. 00	12. 00	$\perp$	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and			0	4, 610	725	13, 515	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	2, 483	2, 201		2. 00
3. 00	HMO IPF Subprovider			- 1	2, 403	2, 201		3. 00
4. 00	HMO IRF Subprovider			- 1		14		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF			1		14		5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF			ł				6. 00
7. 00	Total Adults and Peds. (exclude observation			ł				7. 00
7.00	beds) (see instructions)							7.00
8.00	INTENSIVE CARE UNIT			1				8. 00
9. 00	CORONARY CARE UNIT			- 1				9. 00
10.00	BURN INTENSIVE CARE UNIT			- 1				10.00
11. 00	SURGICAL INTENSIVE CARE UNIT			- 1				11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)			- 1				12. 00
13.00	NURSERY			- 1				13.00
14. 00	Total (see instructions)	0. 00		o	4, 610	725	13, 515	14.00
15.00	CAH visits			- 1				15.00
15. 10	REH hours and visits			- 1				15. 10
16.00	SUBPROVI DER - I PF			- 1				16.00
17.00	SUBPROVI DER - I RF	0. 00		0	179	5	287	17.00
18.00	SUBPROVI DER			- 1				18.00
19.00	SKILLED NURSING FACILITY	0. 00						19.00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE			-				21.00
22. 00	HOME HEALTH AGENCY	0. 00		-				22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )			-				23. 00
24. 00	HOSPI CE	0. 00						24.00
24. 10	HOSPICE (non-distinct part)			-				24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	EAST ADAMS RHC	0.00		-				26. 00
26. 01	48TH AND MAINE RHC	0.00						26. 01
26. 02	MT STERLING RHC	0.00		-				26. 02
26. 03	MAIN CAMPUS RHC	0. 00 0. 00		-				26. 03 26. 04
26. 04 26. 05	BLESSING EXPRESS CLINIC BLESSING WALK IN CLINIC	0.00		1				26. 05
26. 05	HANNI BAL MAIN RHC	0.00		- 1				26. 05
26. 07	PALMYRA RHC	0.00		H				26. 07
26. 07	BOWLING GREEN RHC	0.00		1				26. 08
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00		1				26. 25
27. 00	Total (sum of lines 14-26)	0.00		1				27. 00
28. 00	Observation Bed Days	0.00		1				28. 00
29. 00	Ambulance Trips			1				29. 00
30.00	Employee discount days (see instruction)					ļ		30. 00
31. 00	Employee discount days - IRF			- 1				31. 00
32. 00	Labor & delivery days (see instructions)			- 1				32. 00
32. 01	Total ancillary labor & delivery room			- [				32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days				0			33.00
33. 01	LTCH site neutral days and discharges				0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care							34.00

Provider CCN: 14-0015

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

					To	09/30/2023	Date/Time Pre 12/29/2023 3:	
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst.	(col.2 ± col.	Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	A-6) 3. 00	3) 4. 00	<u>col . 4</u> 5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200. 00	249, 274, 643	0	249, 274, 643	5, 994, 816. 19	41. 58	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0.00	0. 00	2. 00
3. 00	A Non-physician anesthetist Part		0	0	0	0.00	0. 00	3. 00
4. 00	B Physician-Part A -		502, 191	0	502, 191	3, 153. 00	159. 27	4. 00
4. 01 5. 00	Administrative Physicians - Part A - Teaching Physician and Non		0 53, 137, 566	0	1	0. 00 208, 801. 45		
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	О	0.00	0. 00	6. 00
7. 00	services Interns & residents (in an	21. 00	1, 278, 372	0	1, 278, 372	40, 801. 68	31. 33	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	0	O	0.00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		0	0	0	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	1, 782, 006 20, 019, 493			51, 220. 12 483, 285. 49		
10.00	instructions) OTHER WAGES & RELATED COSTS		20,017,170	337, 373	20,007,100	1007 2001 17	12.01	101.00
11. 00	Contract Labor: Direct Patient Care		14, 548, 025	0	14, 548, 025	128, 943. 00	112. 83	11. 00
12. 00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0. 00	12.00
13. 00			323, 491	0	323, 491	1, 983. 51	163. 09	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		0	0	О	0.00	0. 00	14. 00
14. 01 14. 02 15. 00	Home office: Physician Part A - Administrative		0 0 0	0 0 0	0 0 0	0. 00 0. 00 0. 00	0. 00	
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 00
16. 01	Home office Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 01
16. 02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	0	0.00	0. 00	16. 02
17. 00			37, 251, 095	0	37, 251, 095			17. 00
18. 00								18. 00
19. 00 20. 00	1 '		4, 530, 360 0	0	4, 530, 360 0			19. 00 20. 00
21. 00	A		0	0	0			21. 00
22. 00	B Physician Part A -		54, 139	0	54, 139			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0	0			22. 01
23. 00 24. 00 25. 00	Wage-related costs (RHC/FQHC)		5, 596, 229 2, 174, 924 314, 404	0	5, 596, 229 2, 174, 924 314, 404			23. 00 24. 00 25. 00
25. 50	1		0	0	0			25. 50
25. 51	Related organization wage-related (core)		0	0	0			25. 51
25. 52	, ,		0	0	0			25. 52

HOSPITAL WAGE INDEX INFORMATION

43.00 Other General Service

Provider CCN: 14-0015

Peri od: Worksheet S-3 From 10/01/2022 Part II

09/30/2023 Date/Time Prepared: 12/29/2023 3:54 pm Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly Number on of Salaries Sal ari es Related to Wage (col. 4 Reported col . 5) (from Wkst. (col. 2 ± col. Salaries in A-6)3) col. 4 2.00 5.00 1.00 6.00 3.00 4.00 25.53 Home office: Physicians Part A 0 25.53 - Teaching - wage-related (core) OVERHÉAD COSTS - DIRECT SALARIES 26.00 4 00 4, 913, 922 4, 913, 922 208, 575. 63 26.00 Employee Benefits Department 23. 56 27.00 Administrative & General 5.00 33, 112, 720 -22, 549 33, 090, 171 970, 127. 61 34. 11 27.00 28.00 Administrative & General under 0.00 0.00 28.00 contract (see inst.) Maintenance & Repairs 6.00 4, 351, 617 169, 990. 60 29.00 25. 60 29.00 4, 351, 617 0 Operation of Plant 0.00 30.00 7.00 C 0.00 30.00 31.00 Laundry & Linen Service 8.00 46, 982 0 46, 982 2, 148. 70 21.87 31.00 32.00 Housekeepi ng 9.00 4, 032, 283 4, 032, 283 199, 393. 19 20. 22 32.00 33.00 Housekeeping under contract 0.00 0 C 0 0.00 33.00 (see instructions) 34.00 Di etary 10.00 3, 951, 700 -2, 447, 288 1, 504, 412 74, 395. 34 20. 22 34.00 Di etary under contract (see instructions) 0.00 35.00 0.00 35.00 0 36, 00 Cafeteri a 11.00 0 2, 447, 288 2, 447, 288 121, 021. 88 20. 22 36.00 Maintenance of Personnel 37.00 12.00 0.00 0.00 37.00 38.00 Nursing Administration 13.00 9, 959, 109 -67, 306 9, 891, 803 256, 112. 74 38. 62 38.00 39.00 Central Services and Supply 14.00 0.00 0.00 39.00 0 40.00 40.00 Pharmacy 15.00 0 0 0.00 0.00 41.00 Medical Records & Medical 16.00 5, 795, 034 0 5, 795, 034 223, 667. 03 25. 91 41.00 Records Library Social Service 17.00 0.00 42.00 42.00 0 0 0.00

o

18.00

ol

0

0.00

0.00 43.00

Health Financial Systems In Lieu of Form CMS-2552-10 BLESSING HOSPITAL HOSPITAL WAGE INDEX INFORMATION Provider CCN: 14-0015 Peri od:

Worksheet S-3 Part III Date/Time Prepared: From 10/01/2022 To 09/30/2023 12/29/2023 3:54 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col.2 ± col. col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 194, 858, 705 194, 858, 705 5, 745, 213. 06 33. 92 1.00 instructions) 2.00 21, 801, 499 525, 814 22, 327, 313 534, 505. 61 41.77 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 173, 057, 206 -525, 814 172, 531, 392 5, 210, 707. 45 33. 11 3.00 minus line 2) 4.00 Subtotal other wages & related 14, 871, 516 14, 871, 516 130, 926. 51 113.59 4.00 costs (see inst.) Subtotal wage-related costs 5.00 37, 305, 234 C 37, 305, 234 0.00 21.62 5.00 (see inst.) Total (sum of lines 3 thru 5) 225, 233, 956 6.00 6.00 -525, 814 224, 708, 142 5, 341, 633. 96 42 07 7.00 Total overhead cost (see 66, 163, 367 -89, 855 66, 073, 512 2, 225, 432. 72 29.69 7.00

instructions)

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS		Period: Worksheet S-3 From 10/01/2022 Part IV

	To 09/30/.	2023	Date/Time Prep 12/29/2023 3:5	
			Amount	
			Reported	
			1. 00	
	PART IV - WAGE RELATED COSTS			
	Part A - Core List			
	RETI REMENT COST			
1.00	401K Employer Contributions		4, 374, 025	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	İ	-2, 436, 393	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	İ	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees		0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan		0	6. 00
7.00	Employee Managed Care Program Administration Fees		0	7. 00
	HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)		0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	İ	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	İ	30, 937, 871	8. 02
8.03	Health Insurance (Purchased)		0	8. 03
9.00	Prescription Drug Plan	İ	0	9. 00
10.00	Dental, Hearing and Vision Plan		0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)		282, 431	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		624, 336	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	İ	0	14.00
15.00	'Workers' Compensation Insurance	İ	486, 071	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106	5.	0	16.00
	Noncumulative portion)			
	TAXES			
17.00			15, 216, 686	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		353, 121	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
	OTHER	<u> </u>		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (instructions))	(see	0	21. 00
22 00	Day Care Cost and Allowances		0	22. 00
	Tuition Reimbursement		889, 132	23. 00
	Total Wage Related cost (Sum of lines 1 -23)		50, 727, 280	
24.00	Part B - Other than Core Related Cost		50, 727, 200	24.00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)			25. 00
25.00	TOTAL WINDE RELEATED GOOTS (SECTION)	- 1		25.00

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-10		
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 14-0015	Period: Worksheet S-3 From 10/01/2022 Part V		

HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 14-0015	Peri od: From 10/01/2022 To 09/30/2023	Worksheet S-3 Part V Date/Time Pre 12/29/2023 3:	
	Cost Center Description			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		15, 347, 152	50, 727, 280	1. 00
2. 00	Hospi tal		14, 548, 025	37, 251, 095	2. 00
3.00	SUBPROVI DER - I PF				3.00
4. 00	SUBPROVI DER - I RF		349, 200	390, 020	4.00
5.00	Subprovi der - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	SKILLED NURSING FACILITY		446, 402	358, 769	8. 00
9.00	NURSING FACILITY				9. 00
10. 00	OTHER LONG TERM CARE I				10.00
11. 00	Hospi tal -Based HHA		0	624, 885	11.00
12.00	AMBULATORY SURGICAL CENTER (D. P. ) I				12.00
13.00	Hospi tal -Based Hospi ce		0	445, 630	13.00
14.00	Hospital-Based Health Clinic RHC		0	131, 475	14.00
14. 01	Hospital-Based Health Clinic RHC 1		0	245, 961	14.01
14. 02	Hospital-Based Health Clinic RHC 2		0	96, 348	14.02
14. 03	Hospital-Based Health Clinic RHC 3		0	1, 701, 141	14.03
14. 04	Hospital-Based Health Clinic RHC 4		0	254, 342	14.04
14. 05	Hospital-Based Health Clinic RHC 5		0	298, 325	14.05
14. 06	Hospital-Based Health Clinic RHC 6		0	194, 084	14.06
14. 07	Hospital-Based Health Clinic RHC 7		3, 525	37, 362	14.07
14. 08	Hospital-Based Health Clinic RHC 8		0	22, 015	14.08
15. 00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospi tal -Based-CMHC				16.00
	RENAL DIALYSIS I		0	0	17.00
18.00	Other		0	8, 675, 828	18.00
	•				

Heal th	Financial Systems	BLESSI NG F	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	EALTH AGENCY STATISTICAL DATA			CN: 14-0015	Peri od:	Worksheet S-4	
			Component	CCN: 14-7031	From 10/01/2022 To 09/30/2023	Date/Time Pre	pared:
					Home Health	12/29/2023 3: PPS	54 pm
					Agency I		
					1	00	
0.00	County				ADAMS		0. 00
		Title V	Title XVIII	Title XIX	Other	Total	
	HOME HEALTH AGENCY STATISTICAL DATA	1. 00	2.00	3. 00	4. 00	5. 00	
1.00	Home Heal th Ai de Hours	0			0 5, 465		1.00
2.00	Unduplicated Census Count (see instructions)	0. 00	709. 00		00 1,110.00 ployees (Full Ti		2. 00
				Number of Em	proyees (ruir ii	me Equi vai ent)	
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal	work week				
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	(	)	1.00	2. 00	3. 00	
3.00	Administrator and Assistant Administrator(s)		40.00	0.0	0.00	0.00	3. 00
4.00	Director(s) and Assistant Director(s)			0.9			4. 00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			8. 8			5. 00 6. 00
7. 00	Nursing Supervisor			0.0			1
8.00	Physical Therapy Service			8. 7			8. 00
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			0.0			9. 00 10. 00
11. 00	Occupational Therapy Supervisor			0.0	0.00	0.00	•
12.00	Speech Pathology Service			0. 5			
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0.0			•
15.00	Medical Social Service Supervisor			0.0	0.00	0.00	15. 00
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			5. 5			
18. 00	·			0.0			18.00
				•	'	CBSA Data	
	HOME HEALTH AGENCY CBSA CODES					1.00	
19. 00	Enter in column 1 the number of CBSAs where	you provided se	ervices during	the cost repo	orting period.	2	19. 00
20. 00	List those CBSA code(s) in column 1 serviced first code).	during this co	st reporting p	period (line 2	0 contains the	99914	20. 00
20. 01	Tirst code).					99926	20. 01
		Full Ep					
		Without Outliers	With Outliers	LUPA Episode	s PEP Only Epi sodes	Total (cols. 1-4)	
		1.00	2.00	3. 00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	5, 432	358	13	39 111	6, 040	21. 00
22. 00	Skilled Nursing Visits Skilled Nursing Visit Charges	923, 440		1			1
23. 00	Physical Therapy Visits	4, 806		1	122		23. 00
24. 00 25. 00	Physical Therapy Visit Charges Occupational Therapy Visits	817, 020 1, 426			30 20, 740 9 57		1
26. 00	Occupational Therapy Visit Charges	242, 420					
27. 00	Speech Pathology Visit Charges	132		1	0 3 0 510	190 32, 300	1
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	22, 440		,	0 510		•
30.00	Medical Social Service Visit Charges	6, 630	170		0 0	6, 800	30. 00
31. 00 32. 00	Home Health Aide Visits Home Health Aide Visit Charges	1, 483 139, 402		1	0 20 0 1, 880		
33. 00	Total visits (sum of lines 21, 23, 25, 27,	13, 318					
0.4.00	29, and 31)						04.00
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 2, 151, 352	C 216, 574	1	0 20 51, 690	1	34. 00 35. 00
	30, 32, and 34)		210, 374				
36. 00	Total Number of Episodes (standard/non outlier)	1, 371		11	6 33	1, 520	36. 00
37. 00	Total Number of Outlier Episodes		57		3		
38. 00	Total Non-Routine Medical Supply Charges	74, 735	4, 448	1, 95	944	82, 082	38. 00

Heal th	Financial Systems	BLESSI NG	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 14-0015	Peri od:	Worksheet S-8	
			Component	CCN: 14-3422	From 10/01/2022 To 09/30/2023	Date/Time Pro	
					RHC I	12/29/2023 3: Cost	54 piii
			. '				
	[				1.	00	
	Clinic Address and Identification				102 DDALDLE MI	LLC DOAD	1 00
1.00	Street		Ci	ty	102 PRAIRIE MI State	ZIP Code	1.00
				00	2. 00	3. 00	
2.00	City, State, ZIP Code, County		GOLDEN		IL	62339	2. 00
						4.00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "II" for I	ırhan		1.00	3.00
3.00	THOSE TRE-BASED TORICS ONET. Designation - Ent	er ik for fure	ai 0i 0 10i t		nt Award	Date	3.00
					1. 00	2. 00	
	Source of Federal Funds					T	
4. 00 5. 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A						4. 00 5. 00
6.00	Health Services for the Homeless (Section 34						6.00
7. 00	Appal achi an Regional Commission	o(a), 1110 /101)					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 h	ospi tal -based F	RHC or FOHC? Fi	nter "Y" for	1. 00 N		10.00
	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of o	other operation	ns in column			
	inour s. )	Sur	nday	l N	londay	Tuesday	
		from	to	from	to	from	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	Facility hours of operations (1) CLINIC			08: 00	17: 00	08: 00	11. 00
11.00	I CELINI C			08.00	17.00	08.00	11.00
		-			1. 00	2.00	
12. 00 13. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. ´ umn 1. If yes,	100-04, chapteı enter in colur	9, section nn 2 the	N N	C	12. 00 13. 00
	Indiliber 3 berow.			Prov	ider name	CCN	
					1. 00	2. 00	
14. 00	RHC/FQHC name, CCN	\/ (N		20/11/1	VIV	T 1 1 10 11	14.00
		Y/N 1.00	V 2. 00	3. 00	XI X 4. 00	Total Visits 5.00	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		2.00	3.00	4.00	3.00	15. 00
	(See THELLMCTIONS)		Col	l unty			
				00			
2.00	City, State, ZIP Code, County		ADAMS				2.00
		Tuesday		esday		sday	
		to	from	to	from	to	
	Facility hours of operations (1)	6. 00	7. 00	8. 00	9. 00	10.00	
	CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00	11. 00
	!	1 7 7	1 1 1 1		0.5 5 5 5		

Health Financial Systems	BLESSING F	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0015	Peri od:	Worksheet S-8	
				From 10/01/2022		
		Component	CCN: 14-3422	To 09/30/2023		
					12/29/2023 3:	54 pm
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11. 00

IOSPI	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der CC	N: 14-0015	Peri od:	Worksheet S-8	3
			Component C	CCN: 14-8629	From 10/01/2022 To 09/30/2023		
					RHC II	Cost	
					1	00	+
	Clinic Address and Identification						
. 00	Street		1		4800 MAINE	71001	1.
			Ci -		State 2.00	ZIP Code 3.00	
. 00	City, State, ZIP Code, County		QUINCY	50		62301	2.
						1 00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rurs	al or "II" for u	rhan		1.00	3.
. 00	THOSE THE BROCK FUNDS ONET. BOST GRACTION ENCO	JI K TOI TUIC	1 01 0 101 41		nt Award	Date	, <u>J.</u>
					1. 00	2. 00	
. 00	Source of Federal Funds  Community Health Center (Section 330(d), PHS	Δct)	T			Ι	4.
. 00	Migrant Health Center (Section 329(d), PHS Ac						5.
. 00	Health Services for the Homeless (Section 340	O(d), PHS Act)					6.
'. 00 3. 00	Appalachian Regional Commission Look-Alikes						7. 8.
. 00	OTHER (SPECIFY)						9.
0.00	Does this facility operate as other than a ho	penital based F	DUC or EOUC2 En	tor "V" for	1. 00 N	2.00	10.
0.00	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of o	other operations	s in column	IN IN		10.
		Sun	day	M	onday	Tuesday	
		from	to	from	to	from	_
	Facility hours of operations (1)	1.00	2.00	3. 00	4. 00	5. 00	
1. 00	CLINIC						11.
					1.00	2.00	
2. 00	Have you received an approval for an exception	on to the produ	uctivity standa	rd?	1. 00 N	2. 00	12.
3. 00	1 ''	d in CMS Pub. 1 umn 1. If yes,	100-04, chapter enter in columi	9, section n 2 the	N	C	
					der name	CCN	
4 00	RHC/FQHC name, CCN				1. 00	2.00	14.
4. 00	Miles I dile Hallie, Coli	Y/N	V	XVIII	XIX	Total Visits	17.
		1.00	2.00	3. 00	4. 00	5. 00	
5. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in						15.
	column 1. If yes, enter in columns 2, 3 and	ļ					
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	ļ					
	number of total visits for this provider.	ļ					
	(see instructions)		0	2+1/			
			Cour 4. (				
	City, State, ZIP Code, County		ADAMS				2.
2.00		Tuesday	Wedne	sday	Thur	sday	
2. 00			<del></del>		-		
2.00		to 6.00	from 7.00	to 8.00	from 9.00	to 10.00	

Health Financial Systems	BLESSING F	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0015	Peri od:	Worksheet S-8	
				From 10/01/2022		
		Component	CCN: 14-8629	To 09/30/2023	Date/Time Pre 12/29/2023 3:	
				5110 11		54 pili
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC						11. 00

	n Financial Systems TAL-BASED RHC/FOHC STATISTICAL DATA	BLESSI NG F	Provi der C	°N: 14_0015	Peri od:	eu of Form CMS-: Worksheet S-8	
1031 1	TAL-DASED MICHIGIC STATISTICAL DATA			CCN: 14-8630	From 10/01/2022 To 09/30/2023	!	pared
					RHC III	Cost	54 pii
					1.	. 00	
. 00	Clinic Address and Identification Street				521 EAST MAIN	ST	1. (
1.00			Ci	ty	State	ZIP Code	1. (
				00	2. 00	3.00	
2. 00	City, State, ZIP Code, County		MT STERLING		IL	62353	2. (
						1.00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ento	er "R" for rura	ıl or "U" for u	ırban		1.00	3.0
	<u>,</u>				t Award	Date	
					1. 00	2. 00	
4. 00	Source of Federal Funds  Community Health Center (Section 330(d), PHS	Act)		I		Т	4.0
5. 00	Mi grant Health Center (Section 329(d), PHS Ac						5.0
. 00	Health Services for the Homeless (Section 340						6. (
7. 00	Appal achi an Regi onal Commissi on						7. 0
3. 00 9. 00	Look-Alikes OTHER (SPECIFY)						9. 0
7. 00	TOTHER (SPECIFY)						9. (
					1. 00	2.00	
0. 00	Does this facility operate as other than a house or "N" for no in column 1. If yes, indicated 2. (Enter in subscripts of line 11 the type of hours.)	ate number of o	ther operation	s in column	N	0	10. 0
	110df 3. <i>j</i>	Sun	day	Me	onday	Tuesday	
		from	to	from	to	from	
		1. 00	2. 00	3. 00	4. 00	5. 00	
11 00	Facility hours of operations (1)			08: 00	17: 00	08: 00	11. (
11.00	OLI MI O			00.00	17.00	00.00	11.0
					1. 00	2. 00	
12. 00 13. 00	1 ''	d in CMS Pub. 1 umn 1. If yes,	00-04, chapter enter in colum	9, section on 2 the	N N	0	12. 0 13. 0
					<del></del>		
	Themselve selven.				der name	CCN	
14.00					der name 1.00	2. 00	14.6
14. 00	RHC/FQHC name, CCN	V/N	V		1. 00	2. 00	14. (
14. 00		Y/N 1.00	V 2.00				14. (
	RHC/FQHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	1.00	-	XVIII	1. 00 XI X	2.00 Total Visits	
	RHC/FQHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	1.00	-	XVIII	1. 00 XI X	2.00 Total Visits	
	RHC/FQHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	1.00	2.00	XVIII 3.00	1. 00 XI X	2.00 Total Visits	
	RHC/FOHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1.00	2. 00 Cou	XVIII 3.00	1. 00 XI X	2.00 Total Visits	
15. 00	RHC/FQHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2. 00 Cou 4.	XVIII 3.00	1. 00 XI X	2.00 Total Visits	15. (
15. 00	RHC/FOHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1.00	2. 00 Cou 4. BROWN	XVIII 3.00	X1 X 4. 00	2.00 Total Visits	14. 0
	RHC/FQHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Tuesday	2.00  Cou 4.  BROWN  Wedne	XVIII 3.00  inty 00 esday to	1.00  XIX  4.00  Thur	2.00  Total Visits 5.00	15. 0
15. 00	RHC/FQHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2.00  Cou 4.  BROWN  Wedne	XVIII 3.00  inty 00  esday	1. 00 XI X 4. 00	2.00  Total Visits 5.00	15. 0

Health Financial Systems	BLESSI NG	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0015	Peri od:	Worksheet S-8	
		Component	CCN, 14 0420	From 10/01/2022		nonod.
		Component	CCN: 14-8630	To 09/30/2023	12/29/2023 3:	
				RHC III	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00   CLI NI C	08: 00	17: 00				11. 00

Heal th	Financial Systems	BLESSING F	HOSPI TAL		In Lie	u of Form CMS	-2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0015	Peri od:	Worksheet S-	8
			Component	CCN: 14-8631	From 10/01/2022 To 09/30/2023		
					RHC IV	12/29/2023 3 Cost	: 54 piii
						,	
	[				1.	00	
	Clinic Address and Identification				927 BROADWAY		1 00
1.00	Street		Ci	ty	State	ZIP Code	1.00
				00	2.00	3. 00	
2.00	City, State, ZIP Code, County		QUI NCY		IL	62301	2. 00
						1 00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ento	er "R" for rura	al or "II" for i	ırhan		1. 00	0 3.00
0.00	THOUT THE BROED TRIES ONET. Designation Ent	or it for fare			nt Award	Date	0.00
					1.00	2. 00	
4 00	Source of Federal Funds	A 15		T			4 00
4. 00 5. 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A						4. 00 5. 00
6. 00	Health Services for the Homeless (Section 34)						6.00
7. 00	Appal achi an Regi onal Commissi on						7. 00
8.00	Look-Alikes						8. 00
9. 00	OTHER (SPECIFY)						9. 00
					1. 00	2. 00	
10. 00	Does this facility operate as other than a he	ospital-based R	RHC or FQHC? Er	iter "Y" for	N		0 10.00
	yes or "N" for no in column 1. If yes, indica 2.(Enter in subscripts of line 11 the type or						
	hours.)	Sun	day	I .	Monday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3. 00	4. 00	5. 00	
	Facility hours of operations (1)						
11. 00	CLINIC						11. 00
					1. 00	2. 00	
12. 00	Have you received an approval for an exception	on to the produ	uctivity standa	ırd?	N	2.00	12. 00
13. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in coll number of providers included in this report.	umn 1. If yes,	enter in colum	n 2 the	N		0 13.00
	numbers below.			Drov	ider name	CCN	
				FIOV	1. 00	2. 00	
14. 00	RHC/FQHC name, CCN						14. 00
		Y/N	V	XVIII	XIX	Total Visits	
1E 00	Have you provided all or substantially all	1.00	2. 00	3.00	4. 00	5. 00	15 00
15. 00	GME cost? Enter "Y" for yes or "N" for no in						15. 00
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)						
				inty			
2 00	City, State, ZIP Code, County		ADAMS 4.	00			2.00
2.00	Torry, State, Zir Coue, County	Tuesday		esday	Thur	sday	2.00
		to	from	to	from	to	
		6. 00	7. 00	8. 00	9. 00	10.00	
11 00	Facility hours of operations (1)			1			14.00
11.00	CLI NI C	1	I	I	1	l	11. 00

Health Financial Systems	BLESSING F	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0015	Peri od:	Worksheet S-8	1
				From 10/01/2022		
		Component	CCN: 14-8631	To 09/30/2023		
					12/29/2023 3:	54 pm
				RHC I V	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC						11. 00

OSPI	n Financial Systems TAL-BASED RHC/FQHC STATISTICAL DATA	BLESSING I	Provi der C	CN: 14-0015	Peri od:	eu of Form CMS- Worksheet S-8	
			Component	CCN: 14-8634	From 10/01/2022 To 09/30/2023		
					RHC V	Cost	
						-00	4
	Clinic Address and Identification				1.	. 00	
00	Street				420 N 34TH STR	EET	1
			Ci	ty	State	ZIP Code	
	Taxable and the second			00	2. 00	3. 00	
00	City, State, ZIP Code, County		QUI NCY			62301	2
						1. 00	
00	HOSPITAL-BASED FOHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for ι	rban		0	3
					nt Award	Date	
	Course of Fodoral Funda			•	1. 00	2. 00	
00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)					4
00	Mi grant Health Center (Section 329(d), PHS Ad						5
OC	Health Services for the Homeless (Section 340	O(d), PHS Act)					6
00	Appal achi an Regional Commission						7
00 00	Look-Alikes OTHER (SPECIFY)						8
	Torrier (or correspond						
					1. 00	2. 00	
. 00	Does this facility operate as other than a house or "N" for no in column 1. If yes, indicated 2. (Enter in subscripts of line 11 the type of hours.)	ite number of d	other operation	s in column	N	0	10
	Theat of y	Sun	ıday	Monday		Tuesday	
		from	to	from	to	from	
	F:   :   t	1. 00	2. 00	3. 00	4. 00	5. 00	-
00	Facility hours of operations (1)						11
	JOET IN C						
					1. 00	2. 00	
. 00	1 3	in CMS Pub. 1 umn 1. If yes,	100-04, chapter enter in colum	9, section in 2 the	N	0	12
	Trumber's berow.			,	der name	CCN	
	Trumber 5 berow.						+
00					1. 00	2. 00	1.1
. 00	RHC/FQHC name, CCN	Y/N	I v	•	1. 00	2. 00	14
. 00		Y/N 1.00	V 2.00				14
	RHC/FOHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.			XVIII	1. 00 XI X	2.00 Total Visits	
	RHC/FQHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the		2.00	XVIII 3.00	1. 00 XI X	2.00 Total Visits	
	RHC/FOHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.		2.00 Cou	XVIII 3.00	1. 00 XI X	2.00 Total Visits	
. 00	RHC/FOHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1.00	2.00 Cou	XVIII 3.00	1. 00 XI X	2.00 Total Visits	15
5. 00	RHC/FQHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2.00  Cou  4.  ADAMS  Wedne	XVIII 3.00  nty 00 esday	1. 00  XI X  4. 00	2.00 Total Visits 5.00	15
5.00	RHC/FQHC name, CCN  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2.00  Cou	XVIII 3.00	1. 00 XI X 4. 00	2.00 Total Visits 5.00	14

Health Financial Systems	BLESSING HOSPITAL			In Lieu of Form CMS-2552-10			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0015	Peri od:	Worksheet S-8		
				From 10/01/2022			
		Component	CCN: 14-8634	To 09/30/2023			
					12/29/2023 3:	54 pm_	
				RHC V	Cost		
	Fri	day	Sa	turday			
	from	to	from	to			
	11. 00	12.00	13. 00	14. 00			
Facility hours of operations (1)							
11. 00 CLINIC						11. 00	

Heal th	Financial Systems	BLESSI NG I	HOSPI TAL		In Lie	u of Form CMS	-2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0015	Peri od:	Worksheet S-	8
			Component	CCN: 14-8635	From 10/01/2022 To 09/30/2023		
					RHC VI	12/29/2023 3 Cost	5: 54 pm
					KIIC VI		
	F				1.	00	
1. 00	Clinic Address and Identification				1005 BROADWAY		1.00
1.00	Street		Ci	ty	State	ZIP Code	1.00
				00	2.00	3. 00	
2.00	City, State, ZIP Code, County		QUI NCY			62301	2. 00
						1. 00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ento	er "R" for rura	al or "U" for u	ırban			0 3.00
-	, <u>, , , , , , , , , , , , , , , , , , </u>				nt Award	Date	
					1. 00	2. 00	
4 00	Source of Federal Funds	A - + \		I			4 00
4. 00 5. 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A						4. 00 5. 00
6. 00	Health Services for the Homeless (Section 34)						6. 00
7. 00	Appal achi an Regional Commission	. (2),					7. 00
8.00	Look-Alikes						8. 00
9. 00	OTHER (SPECIFY)						9. 00
					1. 00	2. 00	
10. 00	Does this facility operate as other than a he	ospi tal -based R	RHC or FQHC? Er	iter "Y" for	1. 00 N		0 10.00
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of o	other operation	s in column			
	illoui s. )	Sun	day	l .	 Monday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3. 00	4. 00	5. 00	
	Facility hours of operations (1)		l	ı			11 00
11.00	CLINIC						11. 00
					1. 00	2. 00	
12. 00 13. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colonumber of providers included in this report. In numbers below.	d in CMS Pub. 1 umn 1. If yes,		12. 00 0 13. 00			
	Thamber of Ser em			Prov	ider name	CCN	
					1. 00	2. 00	
14. 00	RHC/FQHC name, CCN	V /N	l v	V0/1-1-1	VIV	T-+-! \(' -' +-	14. 00
		Y/N 1.00	2. 00	3. 00	XI X 4. 00	Total Visits 5.00	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				4. 00	3.00	15. 00
				inty			
2 00	City, State, ZIP Code, County		ADAMS 4.	00			2.00
2.00	Tority, State, ZIP Code, County	Tuesday		esday Thur		sday	2.00
		to	from	to	from	to	
		6.00	7. 00	8. 00	9. 00	10.00	
44.55	Facility hours of operations (1)						4.5.5-
11.00	CLI NI C	1	l	l			11. 00

Health Financial Systems	BLESSING HOSPITAL			In Lieu of Form CMS-2552-10			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provi der C	CN: 14-0015	Peri od:	Worksheet S-8			
				From 10/01/2022			
		Component	CCN: 14-8635	To 09/30/2023	12/29/2023 3:		
				RHC VI	Cost		
	Fri	day	Sa	turday			
	from	to	from	to			
	11. 00	12.00	13. 00	14. 00			
Facility hours of operations (1)							
11. 00 CLINIC						11. 00	

Heal th	Financial Systems	BLESSI NG I	HOSPI TAL		In Lie	u of Form CMS	-2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 14-0015	Peri od:	Worksheet S-	
			Component	CCN: 26-8800	From 10/01/2022 To 09/30/2023	Date/Time Pr 12/29/2023 3	
					RHC VII	Cost	. 0 1 piii
	Clinic Address and Identification				1.	00	
1.00	Clinic Address and Identification Street				100 MEDICAL DR	I VF	1.00
1.00	011001		Ci	ty	State	ZIP Code	1.00
				00	2. 00	3. 00	
2.00	City, State, ZIP Code, County		HANNI BAL		MO	63401	2. 00
						1. 00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for u	ırban			0 3.00
					nt Award	Date	3.00
	To a second seco				1. 00	2. 00	
4 00	Source of Federal Funds	A - + >		I			4 00
4. 00 5. 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS Ac						4. 00 5. 00
6. 00	Health Services for the Homeless (Section 340						6. 00
7. 00	Appal achi an Regi onal Commissi on						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 ho	ospi tal -based F	RHC or FQHC? Er	iter "Y" for	N N		0 10.00
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)						
	illoui 3. )	Sun	day	l N	londay	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3. 00	4. 00	5. 00	
11 00	Facility hours of operations (1)		I	1			11 00
11.00	CEINIC						11. 00
					1. 00	2. 00	
12. 00 13. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapter enter in colum	9, section nn 2 the	N		12. 00 0 13. 00
	numbers below.			_			
					ider name 1.00	2. 00	
14.00	RHC/FQHC name, CCN				1.00	2.00	14. 00
	,	Y/N	V	XVIII	XIX	Total Visits	
	T	1.00	2.00	3. 00	4. 00	5. 00	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15. 00
				inty			
2.00	City, State, ZIP Code, County		MARI ON	00			2.00
2.00	Torry, State, ZIP Code, County	Tuesday		esday	Thur	sday	2. 00
		to	from	to	from	to	
		6.00	7. 00	8. 00	9. 00	10.00	
	Facility hours of operations (1)						
11.00	CLI NI C		l	1			11. 00

Health Financial Systems	BLESSING HOSPITAL			In Lieu of Form CMS-2552-10			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0015	Peri od:	Worksheet S-8		
				From 10/01/2022			
		Component	CCN: 26-8800	To 09/30/2023	Date/Time Pre 12/29/2023 3:		
				RHC VII	Cost		
	Fri	day	Sa	turday			
	from	to	from	to			
	11. 00	12.00	13. 00	14. 00			
Facility hours of operations (1)							
11. 00 CLINIC						11. 00	

Heal th	Financial Systems	BLESSING F	HOSPI TAL		In Lie	eu of Form CMS	S-2552-
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0015	Peri od:	Worksheet S	-8
			Component	CCN: 26-8801	From 10/01/2022 To 09/30/2023		
					RHC VIII	12/29/2023 Cost	
					1010 1111		
					1.	00	
1 00	Clinic Address and Identification				(OO) COUNTY DO	AD 22/	
1. 00	Street		Ci	ty	6996 COUNTY RO	ZIP Code	1.
				00	2. 00	3. 00	
2.00	City, State, ZIP Code, County		PALMYRA			63461	2.
						1.00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ento	or "D" for rura	d or "II" for i	ırhan		1. 00	0 3.
3.00	HOSPITAL-BASED FUNCS UNLT. DESIGNATION - ENT	ei k ioi iuia	11 01 0 101 0		nt Award	Date	0 3.
					1. 00	2.00	
•	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS						4.
5. 00 6. 00	Migrant Health Center (Section 329(d), PHS Ad Health Services for the Homeless (Section 340						5. 6.
7. 00	Appalachian Regional Commission	o(d), THS ACT)					7.
8.00	Look-Alikes						8.
9.00	OTHER (SPECIFY)						9.
					1.00	2.00	
10. 00	Does this facility operate as other than a ho	osnital-hased R	RHC or FOHC2 Fr	iter "Y" for	1. 00 N	2. 00	0 10.
10.00	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of c	other operation	s in column			
		Sun	day	N	londay	Tuesday	
		from	to	from	to	from	
	- · · · · · · · · · · · · · · · · · · ·	1.00	2.00	3. 00	4. 00	5. 00	
11 00	Facility hours of operations (1)			1			11.
11.00	TOET NIT C						11.
					1. 00	2. 00	
12. 00 13. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columnumber of providers included in this report. In numbers below.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapter enter in colum	9, section in 2 the	N		0 13.
	Trainber 3 ber ow.			Prov	ider name	CCN	
					1.00	2. 00	
14. 00	RHC/FQHC name, CCN	V /N	l v	VV/III	VIV	Total Vicita	14.
		Y/N 1.00	2. 00	3. 00	XI X 4. 00	Total Visits 5.00	>
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				4. 00	5. 00	15.
				inty			
2 00	City, State, ZIP Code, County		MARI ON	00			2.
2.00	Torry, State, Zir Code, County	Tuesday		esday	Thur	sday	2.
		to	from	to	from	to	
		6.00	7. 00	8. 00	9. 00	10. 00	
44.05	Facility hours of operations (1)						
11.00	CLI NI C	I	I	I		l	11.

Health Financial Systems	BLESSI NG 1	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0015	Peri od:	Worksheet S-8	
				From 10/01/2022		
		Component	CCN: 26-8801	10 09/30/2023	Date/Time Pre 12/29/2023 3:	
				RHC VIII	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC						11. 00

Heal th	Financial Systems	BLESSI NG I	HOSPI TAL		In Lie	eu of Form CMS	-2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0015	Peri od:	Worksheet S-	-8
			Component	CCN: 26-8802	From 10/01/2022 To 09/30/2023	Date/Time Pr 12/29/2023 3	
					RHC I X	Cost	7. 54 piii
					1.	00	
1. 00	Clinic Address and Identification Street				710 BUSI NESS 6	1 SOUTU	1.00
1.00	JSH 66 t		Ci	ty	State	ZIP Code	1.00
				00	2.00	3. 00	
2.00	City, State, ZIP Code, County		BOWLING GREEN		MO	63334	2. 00
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	or "D" for rurs	al or "II" for i	ırhan		1.00	0 3.00
3.00	HOSPITAL-BASED FUNCS ONLY. DESIGNATION - EITE	el K TOLTULA	11 01 0 101 0		nt Award	Date	3.00
					1. 00	2.00	
	Source of Federal Funds			•			
4.00	Community Health Center (Section 330(d), PHS						4. 00
5.00	Migrant Health Center (Section 329(d), PHS Ad						5. 00
6.00	Health Services for the Homeless (Section 340	D(d), PHS Act)					6.00
7. 00 8. 00	Appalachian Regional Commission Look-Alikes						7. 00 8. 00
9. 00	OTHER (SPECIFY)						9. 00
7.00	Torrier (or correspond						7.00
					1. 00	2. 00	
10. 00	Does this facility operate as other than a hoyes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of o	other operation	ns in column	N		0 10.00
	11001 3. )	Sun	iday	l N	londay	Tuesday	
		from	to	from	to	from	
	- · · · · · · · · · · · · · · · · · · ·	1. 00	2. 00	3. 00	4. 00	5. 00	
11 00	Facility hours of operations (1)	I	1				11 00
11.00	CLINIC						11. 00
					1. 00	2.00	
12. 00 13. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column number of providers included in this report.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapter enter in colum	9, section nn 2 the	N		12. 00 0 13. 00
				Prov	ider name	CCN	
					1. 00	2. 00	
14.00	RHC/FQHC name, CCN						14. 00
		Y/N	V 2.00	XVIII	XIX	Total Visits	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2.00	3.00	4.00	5. 00	15. 00
				inty			
2.00	City Ctate 7ID Code County			00			2.00
2.00	City, State, ZIP Code, County	Tuesday	PI KE Wedn	esday	Thur	sday	2. 00
		to	from	to	from	to	
		6.00	7. 00	8. 00	9. 00	10.00	
	Facility hours of operations (1)						
11. 00	CLINIC						11. 00

Health Financial Systems	BLESSING F	IOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-0015	Peri od:	Worksheet S-8	
				From 10/01/2022		
		Component	CCN: 26-8802	To 09/30/2023	Date/lime Pre 12/29/2023 3:	
				RHC IX	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC						11. 00

Heal th Financial Systems   BLESSING HOSPITAL   In Lieu of Form CMS-2552-10				D. 500. NO.				6.5	
Hospice CN: 14-1501   From 10/01/2022   PARTS   TRROUGH IV Date/Time Prepared: 12/29/2023 3:54 pm			DATA	BLESSING		CN. 14 001E			
Hospice CN: 14-1501   To 09/30/2023   Date/Time Prepared: 12/29/2023 3:54 pm	HUSPI I	AL-BASED HOSPICE IDENTIFICATION	DATA		Provider C	CN: 14-0015			
Displays					Hospi ce CCI	N: 14-1501		Date/Time Pre	pared:
Unduplicated   Days					-			12/29/2023 3:	54 pm_
Days   Title XVIII   Title XIX   Title XVIII   Title XIX   Nursing   Facility   Skilled   Nursing   Facility   Skilled   Nursing   Facility   Skilled   Nursing   Facility   Skilled   Nursing   Facility   Skilled   Nursing   Facility   Skilled   Nursing   Facility   Skilled   Nursing   Facility   Skilled   Nursing   Facility   Skilled   Nursing   Facility   Skilled   Nursing   Facility   Skilled   Nursing   Facility   Skilled   Nursing   Facility   Skilled   Nursing   Facility   Skilled   Nursing   Facility   Skilled   Nursing   Facility   Skilled							Hospi ce I		
Title XVIII   Title XIX									
Skilled   Nursing   Facility				Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
Nursing Facility   5)			THE XVIII	TI LIC XIX			All other		
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015   1.00   2.00   3.00   4.00   5.00   6.00   1.00									
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015   1.00   Hospice Continuous Home Care								,	
1.00							5. 00	6. 00	
2.00			OST REPORTING F	PERI ODS BEGINNI	NG BEFORE OCTO	BER 1, 2015			
3.00									
4.00   Hospice General Inpatient Care									
Total Hospice Days									1
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015  6.00 Number of patients receiving hospice care  7.00 Total number of unduplicated Continuous Care hours billable to Medicare  8.00 Average Length of Stay (line 5 / line 6)  9.00 Unduplicated census count  NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.  Title XVIII Title XIX Other Total (sum of cols. 1 through 3)  1.00 2.00 3.00 4.00  PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015  10.00 Hospice Continuous Home Care 18,500 733 816 20,049 11.00  11.00 Hospice Routine Home Care 18,500 733 816 20,049 11.00  12.00 Hospice General Inpatient Care 520 40 37 597 13.00  14.00 Total Hospice Days 773 853 20,661 14.00  15.00 Hospice Inpatient Respite Care 15 0 0 0 15 12.00  16.00 Hospice Inpatient Respite Care 15 0 0 0 15 15.00  17.00 Hospice Inpatient Respite Care 15 0 0 0 15 15.00  18.00 Hospice Inpatient Respite Care 15 0 0 0 15 15.00  19.00 Hospice Inpatient Respite Care 15 0 0 0 15 15.00					•				
6.00   Number of patients receiving hospice care	5.00		REPORTING PERI	ODS REGINNING	REFORE OCTORER	2 1 2015			3.00
Note	6 00		KEI OKTTNO TEKI	DEGITIMITIES	DEFORE GOTOBER	1, 2010			6.00
Continuous Care hour's billable to Medicare	0.00								0.00
Title XVIII   Title XIX   Other   Total (sum of cols. 1 through 3)	7.00	Total number of unduplicated							7. 00
8.00   Average Length of Stay (line 5   9.00   Unduplicated census count   9.00   Unduplicated census count   9.00    NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.    Title XVIII   Title XIX   Other   Total (sum of cols. 1 through 3)									
9.00   Unduplicated census count   9.00   NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.     Title XVIII									
9.00 Unduplicated census count  NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.  Title XVIII	8. 00								8. 00
NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.    Title XVIII	0.00								0.00
Title XVIII   Title XIX   Other   Total (sum of cols. 1 through 3)   1.00   2.00   3.00   4.00		<u> </u>		<u> </u>	<u> </u>	2 1 4			9.00
Col s. 1   through 3	NOTE:	Parts I and II, columns I and 2	arso include	the days report		3 and 4.			
No.   No.					Title XVIII	Title XIX	0ther		
1.00   2.00   3.00   4.00									
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015   10.00   Hospice Continuous Home Care					1.00	0.00	2.00		
10.00   Hospi ce Conti nuous Home Care   0 0 0 0 0 0 10.00   11.00   12.00   Hospi ce Routi ne Home Care   18,500 733 816 20,049 11.00   12.00   Hospi ce Inpatient Respi te Care   15 0 0 0 15 12.00   13.00   14.00   14.00   15.0		DADT III FNDOLIMENT DAVE FOR	COCT DEDODTING	DEDLODE DECLA				4.00	
11.00	10 00		CUST REPURITING	PERIODS BEGIN	INTING ON OR AFT	ER UCTUBER I			10 00
12.00   Hospi ce Inpatient Respite Care   15					18 500	7	-		
13.00 Hospi ce General Inpati ent Care 520 40 37 597 13.00  14.00 Total Hospi ce Days 19,035 773 853 20,661  PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015  15.00 Hospi ce Inpati ent Respi te Care 15 0 0 15 15.00						1			•
14.00     Total Hospice Days     19,035     773     853     20,661     14.00       PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015       15.00     Hospice Inpatient Respite Care     15     0     0     15     15.00						1			
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015  15.00 Hospice Inpatient Respite Care  15 0 0 15 15.00									
15. 00 Hospi ce Inpati ent Respi te Care 15 0 0 15 15. 00			AL DATA FOR COS	ST REPORTING PE					
16. 00   Hospi ce General Inpatient Care     520   40   37   597   16. 00									
	16. 00	Hospice General Inpatient Care			520	1	40 37	597	16. 00

OSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 14-0015	Peri od: From 10/01/2022	Worksheet S-10 Parts I & II	0
				To 09/30/2023	Date/Time Pre 12/29/2023 3:	pared 54 pm
					1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA					
	Uncompensated and Indigent Care Cost-to-Charge Ratio					
00	Cost to charge ratio (see instructions)				0. 185237	1. (
	Medicaid (see instructions for each line)					_
00	Net revenue from Medicaid				39, 978, 295	
00	Did you receive DSH or supplemental payments from Medicaid?		- 6 W!: -	-: -10	Y	3.
00	If line 3 is yes, does line 2 include all DSH and/or supplements			ai d?	N 14 137 130	4.
00 00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid charges	on wearcar	u		14, 136, 130 388, 797, 997	5. 6.
00	Medicaid cost (line 1 times line 6)				72, 019, 775	
00	Difference between net revenue and costs for Medicaid program (	see instru	ctions)		17, 905, 350	
00	Children's Health Insurance Program (CHIP) (see instructions for				17, 700, 000	0.
00	Net revenue from stand-alone CHIP	00011 11111	<u> </u>		0	9.
. 00	Stand-alone CHIP charges				0	10.
. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11.
00	Difference between net revenue and costs for stand-alone CHIP (	see instru	ctions)		0	12.
	Other state or local government indigent care program (see insti	ructions fo	or each line	)		
00	Net revenue from state or local indigent care program (Not incl	uded on li	nes 2, 5 or '	9)	0	13.
00	Charges for patients covered under state or local indigent care	program (	Not included	in lines 6 or	0	14.
	[10]					
00	State or local indigent care program cost (line 1 times line 14)		,		0	15.
00	Difference between net revenue and costs for state or local indi				0	16.
	Grants, donations and total unreimbursed cost for Medicaid, CHIF	and State	ezrocar indig	gent care program	is (see	
00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to full</pre>	ndi ng char	ity care		0	17.
00	Government grants, appropriations or transfers for support of he	-	-		0	
00	Total unreimbursed cost for Medicaid, CHIP and state and local			s (sum of lines	17, 905, 350	•
00	8, 12 and 16)	riiai goire	oar o program	5 (Sum St 111165	, , , , , , , , , , , , , , , , , ,	
			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
	Uncompensated care cost (see instructions for each line)		1. 00	2. 00	3. 00	
00	Charity care charges and uninsured discounts (see instructions)		17, 653, 5	32 3, 874, 005	21, 527, 537	20.
00	Cost of patients approved for charity care and uninsured discour	nts (see	3, 270, 0			
	instructions)		., .,		, , , , , ,	
00	Payments received from patients for amounts previously written	off as		0 0	0	22.
	charity care					
00	Cost of charity care (see instructions)		3, 270, 0	87 3, 874, 005	7, 144, 092	23.
					1 00	
00	Does the amount on line 20 col. 2, include charges for patient of	daye bayan	d a Lanath a	f ctov limit	1. 00 N	24.
00	imposed on patients covered by Medicaid or other indigent care		u a rength o	ı Stayırımı t	IN	24.
00	If line 24 is yes, enter the charges for patient days beyond the		care progra	m's Lenath of	0	25.
00	stay limit	c margent	care progra	. S rength of	U	20.
01	Charges for insured patients' liability (see instructions)				0	25.
00	Bad debt amount (see instructions)				14, 463, 220	
00					529, 794	
01	Medicare allowable bad debts (see instructions)				815, 069	•
00	Non-Medicare bad debt amount (see instructions)				13, 648, 151	28.

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

2, 813, 418 29. 00 9, 957, 510 30. 00 27, 862, 860 31. 00

SPITAL UNCOMPENSATED AND INDIGENT CAR	E DATA	Provider CC	CN: 14-0015	Peri od: From 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Pre 12/29/2023 3:	pare	
					1. 00		
PART II - HOSPITAL DATA							
Uncompensated and Indigent Care (	ost-to-Charge Ratio						
00 Cost to charge ratio (see instru					0. 163018	1	
Medicaid (see instructions for ea	ch line)						
Net revenue from Medicaid						2	
Did you receive DSH or supplement	al payments from Medicaid?					3	
00 If line 3 is yes, does line 2 inc				ai d?		4	
OO    If line 4 is no, then enter DSH a	and/or supplemental payments	from Medicai	d			5	
00 Medicaid charges						6	
Medicaid cost (line 1 times line						7	
Difference between net revenue an						8	
Children's Health Insurance Progr		Tor each line	9)				
Net revenue from stand-alone CHII OO Stand-alone CHIP charges	•					10	
	os lino 10)					11	
Other state or local government i				)		12	
00 Net revenue from state or local i						13	
O Charges for patients covered under state or local indigent care program (Not included in lines 6 or							
10)		p9 (				14	
00 State or local indigent care production	ıram cost (line 1 times line	14)				15	
						16	
Grants, donations and total unrei	mbursed cost for Medicaid,	CHIP and state	e/Local indi	gent care program	is (see		
instructions for each line)							
00 Private grants, donations, or end		0	,			17	
00 Government grants, appropriations	• •					18	
.00 Total unreimbursed cost for Medic	caid, CHIP and state and Id	ical indigent	care program	s (sum of lines		19	
8, 12 and 16)			Uni nsured	Insured	Total (col. 1		
			patients	pati ents	+ col . 2)		
			1. 00	2. 00	3. 00		
Uncompensated care cost (see inst	ructions for each line)						
00 Charity care charges and uninsure	ed discounts (see instructio	ns)	17, 653, 5	32 3, 874, 005	21, 527, 537	20	
00 Cost of patients approved for cha	nrity care and uninsured dis	counts (see	2, 877, 8	43 3, 874, 005	6, 751, 848	2	
instructions)					_	١	
00 Payments received from patients	for amounts previously writt	en off as		0 0	0	22	
charity care	.+:>		2 077 0	2 074 005	/ 751 040	1 2	
00 Cost of charity care (see instru	ctions)		2, 877, 8	43 3, 874, 005	6, 751, 848	23	
					1. 00	$\vdash$	
00 Does the amount on line 20 col.	) include charges for natio	ent days hevon	d a Length o	f stav limit	N N	24	
imposed on patients covered by Me			a a rength o	i Stay iiiii t	IN	27	
00 If line 24 is yes, enter the chair			care progra	m's Length of	0	25	
stay limit	grant and days beyond	oai goitt	-3. 5 p. 591 a	2 . ogtii oi		1	
01 Charges for insured patients' lia	ability (see instructions)				0	25	
00 Bad debt amount (see instructions					14, 463, 220	26	
00 Medicare reimbursable bad debts					519, 619		
.01 Medicare allowable bad debts (see	e instructions)				799, 415	27	
00 Non-Medicare bad debt amount (see	e instructions)				13, 663, 805	28	
00 Cost of non-Medicare and non-reig					2 507 242		

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

2, 507, 242 29. 00 9, 259, 090 30. 00 9, 259, 090 31. 00

Cost Center Description		Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	BLESSING HO		CN: 14-0015 F	<u>In Lie</u> Period:	eu of Form CMS-: Worksheet A	2552-10
Cost Center Description	KLULAS	STITICATION AND ADJUSTMENTS OF TRIAL BALANCE O	I LAFLINGES	Frovider C	F	rom 10/01/2022		
Column					1	o 09/30/2023	Date/Time Pre	pared: 54 nm
		Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		l piii
					+ col . 2)	ons (See A-6)		
December   December			1.00	2.00	3.00	4. 00		
1.01 DIOTI] CAM PEL COSTS-BUILER SHILDING  1.02 DIOTI] CAM PEL COSTS-BUILER SHILDING  1.02 DIOTI] CAM PEL COSTS-BUILER SHILDING  1.03 DIOTI] CAM PEL COSTS-BUILER SHILDING  1.04 DIOTI] CAM PEL COSTS-BUILER SHILDING  1.05 DIOTI] CAM PEL COSTS-BUILER SHILDING  1.06 DIOTI] CAM PEL COSTS-BUILER SHILDING  1.07 DIOTI] CAM PEL COSTS-BUILER SHILDING  1.08 DIOTI] CAM PEL COSTS-BUILER SHILDING  1.09 DIOTI] CAM PEL COSTS-BUILER SHILDING  1.00 DIOTI] CAM PEL COSTS-BUILER SHILDING  1.00 DIOTI] CAM PEL COSTS-BUILER SHILDING  1.00 DIOTI] CAM PEL COSTS-BUILER SHILDING  1.00 DIOTI] CAM PEL COSTS-BUILER SHILDING  1.00 DIOTI] CAM PEL COSTS-BUILER SHILDING  1.00 DIOTI] CAM PEL COSTS-BUILER SHILDING  1.00 DIOTI] CAM PEL COSTS-BUILER SHILDING  1.00 DIOTI] CAM PEL COSTS-BUILER SHILDING  1.00 DIOTI] CAM PEL COSTS-BUILDING  1.00 DIOTI]								
1.02   DOTOS   CAP REL COSTS - GLI BLIGS & FI XIURES   1.781, 027				-			-	
1.03   0.0103   CAP REL COSTS-MER BLID & FIXTURES   1.781,021   2.766,698   4.549,619   1.03   1.04   1.05   1.0				-				
1.05   00100  CAP PRIL COSTS -SURCEPY CEPTER   0					1			
1.06   00100  CAP REL COSTS-SINGERY ENTER   0   0   0   0   0   0   1.00				C		4, 029, 596		
1.07   001071 CAP REL COSTS-SURGERY CEPTER   0   0   0   0   0   1.07				C		0	-	
0.000   OLD   CAP REL COSTS-HANNI BEAL				C		Ö	· -	
2.00   0.0200   CAP   REL COSTS-MORLE EQUIP				C	) c	0	0	
3.00   00300   OITHER CAP PEL COSTS   4, 913, 922   53, 922, 302   57, 936, 224   4. 00   004   50, 900		1 1		14 420 024	14 420 024	0	1	1
0.00   0.00   DEPLOYEE BENEFITS DEPARTEINT				14, 430, 930	14, 430, 930	422, 102		
0.000   0.000   MAINTENNINCE & REPAIRS   4, 391, 617   9, 278, 239   13, 629, 856   0   13, 629, 856   6, 00   9, 00   0.000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000			4, 913, 922	53, 022, 302	57, 936, 224	. 0	57, 936, 224	
8.00   00800   LANINDRY & LINEN SERVICE   46, 982   1,552,673   1,609,655   0   1,609,655   8.00			1					
9.00   0.0900   NUSEKEEPING			1					
11.00 0 1100 (CAFETERIA ) 9,995 (109 2, 2,114,822 12,073,317 -67,306 4, 25,907,892 13,00 13.00 1300 (MISS) MISS MAX MINIS STRATION 9,995 (109 1, 2,114,822 12,073,317 -1,706,023 1, 206,622 13,00 0, 2020 (1020) (MISS) MES PROKORAM 1, 4690,801 1, 4690,801 1, 3,680,072 1, 279,1501 1, 706,023 1, 706,0		1 1	1					
13.00   01300   NURSING ADMINISTRATION   9,999   109   2,114, 822   12,073,931   -67,306   12,006,625   13.00		1 1	1		1			
16.00   01600   MEDICAL RECORDS & LIBRARY   5,795,034   1,490,467   7,291,501   0,0   7,291,501   16.00   1.218,372   1.218,		1 1	<u>ا</u>	-	1			
20.00   02000   NURSING PROGRAM   4.690, 801   3., 8690, 072   8. 360, 873   -1, 706, 023   6.654, 859   02.00   02000   1.87 SERVICES-SALARY & FRINGES APPRIVD   1, 278, 372   0, 1, 962, 537   0, 0, 12.78, 372   21.00   02000   1.87 SERVICES-OTHER PREMI COSTS APPRIVD   0   0   0   0   0   0   0   0   0								
22.00   02200   RAY SERVICES_OTHER PROM COSTS APPRVD   0   1, 962, 537   20, 00   20.00   PARAMED ED PROM   0   0   0   0   0   0   0   0   0		02000 NURSI NG PROGRAM			8, 360, 873	-1, 706, 023		1
23 00   02300   PARAMED ED PROM. ABDIOLOGY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1, 278, 372	1 0/0 50				
23.01   02301   PARAMED ED PROM-LABORATORY   0   0   0   663, 993   663, 993   23.01   23.02   02302   PARAMED ED PROM-LABORATORY   0   0   0   0   0   0   0   337, 863   23.03   23.03   02303   PARAMED ED PROM-PERPIRATORY   0   0   0   0   0   0   0   0   0		1 1	0	1, 962, 537				1
23. 03 02303 PARAMED ED PRIGN_PRISNACY 0 0 0 0 20, 567 209, 567 230, 507 209, 567 20			0	C	1	_	663, 993	
23.04   DARAMED ED PRIGN_RESPIRATIORY   0   0   20,9.57   20,9.5			0	C	0			
INPATE INT ROUTINE SERVI CE COST CENTERS   37, 807, 509   16, 255, 692   54, 063, 201   844, 474   54, 907, 673   30, 00   30, 00   3000   ADULTS & PEDIATRIC S   37, 807, 509   16, 255, 692   54, 063, 201   844, 474   54, 907, 675   30, 00   31, 00   3010   INTENSI VE CARE UNIT   6, 399, 414   2, 793, 107   9, 192, 521   -367, 304   8, 825, 217   31, 00   43, 00   4300   NURSERY   7, 2499, 775   41, 00   44, 00   4400   04400   SURPROVIDER - IRF   1, 782, 006   670, 400   432, 176   -62, 046   370, 130   43, 00   44, 00   04400   SKI LLED NURSING FACILITY   1, 782, 006   670, 400   452, 176   -62, 046   370, 130   43, 00   44, 00   04400   OFFICIAL REVISED   SERVICE COST CENTERS   1, 782, 006   670, 400   40, 00   6400   OFFICIAL REVISED   670, 400   40, 366, 915   -20, 303, 042   20, 083, 873   50, 00   50, 00   OFFICIAL REVISED   600, 00   676, 000   076, 707   369, 015   1, 145, 722   -184, 528   961, 194   52, 00   52, 00   05200   DELYERY ROOM & LABOR ROOM   17,6 707   369, 015   1, 145, 722   -184, 528   961, 194   52, 00   53, 00   05300   ARSTHESI OLOSY   218, 623   648, 623   737, 837, 837, 837, 837, 837, 837, 837,			1	15, 346				
1-1 00   03100   INTENSIVE CARE UNIT	23.04		0		ή	204, 307	204, 307	23.04
41 .00   04100   SUBPROVI DER - I RF   1,929,839   579,713   2,509,552   -9,777   2,499,775   41 .00   44 .00   43 .00   04300   NURSERY   364,027   68,149   432,1716   -62,046   370,130   43 .00   04300   NURSERY   1,782,000   670,400   2,452,406   -17,374   2,435,032   44 .00   44 .00   55 .00   55 .00								
43.00   04300   NURSERY   364, 027   68, 149   432, 176   -62, 046   370, 130   43.00			1		1			1
A4 00   O4400   SKILLED NURSING FACILITY			1		1			1
50.00   050000   050000   050000   050000   050000   050000   050000   05000	44.00		1, 782, 006	670, 400	2, 452, 406	-17, 374	2, 435, 032	44. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM   776, 707   369, 015   1, 145, 722   -184, 528   951, 194   \$2.00     53.00   05300   ANESTHESIOLOGY   218, 623   958, 422   1, 177, 045   -452, 208   724, 837   \$3.00     54.00   05400   RADIOLOGY-DIAGNOSTIC   1, 025, 273   379, 284   1, 404, 557   -5, 985   1, 398, 572   \$5.00     55.00   05500   RADIOLOGY-THERAPEUTIC   1, 025, 273   379, 284   1, 404, 557   -5, 985   1, 398, 572   \$5.00     55.00   05500   RADIOLOGY-THERAPEUTIC   1, 025, 273   379, 284   1, 404, 557   -5, 985   1, 398, 572   \$5.00     55.00   05500   CTS CANN CE IMAGING (MRI )   337, 767   167, 604   505, 371   -7, 114   498, 257   \$8.00     60.00   06000   LABORATORY   3, 569, 471   10, 144, 436   13, 713, 907   -32, 616   13, 681, 291   60.00     60.00   06000   LABORATORY   4, 406   4, 436   13, 713, 907   -32, 616   13, 681, 291   60.00     60.00   06000   RESPIRATORY THERAPY   2, 266, 627   715, 160   3, 341, 187   -450, 252   2, 890, 935   65.00     60.00   06000   PHYSI CAL THERAPY   986, 980   3, 594   990, 574   -1, 561   989, 013   67.00     60.00   06000   SPECEL PATHOLOGY   2, 720, 973   10, 118, 993   12, 839, 966   -8, 728, 260   4, 111, 706   69.00     60.00   06000   SPECEL PATHOLOGY   2, 720, 973   10, 118, 993   12, 839, 966   -8, 728, 260   4, 111, 706   69.00     60.00   06000   ELECTROCARDIOLOGY   2, 720, 973   10, 118, 993   12, 839, 966   -8, 728, 260   4, 111, 706   69.00     71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   1, 267, 542   1, 529, 520   2, 797, 062   14, 549, 475   17, 346, 537   71.00     72.00   07200   DRUGS CHARGED TO PATIENTS   5, 177, 651   24, 499, 307   29, 676, 958   628   29, 677, 586   73.00     73.00   07300   DRUGS CHARGED TO PATIENTS   5, 177, 651   24, 499, 307   29, 676, 958   628   29, 677, 586   73.00     73.00   07300   DRUGS CHARGED TO PATIENTS   5, 177, 651   24, 499, 307   29, 676, 958   628   29, 677, 586   73.00     73.00   07300   DRUGS CHARGED TO PATIENTS   5, 177, 651   24, 499, 307   29, 676, 958   628   29, 677, 586   73.00	EO 00		11 220 754	20 OE7 141	40 204 015	20 202 042	20 002 072	   E0 00
53.00   05300   ARSTHESI OLOGY   218, 623   958, 422   1,177, 045   -452, 208   724, 837   53.00			1					1
55.00   05500   RADI OLOGY-THERAPEUTI C   1,025,273   379,284   1,404,557   -5,985   1,398,572   55.00   5700   CT SCAN   653,721   643,723   1,297,444   -81,641   1,215,803   57.00   58.00   05000   MAGNETI C RESONANCE I MAGI NG (MRI )   337,767   167,604   505,371   -7,114   498,257   58.00   06200   MAGNETI C RESONANCE I MAGI NG (MRI )   337,767   167,604   505,371   -7,114   498,257   58.00   06200   MHOLE BLOOD & PACKED RED BLOOD CELLS   201,369   1,199,399   1,400,768   0 1,400,768   0 0,400,768   0 1,400,768   0 0,400,768   0 0,400,768   0 0,400,768   0 0,400,768   0 0,400,768   0 0,400,768   0 0,400,768   0 0,400,768   0 0,400,768   0 0,400,768   0 0,400,768   0 0,400,768   0 0,400,769   0 0,400			1					
57.00   05700   05700   05700   05700   05700   05700   0580			1					
58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI)   337,767   167,604   505,371   -7,114   498,257   88. 00   06000   LABORATORY   3,569,471   10,144,436   13,713,907   -32,616   13,681,291   60. 00   60. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   201,369   1,199,399   1,400,768   0   1,400,768   62. 00   06500   RESPIRATORY THERAPY   2,626,027   715,160   3,341,187   -450,252   2,890,935   65. 00   06500   06700   00CUPATIONAL THERAPY   1,525,328   11,235   1,536,563   0   1,536,563   66. 00   60. 00   00CUPATIONAL THERAPY   986,980   3,594   990,574   -1,561   989,013   67. 00   68. 00   06800   SPEECH PATHOLOGY   2,740,973   10,118,993   12,839,966   -8,728,260   4,111,706   9. 00   70. 00   00CUPATIONAL THERAPY   506,453   237,217   743,670   -5,504   738,166   70. 00   70. 00   00CUPATIONAL THERAPY   506,453   237,217   743,670   -5,504   738,166   70. 00   70. 00   00CUPATIONAL THERAPY   506,453   237,217   743,670   -5,504   738,166   70. 00   70. 00   00CUPATIONAL THERAPY   506,453   237,217   743,670   -5,504   738,166   70. 00   71. 00   00   00   00   00   00   00   00			1		1 ' '			•
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   201, 369   1, 199, 399   1, 400, 768   0   1, 400, 768   65.00   06500   RESPIRATORY THERAPY   2, 626, 027   715, 160   3, 341, 187   -450, 252   2, 890, 935   65.00   06.00   06600   PHYSI CAL THERAPY   1, 525, 328   11, 235   1, 536, 563   0   1, 536, 563   66.00   06.00   0600   0CCUPATI ONAL THERAPY   986, 980   3, 594   990, 574   -1, 561   989, 013   67.00   68.00   06800   SPEECH PATHOLOGY   234, 775   5, 047   239, 822   -260   239, 562   68.00   06900   ELECTROCARDI OLOGY   2, 720, 973   10, 118, 993   12, 839, 966   -8, 728, 260   4, 111, 706   69.00   070, 00   07000   ELECTROENCEPHALGGRAPHY   506, 453   237, 217   743, 670   -5, 504   738, 166   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   1, 267, 542   1, 259, 520   2, 797, 062   14, 549, 475   17, 346, 535   71.00   73.00   07200   IMPL DEV. CHARGED TO PATI ENTS   5, 177, 651   24, 499, 307   29, 676, 958   628   29, 677, 586   73.00   73.00   DRUGS CHARGED TO PATI ENTS   5, 177, 651   24, 499, 307   29, 676, 958   628   29, 677, 586   73.00   73.00   0800   EAST ADAMS RHC   88.00   8800   EAST ADAMS RHC   428, 550   154, 277   582, 827   -1, 260   581, 567   88.01   8801   481H AND MAI NE RHC   1, 833, 542   113, 853   1, 477, 395   88.01   8804   BLESSI NG EXPRESS CLINIC   1, 193, 803   201, 402   1, 395, 205   119, 269   1, 514, 474   88.04   88.05   08805   BLESSI NG WALK IN CLINIC   2, 741, 814   192, 135   2, 933, 949   -1, 917   2, 932, 032   88.05   88.07   88.07   88.08   08808   BWILING RHC   284, 385   41, 347, 955   41, 400   48.0		1 1	1		505, 371	-7, 114		1
65.00   06500   RESPIRATORY THERAPY   2,626,027   715,160   3,341,187   -450,252   2,890,935   65.00   66.00   06600   PHYSI CAL THERAPY   1,525,328   11,235   1,536,563   0   1,536,563   66.00   67.00   060700   OCUPATI ONAL THERAPY   986,990   3,594   999,574   -1,561   989,013   67.00   68.00   06800   SPEECH PATHOLOGY   234,775   5,047   239,822   -260   239,562   68.00   69.00   06900   ELECTROCARDIOLOGY   2,720,973   10,118,993   12,839,966   -8,728,260   4,111,706   69.00   71.00   07000   ELECTROCARDIOLOGY   2,720,973   10,118,993   12,839,966   -8,728,260   4,111,706   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   1,267,542   1,529,520   2,797,062   14,549,475   17,346,537   71.00   72.00   07200   IMPL DEV. CHARGED TO PATIENTS   5,177,651   24,499,307   29,676,958   628   29,677,586   73.00   73.00   07300   RUSC CHARGED TO PATIENTS   5,177,651   24,499,307   29,676,958   628   29,677,586   73.00   74.00   07400   RENAL DI ALYSI S   0   958,157   958,157   -22   958,135    TOUTPATI ENT SERVICE COST CENTERS  88.01   08801   48TH AND MAINE RHC   1,833,542   113,853   1,947,395   0   1,947,395   88.01   88.01   08801   48TH AND MAINE RHC   1,833,542   113,853   1,947,395   119,269   1,514,474   88.03   88.04   08804   BLESSING EXPRESS CLINIC   1,193,803   201,402   1,395,205   119,269   1,514,474   88.03   88.04   08804   BLESSING EXPRESS CLINIC   1,193,803   201,402   1,395,205   119,269   1,514,474   88.04   88.05   08805   BLESSING EXPRESS CLINIC   1,193,803   201,402   1,395,205   119,269   1,514,474   88.04   88.06   08806   BANNIB BAL MAIN RHC   3,385,141   347,954   3,733,095   -511,997   3,221,098   88.06   88.07   08807   PALMYRA RHC   2,448,382   61,949   346,331   27,002   373,333   88.07   88.08   08808   BOWLING GREEN RHC   34,881,915   5,420,817   40,302,732   -47,988   39,354,744   90.00   90.01   09001   0UTPATI ENT I NFUSI ON   34,881,915   55, 420,817   40,302,732   -40,408   662,326   90.02   90.03   04951   HANNIB BAL INIFUSI ON   34,885   55,420,817   40,302,732   -		1 1	1			1		
66. 00   06600   PHYSI CAL THERAPY   1, 525, 328   11, 235   1, 536, 563   0   1, 536, 563   66. 00   67. 00   06700   0   0   0   0   0   0   0   0   0			1					
68. 00   06800   SPECH PATHOLOGY   234, 775   5, 047   239, 822   -260   239, 562   68. 00   69. 00   06900   ELECTROCARDI OLOGY   2, 720, 973   10, 118, 993   12, 839, 966   -8, 728, 260   4, 111, 706   69. 00   70. 00		1 1	1		1			1
69. 00   06900   ELECTROCARDI OLOGY   2, 720, 973   10, 118, 993   12, 839, 966   -8, 728, 260   4, 111, 706   69. 00   70. 00   70. 00   ELECTROCARDI OLOGY   506, 453   237, 217   743, 670   -5, 504   738, 166   70. 00   70. 00   70. 00   ELECTROCARDICORAPHY   506, 453   237, 217   743, 670   -5, 504   738, 166   70. 00   70		1 1	1		1			1
70. 00   07000   ELECTROENCEPHALOGRAPHY   506, 453   237, 217   743, 670   -5, 504   738, 166   70. 00   71. 00   77000   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   1, 267, 542   1, 529, 520   2, 797, 062   14, 549, 475   17, 346, 537   71. 00   72. 00   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   5, 177, 651   24, 499, 307   29, 676, 958   628   29, 677, 586   73. 00   73. 00   07400   RENAL DI ALYSI S   0   958, 157   958, 157   -22   958, 135   74. 00   958, 157   958, 157   -22   958, 135   74. 00		1 1			1			1
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   16, 635, 404   16, 635, 404   72. 00   73.00   07300   DRUGS CHARGED TO PATIENTS   5, 177, 651   24, 499, 307   29, 676, 958   628   29, 677, 586   73. 00   74.00   70.00   RENAL DIALYSIS   0   958, 157   958, 157   -22   958, 135   74. 00   70.00   70.00   RENAL DIALYSIS   0   958, 157   958, 157   -22   958, 135   74. 00   70.00   70.00   RENAL DIALYSIS   0   958, 157   -22   958, 135   74. 00   70.00   70.00   RENAL DIALYSIS   0   958, 157   -22   958, 135   74. 00   70.00   70.00   70.00   RENAL DIALYSIS   0   958, 157   -22   958, 135   74. 00   70.00			1		1			1
73. 00   07300   DRUGS CHARGED TO PATIENTS   5, 177, 651   24, 499, 307   29, 676, 958   628   29, 677, 586   73. 00   74. 00   07400   RENAL DI ALYSI S   0   958, 157   958, 157   958, 157   74. 00   000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   000000			1 1					1
74. 00 O7400 RENAL DIALYSIS O 958, 157 958, 157 -22 958, 135 74. 00 OUTPATIENT SERVICE COST CENTERS  88. 00 08800 FAST ADAMS RHC 561, 067 304, 285 865, 352 49, 250 914, 602 88. 00 8800 8801 48TH AND MAINE RHC 1, 833, 542 113, 853 1, 947, 395 0 1, 947, 395 88. 01 88. 02 08802 MT STERLING RHC 428, 550 154, 277 582, 827 -1, 260 581, 567 88. 02 88. 03 08803 MAIN CAMPUS RHC 15, 743, 052 2, 558, 187 18, 301, 239 -1, 140, 043 17, 161, 196 88. 03 88. 04 08804 BLESSING EXPRESS CLINIC 1, 193, 803 201, 402 1, 395, 205 119, 269 1, 514, 474 88. 04 88. 05 08805 BLESSING WALK IN CLINIC 2, 741, 814 192, 135 2, 933, 949 -1, 917 2, 932, 032 88. 05 08805 BLESSING WALK IN RHC 3, 385, 141 347, 954 3, 733, 095 -511, 997 3, 221, 098 88. 06 08806 HANNI BAL MAIN RHC 3, 385, 141 347, 954 3, 733, 095 -511, 997 3, 221, 098 88. 06 08808 BOWLING GREEN RHC 116, 547 30, 353 146, 900 -8, 877 138, 023 88. 08 08808 BOWLING GREEN RHC 116, 547 30, 353 146, 900 -8, 877 138, 023 88. 08 0808 BOWLING GREEN RHC 116, 547 30, 353 146, 900 -8, 877 138, 023 88. 08 090. 00 09000 CLINIC 34, 881, 915 5, 420, 817 40, 302, 732 -947, 988 39, 354, 744 90. 00 90. 00 09001 OUTPATIENT INFUSION 361, 705 52, 924 414, 629 -3, 776 410, 853 90. 01 90. 02 04950 ONCOLOGY 552, 715 114, 259 666, 974 -4, 648 662, 326 90. 02 90. 03 04951 HANNI BAL INFUSION 23, 115 57 23, 172 0 23, 172 90. 03 91. 00 09100 EMERGENCY 13, 508, 602 2, 776, 100 16, 284, 702 -261, 477 16, 023, 225 91. 00		1 1	1	-	1			
Section   Sect			1 1		1			1
88. 01       08801 d8801 d8801 d8802       48TH AND MAINE RHC       1,833,542 d28,550       113,853 d2,277       1,947,395 d2,2827       -1,260 d581,567 d88.02       88.01 d28,550 d2,277       582,827 d2,277       -1,260 d581,567 d88.02       88.02 d2,558,187 d2,277       582,827 d2,277       -1,260 d581,567 d88.02       88.02 d2,558,187 d2,277       -1,140,043 d2,272       17,161,196 d88.03       88.03 d8,08 d2,278       -1,260 d581,567 d88.02       -1,140,043 d2,273       17,161,196 d88.03       88.03 d8,08 d2,278       -1,260 d581,567 d88.02       -1,140,043 d2,278       17,161,196 d88.03       88.03 d88.03 d88.03       88.05 d880,520 d8,18 d8,1		OUTPATIENT SERVICE COST CENTERS						
88. 02       08802 MT STERLING RHC       428,550       154,277       582,827       -1,260       581,567       88.02         88. 03       08803 MAIN CAMPUS RHC       15,743,052       2,558,187       18,301,239       -1,140,043       17,161,196       88.03         88. 04       08804 BLESSING EXPRESS CLINIC       1,193,803       201,402       1,395,205       119,269       1,514,474       88.04         88. 05       08805 BLESSING WALK IN CLINIC       2,741,814       192,135       2,933,949       -1,917       2,932,032       88.05         88. 07       08807 PALMYRA RHC       3,385,141       347,954       3,733,095       -511,997       3,221,098       88.06         88. 08       08808 BOWLING GREEN RHC       284,382       61,949       346,331       27,002       373,333       88.07         90. 01       09000 CLINIC       34,881,915       5,420,817       40,302,732       -947,988       39,354,744       90.00         90. 01       09001 OUTPATI ENT INFUSION       361,705       52,924       414,629       -3,776       410,833       90.01         90. 03       04951 HANNI BAL INFUSION       23,115       57       23,172       0       23,172       90.03         91. 00       09100 EMERGENCY <t< td=""><td></td><td>1 1</td><td>1</td><td></td><td>1</td><td></td><td></td><td>1</td></t<>		1 1	1		1			1
88. 03       08803 MAI N CAMPUS RHC       15, 743, 052 2, 558, 187       18, 301, 239 1, 402 1, 395, 205 119, 269 1, 514, 474 88. 03         88. 04 08804 BLESSI NG EXPRESS CLINIC       1, 193, 803 201, 402 1, 395, 205 119, 269 1, 514, 474 88. 04         88. 05 08805 BLESSI NG WALK I N CLINIC       2, 741, 814 192, 135 2, 933, 949 -1, 917 2, 932, 032 88. 05         88. 06 08806 HANNI BAL MAI N RHC       3, 385, 141 347, 954 3, 733, 095 -511, 997 3, 221, 098 88. 06         88. 07 08807 PALMYRA RHC       284, 382 61, 949 346, 331 27, 002 373, 333 88. 07         88. 08 08808 BOWLI NG GREEN RHC       116, 547 30, 353 146, 900 -8, 877 138, 023 88. 08         90. 01 09001 OUTPATI ENT I NFUSI ON       361, 705 52, 924 414, 629 -3, 776 410, 833 90. 01         90. 02 04950 ONCOLOGY       552, 715 114, 259 666, 974 -4, 648 662, 326 90. 02         90. 03 04951 HANNI BAL I NFUSI ON       23, 115 57 23, 172 0 23, 172 0 23, 172 90. 03         91. 00 09100 EMERGENCY       13, 508, 602 2, 776, 100 16, 284, 702 -261, 477 16, 023, 225 91. 00		1 1	1		1			
88. 05     08805     BLESSI NG WALK I N CLINI C     2, 741, 814     192, 135     2, 933, 949     -1, 917     2, 932, 032     88. 05       88. 06     08806     HANNI BAL MAI N RHC     3, 385, 141     347, 954     3, 733, 095     -511, 997     3, 221, 098     88. 06       88. 07     08807     PALMYRA RHC     284, 382     61, 949     346, 331     27, 002     373, 333     88. 07       90. 00     09000     CLI NI C     34, 881, 915     5, 420, 817     40, 302, 732     -947, 988     39, 354, 744     90. 00       90. 01     09001     OUTPATI ENT I NFUSI ON     361, 705     52, 924     414, 629     -3, 776     410, 833     90. 02       90. 02     04950     ONCOLOGY     552, 715     114, 259     666, 974     -4, 648     662, 326     90. 02       90. 03     04951     HANNI BAL I NFUSI ON     23, 115     57     23, 172     0     23, 172     90. 03       91. 00     09100     EMERGENCY     13, 508, 602     2, 776, 100     16, 284, 702     -261, 477     16, 023, 225     91. 00		1 1	1					
88. 06     08806   HANNI BAL MAI N RHC     3, 385, 141   347, 954   3, 733, 095   -511, 997   3, 221, 098   88. 06       88. 07   08807   PALMYRA RHC     284, 382   61, 949   346, 331   27, 002   373, 333   88. 07       88. 08   08808   BOWLI NG GREEN RHC     116, 547   30, 353   146, 900   -8, 877   138, 023   88. 08       90. 00   09000   CLI NI C     34, 881, 915   5, 420, 817   40, 302, 732   -947, 988   39, 354, 744   90. 00       90. 01   09001   0UTPATI ENT I NFUSI ON   90. 02   04950   0NCOLOGY   04950   0NCOLOGY   552, 715   114, 259   666, 974   -4, 648   662, 326   90. 02       90. 03   04951   HANNI BAL I NFUSI ON   91.00   09100   EMERGENCY     13, 508, 602   2, 776, 100   16, 284, 702   -261, 477   16, 023, 225   91. 00								1
88. 07     08807 PALMYRA RHC     284, 382     61, 949     346, 331     27, 002     373, 333     88. 07       88. 08     08808 BOWLI NG GREEN RHC     116, 547     30, 353     146, 900     -8, 877     138, 023     88. 08       90. 01     09000 CLI NI C     34, 881, 915     5, 420, 817     40, 302, 732     -947, 988     39, 354, 744     90. 00       90. 01     09001 OUTPATI ENT I NFUSI ON     361, 705     52, 924     414, 629     -3, 776     410, 853     90. 01       90. 03     04950 ONCOLOGY     552, 715     114, 259     666, 974     -4, 648     662, 326     90. 03       91. 00     09100 EMERGENCY     13, 508, 602     2, 776, 100     16, 284, 702     -261, 477     16, 023, 225     91. 00		1 1	1 1					
88. 08     08808   08808   090000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000								
90. 01   09001   0UTPATI ENT I NFUSI ON   361, 705   52, 924   414, 629   -3, 776   410, 853   90. 01   90. 02   04950   0NCOLOGY   552, 715   114, 259   666, 974   -4, 648   662, 326   90. 02   90. 03   04951   HANNI BAL I NFUSI ON   23, 115   57   23, 172   0   23, 172   90. 03   91. 00   09100   EMERGENCY   13, 508, 602   2, 776, 100   16, 284, 702   -261, 477   16, 023, 225   91. 00	88. 08	1 1	1		1		138, 023	88. 08
90. 02     04950     ONCOLOGY     552, 715     114, 259     666, 974     -4, 648     662, 326     90. 02       90. 03     04951     HANNI BAL I NFUSI ON     23, 115     57     23, 172     0     23, 172     90. 03       91. 00     09100     EMERGENCY     13, 508, 602     2, 776, 100     16, 284, 702     -261, 477     16, 023, 225     91. 00		1 1	1 1		1			1
90. 03   04951   HANNI BAL   NFUSI ON 23, 115 57 23, 172 0 23, 172 90. 03 91. 00   09100   EMERGENCY 13, 508, 602 2, 776, 100 16, 284, 702 -261, 477 16, 023, 225 91. 00								
	90. 03	04951 HANNI BAL I NFUSI ON	23, 115	57	23, 172	. 0	23, 172	90. 03
72. 00   07200   003LNVATI ON DED3 (NON-DISTINCT PART)   92. 00			13, 508, 602	2, 776, 100	16, 284, 702	-261, 477	16, 023, 225	
	72.00	10.200 OBSERVATION BEDS (NON-DISTINCT PART)	<u>1</u>		1	1	I	72.00

Health Financial Systems	BLESSI NG H	OSPI TAL		In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		Peri od:	Worksheet A	
				From 10/01/2022 o 09/30/2023	Date/Time Pre	pared·
					12/29/2023 3:	
Cost Center Description	Sal ari es	0ther		Reclassi fi cati	Reclassi fied	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00	2.00	3. 00	4. 00	col . 4) 5.00	
93. 99 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	1, 021, 443	36, 463				93, 99
OTHER REIMBURSABLE COST CENTERS	1, 021, 443	30, 403	1, 037, 400	) <sub> </sub> -23	1,057,663	73.77
101.00 10100 HOME HEALTH AGENCY	3, 088, 055	804, 607	3, 892, 662	-14, 310	3, 878, 352	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE		3, 395, 257	3, 395, 257	-3, 395, 257	0	113. 00
116. 00 11600 HOSPI CE	2, 181, 548	715, 957	2, 897, 505	14, 070	2, 911, 575	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	241, 457, 910	346, 908, 071	588, 365, 981	-542, 837	587, 823, 144	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	5, 397, 378	1, 604, 451	7, 001, 829	517, 802		
193. 00 19300 NONPALD WORKERS	0	0	(	0		193. 00
193. 01 19301 DENMAN SERVICES	0	0	(	0	-	193. 01
193. 02 19302 UNUSED SPACE	0	0	(	0		193. 02
193. 03 19303 RENTED SPACE	0	0	(	0		193. 03
193. 04 19304 RETAIL PHARMACIES	2, 108, 491	18, 907, 760				
193. 05 19305 WELLNESS CENTER	310, 864	131, 392			442, 256	1
200.00   TOTAL (SUM OF LINES 118 through 199)	249, 274, 643	367, 551, 674	616, 826, 317	'I 0	616, 826, 317	J200. 00

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

			12/29/2023 3:	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
GENERAL SERVICE COST CENTERS	6. 00	7.00		
1. 00 O0100 CAP REL COSTS-BLDG & FLXT	1 0	ol		1.00
1. 01 O0101 CAP REL COSTS-BUTLER BUILDING	15, 464	1		1. 01
1.02 00102 CAP REL COSTS-OLD BLDG & FIXTURES	-9, 908, 017	1		1. 02
1.03 O0103 CAP REL COSTS-NEW BLDG & FIXTURES	5, 514, 122			1. 03
1.04 O0104 CAP REL COSTS-MOB	-2, 682, 630	1, 346, 966		1. 04
1.05   00105   CAP REL COSTS-OAK STREET MALL	800, 691	800, 691		1. 05
1.06 O0106 CAP REL COSTS-BRCN AT 36TH ST	137, 622			1. 06
1.07 O0107 CAP REL COSTS-SURGERY CENTER	1, 097, 072			1. 07
1. 08 00108 CAP REL COSTS-48TH AND MAINE	1, 529, 311	1		1.08
1. 09 00109 CAP REL COSTS-HANNI BAL	423, 756	1		1. 09
2. 00   00200 CAP REL COSTS-MVBLE EQUIP	2, 062, 719			2.00
3.00   00300 OTHER CAP REL COSTS 4.00   00400 EMPLOYEE BENEFITS DEPARTMENT	-48, 896, 410	1		3. 00 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	-60, 508, 836			5.00
6. 00 00600 MAI NTENANCE & REPAI RS	-943, 137			6.00
8. 00 00800 LAUNDRY & LINEN SERVICE	13, 946			8.00
9. 00   00900   HOUSEKEEPI NG	-79, 600			9. 00
10. 00   01000 DI ETARY	-1, 129, 657	1		10.00
11. 00   01100   CAFETERI A	-1, 996, 359			11. 00
13.00 01300 NURSING ADMINISTRATION	972, 352			13. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	2, 194, 148	9, 485, 649		16. 00
20. 00 02000 NURSI NG PROGRAM	-3, 833, 388	2, 821, 462		20. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	1, 278, 372		21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0			22. 00
23. 00   02300   PARAMED ED PRGM	0	- 1		23. 00
23. 01   02301   PARAMED ED   PRGM-RADI OLOGY	-364, 020	1		23. 01
23. 02   02302   PARAMED ED   PRGM-LABORATORY	-78, 860	1		23. 02
23. 03   02303   PARAMED ED PRGM-PHARMACY	0			23. 03
23. 04   02304  PARAMED ED PRGM-RESPIRATORY   I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-50, 838	158, 729		23. 04
30. 00   03000   ADULTS & PEDI ATRI CS	-7, 998, 613	46, 909, 062		30.00
31. 00   03100   INTENSI VE CARE UNI T	-1, 937, 000			31.00
41. 00   04100   SUBPROVI DER -   I RF	-17, 473			41. 00
43. 00   04300   NURSERY	17,170			43. 00
44. 00 04400 SKILLED NURSING FACILITY	-1, 036	1		44. 00
ANCILLARY SERVICE COST CENTERS	•	· · · · · ·		
50. 00   05000   OPERATING ROOM	-29, 024	20, 054, 849		50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	961, 194		52. 00
53. 00   05300   ANESTHESI OLOGY	0	724, 837		53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	-1, 282, 353			54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0			55. 00
57. 00   05700   CT SCAN	0			57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	1 112 013	,		58. 00
60. 00 06000 LABORATORY	1, 112, 813	1 ' ' 1		60.00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS 65. 00   06500   RESPI RATORY THERAPY	-5, 557	1,,		62. 00 65. 00
66. 00   06600 PHYSI CAL THERAPY	-5, 557	1		66.00
67. 00   06700   OCCUPATI ONAL THERAPY		1		67.00
68. 00 06800 SPEECH PATHOLOGY	0	1		68.00
69. 00 06900 ELECTROCARDI OLOGY	-16, 381	1		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	-19, 185			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-301, 152			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	16, 635, 404		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	-98, 680	29, 578, 906		73. 00
74. 00 07400 RENAL DIALYSIS	0	958, 135		74. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00   08800   EAST ADAMS RHC	-81, 673			88. 00
88. 01   08801   48TH AND MAINE RHC	10, 126			88. 01
88. 02   08802   MT STERLI NG RHC	-63, 464			88. 02
88. 03   08803   MAI N CAMPUS RHC	-3, 826, 526	1		88. 03
88. 04 08804 BLESSING EXPRESS CLINIC	12, 699			88. 04
88. 05   08805   BLESSING WALK IN CLINIC	20, 194			88. 05
88. 06   08806 HANNI BAL MAIN RHC 88. 07   08807 PALMYRA RHC	18, 366	1		88.06
88. 07   08807   PALMYKA KHC 88. 08   08808   BOWLI NG GREEN RHC	-5, 448 -316			88. 07 88. 08
90. 00   09000   CLI NI C	-29, 903, 783			90.00
90. 00   09000   CETNIC 90. 01   09001   OUTPATIENT INFUSION	-29, 903, 763	1		90.00
90. 02   04950  ONCOLOGY		1		90.01
90. 03   04951   HANNI BAL   I NFUSI ON	0	23, 172		90. 02
91. 00 09100 EMERGENCY	-7, 498, 153			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1			92. 00
93. 99 09399 PARTIAL HOSPITALIŽATION PROGRAM	0	1, 057, 883		93. 99

Health Financial Systems

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0015

Period:
From 10/01/2022

Worksheet A

			To 09/30/2023 Date/Time Preparation 12/29/2023 3:54	ared: 4 pm_
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)   6.00	For Allocation 7.00		
OTHER REIMBURSABLE COST CENTERS	9. 99			
101.00 10100 HOME HEALTH AGENCY	-8, 058	3, 870, 294	11	01.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE	0	0	1	13.00
116. 00 11600 HOSPI CE	173, 624	3, 085, 199	1	16.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-167, 456, 602	420, 366, 542	1	18.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1	90.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	-2, 412	7, 517, 219	1	92.00
193.00 19300 NONPALD WORKERS	0	0	1	93.00
193. 01 19301 DENMAN SERVICES	0	0	1	93. 01
193. 02 19302 UNUSED SPACE	0	0	11	93. 02
193. 03 19303 RENTED SPACE	0	0	11	93. 03
193.04 19304 RETAIL PHARMACIES	0	21, 041, 286	11	93. 04
193. 05 19305 WELLNESS CENTER	-51	442, 205	11	93. 05
200.00   TOTAL (SUM OF LINES 118 through 199)	-167, 459, 065	449, 367, 252	20	00.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 14-0015 

					e/Time Prepared: 29/2023 3:54 pm
		Increases		0.11	
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00	
	A - RECLASS CAFETERIA COSTS	3.00	4.00	3.00	
1.00	CAFETERI A	11.00	2, 447, 288	3, 460, 604	1. 00
	B - RECLASS C-SECTION COSTS		2, 447, 288	3, 460, 604	
1.00	OPERATING ROOM	50.00	14, 788	0	1.00
	0		14, 788	<u>0</u>	
	C - RECLASS PORTION OF HANNIBA				
1. 00	PHYSICIANS' PRIVATE OFFICES	192.00	401, 181 401, 181	11 <u>0, 8</u> 16 110, 816	1.00
	D - RECLASS CAPITAL RELATED IN	ISURANCE	401, 101	110, 010	
1.00	CAP REL COSTS-BUTLER	1. 01	0	64, 027	1. 00
2. 00	BUILDING CAP REL COSTS-OLD BLDG &	1. 02	0	122, 979	2. 00
2.00	FIXTURES	1.02	o o	122, 979	2.00
3.00	CAP REL COSTS-NEW BLDG &	1. 03	0	177, 636	3. 00
4 00	FI XTURES	2 22		00.001	4 00
4. 00	CAP REL COSTS-MVBLE EQUIP			2 <u>2, 981</u> 387, 623	4. 00
	E - RECLASS VOLUNTEER SERVICES	5	<u> </u>	307, 023	
1.00	HOSPI CE	116.00	23, 085	<u>3, 8</u> 72	1. 00
	O FOLIAGO TEACHINO FEEG		23, 085	3, 872	
1. 00	F - RECLASS TEACHING FEES ADULTS & PEDIATRICS	30. 00	72, 724	0	1.00
1.00	TOTALS		$\frac{72,724}{72,724}$	0	1.00
	G - RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-NEW BLDG &	1. 03	0	2, 883, 673	1.00
2. 00	FIXTURES CAP REL COSTS-MVBLE EQUIP	2. 00	0	399, 121	2. 00
3.00	ADMI NI STRATI VE & GENERAL	5. 00	ő	112, 463	3. 00
	0			3, 395, 257	
4 00	H - RECLASS RAD AND PT WAGES	5.4.00l	70.044		1.00
1. 00 2. 00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-DI AGNOSTI C	54. 00 54. 00	70, 941 191, 875	0	1. 00 2. 00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	21, 475	Ö	3. 00
4.00	RADI OLOGY-DI AGNOSTI C	5400	1 <u>0, 1</u> 32		4. 00
	TOTALS	CURRILLEC	294, 423	0	
1. 00	I - RECLASS CHARGEABLE MEDICAL MEDICAL SUPPLIES CHARGED TO	71. 00	ol	14, 549, 475	1.00
00	PATI ENTS	,		, ,	
2.00	IMPL. DEV. CHARGED TO	72. 00	0	16, 635, 404	2. 00
3. 00	PATIENTS DRUGS CHARGED TO PATIENTS	73. 00	0	628	3.00
4. 00	DROGS CHARGED TO TATTENTS	0.00	o	0	4.00
5.00		0.00	O	0	5. 00
6.00		0.00	0	0	6.00
7. 00 8. 00		0. 00 0. 00	0	0	7. 00 8. 00
9. 00		0.00	Ö	Ö	9. 00
10.00		0.00	0	0	10. 00
11.00		0.00	0	0	11.00
12. 00 13. 00		0. 00 0. 00	0	0	12. 00 13. 00
14. 00		0.00	o	0	14.00
15. 00		0.00	0	0	15. 00
16.00		0.00	0	0	16. 00
17. 00 18. 00		0. 00 0. 00	0	0	17. 00 18. 00
19. 00		0.00	0	0	19.00
20. 00		0.00	ő	Ö	20. 00
21. 00		0.00	0	0	21. 00
22. 00		0.00	0	0	22. 00
23. 00 24. 00		0. 00 0. 00	0	0	23. 00 24. 00
25. 00		0.00	Ö	Ö	25. 00
26. 00		0.00		0	26. 00
	DECLASS DESCEPTOR DAY		0	31, 185, 507	
1. 00	J - RECLASS PRECEPTOR PAY NURSING PROGRAM	20. 00	876, 574	0	1.00
2. 00		0.00	0	o	2. 00
3.00		0.00	0	0	3. 00
4.00		0.00	0	0	4.00
5. 00 6. 00		0. 00 0. 00	0	0	5. 00 6. 00
7. 00		0.00	ő	o	7. 00
	·		-1	- 1	

Health Financial Systems RECLASSIFICATIONS Provider CCN: 14-0015 

					10 09/30/2023 Date/11/lie P1	
		Increases		·		
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0. 00 0. 00	0	0		11.00
12. 00 13. 00		0.00	0	0		12. 00 13. 00
14. 00	•	0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16. 00		0.00	0	0		16. 00
10.00	0 — — — — —		876, 574	— — <u>ö</u>		10.00
	K - RECLASS RENT EXPENSE	1		<u>'</u>		
1.00	CAP REL COSTS-MOB	1.04	0	2, 064, 330		1. 00
2.00	CAP REL COSTS-MOB	1. 04	0	1, 965, 266		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00 9. 00		0.00	0	0		8. 00
9. 00 10. 00		0. 00 0. 00	0	0		9. 00 10. 00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	0		12.00
13. 00		0.00	0	0		13. 00
13.00	0 — — — — —		— — <del>ŏ</del>	4, 029, 596		13.00
	L - RECLASS LEASEHOLD IMP DEF	PR	-1	.,		
1.00	ELECTROENCEPHALOGRAPHY	70.00	0	3, 944		1. 00
2.00	EAST ADAMS RHC	88.00	0	49, 250		2. 00
3.00	MT STERLING RHC	88. 02	0	69, 681		3. 00
4.00	BLESSING EXPRESS CLINIC	88. 04	0	95, 069		4. 00
5.00	PALMYRA RHC	88. 07	0	48, 477		5. 00
6.00	BOWLING GREEN RHC	88. 08	0	1, 255		6. 00
7. 00	RETAIL PHARMACIES	193.04		2 <u>5, 0</u> 35		7. 00
	M - RECLASS OTHER PARAMEDIC F	DDOCDAMC	0	292, 711		
1. 00	PARAMED ED PRGM-RESPIRATORY	23. 04	176, 960	32, 607		1. 00
2. 00	ADMINISTRATIVE & GENERAL	5.00	78, 479	55, 596		2. 00
3.00	PARAMED ED PRGM-LABORATORY	23. 02	135, 875	44, 386		3. 00
4. 00	PARAMED ED PRGM-RADI OLOGY	23. 02	462, 838	201, 155		4. 00
5. 00	ADULTS & PEDIATRICS	30.00	658, 227	683, 674		5. 00
0.00	0	— <del></del>	1, 512, 379	<u> 1, 017, 418</u>		0.00
	N - RECLASS CONTRACTED HOUSE	KEEPI NG		, , , , , ,		
1.00	HOUSEKEEPI NG	9.00	0	250, 168		1. 00
2.00	BLESSING EXPRESS CLINIC	88. 04	О	24, 200		2. 00
3.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	5, 805		3. 00
4.00		0.00	O	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00		0.00	•	0		8. 00
F00 00	O Constant		0	280, 173		F00 00
500.00	Grand Total: Increases		5, 642, 442	44, 163, 577		500.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: Worksheet A-6 From 10/01/2022 To 09/30/2023 Date/Time Prepared: Provider CCN: 14-0015

						2023 3: 54 pm
		Decreases	6.1	011		
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref.	
	A - RECLASS CAFETERIA COSTS	7.00	0.00	7. 00	10.00	
1.00	DI ETARY	10.00	2, 447, 288	3, 460, 604		1. 00
	O DESCRIPTION OF THE PROPERTY		2, 447, 288	3, 460, 604		
1. 00	B - RECLASS C-SECTION COSTS DELIVERY ROOM & LABOR ROOM	52. 00	14, 788	0	0	1. 00
1.00	0		14, 788	ö		1.00
	C - RECLASS PORTION OF HANNIBA	AL MAIN RHC				
1.00	HANNIBAL MAIN RHC		401, 181	11 <u>0, 8</u> 16		1. 00
	D - RECLASS CAPITAL RELATED II	NSTIRANCE	401, 181	110, 816		
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	0	387, 623	12	1. 00
2.00		0.00	О	0		2. 00
3.00		0.00	0	0		3.00
4. 00		0.00		<u></u> 00387, 623		4. 00
	E - RECLASS VOLUNTEER SERVICES		<u> </u>	307, 023		
1.00	ADMINISTRATIVE & GENERAL	5.00	23, 085	3, 872	0	1. 00
	0		23, 085	3, 872		
1. 00	F - RECLASS TEACHING FEES ADMINISTRATIVE & GENERAL	5. 00	72, 724	0	0	1. 00
1.00	TOTALS		$-\frac{72,724}{72,724}$	<sup>0</sup>	<u> </u>	1.00
	G - RECLASS INTEREST EXPENSE		. = , . = .			
1.00	I NTEREST EXPENSE	113. 00	0	3, 395, 257		1. 00
2.00		0.00	0	0		2.00
3. 00		0.00		00 3, 395, 257	0	3. 00
	H - RECLASS RAD AND PT WAGES		<u> </u>	0,070,207		
1.00	MT STERLING RHC	88. 02	70, 941	0		1. 00
2.00	MAIN CAMPUS RHC PALMYRA RHC	88. 03 88. 07	191, 875	0		2.00
3. 00 4. 00	BOWLING GREEN RHC	88. 07 88. 08	21, 475 10, 132	0		3. 00 4. 00
1. 00	TOTALS		294, 423	_		1.00
	I - RECLASS CHARGEABLE MEDICAL					
1.00	ADULTS & PEDIATRICS	30.00	0	209, 546		1.00
2. 00 3. 00	INTENSIVE CARE UNIT SUBPROVIDER - IRF	31. 00 41. 00	O  O	269, 021 2, 102		2. 00 3. 00
4. 00	NURSERY	43. 00	Ö	24, 872		4.00
5.00	SKILLED NURSING FACILITY	44.00	О	3, 518	I	5. 00
6.00	OPERATING ROOM	50.00	0	20, 106, 472	· · · · · · · · · · · · · · · · · · ·	6. 00
7. 00 8. 00	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	52. 00 53. 00	0	152, 583 452, 208	· · · · · · · · · · · · · · · · · · ·	7. 00 8. 00
9. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	368, 953		9. 00
10.00	RADI OLOGY-THERAPEUTI C	55.00	O	5, 985	0	10.00
11. 00	CT SCAN	57. 00	0	81, 641		11. 00
12. 00	MAGNETIC RESONANCE IMAGING (MRI)	58. 00	O	7, 114	0	12. 00
13. 00	LABORATORY	60.00	o	32, 616	О	13. 00
14.00	RESPIRATORY THERAPY	65.00	O	405, 608		14. 00
15.00	OCCUPATI ONAL THERAPY	67. 00	0	1, 561		15. 00
16. 00 17. 00	SPEECH PATHOLOGY ELECTROCARDI OLOGY	68. 00 69. 00	0	260 8, 728, 260		16. 00 17. 00
18. 00	ELECTROCARDI OLOGI ELECTROENCEPHALOGRAPHY	70.00	0	9, 448		18. 00
19. 00	RENAL DIALYSIS	74.00	o	22		19. 00
20.00	CLINIC	90.00	О	164, 279		20. 00
21. 00	OUTPATIENT INFUSION	90. 01	0	3, 776		21. 00
22. 00 23. 00	ONCOLOGY EMERGENCY	90. 02 91. 00	0	4, 648 140, 583		22. 00 23. 00
24. 00	PARTI AL HOSPI TALI ZATI ON	93. 99	Ö	23		24. 00
	PROGRAM					
25. 00	HOME HEALTH AGENCY	101.00	0	5, 924		25. 00
26. 00	HOSPICE	116. 00	0	<u>4, 4</u> 84 31, 185, 507		26. 00
	J - RECLASS PRECEPTOR PAY			5., 100, 007		
1.00	ADMI NI STRATI VE & GENERAL	5. 00	5, 219	0		 1. 00
2.00	NURSING ADMINISTRATION	13. 00	67, 306	0		2.00
3. 00 4. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	360, 605 98, 283	0		3. 00 4. 00
5. 00	SUBPROVI DER - I RF	41.00	7, 675	0		5. 00
6.00	NURSERY	43.00	37, 174	0	0	6. 00
7.00	SKILLED NURSING FACILITY	44.00	13, 856	0	0	7. 00
8. 00 9. 00	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	50. 00 52. 00	109, 659 17, 157	0	0	8. 00 9. 00
9. 00 10. 00	RADI OLOGY-DI AGNOSTI C	54. 00	7, 773	0		10.00
11. 00	RESPI RATORY THERAPY	65. 00	11, 052	Ö		11. 00
		<u> </u>				

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 10/01/2022 To 09/30/2023 Date/Time Prepared: Provider CCN: 14-0015

						12/29/2023	3:54 pm_
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8.00	9. 00	10.00		
12.00	BLESSING WALK IN CLINIC	88. 05	1, 917	(			12. 00
13.00	CLINIC	90.00	1, 215	(	٦ - ١		13. 00
14.00	EMERGENCY	91.00	120, 894	(	0		14. 00
15. 00	HOME HEALTH AGENCY	101. 00	8, 386	(	0		15. 00
16.00	HOSPICE	116. 00	<u>8, 4</u> 03	(	00		16. 00
	0		876, 574	(			
	K - RECLASS RENT EXPENSE						
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 965, 266			1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	44, 471			2. 00
3.00	DI ETARY	10. 00	0	1, 957			3. 00
4. 00	OPERATING ROOM	50.00	0	91, 945			4. 00
5.00	OPERATING ROOM	50.00	0	4, 706			5. 00
6.00	OPERATING ROOM	50.00	0	5, 048			6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	189, 652			7. 00
8.00	RESPI RATORY THERAPY	65. 00	0	33, 592			8. 00
9.00	MAIN CAMPUS RHC	88. 03	0	948, 168			9. 00
10.00	CLINIC	90.00	0	602, 833	3 0		10. 00
11. 00	CLINIC	90.00	0	83, 112			11. 00
12.00	CLINIC	90.00	0	19, 094			12. 00
13.00	CLINIC	90.00	0	3 <u>9, 7</u> 52			13. 00
	0		0	4, 029, 596	5		
	L - RECLASS LEASEHOLD IMP DEF						
1. 00	CAP REL COSTS-NEW BLDG &	1. 03	0	292, 71	1 9		1. 00
	FI XTURES						
2.00		0.00	0	(			2.00
3.00		0.00	0	(	0		3.00
4.00		0.00	0	(	0		4. 00
5.00		0.00	0	(	0		5. 00
6.00		0.00	0	(	0		6. 00
7. 00		0.00	— — <del>0</del>				7. 00
	M - RECLASS OTHER PARAMEDIC F	DDOCDAMS	U	292, 71	I		
1.00	NURSI NG PROGRAM	20.00	1, 512, 379	1, 017, 418	3 0		1.00
2. 00	NORST NO TROOKAW	0.00	1, 312, 379	1,017,410			2. 00
3. 00		0.00	ő	(			3. 00
4. 00		0.00	0	(			4. 00
5. 00		0.00	0	(			5. 00
3.00			1, 512, 379				3.00
	N - RECLASS CONTRACTED HOUSE	CFFPI NG	1,012,077	1,017,110	211		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	600	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	o	189, 070			2. 00
3.00	NURSING PROGRAM	20. 00	0	52, 800			3. 00
4. 00	CLINIC	90.00	o	973			4. 00
5. 00	CLINIC	90.00	o	1, 960			5. 00
6. 00	CLINIC	90.00	o	8, 400			6.00
7. 00	CLINIC	90.00	o	3, 589			7. 00
8. 00	CLINIC	90.00	ol	22, 78			8.00
	0		— — <del>-</del>	280, 173			
500.00	Grand Total: Decreases		5, 642, 442	44, 163, 57			500.00
		•	'				

					To 09/30/2023		
				Acqui si ti ons		12,27,2020 0.	<u> </u>
		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						
1. 00	Land	16, 273, 887	631, 241		0 631, 241	0	1. 00
2.00	Land Improvements	13, 396, 511	248, 159		0 248, 159	·	2. 00
3.00	Buildings and Fixtures	163, 668, 745	17, 135, 583		0 17, 135, 583		3. 00
4.00	Building Improvements	3, 531, 182	756, 540		0 756, 540		4. 00
5.00	Fi xed Equipment	150, 283, 852	8, 441, 603		0 8, 441, 603	942, 287	5. 00
6.00	Movable Equipment	235, 267, 367	18, 556, 063		0 18, 556, 063	581, 284	
7. 00	HIT designated Assets	0	0		0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	582, 421, 544	45, 769, 189		0 45, 769, 189	5, 382, 470	8. 00
9.00	Reconciling Items	0	0		0	0	9. 00
10.00	Total (line 8 minus line 9)	582, 421, 544	45, 769, 189		0 45, 769, 189	5, 382, 470	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	16, 905, 128	0				1. 00
2.00	Land Improvements	13, 522, 538	0				2. 00
3.00	Buildings and Fixtures	177, 074, 509	0				3. 00
4.00	Building Improvements	4, 280, 774	0				4. 00
5.00	Fi xed Equipment	157, 783, 168	0				5. 00
6.00	Movable Equipment	253, 242, 146	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	622, 808, 263	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	622, 808, 263	0				10. 00

In Lieu of Form CMS-2552-10 Health Financial Systems BLESSING HOSPITAL RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 14-0015 Peri od: Worksheet A-7 From 10/01/2022 To 09/30/2023 Part II Date/Time Prepared: 12/29/2023 3:54 pm SUMMARY OF CAPITAL Taxes (see Cost Center Description Depreciation Lease Interest Insurance (see instructions) instructions) 9.00 10.00 11.00 12.00 13.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 0 0 0 0 0 0 0 0 1.01 CAP REL COSTS-BUTLER BUILDING 0 0 0 1.01 CAP REL COSTS-OLD BLDG & FIXTURES 10, 402, 686 1.02 0 0 1.02 1.03 CAP REL COSTS-NEW BLDG & FIXTURES 1, 781, 021 1.03 CAP REL COSTS-MOB 0 0 1.04 0 1.04 CAP REL COSTS-OAK STREET MALL 0 0 1.05 0 1.05 CAP REL COSTS-BRCN AT 36TH ST 1.06 0 1.06 1.07 CAP REL COSTS-SURGERY CENTER 0 0 0 1.07 1.08 CAP REL COSTS-48TH AND MAINE 0 0 0 1.08 0 1.09 CAP REL COSTS-HANNI BAL 0 0 0 1.09 0 2.00 CAP REL COSTS-MVBLE EQUIP 14, 430, 936 0 2.00 3.00 Total (sum of lines 1-2) 26, 614, 643 3.00 SUMMARY OF CAPITAL

		0.11	F		
	Cost Center Description		Total (1) (sum		
		Capi tal -Rel ate	of cols. 9		
		d Costs (see	through 14)		
		instructions)			
		14.00	15. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2	
1.00	CAP REL COSTS-BLDG & FIXT	0	0		1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	0		1. 01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	0	10, 402, 686		1. 02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	0	1, 781, 021		1. 03
1.04	CAP REL COSTS-MOB	0	0		1.04
1.05	CAP REL COSTS-OAK STREET MALL	0	0		1. 05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0		1.06
1.07	CAP REL COSTS-SURGERY CENTER	0	0		1. 07
1.08	CAP REL COSTS-48TH AND MAINE	0	0		1. 08
1.09	CAP REL COSTS-HANNI BAL	0	0		1.09
2.00	CAP REL COSTS-MVBLE EQUIP	0	14, 430, 936		2.00
3.00	Total (sum of lines 1-2)	0	26, 614, 643		3. 00

Health Financial Systems

BLESSING HOSPITAL

In Lieu of Form CMS-2552-10

Heal th	Financial Systems	BLESSI NG 1	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		eriod: rom 10/01/2022 o 09/30/2023	Worksheet A-7 Part III Date/Time Prep 12/29/2023 3:5	pared:
		COM	PUTATION OF RAT	TIOS	ALLOCATION OF		J4 piii
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
				(col. 1 - col. 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	-			0	1. 00
1. 01	CAP REL COSTS-BUTLER BUILDING	41, 946	l e			0	1. 01
1.02	CAP REL COSTS-OLD BLDG & FIXTURES	292, 791, 951	0		0. 494263	0	1. 02
1.03	CAP REL COSTS-NEW BLDG & FIXTURES	46, 304, 332	0	46, 304, 332		0	1. 03
1.04	CAP REL COSTS-MOB	0	0	0	0.000000	0	1. 04
1.05	CAP REL COSTS-OAK STREET MALL	0	0	0	0.000000	0	1. 05
1.06	CAP REL COSTS-BRCN AT 36TH ST	0	0	0	0.000000	0	1.06
1.07	CAP REL COSTS-SURGERY CENTER	0	0	0	0.000000	0	1. 07
1.08	CAP REL COSTS-48TH AND MAINE	0	0	_	0.000000	0	1. 08
1.09	CAP REL COSTS-HANNI BAL	0	0	1	0.000000	0	1. 09
2.00	CAP REL COSTS-MVBLE EQUIP	253, 242, 146				0	2.00
3.00	Total (sum of lines 1-2)	592, 380, 375				0	3. 00
			TION OF OTHER (		SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)	0.00	10.00	
	DART LLL BEGGNOLLLATION OF GARLEY GOOTS OF	6.00	7. 00	8.00	9. 00	10. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CE		1 0	J		0	1 00
1.00	CAP REL COSTS-BLDG & FLXT	0	-	1		0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING CAP REL COSTS-OLD BLDG & FIXTURES	0	0			0	1. 01
1. 02 1. 03	CAP REL COSTS-OLD BLDG & FIXTURES	0		1	494, 669	0	1. 02 1. 03
1.03	CAP REL COSTS-NOB	0			9, 886, 105 630, 428	716, 538	1. 03
1.04	CAP REL COSTS-MOB	0			608, 676	192, 015	1. 04
1.05	CAP REL COSTS-DAK STREET WALL  CAP REL COSTS-BRCN AT 36TH ST				137, 622	192,013	1. 05
1.00	CAP REL COSTS-SURGERY CENTER				1, 097, 072	0	1. 00
1.07	CAP REL COSTS-36KOEKT CENTER			0		0	1. 07
1.00	CAP REL COSTS-HANNI BAL					0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP				16, 892, 776	0	2. 00
3.00	Total (sum of lines 1-2)				31, 715, 879	908, 553	3. 00
3.00	Total (Suil of Titles 1-2)	0	SI	JMMARY OF CAPIT		700, 333	3.00
						T + 1 (2) (	
	Cost Center Description	Interest	Insurance (see		Other Capi tal -Rel ate	Total (2) (sum	
			instructions)	I fistructions)	d Costs (see	of cols. 9	
					instructions)	through 14)	
		11. 00	12.00	13.00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		12.00	13.00	14.00	13.00	
1.00	CAP REL COSTS-BLDG & FLXT	0	0	0	0	0	1. 00
1. 01	CAP REL COSTS-BUTLER BUILDING	0	64, 027		0	79, 491	1. 01
1. 02	CAP REL COSTS-OLD BLDG & FIXTURES	0	122, 979		_	617, 648	1. 02
1. 03	CAP REL COSTS-NEW BLDG & FIXTURES	0	177, 636			10, 063, 741	1. 03
1. 04	CAP REL COSTS-MOB	1 0	177,000	1	_	1, 346, 966	1. 04
1. 05	CAP REL COSTS-OAK STREET MALL	0	l	Ö	0	800, 691	1. 05
1. 06	CAP REL COSTS-BRCN AT 36TH ST	0	ĺ	1	0	137, 622	1. 06
1. 07	CAP REL COSTS-SURGERY CENTER	1 0	ĺ			1, 097, 072	1. 07
1. 08	CAP REL COSTS-48TH AND MAINE	1 0	ĺ	1	_	1, 529, 311	1. 08
1. 09	CAP REL COSTS-HANNI BAL	0	Ö			423, 756	1. 09
2.00	CAP REL COSTS-MVBLE EQUIP	0	22, 981			16, 915, 757	2. 00
3. 00	Total (sum of lines 1-2)	0	387, 623			33, 012, 055	
		•		•			

Health Financial Systems BLESSING HOSPITAL In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 14-0015 Peri od: Worksheet A-8 From 10/01/2022 09/30/2023 Date/Time Prepared: 12/29/2023 3:54 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 1.01 Investment income - CAP REL OCAP REL COSTS-BUTLER 1.01 1.01 COSTS-BUTLER BUILDING (chapter BUI LDI NG Investment income - CAP REL OCAP REL COSTS-OLD BLDG & 1.02 1.02 1.02 COSTS-OLD BLDG & FIXTURES FI XTURES (chapter 2) 1 03 Investment income - CAP REL OCAP REL COSTS-NEW BLDG & 1.03 1.03 COSTS-NEW BLDG & FIXTURES FI XTURES (chapter 2) 1.04 Investment income - CAP REL OCAP REL COSTS-MOB 1.04 1.04 COSTS-MOB (chapter 2) Investment income - CAP REL 1.05 1 05 OCAP REL COSTS-OAK STREET 1.05 COSTS-OAK STREET MALL (chapter MALL 1.06 1.06 Investment income - CAP REL OCAP REL COSTS-BRCN AT 36TH 1.06 COSTS-BRCN AT 36TH ST (chapter Investment income - CAP REL OCAP REL COSTS-SURGERY CENTER 1.07 1.07 1.07 0 COSTS-SURGERY CENTER (chapter Investment income - CAP REL OCAP REL COSTS-48TH AND MAINE 1.08 1.08 1.08 COSTS-48TH AND MAINE (chapter 1.09 Investment income - CAP RFL OCAP REL COSTS-HANNI BAL 1.09 1.09 COSTS-HANNI BAL (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) Investment income - other 3.00 0.00 3.00 (chapter 2) Trade, quantity, and time 4.00 0.00 4.00 di scounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) 6.00 Rental of provider space by suppliers (chapter 8) 0.00 6.00 7 00 -269, 353 ADMI NI STRATI VE & GENERAL 7 00 Tel ephone services (pay 5 00 Α stations excluded) (chapter 8.00 Television and radio service -79, 935 CAP REL COSTS-MVBLE EQUIP 8.00 2.00 (chapter 21) 9.00 9.00 Parking Lot (chapter 21) 0.00 |Provider-based physician -65, 035, 781 10.00 A-8-2 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) 12.00 Related organization A-8-1 -21, 347, 559 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests В -1, 996, 359 CAFETERI A 11.00 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 0.00 0 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents 18.00 Sale of medical records and 0.00 18.00 abstracts Nursing and allied health -280, 726 NURSING PROGRAM 19.00 В 20.00 19.00 education (tuition, fees, books, etc.) -12, 560 DI ETARY 20.00 Vending machines 10.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0 0.00 22.00

overpayments and borrowings to repay Medicare overpayments

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 BLESSING HOSPITAL Provider CCN: 14-0015 

				To	09/30/2023	Date/Time Prep 12/29/2023 3:5	
				Expense Classification on	Worksheet A	12/27/2023 3.	J4 piii
				To/From Which the Amount is t			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	р	1.00	2.00	3.00	4. 00	5. 00	
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of						
24.00	limitation (chapter 14)	4 0 2	0	DUVCI CAL THEDADY	// 00		24.00
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	limitation (chapter 14)						
25.00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation						
	(chapter 21)		_			_	
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
26. 01	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-BUTLER	1. 01	0	26. 01
20.01	COSTS-BUTLER BUILDING		0	BUI LDI NG	1.01	O	20.01
26. 02	Depreciation - CAP REL		0	CAP REL COSTS-OLD BLDG &	1. 02	0	26. 02
	COSTS-OLD BLDG & FIXTURES			FI XTURES			
26. 03	Depreciation - CAP REL			CAP REL COSTS-NEW BLDG &	1. 03	0	26. 03
24 04	COSTS-NEW BLDG & FIXTURES Depreciation - CAP REL			FI XTURES	1 04	0	24 04
26. 04	COSTS-MOB		0	CAP REL COSTS-MOB	1. 04	U	26. 04
26. 05	Depreciation - CAP REL		0	CAP REL COSTS-OAK STREET	1. 05	0	26. 05
	COSTS-OAK STREET MALL			MALL			
26. 06	Depreciation - CAP REL		0	CAP REL COSTS-BRCN AT 36TH	1. 06	0	26. 06
	COSTS-BRCN AT 36TH ST		_	ST		_	
26. 07	Depreciation - CAP REL		0	CAP REL COSTS-SURGERY CENTER	1. 07	0	26. 07
26. 08	COSTS-SURGERY CENTER Depreciation - CAP REL		0	CAP REL COSTS-48TH AND MAINE	1. 08	0	26. 08
20.00	COSTS-48TH AND MAINE		0	CAI REE COSTS-40TH AND WATNE	1.00	O	20.00
26. 09	Depreciation - CAP REL		0	CAP REL COSTS-HANNIBAL	1. 09	0	26. 09
	COSTS-HANNI BAL						
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
20.00	COSTS-MVBLE EQUIP		0	*** Coot Conton Doloted ***	10.00		28. 00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of		_				
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions)	A-8-3	0	SDEEGH DATHOLOGY	68. 00		21 00
31.00	Adjustment for speech pathology costs in excess of	A-8-3	Ü	SPEECH PATHOLOGY	68.00		31. 00
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	O	32. 00
	Depreciation and Interest						
	RENTAL INSURANCE EXPENSE	A	· ·	ADMI NI STRATI VE & GENERAL	5. 00		
	CHILD CARE CENTER	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
33. 02 33. 03	BOOKKEEPING FEES PRINT SHOP	B B		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 02 33. 03
33. 04	HEALTH PROMOTIONS	В		NURSING ADMINISTRATION	13. 00	0	33. 04
33. 05	HOUSEKEEPING SERVICES	В		HOUSEKEEPI NG	9. 00	0	33. 05
33. 06	ADVERTI SI NG	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	Ö	33. 06
33. 07	ADVERTI SI NG	A	-658, 426	ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	ADVERTI SI NG	Α		DI ETARY	10.00	0	33. 08
33. 09	ADVERTI SI NG	A		NURSI NG PROGRAM	20.00	0	33. 09
33. 10	ADVERTI SI NG	A		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 10
33. 11 33. 12	ADVERTI SI NG ADVERTI SI NG	A A		EAST ADAMS RHC HOME HEALTH AGENCY	88. 00 101. 00	0	33. 11 33. 12
33. 12	RENTAL PROPERTY EXPENSE	A		CAP REL COSTS-NEW BLDG &	1. 03	9	33. 12
00. 10	NEWTILE TROPERTY EXILENCE			FI XTURES	1.00	ĺ	00.10
33. 14	REAL ESTATE TAXES ON RENTAL	A		MAINTENANCE & REPAIRS	6. 00	0	33. 14
33. 15	RENTAL PROPERTY EXPENSE	Α		MAINTENANCE & REPAIRS	6. 00	0	33. 15
33. 16	INTEREST INCOME	A		CAP REL COSTS-NEW BLDG &	1. 03	11	33. 16
22 17	INTEREST INCOME	_		FIXTURES CAP REL COSTS-MVBLE EQUIP	2 00	11	22 17
33. 17 33. 18	INTEREST INCOME	A A		ADMINISTRATIVE & GENERAL	2. 00 5. 00	11	
33. 19	DI ETARY OUTSI DE	A		DI ETARY	10. 00	0	33. 19
,	SERVI CES-SALARI ES	.,	33, 201			Ĭ	,
33. 20	DI ETARY OUTSI DE	A	-7, 840	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 20
20.01	SERVI CES-BENEFI TS		E/0 /:-	ADMINI CTDATIVE & CEVES			20.01
33. 21	PHYSICIAN RECRUITMENT LOBBYING EXPENSE	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00		
JJ. ZZ	LODDIING EVERINGE	I 4	-09, 404	ADMINISTRATIVE & GENERAL	5.00	ı Y	33. 22

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Peri od: Worksheet A-8 From 10/01/2022 To 09/30/2023 Date/Time Prepared: Provider CCN: 14-0015

Dependence of a season from two-scheece A   The Country of the C							Date/Time Prep 12/29/2023 3:	
32 27 TRANSFER TO PARENT  A								
32 27 TRANSFER TO PARENT  A								
33.23   ADMINISTRATION   A		Cost Center Description						
32 24 MARSHOS SCHOOL TUITION B -2-3.416, 316)MISSING PROCRAM 32 26 MARSHOS TUITION B -7-8, 860/PARMED B PROU-LABORATORY 2 0 0 32.25 32 26 MARSHOS TUITION B -7-8, 860/PARMED B PROU-LABORATORY 2 0 0 32.25 32 26 MARSHOS SCHOOL TUITION B -7-8, 860/PARMED B PROU-LABORATORY 2 0 0 32.25 32 26 MARSHOS SCHOOL TUITION B -7-8, 860/PARMED B PROU-LABORATORY 2 0 0 32.25 32 27 MARSHOS SCHOOL TUITION B -7-8, 860/PARMED B PROU-LABORATORY 2 0 0 32.26 33 28 MARSHOS SCHOOL TUITION B -7-8, 860/PARMED B PROU-LABORATORY 2 0 0 0 32.26 33 29 MASCLLAREOUS INCOME B -7-1, 273/MISSINS PROCRAM 33 31 BOOK TO MEDICAGE BERRECIATION A -7-8, 860/PARMED B BOOK TO MEDICAGE BERREFIX B PROU-LABORATORY 2 0 0 0 32.27 33 33 SELF-PURBED BRAIL THI INSMANCE A -7-24, 562, 431 BAPUTUKE BERREFIX B DEPARMENT 4 0 0 0 33.33 33 MARSHOS FEES B -7-4, 7-4, 7-4, 7-4, 7-4, 7-4, 7-4, 7-4	33. 23	TRANSFER TO PARENT						33. 23
32 25   LAS SCHOOL TUTTION   8   -78, 860/PARMED EDUCATIVE & GENERAL   5.00   0.32, 25   33.20   HIS SCHOOL TUTTION   8   -80, 889/PARMED EDUCATIVE & GENERAL   5.00   0.32, 26   33.27   MISSINGER   110		•			l e e e e e e e e e e e e e e e e e e e			
32 27 MR SCHOOL TUITION 8 -0.0 33 27 32 70 M SCELLARGUS INCOME 5 -1.27 MINIST NO PROCRAM 5 -1.27							0	
32 28   RADIOLOCOY SCHOOL TUITION   8   -3-64, OZO PARAMEDE ED PREAT AND OLOCY   23. 01   03.32 9   MISCELLARIOUS INCIDENCE   8   -1,275, MISCEL REPORT SCHOOL   1.00   03.32 9   MISCELLARIOUS INCIDENCE   1.00   03.32 9   MISCELLARIOUS INCID		1						
MISCELLANDOUS INCOME   B		1						
A		l control of the cont						
STATURES		·	1				0	
33 33 SELF_FINDED HEALTH INSURANCE A -24, 562, 31 EMPLOYER BENEFITS DEPARTMENT 4, 00 0 33, 33 33 33 33 34 TRABAM ON_CALL A -1.079, 319/ANIM ISTRATIVE & GENERAL 5, 00 0 33, 34 33 35 34 MSCELLAMEDUS INCOME B -39, 000/EMBERGENCY 91, 00 0 33, 35 33 35 36 MSCELLAMEDUS INCOME B -39, 000/EMBERGENCY 91, 00 0 33, 36 33 37 38 MSCELLAMEDUS INCOME B -11, 322/ANIM ISTRATIVE & GENERAL 5, 00 0 33, 37 33 38 MSCELLAMEDUS INCOME B -11, 322/ANIM ISTRATIVE & GENERAL 5, 00 0 33, 37 34 34 MSCELLAMEDUS INCOME B -11, 322/ANIM ISTRATIVE & GENERAL 5, 00 0 33, 37 34 34 MSCELLAMEDUS INCOME B -1, 323/ANIM ISTRATIVE & GENERAL 5, 00 0 33, 37 34 34 MSCELLAMEDUS INCOME B -1, 323/ANIM ISTRATIVE & GENERAL 5, 00 0 33, 43 34 MSCELLAMEDUS INCOME B -1, 328/ANIM ISTRATIVE & GENERAL 5, 00 0 33, 43 43 MSCELLAMEDUS INCOME B -1, 328/ANIM ISTRATIVE & GENERAL 5, 00 0 33, 44 33, 42 MSCELLAMEDUS INCOME B -1, 328/ANIM ISTRATIVE & GENERAL 5, 00 0 33, 43 34 MSCELLAMEDUS INCOME B -268, 940/DIETARY 10, 00 0 33, 43 34 MSCELLAMEDUS INCOME B -268, 940/DIETARY 10, 00 0 33, 43 34 MSCELLAMEDUS INCOME B -268, 940/DIETARY 10, 00 0 33, 43 34 MSCELLAMEDUS INCOME B -268, 940/DIETARY 10, 00 0 33, 43 34 MSCELLAMEDUS INCOME B -268, 950/DIETARY 10, 00 0 33, 43 34 MSCELLAMEDUS INCOME B -268, 740/DIETARY 10, 00 0 33, 46 33, 40 CORFEE BAR B -69, 950/DIETARY 10, 00 0 33, 46 33, 40 CORFEE BAR B -69, 950/DIETARY 10, 00 0 33, 46 33, 40 CORFEE BAR B -69, 950/DIETARY 10, 00 0 33, 46 33, 50 MSCELLAMEDUS INCOME B -224, 70/DIETARY 10, 00 0 33, 48 35, 50 MSCELLAMEDUS INCOME B -224, 70/DIETARY 10, 00 0 33, 48 35, 50 MSCELLAMEDUS INCOME B -224, 70/DIETARY 10, 00 0 33, 48 35, 50 MSCELLAMEDUS INCOME B -224, 70/DIETARY 10, 00 0 33, 48 35, 50 MSCELLAMEDUS INCOME B -224, 70/DIETARY 10, 00 0 33, 48 35, 50 MSCELLAMEDUS INCOME B -224, 70/DIETARY 10, 00 0 33, 48 35, 50 MSCELLAMEDUS INCOME B -224, 70/DIETARY 10, 00 0 33, 48 35, 50 MSCELLAMEDUS INCOME B -224, 70/DIETARY 10, 00 0 33, 48 35, 50 MSCELLAMEDUS INCOME B -224, 70/DIETARY 10, 00 0 33, 50 0 33, 50 0 33, 50 0 33, 50 0 33, 50 0 33, 50 0 33, 50 0 3					FI XTURES		9	
IRAJINA ON-CALL   A		•	1					
33.35 MON-HOSPITAL DEPRECIATION A 2-26,554CAP REL COSTS-MABLE FOULP 9.00 9.33.35 33.35 33.36 MI SCELLANEOUS INCOME B -39,000/EMBERGENCY 91.00 0.33.36 33.37 MI SCELLANEOUS INCOME B -11,322/DAIN IN STRATI VE & GENERAL 5.00 0.33.37 33.37 33.38 MI SCELLANEOUS INCOME B -11,322/DAIN IN STRATI VE & GENERAL 5.00 0.33.37 33.37 33.39 MI SCELLANEOUS INCOME B -20,001/EMBERGENCY 0.00 0.00 0.33.37 33.39 4 MI SCELLANEOUS INCOME B -20,001/EMBERGENCY 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.			1					
MISCELLANGUS INCOME		1	1					
33.38 MI SCELLANGUS INCOME B -514,056/ADM NISTRATIVE & GENERAL 5,00 0,33.38 33.39 MI SCELLANGUS INCOME B -720/DID ITEMPY 10.00 0,33.39 33.39 MI SCELLANGUS INCOME B -733/DIRUGS CHARGED TO PATIENTS 73.00 0,33.40 33.40 33.41 MI SCELLANGUS INCOME B -733/DIRUGS CHARGED TO PATIENTS 73.00 0,33.40 33.40 33.41 MI SCELLANGUS INCOME B -733/DIRUGS CHARGED TO PATIENTS 73.00 0,33.40 33.42 33.41 MI SCELLANGUS INCOME B -7.16 // ADMINISTRATION 13.00 0,33.42 33.43 MI SCELLANGUS INCOME B -7.16 // ADMINISTRATION 13.00 0,33.42 33.43 MI SCELLANGUS INCOME B -7.5 // ADMINISTRATIVE & GENERAL 5.00 0,33.43 43 MI SCELLANGUS INCOME B -7.5 // ADMINISTRATIVE & GENERAL 5.00 0,33.44 33.46 CARF CORDON HATTON B -7.5 // ADMINISTRATIVE & GENERAL 5.00 0,33.47 MI SCELLANGUS INCOME B -7.5 // ADMINISTRATIVE & GENERAL 5.00 0,33.47 MI SCELLANGUS INCOME B -7.5 // ADMINISTRATIVE & GENERAL 5.00 0,33.47 MI SCELLANGUS INCOME B -7.5 // ADMINISTRATIVE & GENERAL 5.00 0,33.48 40 40 // ADMINISTRATIVE & GENERAL 5.00 0,33.49 40 // ADMINISTRATIVE & GENERAL 5.00 0,33.49 40 // ADMINISTRATIVE & GENERAL 5.00 0,33.49 40 // ADMINISTRATIVE & GENERAL 5.00 0,33.49 40 // ADMINISTRATIVE & GENERAL 5.00 0,33.49 40 // ADMINISTRATIVE & GENERAL 5.00 0,33.49 40 // ADMINISTRATIVE & GENERAL 5.00 0,33.50 // ADMINISTRATIVE		1			l e e e e e e e e e e e e e e e e e e e		0	
MISCELLANOUS INCOME								
33.40 MI SCELLANEOUS INCOME B -733 DRUGS CHARGED TO PATIENTS 73.00 0 33.40 33.41 MI SCELLANEOUS INCOME B -1.26 FARADI LOCATO JAGOSTI C 54.00 0 33.41 33.42 MI SCELLANEOUS INCOME B -1.50 NOWES INCOME B -1.50 NOWES INCOME B -1.50 NOWES INCOME B -1.50 NOWES INCOME B -1.50 NOWES INCOME B -1.50 NOWES INCOME B -1.50 NOWES INCOME B -5.62 LIANDM IN STRATI WE & GENERAL 5.00 0 33.43 33.43 MI SCELLANEOUS INCOME B -5.62 LIANDM IN STRATI WE & GENERAL 5.00 0 33.43 33.46 MI SCELLANEOUS INCOME B -4.67, 538 ADMIN IN STRATI WE & GENERAL 5.00 0 33.45 33.46 MI SCELLANEOUS INCOME B -4.67, 538 ADMIN IN STRATI WE & GENERAL 5.00 0 33.47 MI SCELLANEOUS INCOME B -4.67, 538 ADMIN IN STRATI WE & GENERAL 5.00 0 33.47 MI SCELLANEOUS INCOME B -4.67, 538 ADMIN IN STRATI WE & GENERAL 5.00 0 33.47 MI SCELLANEOUS INCOME B -4.69, 599 MI ETARY 10.00 0 33.49 33.50 MI SCELLANEOUS INCOME B -4.69, 599 MI ETARY 10.00 0 33.49 33.50 MI SCELLANEOUS INCOME B -4.69, 599 MI ETARY 10.00 0 33.51 PHARMACY COVERAGE SENSEL A -1.44, 400.60 ADMIN ISTRATI WE & GENERAL 5.00 0 33.50 1 PHARMACY COVERAGE SENSEL A -1.44, 95 SEMPLOS CHARGED TO PATIENTS 73.00 0 33.51 MI TEREST FROM INSURANCE B -9.06, 45 SADMIN ISTRATI WE & GENERAL 5.00 0 33.53 1 PHARMACY COVERAGE SENSELS A -1.44, 95 SEMPLOS CHARGED TO PATIENTS 73.00 0 33.53 33.50 HTM FOR PROPERTY OF SERVES A -1.64 SADMIN ISTRATI WE & GENERAL 5.00 0 33.53 33.50 HTM FOR PROPERTY OF SERVES A -1.64 SADMIN ISTRATI WE & GENERAL 5.00 0 33.53 33.50 HTM FOR PROPERTY WE SERVES A -1.64 SADMIN ISTRATI WE & GENERAL 5.00 0 33.53 33.50 HTM FOR PROPERTY ME SERVES A -1.64 SADMIN ISTRATI WE & GENERAL 5.00 0 33.55 0 HTM FOR PROPERTY ME SERVES A -1.64 SADMIN ISTRATI WE & GENERAL 5.00 0 33.55 0 HTM FOR PROPERTY ME SERVES A -1.64 SADMIN ISTRATI WE & GENERAL 5.00 0 33.55 0 HTM FOR PROPERTY ME SERVES A -1.64 SADMIN ISTRATI WE & GENERAL 5.00 0 33.55 0 HTM FOR PROPERTY ME SERVES A -1.64 SADMIN ISTRATI WE & GENERAL 5.00 0 33.55 0 HTM FOR PROPERTY ME SERVES A -1.64 SADMIN ISTRATI WE & GENERAL 5.00 0 33.55 0 HTM FOR PROPERTY ME SERVES A -1.64 SADMIN IS								
33.42   MISCELLANEOUS INCOME   B   -1,900 WIRSING ADMINISTRATION   13.00   0 33.43		1						
33.43   MISCELLANEOUS INCOME	33. 41	MI SCELLANEOUS I NCOME		-1, 261	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 41
33.44   OCTORS LOUNGE REVENUE   B   -358, Odo DITARY   10.00   0.33, 44								
33.45   ABRE COORDINATION   B								
33. 46   MISCELLAMEOUS INCOME   B   -457, 538   ADMINI STRATIVE & GENERAL   5. 00   0   33. 46							0	
DUTSIDE CATERING		•					Ö	
33. 49   COFFEE BAR   B   -689, 5990  ETARY   10. 00   0   33. 49					PATI ENTS			
33 50   BPS EXPENSES   A   -14, 460, 604   DOMIN ISTRATI VE & GENERAL   5, 00   0, 33, 50		1					0	•
33. 51   PHARMACY COVERAGE SALARIES   A   -72, 984   DRUGS CHARGED TO PATIENTS   73. 00   0.33, 51		•	1		l e e e e e e e e e e e e e e e e e e e		0	
33. 53 PHARMACY COVERAGE EXPENSES A -24,963 DRUGS CHARGED TO PATIENTS 73. 00 0 33. 53 33. 54 INTEREST FROM IN INSURANCE B -96, 453.00M IN STRATI VE & GENERAL 5. 00 0 33. 55 33. 56 OTHER OPERATING EXPENSES A -104,038 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 55 33. 56 OTHER OPERATING EXPENSES A -56,588 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 55 33. 56 OTHER OPERATING EXPENSES A -56,588 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 55 33. 56 OTHER AGE EXPENSES A -399, 424 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 57 33. 58 NP AND PA WAGES A -399, 424 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 57 33. 59 NP AND PA WAGES A -399, 302 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 57 33. 59 NP AND PA WAGES A -723, 887 INTENSI VE CARE UNI T 31. 00 0 33. 58 33. 69 NP AND PA WAGES A -98, 300 OPERATING ROM 50. 00 0 33. 69 33. 60 NP AND PA WAGES A -343, 032 EMERGENCY 91. 00 0 33. 61 33. 61 NP AND PA WAGES A -343, 032 EMERGENCY 91. 00 0 33. 61 33. 62 NP AND PA WAGES A -343, 032 EMERGENCY 91. 00 0 33. 63 33. 64 LOBRY IN GENERAL 5. 00 0 33. 63 33. 64 LOBRY IN GENERAL 5. 00 0 33. 63 33. 64 LOBRY IN GENERAL 5. 00 0 33. 63 33. 64 LOBRY IN GENERAL 5. 00 0 33. 64 33. 65 MI SCELLARICOUS INCOME B -16,809 MAINTENANCE & REPAIRS 6. 00 0 33. 63 33. 66 MI SCELLARICOUS INCOME B -76,809 MAINTENANCE & REPAIRS 6. 00 0 33. 67  PINT TO SECULATION INCOME B -73,908 EMERGENCY 91. 00 0 33. 68 33. 69 EMPLOI YED PHYSICI AN BENEFIT TS A -1,884,010 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 3. 36 34. 60 MSCELLARICOUS INCOME B -73,908 ON TO APPLOYEE BENEFITS DEPARTMENT 4. 00 0 3. 36 35. 70 DEPRECIATION ADJUSTMENT A -9,908,017 CAP REL COSTS-BUTLER 1. 01 9 33. 70 37. 70 DEPRECIATION ADJUSTMENT A -9,908,017 CAP REL COSTS-DAK STREET 1. 01 9 33. 74 33. 75 DEPRECIATION ADJUSTMENT A -9,908,017 CAP REL COSTS-DAK STREET 1. 04 9 33. 73 33. 76 DEPRECIATION ADJUSTMENT A -1,509,017 CAP REL COSTS-DAK STREET 1. 05 9 33. 74 33. 76 DEPRECIATION ADJUSTMENT A -1,509,017 CAP REL COSTS-DAK STREET 1. 00 9 33. 79 33. 79 DEPRECIATION ADJUSTMENT A -1,509,017 CAP REL COSTS-DAK STREET 1. 00 9 33. 79 33.			1					
33. 54   INTEREST FROM INSURANCE   B   -96, 453   ADMINISTRATI VE & GENERAL   5. 00   0   33. 54		1	1		l e e e e e e e e e e e e e e e e e e e		0	
33.56   OTHER OPERATING EXPENSES   A   -104.038   ADMINISTRATIVE & GENERAL   5.00   0   33.55     33.56   OTHER A&G EXPENSES   A   -56.588   ADMINISTRATIVE & GENERAL   5.00   0   33.56     33.57   NP AND PA WAGES   A   -399.424   ADULTS & PEDIATRICS   30.00   0   33.56     33.58   NP AND PA WAGES   A   -732.887   INTENSIVE CARE UNIT   31.00   0   33.59     33.60   NP AND PA WAGES   A   -79.300   OPERATING PROM   50.00   0   33.59     33.60   NP AND PA WAGES   A   -79.300   OPERATING PROM   50.00   0   33.61     33.61   NP AND PA WAGES   A   -1.680,870   CLINIC   90.00   0   33.61     33.62   NP AND PA WAGES   A   -343.032   MERCENCY   91.00   0   33.61     33.63   OLLEGE OF NURSING LOBBYING   A   -665,005   MPLOYEE BENEFITS DEPARTMENT   4.00   0   33.63     33.64   LOBBYING EXPENSES   A   -3.095   SUBPROVIDER - IRF   41.00   0   33.63     33.65   MI SCELLANEOUS INCOME   B   -76,809 MAINTENANCE & REPAIRS   6.00   0   33.67     MI SCELLANEOUS INCOME   B   -76,809 MAINTENANCE & REPAIRS   6.00   0   33.67     HOSPICE RESPITE AND INPATIENT   A   2.294   MOSPICE   116.00   0   33.67     MISCELANEOUS INCOME   B   -73,988   MERCENCY   91.00   0   33.67     MISCELANEOUS INCOME   B   -74,809   MERCENCY   91.00   0   33.67     MISCELANEOUS INCOME   B   -74,809   MERCENCY   91.00   0   33.67     MISCELANEOUS INCOME   B   -74,809   MERCENCY   91.00   0   33.67     MISCELANEOUS INCOME   B   -74,809   MERCENCY   91.00   0   33.67     MISCELANEOUS INCOME   B   -74,809   MERCENCY   91.00   0   33.67     MISCELANEOUS INCOME   B   -74,809   MERCENCY   91.00   0   33.67     MISCELANEOUS INCOME   B   -74,809   MERCENCY   91.00   0   33.67     MISCELANEOUS INCOME   B   -74,809   MERCENCY   91.00   0   33.67     MISCELANEOUS INCOME   B   -74,809   MERCENCY   91.00   0   33.67     MISCELANEOUS INCOME   B   -74,809   MERCENCY   91.00   0   33.67     MISCELANEOUS INCOME   B   -74,809   MERCENCY   91.00   0   33.67     MISCELANEOUS INCOME   B   -74,809   MERCENCY   91.00   0   33.67     MISCELANEOUS INCOME   B   -74,809   MERCENCY   91					l e e e e e e e e e e e e e e e e e e e		0	
33.56   OTHER AMG EXPENSES   A   -56.588 ADMINI STRATIVE & GENERAL   5.00   0.33.56		1	1				0	
33. 57   NP AND PA WAGES   A   -399, 424 ADUITS & PEDIATRICS   30. 00   0   33. 57		·	1					
33. 59   NP AND PA WAGES   A   -98, 300  OPERATING ROOM   90. 00   0   33. 59	33. 57		A			30.00	0	33. 57
33.60   NP AND PA WAGES   A   -1,680,870   CLI NI C   90.00   0   33.60     33.61   NP AND PA WAGES   A   -343,032   EMERGENCY   91.00   0   33.61     33.62   NP AND PA BENEFITS   A   -665,005   EMPLOYTE BENEFITS DEPARTMENT   4.00   0   33.62     33.63   COLLEGE OF NURSING LOBBYING   A   -16,878   NURSING PROGRAM   20.00   0   33.63     33.64   LOBBYI NG EXPENSES   A   -3,095   SUBPROVI DER - IRF   41.00   0   33.65     33.65   MI SCELLANEOUS I NCOME   B   -76,809   MAI NTENANCE & REPAIRS   6.00   0   33.65     33.67   HOSPI CE RESPITE AND I NPATI ENT   PMT   116.00   0   33.67     33.67   HOSPI CE RESPITE AND I NPATI ENT   A   2,294   HOSPI CE   116.00   0   33.69     33.69   EMPLOI YED PHYSI CI AN BENEFITS   A   -1,884,010   EMPLOYEE BENEFITS DEPARTMENT   4.00   0   33.69     33.70   DEPRECIATION ADJUSTMENT   A   -9,908,017 CAP REL COSTS-BUTLER   1.01   9   33.70     33.71   DEPRECIATION ADJUSTMENT   A   8,656,246 CAP REL COSTS-NEW BLDG & 1.02   9   33.71     33.73   DEPRECIATION ADJUSTMENT   A   630,428 CAP REL COSTS-NEW BLDG & 1.03   9   33.74     33.75   DEPRECIATION ADJUSTMENT   A   137,622 CAP REL COSTS-OAK STREET   1.05   9   33.76     33.76   DEPRECIATION ADJUSTMENT   A   137,622 CAP REL COSTS-BROK AT 36TH   1.06   9   33.76     33.76   DEPRECIATION ADJUSTMENT   A   1,097,072 CAP REL COSTS-SURGERY CENTER   1.07   9   33.76     33.76   DEPRECIATION ADJUSTMENT   A   1,097,072 CAP REL COSTS-SURGERY CENTER   1.06   9   33.76     33.77   DEPRECIATION ADJUSTMENT   A   1,097,072 CAP REL COSTS-SURGERY CENTER   1.07   9   33.76     33.78   DEPRECIATION ADJUSTMENT   A   1,299,311 CAP REL COSTS-BRON AT 36TH   1.08   9   33.77     33.79   DEPRECIATION ADJUSTMENT   A   423,756 CAP REL COSTS-BRON BLDG & 1.03   9   33.80     33.80   DEPRECIATION ADJUSTMENT   A   2,914,484 CAP REL COSTS-BRON BLDG & 1.03   9   33.80     33.80   DEPRECIATION ADJUSTMENT   A   2,914,484 CAP REL COSTS-BRON BLDG & 1.03   9   33.80     33.80   DEPRECIATION ADJUSTMENT   A   2,914,484 CAP REL COSTS-BRON BLDG & 1.03   9   33.80     33.80   DE			1					
33. 61   NP AND PA WAGES   A   -343.032 EMERGENCY   91.00   0   33.61     33. 62   NP AND PA BENEFITS   A   -665.005 EMPLOYBE BENEFITS DEPARTMENT   4.00   0   33.62     33. 63   COLLEGE OF NURSING LOBBYING   A   -16.878 NURSING PROGRAM   20.00   0   33.63     33. 64   LOBBYING EXPENSES   A   -3.095 SUBPROVIDER - IRF   41.00   0   33.65     33. 65   MI SCELLANEOUS INCOME   B   -76.809 MAINTENANCE & REPAIRS   6.00   0   33.65     33. 66   MI SCELLANEOUS INCOME   B   -76.809 MAINTENANCE & REPAIRS   6.00   0   33.65     33. 67   HOSPICE RESPITE AND INPATIENT   A   2.294 HOSPICE   116.00   0   33.67     33. 68   HOSPITAL SERVICES TO HOSPICE   A   173.006 HOSPICE   116.00   0   33.69     33. 70   DEPRECIATION ADJUSTMENT   A   -1.884,010 EMPLOYBE BENEFITS DEPARTMENT   4.00   0   33.69     33. 71   DEPRECIATION ADJUSTMENT   A   -9.908,017 CAP REL COSTS-BUTLER   1.01   9   33.70     33. 72   DEPRECIATION ADJUSTMENT   A   -9.908,017 CAP REL COSTS-NEW BLDG &   1.02   9   33.71     33. 73   DEPRECIATION ADJUSTMENT   A   630,428 CAP REL COSTS-OAK STREET   1.05   9   33.74     33. 75   DEPRECIATION ADJUSTMENT   A   608,676 CAP REL COSTS-OAK STREET   1.06   9   33.75     33. 76   DEPRECIATION ADJUSTMENT   A   137,692 CAP REL COSTS-OAK STREET   1.06   9   33.75     33. 76   DEPRECIATION ADJUSTMENT   A   1,097,072 CAP REL COSTS-SURGERY CENTER   1.07   9   33.76     33. 76   DEPRECIATION ADJUSTMENT   A   1,097,072 CAP REL COSTS-SURGERY CENTER   1.07   9   33.76     33. 78   DEPRECIATION ADJUSTMENT   A   1,097,072 CAP REL COSTS-SURGERY CENTER   1.07   9   33.76     33. 78   DEPRECIATION ADJUSTMENT   A   1,097,072 CAP REL COSTS-HANNIBAL   1.09   9   33.78     33. 79   DEPRECIATION ADJUSTMENT   A   2,914,484 CAP REL COSTS-NEW BLDG &   1.03   9   33.80     DEPRECIATION ADJUSTMENT   A   2,914,484 CAP REL COSTS-NEW BLDG &   1.03   9   33.80     DEPRECIATION ADJUSTMENT   A   2,914,484 CAP REL COSTS-NEW BLDG &   1.03   9   33.80     DEPRECIATION ADJUSTMENT   A   2,914,484 CAP REL COSTS-NEW BLDG &   1.03   9   33.80     DEPRECIATION AD			1	·				
33. 62   NP AND PA BENEFITS   A   -665, 005 EMPLOYEE BENEFITS DEPARTMENT   4, 00   0   33, 63			1					
33.64   LOBBYI NG EXPENSES   A   -3,095 SUBPROVI DER - IRF   41.00   0   33.64     33.65   MI SCELLANEOUS I NCOME   B   -76,809 MAINTENANCE & REPAIRS   6.00   0   33.65     33.66   MI SCELLANEOUS I NCOME   B   -76,809 MAINTENANCE & REPAIRS   91.00   0   33.66     33.67   HOSPI CE RESPI TE AND I NPATI ENT PMT   A   2,294 HOSPI CE   116.00   0   33.67     33.68   HOSPI TAL SERVI CES TO HOSPI CE   A   173,006 HOSPI CE   116.00   0   33.69     33.70   DEPRECI ATI ON ADJUSTMENT   A   -1,884,010   EMPLOYEE BENEFI TS DEPARTMENT   4.00   0   33.69     33.71   DEPRECI ATI ON ADJUSTMENT   A   -9,908,017 CAP REL COSTS-BUTLER   1.01   9   33.70     33.71   DEPRECI ATI ON ADJUSTMENT   A   8,656,246 CAP REL COSTS-NEW BLDG & 1.02   9   33.71     33.73   DEPRECI ATI ON ADJUSTMENT   A   608,676 CAP REL COSTS-MOB   1.04   9   33.73     33.74   DEPRECI ATI ON ADJUSTMENT   A   608,676 CAP REL COSTS-OAK STREET   1.05   9   33.74     33.75   DEPRECI ATI ON ADJUSTMENT   A   1,097,072 CAP REL COSTS-BRCN AT 36TH   1.06   9   33.76     33.76   DEPRECI ATI ON ADJUSTMENT   A   1,097,072 CAP REL COSTS-BRCN AT 36TH   1.06   9   33.76     33.76   DEPRECI ATI ON ADJUSTMENT   A   1,529,311 CAP REL COSTS-BRCN AT 36TH   1.06   9   33.76     33.76   DEPRECI ATI ON ADJUSTMENT   A   1,529,311 CAP REL COSTS-BRCN AT 36TH   1.08   9   33.76     33.77   DEPRECI ATI ON ADJUSTMENT   A   1,529,311 CAP REL COSTS-BRCN AT 36TH   1.08   9   33.76     33.78   DEPRECI ATI ON ADJUSTMENT   A   1,529,311 CAP REL COSTS-BRCN AT 36TH   1.08   9   33.76     33.79   DEPRECI ATI ON ADJUSTMENT   A   2,914,484 CAP REL COSTS-BRCN BLDG & 1.03   9   33.80     DEPRECI ATI ON ADJUSTMENT   A   2,914,484 CAP REL COSTS-BRCN BLDG & 1.03   9   33.80     DEPRECI ATI ON ADJUSTMENT   A   2,914,484 CAP REL COSTS-BRCN BLDG & 1.03   9   33.80     DEPRECI ATI ON ADJUSTMENT   A   2,914,484 CAP REL COSTS-BRCN BLDG & 1.03   9   33.80     DEPRECI ATI ON ADJUSTMENT   A   2,914,484 CAP REL COSTS-BRCN BLDG & 1.03   9   33.80     DEPRECI ATI ON ADJUSTMENT   A   2,914,484 CAP REL COSTS-BRCN BLDG		NP AND PA BENEFITS	1			4. 00		33. 62
33. 65   MI SCELLANEOUS I NCOME   B   -76, 809 MAI NTENANCE & REPAIRS   6. 00   0   33. 65     33. 66   MI SCELLANEOUS I NCOME   B   -37, 988   EMERGENCY   91. 00   0   33. 66     33. 67   HOSPI CE RESPITE AND I NPATI ENT PMT   A   2, 294   HOSPI CE   116. 00   0   33. 67     33. 68   HOSPI TAL SERVI CES TO HOSPI CE PTS   173, 006   HOSPI CE PTS   116. 00   0   33. 68     33. 69   EMPLOI YED PHYSI CI AN BENEFI TS   A   -1, 884, 010   EMPLOYEE BENEFI TS DEPARTMENT   4. 00   0   33. 69     33. 70   DEPRECI ATI ON ADJUSTMENT   A   -9, 908, 017   CAP REL COSTS - BUT LER BUILDING   1. 01   9   33. 70     33. 71   DEPRECI ATI ON ADJUSTMENT   A   -9, 908, 017   CAP REL COSTS - NEW BLDG &   1. 02   9   33. 71     33. 72   DEPRECI ATI ON ADJUSTMENT   A   8, 656, 246   CAP REL COSTS - NEW BLDG &   1. 03   9   33. 72     33. 73   DEPRECI ATI ON ADJUSTMENT   A   630, 428   CAP REL COSTS - OAK STREET   1. 05   9   33. 73     33. 75   DEPRECI ATI ON ADJUSTMENT   A   630, 428   CAP REL COSTS - OAK STREET   1. 05   9   33. 75     33. 76   DEPRECI ATI ON ADJUSTMENT   A   1, 097, 072   CAP REL COSTS - SURGERY CENTER   1. 07   9   33. 76     33. 77   DEPRECI ATI ON ADJUSTMENT   A   1, 097, 072   CAP REL COSTS - SURGERY CENTER   1. 07   9   33. 76     33. 78   DEPRECI ATI ON ADJUSTMENT   A   1, 299, 311   CAP REL COSTS - SURGERY CENTER   1. 09   9   33. 78     33. 79   DEPRECI ATI ON ADJUSTMENT   A   423, 756   CAP REL COSTS - MUBLE EQUIP   2. 00   9   33. 79     33. 80   DEPRECI ATI ON ADJUSTMENT   A   2, 914, 484   CAP REL COSTS - MUBLE EQUIP   2. 00   9   33. 79     33. 80   DEPRECI ATI ON ADJUSTMENT   A   2, 914, 484   CAP REL COSTS - MUBLE EQUIP   2. 00   9   33. 79     33. 80   DEPRECI ATI ON ADJUSTMENT   A   2, 914, 484   CAP REL COSTS - MUBLE EQUIP   2. 00   9   33. 80     33. 80   DEPRECI ATI ON ADJUSTMENT   A   2, 914, 484   CAP REL COSTS - MUBLE EQUIP   2. 00   9   33. 80     33. 80   DEPRECI ATI ON ADJUSTMENT   A   2, 914, 484   CAP REL COSTS - MUBLE EQUIP   2. 00   9   33. 80     33. 80   DEPRECI ATI ON ADJUSTMENT		1	1					
33. 66   MI SCELLANEOUS I NCOME   B   -37, 988   EMERGENCY   91.00   0   33. 66     33. 67   HOSPI CE RESPITE AND I NPATIENT   A   2,294   HOSPI CE   116.00   0   33. 67     33. 68   HOSPI TAL SERVI CES TO HOSPI CE   A   173, 006   HOSPI CE   116.00   0   33. 68     33. 69   EMPLOI YED PHYSI CI AN BENEFI TS   A   -1,884, 010   EMPLOYEE BENEFI TS DEPARTMENT   4.00   0   33. 69     33. 70   DEPRECIATI ON ADJUSTMENT   A   -1,884, 010   EMPLOYEE BENEFI TS DEPARTMENT   4.00   9   33. 70     33. 71   DEPRECIATI ON ADJUSTMENT   A   -9,908, 017   CAP REL COSTS-BUTLER   1.01   9   33. 71     33. 72   DEPRECIATI ON ADJUSTMENT   A   8,656,246   CAP REL COSTS-NEW BLDG &   1.03   9   33. 72     33. 73   DEPRECIATI ON ADJUSTMENT   A   630, 428   CAP REL COSTS-NOB   1.04   9   33. 73     33. 74   DEPRECIATI ON ADJUSTMENT   A   608, 676   CAP REL COSTS-OAK STREET   1.05   9   33. 74     33. 75   DEPRECIATI ON ADJUSTMENT   A   1,097, 072   CAP REL COSTS-BRON AT 36TH   1.06   9   33. 75     33. 76   DEPRECIATI ON ADJUSTMENT   A   1,097, 072   CAP REL COSTS-SURGERY CENTER   1.07   9   33. 76     33. 78   DEPRECIATI ON ADJUSTMENT   A   1,529, 311   CAP REL COSTS-HANNI BAL   1.09   9   33. 78     33. 79   DEPRECIATI ON ADJUSTMENT   A   2,914, 484   CAP REL COSTS-MVBLE EQUI P   2.00   9   33. 79     33. 80   DEPRECIATI ON ADJUSTMENT   A   2,914, 484   CAP REL COSTS-NEW BLDG &   1.03   9   33. 79     33. 80   DEPRECIATI ON ADJUSTMENT   A   2,914, 484   CAP REL COSTS-MVBLE EQUI P   2.00   9   33. 79     33. 80   DEPRECIATI ON ADJUSTMENT   A   2,914, 484   CAP REL COSTS-NEW BLDG &   1.03   9   33. 80     33. 80   DEPRECIATI ON ADJUSTMENT   A   2,914, 484   CAP REL COSTS-NEW BLDG &   1.03   9   33. 80     33. 80   DEPRECIATI ON ADJUSTMENT   A   2,914, 484   CAP REL COSTS-NEW BLDG &   1.03   9   33. 80     33. 80   DEPRECIATION ADJUSTMENT   A   2,914, 484   CAP REL COSTS-NEW BLDG &   1.03   9   33. 80     33. 80   DEPRECIATION ADJUSTMENT   A   2,914, 484   CAP REL COSTS-NEW BLDG &   1.03   9   33. 80     33. 80   DEPRECIATION ADJUSTMEN		1	1					
33. 67   HOSPI CE RESPITE AND INPATIENT PMT		1						
PTS			1				0	
33. 70   DEPRECIATION ADJUSTMENT   A   15, 464   CAP REL COSTS-BUTLER   BUILDING   SUILDING   SUI		PTS						
33. 71 DEPRECIATION ADJUSTMENT  A		1	1 . 1	15, 464	CAP REL COSTS-BUTLER		9	
33. 72   DEPRECIATION ADJUSTMENT   A   8,656,246   CAP REL COSTS-NEW BLDG & 1. 03   9   33. 72   FIXTURES	33. 71	DEPRECIATION ADJUSTMENT	А	-9, 908, 017	CAP REL COSTS-OLD BLDG &	1. 02	9	33. 71
33. 74 DEPRECIATION ADJUSTMENT  A 608, 676 CAP REL COSTS-OAK STREET  1. 05 9 33. 74 MALL  33. 75 DEPRECIATION ADJUSTMENT  A 137, 622 CAP REL COSTS-BRCN AT 36TH  ST  33. 76 DEPRECIATION ADJUSTMENT  A 1, 097, 072 CAP REL COSTS-SURGERY CENTER  33. 77 DEPRECIATION ADJUSTMENT  A 1, 529, 311 CAP REL COSTS-48TH AND MAINE  1. 08 9 33. 77  33. 78 DEPRECIATION ADJUSTMENT  A 423, 756 CAP REL COSTS-HANNI BAL  33. 79 DEPRECIATION ADJUSTMENT  A 2, 914, 484 CAP REL COSTS-MVBLE EQUIP  33. 80 DEPRECIATION ADJUSTMENT  A 2, 914, 484 CAP REL COSTS-NEW BLDG & 1. 03 9 33. 80			A	8, 656, 246	CAP REL COSTS-NEW BLDG & FIXTURES	1. 03	9	
33. 75 DEPRECIATION ADJUSTMENT  A 137, 622 CAP REL COSTS-BRCN AT 36TH  5 ST  33. 76 DEPRECIATION ADJUSTMENT  A 1,097,072 CAP REL COSTS-SURGERY CENTER  33. 77 DEPRECIATION ADJUSTMENT  A 1,097,072 CAP REL COSTS-48TH AND MAINE  1. 07 9 33. 76  1. 08 9 33. 77  33. 78 DEPRECIATION ADJUSTMENT  A 423,756 CAP REL COSTS-HANNI BAL  1. 09 9 33. 78  DEPRECIATION ADJUSTMENT  A 2,914,484 CAP REL COSTS-MVBLE EQUIP  33. 79 DEPRECIATION ADJUSTMENT  A 2,914,484 CAP REL COSTS-NEW BLDG & 1. 03 9 33. 79  DEPRECIATION ADJUSTMENT  A 2-69,061 CAP REL COSTS-NEW BLDG & 1. 03 9 33. 80			1	608, 676	CAP REL COSTS-OAK STREET		- 1	
33. 77 DEPRECIATION ADJUSTMENT 33. 78 DEPRECIATION ADJUSTMENT A 1, 529, 311 CAP REL COSTS-48TH AND MAINE 1. 08 9 33. 77 423, 756 CAP REL COSTS-HANNIBAL 1. 09 9 33. 78 33. 79 DEPRECIATION ADJUSTMENT A 2, 914, 484 CAP REL COSTS-MVBLE EQUIP 2. 00 9 33. 79 DEPRECIATION ADJUSTMENT A -269, 061 CAP REL COSTS-NEW BLDG & 1. 03 9 33. 80 FI XTURES	33. 75	DEPRECIATION ADJUSTMENT	A		l e e e e e e e e e e e e e e e e e e e	1. 06	9	33. 75
33. 77 DEPRECIATION ADJUSTMENT 33. 78 DEPRECIATION ADJUSTMENT A 1, 529, 311 CAP REL COSTS-48TH AND MAINE 1. 08 9 33. 77 423, 756 CAP REL COSTS-HANNIBAL 1. 09 9 33. 78 33. 79 DEPRECIATION ADJUSTMENT A 2, 914, 484 CAP REL COSTS-MVBLE EQUIP 2. 00 9 33. 79 DEPRECIATION ADJUSTMENT A -269, 061 CAP REL COSTS-NEW BLDG & 1. 03 9 33. 80 FI XTURES	33. 76	DEPRECIATION ADJUSTMENT	A	1, 097, 072	CAP REL COSTS-SURGERY CENTER	1. 07	9	33. 76
33. 79 DEPRECIATION ADJUSTMENT A 2, 914, 484 CAP REL COSTS-MVBLE EQUIP 2. 00 9 33. 79 33. 80 DEPRECIATION ADJUSTMENT A 2, 914, 484 CAP REL COSTS-NEW BLDG & 1. 03 9 33. 80 FI XTURES	33. 77	DEPRECIATION ADJUSTMENT	A	1, 529, 311	CAP REL COSTS-48TH AND MAINE	1. 08		33. 77
33. 80 DEPRECIALTON ADJUSTMENT A -269, 061 CAP REL COSTS-NEW BLDG & 1. 03 9 33. 80 FI XTURES		1	1					
FIXTURES		1	1					
33. 81   CONTRACTED HOUSEKEEPI NG   A   -117   HOUSEKEEPI NG   9. 00   0   33. 81					FI XTURES			
	33. 81	CONTRACTED HOUSEKEEPING	Α	-117 	HOUSEKEEPI NG	9. 00	0	33. 81

Heal th	Financial Systems		BLESSI NG 1	HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
ADJUST	TMENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 10/01/2022		
					To 09/30/2023	Date/Time Pre 12/29/2023 3:	
				Expense Classification or	Worksheet A	12/2//2023 3.	OT PIII
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
33. 82	CONTRACTED HOUSEKEEPING	A	•	HOUSEKEEPI NG	9. 00		33. 82
33. 83	PROVI DER TAX	A	-14, 152, 759	ADMINISTRATIVE & GENERAL	5. 00		33. 83
33. 84	COMMUNITY BENEFIT	A	•	ADMINISTRATIVE & GENERAL	5. 00		33. 84
33. 85	TUITION FOR SOPHOMORE STUDENTS	В	•	ADULTS & PEDIATRICS	30.00		33. 85
33. 86	COSTS FOR NON-RHC ACTIVITY	A	-3, 511, 718	MAIN CAMPUS RHC	88. 03	0	33. 86
33. 87	SNU PHYSICIAN	A	•	SKILLED NURSING FACILITY	44. 00		33. 87
33. 88	CONTRACTED HOUSEKEEPING	A	-4, 803	MAINTENANCE & REPAIRS	6. 00	0	33. 88
33. 89	MI SCELLANEOUS I NCOME	В	-7, 330	MAIN CAMPUS RHC	88. 03	0	33. 89
33. 90	MI SCELLANEOUS I NCOME	В	-387, 939	MAIN CAMPUS RHC	88. 03	0	33. 90
33. 91	MI SCELLANEOUS I NCOME	В	-88, 542	ADMINISTRATIVE & GENERAL	5. 00	0	33. 91
	EQUI PMENT RENT	В	-106, 155	CAP REL COSTS-MVBLE EQUIP	2.00	9	33. 92
50.00	TOTAL (sum of lines 1 thru 49)		-167, 459, 065				50.00
	(Transfer to Worksheet A,						
	(Transfer to Worksheet A,						

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

column 6, line 200.)

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.

Health Financial Systems BLESSING HOSTATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 14-0015 OFFICE COSTS

				10 09/30/2023	Date/lime Pre 12/29/2023 3:	
	Li ne No.	Cost Center	Expense I tems	Amount of Allowable Cost	Amount	
	1.00	2.00	3. 00	4. 00	5 5. 00	
			TRANSACTIONS WITH RELATED OR			
	HOME OFFICE COSTS:					
1.00		MAINTENANCE & REPAIRS	BI O-MED	840, 064	1, 824, 243	1.00
2. 00 3. 00		OPERATING ROOM RADIOLOGY-DIAGNOSTIC	BI O-MED BI O-MED	272 1, 079	590 2, 343	2. 00 3. 00
4. 00		BLESSING EXPRESS CLINIC	BI O-MED	31	68	4. 00
4. 01		BLESSING WALK IN CLINIC	BI O-MED	1, 168	2, 537	4. 01
4. 02		PALMYRA RHC	BI O-MED	874	1, 898	4. 02
4. 03 4. 04		BOWLING GREEN RHC	BI O-MED BI O-MED	719 1, 425	1, 561 3, 094	4. 03 4. 04
4. 05		ł	BI O-MED	2, 063	4, 479	4. 05
4. 06		WELLNESS CENTER	BI O-MED	56	122	4. 06
4. 07 4. 08		LAUNDRY & LINEN SERVICE LABORATORY	LAUNDRY LAUNDRY	1, 563, 389	1, 549, 443	4. 07 4. 08
4.00		MT STERLING RHC	LAUNDRY	215 148	213 147	4. 00
4. 10		MAIN CAMPUS RHC	LAUNDRY	4, 659	4, 617	4. 10
4. 11		BLESSING EXPRESS CLINIC	LAUNDRY	1, 578	1, 564	4. 11
4. 12 4. 13		PALMYRA RHC CLINIC	LAUNDRY LAUNDRY	40 2, 741	40 2, 717	4. 12 4. 13
4. 13		PHYSICIANS' PRIVATE OFFICES	LAUNDRY	496	492	4. 13
4. 15		WELLNESS CENTER	LAUNDRY	1, 725	1, 710	4. 15
4. 16		EAST ADAMS RHC	EAST ADAMS RENT	280	86, 582	4. 16
4. 17 4. 18		ADMINISTRATIVE & GENERAL MEDICAL RECORDS & LIBRARY	HOME OFFICE	59, 872, 202 9, 485, 649	20, 628, 187 0	4. 17 4. 18
4. 19		ł	BCS BENEFITS	0	2, 480, 270	4. 19
4. 20		CAP REL COSTS-MOB	MOB RENT	716, 538	2, 064, 330	4. 20
4. 21		CAP REL COSTS-MOB	MOB RENT	0	1, 965, 266	4. 21
4. 22 4. 23		MAINTENANCE & REPAIRS DIETARY	MOB UTILITIES DIETICIAN COSTS	210, 885	0 5, 452	4. 22 4. 23
4. 24		ł	DIETICIAN BENEIFTS	Ö	1, 114	4. 24
4. 25		ADMINISTRATIVE & GENERAL	DATA ANALYTICS WAGES	0	1, 182, 432	4. 25
4. 26 4. 27		ADMINISTRATIVE & GENERAL EMPLOYEE BENEFITS DEPARTMENT	FISCAL SERVICES WAGES HUMAN RESOURCES WAGES	0	1, 447, 390 1, 306, 770	4. 26 4. 27
4. 28		ADMINISTRATIVE & GENERAL	INFORMATION SYSTEMS WAGES	0	7, 287, 764	4. 28
4. 29	5. 00	ADMINISTRATIVE & GENERAL	PURCHASING WAGES	0	1, 009, 380	4. 29
4. 30		}	SHARED DEPARTMENTS BENEFITS	0	5, 578, 721	4. 30
4. 31 4. 32		NURSING ADMINISTRATION ADMINISTRATIVE & GENERAL	CARE MANAGEMENT WAGES DATA ANALYTICS EXPENSES	0	4, 067, 519 99, 168	4. 31 4. 32
4. 33		ADMINISTRATIVE & GENERAL	FISCAL SERVICES EXPENSES	Ö	160, 405	4. 33
4. 34		EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES EXPENSES	0	1, 457, 784	4. 34
4. 35 4. 36		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	INFORMATION SYSTEMS EXPENSES PURCHASING EXPENSES	0	15, 008, 096 775, 213	4. 35 4. 36
4. 37		NURSING ADMINISTRATION	CARE MANAGEMENT EXPENSES	0	5, 556	4. 37
4. 38		MEDICAL RECORDS & LIBRARY	HIM WAGES	0	5, 795, 034	4. 38
4. 39		ADMINISTRATIVE & GENERAL	PFS WAGES	0	5, 329, 417	4. 39
4. 40 4. 41		ADMINISTRATIVE & GENERAL EMPLOYEE BENEFITS DEPARTMENT	PT ACCESS WAGES REVENUE CYCLE BENEFITS	0	4, 832, 431 7, 898, 616	4. 40 4. 41
4. 42		ł .	HIM EXPENSES	Ö	1, 496, 467	4. 42
4. 43		li e	PFS EXPENSES	0	4, 047, 625	4. 43
4. 44 4. 45		ADMINISTRATIVE & GENERAL ELECTROENCEPHALOGRAPHY	PT ACCESS EXPENSES SLEEP STUDY WAGES	0	362, 372 13, 616	4. 44 4. 45
4. 46		EMPLOYEE BENEFITS DEPARTMENT		Ö	2, 790	4. 46
4.47		ELECTROENCEPHALOGRAPHY	SLEEP STUDY EXPENSES	0	1, 172	4. 47
4.48		ADULTS & PEDIATRICS	TELEMETRY WAGES	0	9, 938	4. 48
4. 49 4. 50		EMPLOYEE BENEFITS DEPARTMENT MEDICAL SUPPLIES CHARGED TO	TELEMETRY BENEFITS LOGISTICS MANAGER WAGES	0	2, 036 78, 001	4. 49 4. 50
4. 51		l e e e e e e e e e e e e e e e e e e e	LOGISTICS MANAGER BENEFITS	0	15, 982	4. 51
4. 52		ADMINISTRATIVE & GENERAL	OAK STREET MALL	0	358, 476	4. 52
4. 53 4. 54		CAP REL COSTS-OAK STREET MAL CAP REL COSTS-OAK STREET MAL	OAK STREET MALL	381, 045	0 189, 030	4. 53 4. 54
4. 55		NURSING ADMINISTRATION	HOME OFFICE	5, 122, 164	0	4. 55
4.56	88.00	EAST ADAMS RHC	HOME OFFICE-EAST ADAMS	4, 697	0	4. 56
4.57		48TH AND MAINE RHC	HOME OFFICE AT STEELING	10, 126	0	4. 57
4. 58 4. 59		MT STERLING RHC MAIN CAMPUS RHC	HOME OFFICE-MT STERLING HOME OFFICE-MAIN	1, 662 83, 236	0	4. 58 4. 59
4. 60		BLESSING EXPRESS CLINIC	HOME OFFICE-EXPRESS	12, 722	o	4. 60
4. 61		BLESSING WALK IN CLINIC	HOME OFFICE-WALK-IN	21, 563	0	4. 61
4. 62 4. 63		HANNIBAL MAIN RHC PALMYRA RHC	HOME OFFICE-HANNIBAL MAIN HOME OFFICE-PALMYRA	18, 366 1, 542	0	4. 62 4. 63
4. 63 4. 64		BOWLING GREEN RHC	HOME OFFICE-PALMYRA HOME OFFICE-BOWLING GREEN	526	0	4. 63 4. 64
4.65	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE-CHIEFS	1, 388, 514	0	4. 65
4. 66	60.00	LABORATORY	MOLECULAR LAB	1, 974, 253	861, 442	4. 66

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME

Provider CCN: 14-0015

Peri od: Worksheet A-8-1

From 10/01/2022 OFFICE COSTS 09/30/2023 Date/Time Prepared:

				_	12/29/2023 3:	54 pm
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	i l
				Allowable Cost	Included in	ı
					Wks. A, column	i
					5	i
	1. 00	2. 00	3. 00	4. 00	5. 00	
4.67	116. 00	HOSPI CE	RENT	0	850	4. 67
4.68	116. 00	HOSPI CE	RENT	0	826	4. 68
4.69	88. 02	MT STERLING RHC	MT STERLING RENT	21, 597	86, 724	4. 69
4.70	88. 03	MAIN CAMPUS RHC	CPC USE	3, 548	6, 365	4. 70
4.71	90.00	CLI NI C	CPC USE	30, 176	67, 403	4. 71
4.72	5. 00	ADMINISTRATIVE & GENERAL	RHC DIRECTOR WAGES	0	142, 097	4. 72
4.73	4.00	EMPLOYEE BENEFITS DEPARTMENT	RHC DIRECTOR BENEFITS	0	34, 397	4. 73
4.74	5. 00	ADMINISTRATIVE & GENERAL	RHC DI RECTOR EXPENSES	0	4, 426	4. 74
4.75	90.00	CLI NI C	BARIATRIC RENT	48, 848	78, 517	4. 75
4.76	88. 07	PALMYRA RHC	PALMYRA RENT	7, 597	13, 563	4. 76
4.77	5. 00	ADMINISTRATIVE & GENERAL	CHIEF MEDICAL OFFICERS WAGES	0	1, 283, 073	4. 77
4.78	4.00	EMPLOYEE BENEFITS DEPARTMENT	CHIEF MEDICAL OFFICERS BENEF	0	156, 074	4. 78
5.00	TOTALS (sum of lines 1-4).			81, 840, 478	103, 188, 037	5. 00
	Transfer column 6, line 5 to					I
	Worksheet A-8, column 2,					I
	line 12.					l
* The	amounts on Lines 1 4 (and sub	! _ +			/ 1:	

The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropri ate

Positive amounts increase cost and negative amounts decrease cost.

For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable

should be indicated in column 4 of this part.

			Related Organization(s) and/				
Symbol (1)	Name	Percentage of	Name	Percentage of			
		Ownershi p		Ownershi p			
1. 00	2. 00	3. 00	4. 00	5. 00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

6.00	G		O. OO DENMAN SERVICES	0.00	6. 00
7.00	G		O. OO BLESSING FOUND	0.00	7. 00
8.00	В		0.00 BLESS CORP SVCS	0.00	8. 00
9.00	G		O. OO RI VERCORSS DI AG	0.00	9. 00
10.00	G		O.OOILLINI COMM HOS	0.00	10. 00
100.00	G. Other (financial or	BROTHER/SI STER			100.00
	non-financial) specify:				

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

BLESSING HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems BLESSING HOSTATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 14-0015 OFFICE COSTS

					To 09/30/2023   Date/lime Pre   12/29/2023 3:	
	Net	Wkst. A-7 Ref.			127 277 2020 3.	от рііі
	Adjustments					
	(col. 4 minus					
	col. 5)* 6.00	7. 00				
			I MENTS REQUIRED AS A RESULT OF TRAI	NSACTIONS WITH RELATED OF	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO		LENTO REGORNES NO R REGGET G. 110.	nerieri ene in in nezarreb e	NOTHIN EARLY ONE ON SEALINED	
1.00	-984, 179					1. 00
2. 00	-318					2. 00
3.00	-1, 264					3. 00
4. 00 4. 01	-37 -1, 369					4. 00 4. 01
4. 02	-1, 024					4. 01
4. 03	-842					4. 03
4.04	-1, 669	0				4. 04
4. 05	-2, 416					4. 05
4.06	-66					4. 06
4. 07 4. 08	13, 946					4. 07 4. 08
4. 00	1	0				4. 08
4. 10	42	Ö				4. 10
4. 11	14	0				4. 11
4. 12	0					4. 12
4. 13	24					4. 13
4. 14 4. 15	4 15					4. 14 4. 15
4. 16	-86, 302					4. 15
4. 17	39, 244, 015					4. 17
4. 18	9, 485, 649					4. 18
4. 19	-2, 480, 270					4. 19
4. 20 4. 21	-1, 347, 792 -1, 965, 266					4. 20 4. 21
4. 21	210, 885					4. 21
4. 23	-5, 452					4. 23
4. 24	-1, 114	0				4. 24
4. 25	-1, 182, 432					4. 25
4. 26	-1, 447, 390					4. 26
4. 27 4. 28	-1, 306, 770 -7, 287, 764					4. 27 4. 28
4. 29	-1, 009, 380					4. 29
4.30	-5, 578, 721					4. 30
4. 31	-4, 067, 519	0				4. 31
4. 32	-99, 168					4. 32
4. 33 4. 34	-160, 405 -1, 457, 784					4. 33
4. 34	-15, 008, 096					4. 34 4. 35
4. 36	-775, 213					4. 36
4.37	-5, 556	0				4. 37
4. 38	-5, 795, 034	1				4. 38
4. 39	-5, 329, 417					4. 39
4. 40 4. 41	-4, 832, 431 -7, 898, 616					4. 40 4. 41
4. 42	-1, 496, 467	0				4. 42
4.43	-4, 047, 625	0				4. 43
4.44	-362, 372					4. 44
4. 45	-13, 616	0				4. 45
4. 46 4. 47	-2, 790 -1, 172	0				4. 46 4. 47
4. 48	-9, 938	0				4. 48
4.49	-2, 036	0				4. 49
4.50	-78, 001	0				4. 50
4. 51	-15, 982	0				4. 51
4. 52 4. 53	-358, 476 381, 045					4. 52 4. 53
4. 53	-189, 030					4. 53
4. 55	5, 122, 164	0				4. 55
4. 56	4, 697	0				4. 56
4. 57	10, 126	0				4. 57
4.58	1, 662	0				4. 58
4. 59 4. 60	83, 236 12, 722	0				4. 59 4. 60
4. 61	21, 563	0				4. 61
4. 62	18, 366	0				4. 62
4.63	1, 542	0				4. 63
4.64	526					4. 64
4. 65 4. 66	1, 388, 514 1, 112, 811	0				4. 65 4. 66
4.00	1, 112, 811	1 0	l			4.00

OFFICE COSTS

Provider CCN: 14-0015

From 10/01/2022 To 09/30/2023

Date/Time Prepared: 12/29/2023 3:54 pm Net Wkst. A-7 Ref Adjustments (col. 4 minus col. 5)\* 6.00 7.00 4.67 -850 0 4. 67 0 4.68 -826 4.68 0 4.69 4.69 -65, 127 0 4.70 -2, 817 4.70 0 4.71 -37, 227 4.71 4.72 -142, 097 0 0 0 4.72 -34, 397 4.73 4.73 4.74 -4, 426 4.74 4.75 -29,669 0 4.75 4.76 -5, 966 0 4. 76 0 4.77 -1, 283, 073 4.77 4.78 -156, 074 0 4. 78 5.00 -21, 347, 559 5.00

Positive amounts increase cost and negative amounts decrease cost.

For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part

Rel ated Organi zation(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

i ei ilibui	Schieff under title Aviii.	
6.00	BI O-MED/LAUNDRY	6. 00
7.00	FUND RAISING	7. 00
8.00	HOME OFFICE	8. 00
9.00	LABORATORY	9. 00
10.00	HOSPI TAL	10.00
100.00		100.00

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

The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropri ate.

Peri od: Worksheet A-8-2 From 10/01/2022 To 09/30/2023 Date/Time Prepared:

					'	077 007 2020	12/29/2023 3:	54 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				· ·	'		Hours	
	1. 00	2.00	3, 00	4. 00	5. 00	6. 00	7. 00	
1. 00		ADMINISTRATIVE & GENERAL	4, 094, 247	3, 478, 351	615, 896	211, 500	4, 136	1. 00
2.00		ADULTS & PEDIATRICS	7, 270, 351		72, 248		375	
3. 00		INTENSIVE CARE UNIT	1, 237, 812		48, 295		240	
4. 00		SUBPROVI DER - I RF	45, 900		45, 900	211, 500	310	
5.00		OPERATING ROOM	-53, 072	1	33, 682	211, 500	187	5. 00
6.00					33,062	211,500	107	
		RADI OLOGY - DI AGNOSTI C	1, 278, 801	1, 278, 801	_	Ĭ		
7.00		RESPIRATORY THERAPY	17, 250		17, 250		115	
8. 00		ELECTROCARDI OLOGY	36, 401		36, 401	246, 400	169	
9. 00		ELECTROENCEPHALOGRAPHY	13, 650		13, 650	211, 500	91	9. 00
10. 00		CLINIC	28, 155, 594		1, 628	211, 500	12	
11. 00		EMERGENCY	7, 271, 519		301, 203	211, 500	1, 883	
12. 00	5. 00	ADMINISTRATIVE & GENERAL	16, 434, 796		0	0	0	
200.00			65, 803, 249	64, 617, 096	1, 186, 153			200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8.00	9. 00	12. 00	13.00	14.00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	420, 560	21, 028	1, 333		0	1. 00
2.00	30.00	ADULTS & PEDIATRICS	38, 131	1, 907	25, 466	253	0	2. 00
3.00	31.00	INTENSIVE CARE UNIT	24, 404	1, 220	7, 559	295	0	3. 00
4.00	41. 00	SUBPROVIDER - IRF	31, 522	1, 576	0	0	0	4. 00
5.00	50. 00	OPERATING ROOM	19, 015	951	3, 928	-2, 493	0	5. 00
6.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	6, 052	0	0	6. 00
7. 00	65. 00	RESPI RATORY THERAPY	11, 693	585	0	0	0	7. 00
8. 00	69. 00	ELECTROCARDI OLOGY	20, 020	1, 001	0	0	0	8. 00
9. 00	70. 00	ELECTROENCEPHALOGRAPHY	9, 253	463	0	0	0	9. 00
10. 00		CLI NI C	1, 220		142, 644	8	0	
11. 00		EMERGENCY	191, 468		46, 292	_	o o	
12. 00		ADMINISTRATIVE & GENERAL	171, 100	7, 3, 5	0, 2,2	1, 7.10	o o	
200.00	5.00	ADMINISTRATIVE & GENERAL	767, 286	38, 365	233, 274	182	0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	J	200.00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Auj us tillerit		
		racittifici	Share of col.		Di Sai i Owanec			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADMINISTRATIVE & GENERAL	0		195, 135	3, 673, 486		1. 00
2.00		ADULTS & PEDIATRICS	0	· ·	33, 864	7, 231, 967		2. 00
3. 00		INTENSIVE CARE UNIT	1 0		23, 596	1, 213, 113		3. 00
4. 00		SUBPROVI DER - I RF		31, 522	14, 378	14, 378		4. 00
5.00		OPERATING ROOM		16, 522	17, 160			5. 00
				10, 522				6. 00
6.00		RADI OLOGY - DI AGNOSTI C		_	0			
7.00		RESPIRATORY THERAPY		1, 0,0	5, 557	5, 557		7. 00
8.00		ELECTROCARDI OLOGY	0	20, 020	16, 381	16, 381		8. 00
9. 00		ELECTROENCEPHALOGRAPHY	0	9, 253	4, 397	4, 397		9. 00
10. 00		CLINIC	0	.,	400			10. 00
11. 00		EMERGENCY	0	193, 386	107, 817	7, 078, 133		11. 00
12. 00	5. 00	ADMINISTRATIVE & GENERAL	0	0	0	16, 434, 796		12. 00
200.00			0	767, 468	418, 685	65, 035, 781		200. 00

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

			To		Date/Time Pre 12/29/2023 3:	
			CAPITAL REL	ATED COSTS		
Cost Center Description	Net Expenses	BLDG & FIXT	BUTLER	OLD BLDG &	NEW BLDG &	
	for Cost Allocation		BUI LDI NG	FI XTURES	FI XTURES	
	(from Wkst A					
	0	1. 00	1. 01	1. 02	1. 03	
GENERAL SERVICE COST CENTERS  1. 00 00100 CAP REL COSTS-BLDG & FLXT	0	0				1. 00
1. 01   00100 CAP REL COSTS-BLDG & TTXT	79, 491	0	79, 491			1. 00
1.02 O0102 CAP REL COSTS-OLD BLDG & FIXTURES 1.03 O0103 CAP REL COSTS-NEW BLDG & FIXTURES	617, 648	0	0	617, 648	10 0/2 7/1	1. 02
1.03   O0103   CAP REL COSTS-NEW BLDG & FIXTURES 1.04   O0104   CAP REL COSTS-MOB	10, 063, 741 1, 346, 966	0	0	0	10, 063, 741 0	1. 03 1. 04
1.05 00105 CAP REL COSTS-OAK STREET MALL	800, 691	0	0	0	0	1.05
1.06   O0106 CAP REL COSTS-BRCN AT 36TH ST 1.07   O0107 CAP REL COSTS-SURGERY CENTER	137, 622 1, 097, 072	0	0	0	0	1. 06 1. 07
1. 08 O0108 CAP REL COSTS-48TH AND MAINE 1. 09 O0109 CAP REL COSTS-HANNI BAL	1, 529, 311	0	0	0	0	1. 08 1. 09
1. 09   00109 CAP REL COSTS-HANNIBAL 2. 00   00200 CAP REL COSTS-MVBLE EQUIP	423, 756 16, 915, 757	O <sub>1</sub>	U	O.	Ü	2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	9, 039, 814 86, 683, 940	0	12.750	8, 372	655, 083	4. 00 5. 00
5.00   00500   ADMINISTRATIVE & GENERAL 6.00   00600   MAINTENANCE & REPAIRS	12, 686, 719	0	13, 758 0	158, 893 104, 324	1, 739, 586 1, 106, 114	6. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	1, 623, 601	0	0	9, 760	21, 136	8. 00
9. 00   00900   HOUSEKEEPI NG 10. 00   01000   DI ETARY	6, 768, 062 2, 500, 122	0	0	20, 756 0	40, 308 226, 289	9. 00 10. 00
11. 00 01100 CAFETERI A	3, 911, 533	0	0	0	90, 001	11.00
13.00   01300   NURSI NG ADMINI STRATI ON 16.00   01600   MEDI CAL RECORDS & LI BRARY	12, 978, 977 9, 485, 649	0	0	23, 116 1, 490	14, 338 30, 119	13. 00 16. 00
20. 00 02000 NURSI NG PROGRAM	2, 821, 462	0	0	0	32, 350	20. 00
21. 00   02100   1&R SERVI CES-SALARY & FRINGES APPRVD 22. 00   02200   1&R SERVI CES-OTHER PRGM COSTS APPRVD	1, 278, 372 1, 962, 537	0	0	0 1, 490	0	21. 00 22. 00
23. 00   02300   PARAMED ED PRGM	0	0	0	0	0	23. 00
23. 01   02301   PARAMED ED PRGM-RADIOLOGY 23. 02   02302   PARAMED ED PRGM-LABORATORY	299, 973 101, 401	0	0	0	10, 902 8, 359	23. 01 23. 02
23. 03 02303 PARAMED ED PRGM-PHARMACY	337, 863	0	0	0	0	23. 03
23. 04 02304 PARAMED ED PRGM-RESPIRATORY INPATIENT ROUTINE SERVICE COST CENTERS	158, 729	0	0	0	461	23. 04
30. 00 03000 ADULTS & PEDIATRICS	46, 909, 062	0	0	1, 078	2, 970, 790	30. 00
31. 00   03100   INTENSI VE CARE UNI T 41. 00   04100   SUBPROVI DER -   IRF	6, 888, 217 2, 482, 302	0	0	50, 514 23, 568	197, 181 71, 022	31. 00 41. 00
43. 00   04300   NURSERY	370, 130	0	0	0	53, 055	43. 00
44.00   04400  SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	2, 433, 996	0	0	0	174, 558	44. 00
50. 00 05000 OPERATING ROOM	20, 054, 849	0	0	32, 194	419, 394	50. 00
52. 00   05200   DELIVERY ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY	961, 194 724, 837	0	0	38, 730 3, 194	0 10, 084	52. 00 53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	7, 947, 552	0	0	7, 751	228, 312	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C 57. 00   05700   CT   SCAN	1, 398, 572 1, 215, 803	0	0	0 3, 036	169, 144 15, 379	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	498, 257	Ō	0	O	29, 584	58. 00
60. 00   06000   LABORATORY 62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS	14, 794, 104 1, 400, 768	0	0	3, 250 0	166, 928 5, 726	
65. 00 06500 RESPI RATORY THERAPY	2, 885, 378	0	0	4, 094	47, 373	65. 00
66. 00   06600  PHYSI CAL THERAPY 67. 00   06700  OCCUPATI ONAL THERAPY	1, 536, 563 989, 013	0	0	0	50, 541 24, 423	1
68.00 06800 SPEECH PATHOLOGY	239, 562	Ō	0	0	8, 270	68. 00
69. 00   06900   ELECTROCARDI OLOGY 70. 00   07000   ELECTROENCEPHALOGRAPHY	4, 095, 325 718, 981	0	0	43, 144 9, 368	68, 181 0	69. 00 70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 045, 385	Ō	30, 646	0	108, 876	71. 00
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS 73.00   07300   DRUGS CHARGED TO PATIENTS	16, 635, 404 29, 578, 906	0	35, 087 0	0 2, 935	124, 478 87, 249	1
74. 00 07400 RENAL DIALYSIS	958, 135	0	0	2, 733	07, 247	74. 00
OUTPATIENT SERVICE COST CENTERS  88. 00 08800 EAST ADAMS RHC	832, 929	٥	O	ol	0	88. 00
88. 01   08800   EAST   ADAMS   RIC 88. 01   08801   48TH   AND   MAI NE   RHC	1, 957, 521	0	0	0	0	88. 01
88. 02   08802   MT   STERLING   RHC	518, 103	0	0	0	0	88. 02
88. 03   08803   MAIN CAMPUS RHC 88. 04   08804   BLESSING EXPRESS CLINIC	13, 334, 670 1, 527, 173	0	0	0	0	88. 03 88. 04
88. 05   08805   BLESSING WALK IN CLINIC	2, 952, 226	0	0	o	55, 182 0	
88. 06   08806   HANNI BAL MAIN RHC 88. 07   08807   PALMYRA RHC	3, 239, 464 367, 885	0	0	0	0	88. 06 88. 07
88. 08   08808   BOWLI NG GREEN RHC	137, 707	0	0	o	10.927	88. 08
90. 00   09000   CLI NI C 90. 01   09001   OUTPATI ENT   I NFUSI ON	9, 450, 961 410, 853	0	0	0	19, 827 52, 043	90. 00 90. 01
90. 02   04950   ONCOLOGY	662, 326	0	0	0	25, 836	90. 02
90. 03  04951 HANNI BAL   INFUSI ON	23, 172	O	0	이	0	90. 03

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS BLESSING HOSPITAL Provider CCN: 14-0015

			To	09/30/2023	Date/Time Pre 12/29/2023 3:	
		CAPITAL RELATED COSTS				
Cost Center Description	Net Expenses	BLDG & FIXT	BUTLER	OLD BLDG &	NEW BLDG &	
	for Cost Allocation		BUI LDI NG	FI XTURES	FIXTURES	
	(from Wkst A					
	col. 7)					
	0	1.00	1. 01	1. 02	1. 03	
91. 00   09100   EMERGENCY	8, 525, 072	0	0	31, 971	221, 990	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
93. 99 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	1, 057, 883	0	0	0	48, 102	93. 99
OTHER REIMBURSABLE COST CENTERS	1					
101. 00 10100 HOME HEALTH AGENCY	3, 870, 294	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS		-		1		
113. 00 11300   INTEREST EXPENSE	0.005.400					113.00
116. 00 11600 HOSPI CE	3, 085, 199	0	70 401	502.020		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	420, 366, 542	U	79, 491	583, 028	9, 428, 574	1118.00
NONREIMBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		ما	0	17 227	11, 854	100 00
190.00 19000 BIFT, FLOWER, COFFEE SHOP & CANTEEN	7, 517, 219	0	0	16, 336		190.00
193. 00 19300 NONPALD WORKERS	7,517,219	0	0	0		193. 00
193. 01 19301 DENMAN SERVICES		0	0	0	14, 874	
193. 02 19302 UNUSED SPACE		0	0	14, 042	369, 627	
193. 03 19303 RENTED SPACE	0	0	0	4, 242	230, 364	
193. 04 19304 RETAIL PHARMACIES	21, 041, 286	0	0	., 2 .2		193. 04
193. 05 19305 WELLNESS CENTER	442, 205	o	0	o		193. 05
200.00 Cross Foot Adjustments				]	_	200. 00
201.00 Negative Cost Centers	1	o	0	o	0	201.00
202.00 TOTAL (sum lines 118 through 201)	449, 367, 252	0	79, 491	617, 648	10, 063, 741	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

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

12/29/2023 3:54 pm CAPITAL RELATED COSTS MOB OAK STREET BRCN AT 36TH SURGERY CENTER 48TH AND MAINE Cost Center Description MALI ST 1.04 1.07 1.08 1.05 1.06 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.01 00101 CAP REL COSTS-BUTLER BUILDING 1.01 00102 CAP REL COSTS-OLD BLDG & FIXTURES 1.02 1 02 00103 CAP REL COSTS-NEW BLDG & FIXTURES 1.03 1.03 1.04 00104 CAP REL COSTS-MOB 1, 346, 966 1.04 00105 CAP REL COSTS-OAK STREET MALL 800, 691 1.05 1.05 00106 CAP REL COSTS-BRCN AT 36TH ST 1.06 1.06 137, 622 1.07 00107 CAP REL COSTS-SURGERY CENTER 0 C 1, 097, 072 1.07 00108 CAP REL COSTS-48TH AND MAINE 1, 529, 311 1.08 1.08 0 00109 CAP REL COSTS-HANNI BAL 0 1 09 0 0 Λ 1.09 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 33, 929 4.00 00500 ADMINISTRATIVE & GENERAL 282, 285 487, 959 170, 060 627, 634 5.00 2, 403 5.00 00600 MAINTENANCE & REPAIRS 6.00 25, 738 C 166, 571 27, 523 6.00 8.00 00800 LAUNDRY & LINEN SERVICE 0 0 8.00 0 9.00 00900 HOUSEKEEPI NG 0 338 0 5, 719 6, 922 9.00 01000 DI ETARY 10 00 3 810 0 0 22 296 10 00 11.00 01100 CAFETERI A 0 0 0 Ω 11.00 01300 NURSING ADMINISTRATION 0 48, 099 0 0 13.00 13.00 0 0 16.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 0 02000 NURSING PROGRAM 0 100, 273 20.00 41, 782 0 20 00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 C 0 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 0 0 0 0 22.00 23 00 02300 PARAMED ED PRGM 0 23 00 0 23.01 02301 PARAMED ED PRGM-RADI OLOGY 19, 965 0 0 23.01 02302 PARAMED ED PRGM-LABORATORY 937 0 23.02 23.02 3.607 0 0 ol 23.03 02303 PARAMED ED PRGM-PHARMACY 0 23.03 C 02304 PARAMED ED PRGM-RESPIRATORY 0 621 0 23.04 23.04 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 15, 586 0 31, 339 0 0 30.00 03000 ADULTS & PEDIATRICS 30.00 0 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 C 0 04100 SUBPROVIDER - IRF 0 41.00 Ω 0 41.00 43.00 04300 NURSERY 0 0 0 0 0 43.00 04400 SKILLED NURSING FACILITY 44.00 0 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50 00 88.293 05000 OPERATING ROOM Ω 0 754, 722 0 50 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 52.00 53 00 05300 ANESTHESI OLOGY 1, 954 0 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 86, 232 0 54.00 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C Ω Λ 55.00 57.00 05700 CT SCAN 0 0 0 0 0 0 0 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 06000 LABORATORY 0 0 60.00 0 0 60.00 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 C 0 62.00 65.00 06500 RESPIRATORY THERAPY 28.527 65.00 06600 PHYSI CAL THERAPY 0 0 66.00 0 66.00 06700 OCCUPATIONAL THERAPY 0 0 67 00 C 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 O 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 C 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS C 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72.00 o 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73.00 0 07400 RENAL DIALYSIS 74.00 O 0 74.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 EAST ADAMS RHC 0 88.00 0 08801 48TH AND MAINE RHC 0 0 0 108,009 88.01 88.01 0 0 88.02 08802 MT STERLING RHC 0 C 88.02 0 0 88.03 08803 MAIN CAMPUS RHC 483, 635 0 0 88.03 88.04 08804 BLESSING EXPRESS CLINIC 0 0 0 88.04 0 0 88 05 08805 BLESSING WALK IN CLINIC 0 Ω 0 88 05 0 0 88.06 08806 HANNIBAL MAIN RHC 0 0 88.06 08807 PALMYRA RHC 0 0 0 88.07 88.07 0 0 88.08 08808 BOWLING GREEN RHC 0 0 0 88.08 350, 672 0 53, 596 90 00 09000 CLINIC Ω 90 00 90.01 09001 OUTPATIENT INFUSION 0 C 0 0 90.01 0 04950 ONCOLOGY 90.02 90.02 0 90.03 04951 HANNI BAL INFUSION 0 0 90.03 0 0 0 0 91 00 109100 EMERGENCY 25, 302 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 09399 PARTIAL HOSPITALIZATION PROGRAM 0 93.99

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS BLESSING HOSPITAL Provider CCN: 14-0015

| Period: | Worksheet B | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared:

			1	o 09/30/2023	Date/lime Prepared:   12/29/2023 3:54 pm		
	CAPITAL RELATED COSTS						
Cost Center Description	MOB	OAK STREET	BRCN AT 36TH	SURGERY CENTER	48TH AND MAINE		
		MALL	ST				
	1. 04	1. 05	1. 06	1. 07	1. 08		
OTHER REIMBURSABLE COST CENTERS							
101.00 10100 HOME HEALTH AGENCY	0	22, 285	0	0	0 101. 00		
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE					113. 00		
116. 00 11600 H0SPI CE	0	0	0	0	0 116. 00		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 325, 408	722, 541	137, 622	1, 097, 072	845, 980 118. 00		
NONREI MBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190. 00		
192.00 19200 PHYSICIANS' PRIVATE OFFICES	21, 558	0	0	0	683, 331 192. 00		
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00		
193. 01 19301 DENMAN SERVICES	0	0	0	0	0 193. 01		
193. 02 19302 UNUSED SPACE	0	0	0	0	0 193. 02		
193. 03 19303 RENTED SPACE	0	0	0	0	0 193. 03		
193. 04 19304 RETALL PHARMACLES	0	0	0	0	0 193. 04		
193. 05 19305 WELLNESS CENTER	0	78, 150	0	0	0 193. 05		
200.00 Cross Foot Adjustments					200. 00		
201.00 Negative Cost Centers	0	0	0	0	0 201. 00		
202.00   TOTAL (sum lines 118 through 201)	1, 346, 966	800, 691	137, 622	1, 097, 072	1, 529, 311 202. 00		

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2022 Part I
To 09/30/2023 Date/Time Prepared:
11/29/2023 3:54 pm

				10	09/30/2023	12/29/2023 3:	
		CAPITAL REL	ATED COSTS				
	Cost Center Description	HANNI BAL	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	ADMI NI STRATI VE & GENERAL	
		1. 09	2. 00	DEPARTMENT 4.00	4A	5. 00	
GEI	NERAL SERVICE COST CENTERS		2.00			0.00	
	100 CAP REL COSTS-BLDG & FIXT						1. 00
1	101 CAP REL COSTS-BUTLER BUILDING						1. 01
	102 CAP REL COSTS-OLD BLDG & FIXTURES						1. 02
	103 CAP REL COSTS-NEW BLDG & FIXTURES 104 CAP REL COSTS-MOB						1. 03 1. 04
	105 CAP REL COSTS-WOD						1. 05
	106 CAP REL COSTS-BRCN AT 36TH ST						1. 06
	107 CAP REL COSTS-SURGERY CENTER						1. 07
	108 CAP REL COSTS-48TH AND MAINE						1. 08
	109 CAP REL COSTS-HANNI BAL	423, 756					1. 09
	200 CAP REL COSTS-MVBLE EQUIP	0	16, 915, 757	0.7/0.504			2.00
	400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL	0 119, 219	23, 323 7, 641, 509	9, 760, 521 611, 230	98, 538, 476	98, 538, 476	4. 00 5. 00
	600 MAINTENANCE & REPAIRS	16, 279	240, 965	251, 493	14, 625, 726		6. 00
	800 LAUNDRY & LINEN SERVICE	0	1, 296	2, 715	1, 658, 508		8. 00
	900 HOUSEKEEPI NG	1, 098	285, 384	233, 038	7, 361, 625		9. 00
	000 DI ETARY	0	148, 441	84, 733	2, 985, 691	838, 600	10. 00
	100 CAFETERI A	0	0	141, 436	4, 142, 970		11. 00
	300 NURSI NG ADMI NI STRATI ON	10.074	1, 057, 370	336, 603	14, 458, 503		13.00
4	600 MEDICAL RECORDS & LIBRARY 000 NURSING PROGRAM	10, 274 0	5, 853 158, 352	0 233, 772	9, 533, 385 3, 387, 991	2, 677, 670 951, 595	16. 00 20. 00
4	100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	156, 352	73, 881	1, 352, 253		21. 00
	200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	o	743	0	1, 964, 770		22. 00
	300 PARAMED ED PRGM	0	0	o	0	0	23. 00
	301 PARAMED ED PRGM-RADI OLOGY	0	23, 676	26, 749	381, 265		23. 01
4	302 PARAMED ED PRGM-LABORATORY	0	3, 388	7, 853	125, 545		23. 02
	303 PARAMED ED PRGM-PHARMACY 304 PARAMED ED PRGM-RESPIRATORY	0	0 2, 259	18, 639 10, 227	356, 502 172, 297		23. 03 23. 04
	PATIENT ROUTINE SERVICE COST CENTERS	U <sub>I</sub>	2, 239	10, 221	172, 297	40, 394	23.04
	000 ADULTS & PEDI ATRI CS	0	214, 499	1, 921, 667	52, 064, 021	14, 623, 521	30. 00
	100 INTENSIVE CARE UNIT	0	148, 933	271, 805	7, 556, 650	2, 122, 459	31. 00
	100 SUBPROVI DER – I RF	0	4, 990	111, 088	2, 692, 970		41. 00
	300 NURSERY 400 SKILLED NURSING FACILITY	0	12, 777 996	18, 890 102, 187	454, 852 2, 711, 737		43. 00 44. 00
	CILLARY SERVICE COST CENTERS	<u> </u>	770	102, 107	2, 711, 737	701,034	44.00
	000 OPERATING ROOM	0	2, 823, 229	649, 001	24, 821, 682	6, 971, 740	50. 00
	200 DELIVERY ROOM & LABOR ROOM	0	14, 951	43, 042	1, 057, 917		52.00
	300 ANESTHESI OLOGY	0	124, 326		877, 030		53. 00
	400 RADI OLOGY-DI AGNOSTI C 500 RADI OLOGY-THERAPEUTI C	5, 819 0	417, 225	270, 387	8, 963, 278 1, 790, 374		54. 00 55. 00
	700 CT SCAN	0	163, 404 397, 357	59, 254 37, 780	1, 669, 355		57. 00
	800 MAGNETIC RESONANCE IMAGING (MRI)	Ö	141, 958		689, 320		58. 00
	000 LABORATORY	0	249, 051	206, 290	15, 419, 623		60.00
62. 00 06	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	11, 497	11, 638	1, 429, 629		62. 00
1	500 RESPI RATORY THERAPY	0	214, 053	151, 127	3, 330, 552		65. 00
	600 PHYSI CAL THERAPY	0	5, 414	88, 153	1, 680, 671	472, 055	66.00
	700 OCCUPATI ONAL THERAPY 800 SPEECH PATHOLOGY	0	2, 786	57, 041 13, 568	1, 070, 477 264, 186	300, 668 74, 203	67. 00 68. 00
	900 ELECTROCARDI OLOGY	0	491, 744	157, 253	4, 855, 647	1, 363, 820	69. 00
	000 ELECTROENCEPHALOGRAPHY	0	39, 178	28, 483	796, 010		70. 00
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	81, 209	68, 747	17, 334, 863	4, 868, 895	71. 00
	200 I MPL. DEV. CHARGED TO PATIENTS	0	92, 835	0	16, 887, 804		72. 00
	300 DRUGS CHARGED TO PATIENTS	4, 705	694, 655	295, 014	30, 663, 464		73. 00
	400 RENAL DIALYSIS TPATIENT SERVICE COST CENTERS	0	0	0	958, 135	269, 114	74. 00
	800 EAST ADAMS RHC	0	138	32, 426	865, 493	243, 094	88. 00
	801 48TH AND MAINE RHC	0	0	105, 966	2, 171, 496		88. 01
	802 MT STERLING RHC	0	24, 765	20, 667	563, 535		88. 02
	803 MAIN CAMPUS RHC	0	52, 271	898, 749	14, 769, 325		88. 03
	804 BLESSING EXPRESS CLINIC	0	32, 522 10, 925	68, 993	1, 628, 688		88. 04
	805 BLESSING WALK IN CLINIC 806 HANNIBAL MAIN RHC	0 72, 010	19, 825 0	158, 347 172, 452	3, 185, 580 3, 483, 926		88. 05 88. 06
	807 PALMYRA RHC	72,010	1, 857	15, 194	3, 463, 926		88. 07
	808 BOWLING GREEN RHC	o	573	6, 150	144, 430		88. 08
90.00 09	000 CLI NI C	88, 233	336, 456	403, 746	10, 703, 491	3, 006, 322	90. 00
	001 OUTPATIENT INFUSION	0	0	20, 904	483, 800		90. 01
	950 ONCOLOGY	0 0 0 1	0	31, 943	720, 105		90. 02
	951 HANNI BAL I NFUSI ON 100 EMERGENCY	25, 061 0	0 133, 934	1, 336 357, 828	49, 569 9, 296, 097	13, 923 2, 611, 023	90. 03 91. 00
1	200 OBSERVATION BEDS (NON-DISTINCT PART)	Ĭ	100, 704	337, 320	0, 270, 077		92. 00
		<u>'</u>		<u>'</u>			

Health Financial Systems	BLESSING HOSPITAL		In Lieu of Form CMS-2552-10	
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 14-0015	Peri od:	Worksheet B	

near th Trhancial Systems	DEE331 NO 1	IOSI I IAL		III LI C	Su of Form CW3-2	2332-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 10/01/2022 To 09/30/2023		
	CAPITAL REL	ATED COSTS				
Cost Center Description	HANNI BAL	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
	1. 09	2.00	4. 00	4A	5. 00	
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	14, 762	59, 03	2 1, 179, 779	331, 368	93. 99
OTHER REIMBURSABLE COST CENTERS				_		
101.00 10100 HOME HEALTH AGENCY	0	466	177, 98	3 4, 071, 028	1, 143, 442	101. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	7, 880				
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	342, 698	16, 565, 075	9, 285, 58	3 418, 007, 038	89, 730, 238	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 28, 190		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	39, 629	215, 502	335, 11	6 8, 812, 355		
193. 00 19300 NONPALD WORKERS	0	0		0 0		193. 00
193. 01 19301 DENMAN SERVICES	0	0		0 14, 874		193. 01
193. 02 19302 UNUSED SPACE	0	0		0 383, 669		
193. 03 19303 RENTED SPACE	40, 743	0		0 275, 349	,	
193. 04 19304 RETAIL PHARMACIES	686	90, 238		· · · · ·		
193. 05 19305 WELLNESS CENTER	0	44, 942	17, 96	6 583, 263		
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)	423, 756	16, 915, 757	9, 760, 52	1 449, 367, 252	98, 538, 476	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2022 | Part I | To 09/30/2023 | Date/Time Prepared: | 12/29/2023 3: 54 pm

Cost Center Des	scrintion	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	12/29/2023 3: CAFETERI A	
cost center bes	ser i per on	REPAI RS	LINEN SERVICE				
GENERAL SERVICE COST	CENTERS	6. 00	8. 00	9. 00	10. 00	11. 00	
1. 00 00100 CAP REL COSTS-B					Ι		1.00
1.01   00101   CAP REL COSTS-B							1. 01
1. 02 00102 CAP REL COSTS-C							1.02
1. 03   00103   CAP   REL   COSTS - N 1. 04   00104   CAP   REL   COSTS - N							1. 03 1. 04
1. 05 00105 CAP REL COSTS-0							1.05
1.06   00106 CAP REL COSTS-E							1.06
1.07   00107   CAP REL COSTS-S							1. 07
1. 08   00108 CAP REL COSTS-4							1.08
1. 09   00109   CAP REL COSTS-H 2. 00   00200   CAP REL COSTS-N							1. 09 2. 00
4.00   00400 EMPLOYEE BENEFI							4.00
5. 00 00500 ADMI NI STRATI VE							5. 00
6.00   00600   MAI NTENANCE & R		18, 733, 698					6. 00
8.00   00800   LAUNDRY & LINEN	I SERVICE	77, 877	2, 202, 215				8. 00
9. 00   00900   HOUSEKEEPI NG		174, 268	22, 295	9, 625, 870	4 457 500		9.00
10. 00   01000   DI ETARY 11. 00   01100   CAFETERI A		389, 339 141, 088	16, 217 0	226, 653 82, 142	4, 456, 500	5, 529, 848	10. 00 11. 00
13. 00 01300 NURSI NG ADMINIS	STRATI ON	231, 416	0	134, 741	0	275, 122	13.00
16.00 01600 MEDICAL RECORDS		83, 730	0	48, 769	O	0	16.00
20. 00 02000 NURSI NG PROGRAM		689, 842	0	401, 566	0	158, 246	1
	LARY & FRINGES APPRVD	0	0	0	0	0	21.00
	THER PRGM COSTS APPRVD	6, 832	0	3, 986 0	0	66, 802 0	22. 00 23. 00
23. 00   02300   PARAMED ED PRGN 23. 01   02301   PARAMED ED PRGN		59, 830	0	34, 858	0	18, 140	23. 00
23. 02 02302 PARAMED ED PRGM		34, 882	0	20, 321	o	4, 141	1
23.03 O2303 PARAMED ED PRGN		0	0	0	O	10, 319	23. 03
23. 04 02304 PARAMED ED PRGN		2, 052	0	1, 172	0	7, 739	23. 04
I NPATI ENT ROUTI NE SER		4 0/7 202	7/4 700	2 022 210	2 545 072	1 40/ 005	20.00
30.00   03000   ADULTS & PEDI AT 31.00   03100   INTENSI VE CARE		4, 867, 203 540, 687	764, 788 123, 421	2, 833, 319 314, 735	3, 545, 972 345, 721	1, 496, 095 192, 788	30. 00 31. 00
41. 00   04100   SUBPROVI DER - I		219, 385	119, 750	127, 707	281, 629	80, 949	41.00
43.00 04300 NURSERY		83, 170	13, 351	48, 379	0	11, 527	43. 00
44. 00 04400 SKI LLED NURSI NO		273, 643	87, 793	159, 282	283, 178	83, 855	44. 00
ANCILLARY SERVICE COS 50.00 OFERATING ROOM	SI CENTERS	1, 561, 460	174, 965	908, 956	0	519, 653	50.00
52. 00   05200   DELI VERY ROOM &	LABOR ROOM	177, 555	60, 825	103, 322	o	33, 306	52.00
53. 00   05300   ANESTHESI OLOGY		35, 138	0	20, 477	0	17, 461	53. 00
54. 00   05400   RADI OLOGY-DI AGN		617, 118	154, 112	359, 206	0	214, 335	•
55. 00   05500   RADI OLOGY-THERA 57. 00   05700   CT   SCAN	APEUTI C	265, 155	85, 907	154, 358	0	30, 061	55.00
57. 00   05700   CT SCAN 58. 00   05800   MAGNETI C RESONA	INCE IMAGING (MRI)	38, 029 46, 377	59, 008 13, 832	22, 118 26, 964	0	26, 028 13, 632	57. 00 58. 00
60. 00   06000   LABORATORY	with the control of t	276, 580	217	161, 002	ő	198, 721	
	PACKED RED BLOOD CELLS	8, 977	0	5, 236	o	11, 120	•
65. 00 06500 RESPIRATORY THE		161, 467	0	94, 022	0	110, 372	65. 00
66. 00   06600   PHYSI CAL THERAF		79, 230	0	46, 112	0	57, 053	1
67. 00   06700   0CCUPATI ONAL TH		38, 286 12, 964	0	22, 275 7, 581	0	37, 651 8, 486	1
69. 00 06900 ELECTROCARDI OLO		304, 677	87, 474	177, 336	o	109, 869	69.00
70. 00 07000 ELECTROENCEPHAL		42, 949	666	25, 010	o	24, 670	70.00
	S CHARGED TO PATIENTS	180, 516	13, 552	105, 042	0	39, 741	1
72. 00   07200   IMPL. DEV. CHAR		206, 351	15, 491	120, 126	0	49, 477	72.00
73. 00   07300   DRUGS CHARGED T 74. 00   07400   RENAL DI ALYSI S	O PATIENTS	163, 822	0	95, 351 0	0	173, 983 0	73. 00 74. 00
74.00 O7400 RENAL DIALYSIS OUTPATIENT SERVICE CO	OST CENTERS	l o	U	U	U <sub>I</sub>	0	74.00
88. 00 08800 EAST ADAMS RHC		0	0	0	0	0	88. 00
88. 01 08801 48TH AND MAINE		123, 344	0	71, 826	0	0	88. 01
88. 02   08802   MT   STERLING   RHC		0	0	0	0	0	88. 02
88. 03   08803   MAI N CAMPUS RHC 88. 04   08804   BLESSI NG EXPRES		1, 160, 206	0	675, 347	0	419, 641 0	88. 03 88. 04
88. 05   08805   BLESSING WALK   I		86, 504	0	50, 333	0	65, 009	88. 05
88. 06   08806   HANNI BAL MAIN R		208, 030	Ö	121, 064	ő	03, 007	88. 06
88.07 08807 PALMYRA RHC		0	0	0	O	0	88. 07
88. 08   08808   BOWLI NG GREEN R	RHC	0	0	0	O	0	88. 08
90. 00   09000   CLI NI C	ICL ON	1, 188, 419	0	691, 838	0	421, 203	90.00
90. 01   09001   0UTPATI ENT   I NFU 90. 02   04950   ONCOLOGY	121 NN	81, 584 40, 501	725 0	47, 519 23, 603	0	18, 954 25, 186	90. 01 90. 02
90. 02   04950   UNCOLUGY 90. 03   04951   HANNI BAL   I NFUSI	ON	72, 398	0	42, 126	0	25, 186	90.02
91. 00 09100 EMERGENCY		548, 731	380, 611	319, 424	ő	277, 756	91.00
92.00 09200 OBSERVATION BED	OS (NON-DISTINCT PART)						92. 00
93. 99 09399 PARTI AL HOSPI TA		75, 406	0	43, 924	0	49, 653	93. 99
OTHER REIMBURSABLE CO		47, 706	0	27, 745	0	0	101. 00
101.00 10100 110WL HEALTH AGE	INO I	47,700	U	21, 145	υĮ	0	1101.00

Health Financial Systems	BLESSING HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B		
				From 10/01/2022	Part I		
				To 09/30/2023	Date/Time Pre		
					12/29/2023 3:	54 pm_	
Cost Center Description	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NO	DI ETARY	CAFETERI A		
	REPAI RS	LINEN SERVICE					
	6. 00	8. 00	9. 00	10.00	11. 00		

					12/29/2023 3:	54 pm
Cost Center Description	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	REPAI RS	LINEN SERVICE				
	6. 00	8. 00	9. 00	10.00	11. 00	
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 H0SPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	15, 724, 724	2, 195, 000	9, 006, 873	4, 456, 500	5, 358, 744	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	93, 476	7, 215	54, 397	0	0	190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	946, 557	0	551, 001	0	171, 104	192.00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01 19301 DENMAN SERVICES	23, 317	0	13, 599	0	0	193. 01
193. 02 19302 UNUSED SPACE	643, 816	0	0	0	0	193. 02
193. 03 19303 RENTED SPACE	1, 119, 286	0	0	0	0	193. 03
193.04 19304 RETAIL PHARMACIES	15, 226	0	0	0	0	193. 04
193. 05 19305 WELLNESS CENTER	167, 296	0	0	0	0	193. 05
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00   TOTAL (sum lines 118 through 201)	18, 733, 698	2, 202, 215	9, 625, 870	4, 456, 500	5, 529, 848	202. 00

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

				Т	09/30/2023	Date/Time Prep 12/29/2023 3: RESIDENTS	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	MEDI CAL RECORDS &	NURSI NG PROGRAM	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	
		13.00	16. 00	20. 00	21. 00	22. 00	
1. 00 00100 1. 01 00101 1. 02 00102 1. 03 00103 1. 04 00106 1. 05 00106 1. 06 00106 1. 07 00107 1. 08 00108 1. 09 00109 2. 00 00200 4. 00 00400 5. 00 00500 6. 00 00600 8. 00 00800	RAL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT  CAP REL COSTS-BUTLER BUILDING  CAP REL COSTS-OLD BLDG & FIXTURES  CAP REL COSTS-NEW BLDG & FIXTURES  CAP REL COSTS-MOB  CAP REL COSTS-MOB  CAP REL COSTS-BRCN AT 36TH ST  CAP REL COSTS-BRCN AT 36TH ST  CAP REL COSTS-BRCN AMAINE  CAP REL COSTS-HANNI BAL  CAP REL COSTS-HANNI BAL  CAP REL COSTS-MVBLE EQUIP  DEMPLOYEE BENEFITS DEPARTMENT  ADMINISTRATIVE & GENERAL  MAINTENANCE & REPAIRS  LAUNDRY & LINEN SERVICE						1. 00 1. 01 1. 02 1. 03 1. 04 1. 05 1. 06 1. 07 1. 08 1. 09 2. 00 4. 00 5. 00 6. 00 8. 00 9. 00
10. 00	DIETARY  CAFETERIA  NURSING ADMINISTRATION  MEDICAL RECORDS & LIBRARY  NURSING PROGRAM  I &R SERVICES-SALARY & FRINGES APPRVD  I &R SERVICES-OTHER PRGM COSTS APPRVD  PARAMED ED PRGM  PARAMED ED PRGM-RADIOLOGY  PARAMED ED PRGM-PHARMACY  PARAMED ED PRGM-PESPIRATORY  I ENT ROUTINE SERVICE COST CENTERS	19, 160, 785 0 0 0 0 0 0 0 0	12, 343, 554 0 0 0 0 0 0 0 0	5, 589, 240	1, 732, 064	2, 594, 241	10. 00 11. 00 13. 00 16. 00 20. 00 21. 00 22. 00 23. 00 23. 01 23. 02 23. 03 23. 04
30.00 03000	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	9, 470, 998 1, 220, 447	9, 779, 060 953, 469	4, 122, 537 291, 173		2, 333, 224 72, 505	30. 00 31. 00
43.00 04300	SUBPROVI DER - I RF  NURSERY	512, 436 72, 961	776, 649 16, 170	51, 180 84, 378	l .	0 17, 401 0	41. 00 43. 00
	SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	530, 832	780, 899	26, 051	0	U	44. 00
50. 00 05000 52. 00 05300 53. 00 05300 54. 00 05400 55. 00 05500 57. 00 05700 68. 00 06500 66. 00 06600 66. 00 06600 67. 00 06700 70. 00 07000 71. 00 07300 73. 00 07400 00TPA	DOPERATING ROOM DELIVERY ROOM & LABOR ROOM DANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C D RADI OLOGY-THERAPEUTI C D CT SCAN MAGNETIC RESONANCE I MAGING (MRI) LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELLS RESPIRATORY THERAPY DPHYSI CAL THERAPY DOCCUPATIONAL THERAPY SPEECH PATHOLOGY ELECTROCARDI OLOGY ELECTROCARDI OLOGY MEDI CAL SUPPLIES CHARGED TO PATIENTS I MPL. DEV. CHARGED TO PATIENTS DRIGHT SERVICE COST CENTERS	3, 289, 697 210, 861 110, 530 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0	262, 356 246, 910 0 0 0 0 0 0 0 0 0 0 47, 030 0 0	0 1, 936 1, 936 0 0 0 3, 873 0 0 0	11, 601 0 2, 900 2, 900 0 0 5, 800 0 0 0 44, 953 5, 800 0	50. 00 52. 00 53. 00 54. 00 55. 00 57. 00 58. 00 60. 00 62. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00
88. 01 08801 88. 02 08802 88. 03 08803 88. 04 08806 88. 05 08806 88. 07 08807 88. 08 08808 90. 00 09000 90. 01 09001 90. 02 04950 91. 00 09100	DEAST ADAMS RHC 48TH AND MAINE RHC 2 MT STERLING RHC 3 MAIN CAMPUS RHC 4 BLESSING EXPRESS CLINIC 5 BLESSING WALK IN CLINIC 6 HANNIBAL MAIN RHC 7 PALMYRA RHC 8 BOWLING GREEN RHC 0 CLINIC 0 OUTPATIENT INFUSION 0 ONCOLOGY 1 HANNIBAL INFUSION 0 EMERGENCY 0 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0 0 0 0 0 0 120, 023 159, 405 0 1, 758, 326	0 0 0 0 0 0 0 0 0 0 0 37, 307	0 0 0 43, 342 0 0 0 58, 327 44, 264 0 0 240, 224	0 0 0 24, 204 0 0	0 0 0 0 0 0 0 36, 253 0 0 0	88. 00 88. 01 88. 02 88. 03 88. 04 88. 05 88. 06 88. 07 88. 08 90. 01 90. 01 90. 02 90. 03 91. 00

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 14-0015	Peri od: Worksheet B

				from 10/01/2022 o 09/30/2023				
				INTERNS &	RESI DENTS			
Cost Center Description	NURSI NG ADMI NI STRATI ON	MEDI CAL RECORDS & LI BRARY	NURSI NG PROGRAM	Y & FRINGES	SERVICES-OTHER PRGM COSTS			
	13. 00	16. 00	20.00	21. 00	22. 00			
93.99 O9399 PARTIAL HOSPITALIZATION PROGRAM	314, 312	0	10, 374	0	0	93. 99		
OTHER REIMBURSABLE COST CENTERS								
101.00 10100 HOME HEALTH AGENCY	868, 017	0	55, 330	0	0	101. 00		
SPECIAL PURPOSE COST CENTERS								
113.00 11300 I NTEREST EXPENSE						113. 00		
116. 00 11600 HOSPI CE	521, 940	0	5, 764			116. 00		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	19, 160, 785	12, 343, 554	5, 589, 240	1, 732, 064	2, 594, 241	118. 00		
NONREI MBURSABLE COST CENTERS								
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0		190. 00		
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	(	0		192. 00		
193. 00 19300 NONPALD WORKERS	0	0	(	0		193. 00		
193. 01 19301 DENMAN SERVICES	0	0	(	0		193. 01		
193. 02 19302 UNUSED SPACE	0	0	(	0		193. 02		
193. 03 19303 RENTED SPACE	0	0	(	0		193. 03		
193.04 19304 RETAIL PHARMACIES	0	0	(	0		193. 04		
193. 05 19305 WELLNESS CENTER	0	0	(	0		193. 05		
200.00 Cross Foot Adjustments			(	0		200. 00		
201.00 Negative Cost Centers	0	0	(	0		201. 00		
202.00   TOTAL (sum lines 118 through 201)	19, 160, 785	12, 343, 554	5, 589, 240	1, 732, 064	2, 594, 241	202. 00		

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2022 | Part I | To 09/30/2023 | Date/Time Prepared: | 12/29/2023 3: 54 pm

	Cost Center Description	PARAMED ED PRGM	PARAMED ED	PARAMED ED PRGM-LABORATOR	PARAMED ED PRGM-PHARMACY	12/29/2023 3: PARAMED ED PRGM-RESPIRATO	
				Υ		RY	
	GENERAL SERVICE COST CENTERS	23. 00	23. 01	23. 02	23. 03	23. 04	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BUTLER BUILDING						1. 01
1. 02	00102 CAP REL COSTS-OLD BLDG & FIXTURES						1. 02
1.03	00103 CAP REL COSTS-NEW BLDG & FIXTURES						1.03
1.04	00104 CAP REL COSTS -MOB						1.04
1. 05 1. 06	00105 CAP REL COSTS-OAK STREET MALL 00106 CAP REL COSTS-BRCN AT 36TH ST						1. 05 1. 06
1. 07	00100 CAF REL COSTS-SURGERY CENTER						1. 00
1. 08	00108 CAP REL COSTS-48TH AND MAINE						1. 08
1.09	00109 CAP REL COSTS-HANNI BAL						1. 09
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6.00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSING ADMINISTRATION						13. 00
16.00	01600 MEDICAL RECORDS & LIBRARY						16. 00
20.00	02000 NURSI NG PROGRAM						20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD						21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD						22. 00
23. 00 23. 01	O2300   PARAMED ED PRGM   O2301   PARAMED ED PRGM-RADIOLOGY		601, 180				23. 00 23. 01
23. 01	02302 PARAMED ED PRGM-LABORATORY		001, 100	220, 151			23. 01
23. 03	02303 PARAMED ED PRGM-PHARMACY			220, 101	466, 953		23. 03
23. 04	02304 PARAMED ED PRGM-RESPIRATORY				,	231, 654	23. 04
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	(			_		30. 00
31. 00	03100 I NTENSI VE CARE UNI T	(		1	_	1	31. 00
41. 00	04100 SUBPROVI DER - I RF		ł .		_	0	41.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY			1	_		43. 00 44. 00
44.00	ANCI LLARY SERVI CE COST CENTERS		7	7			1 44.00
50.00	05000 OPERATING ROOM	(	C	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM			) c	0	-	52. 00
53. 00	05300 ANESTHESI OLOGY	(	1	0	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C			1	0	0	54.00
55. 00 57. 00	05500  RADI OLOGY-THERAPEUTI C   05700  CT SCAN				0	0	55. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)				0	0	58.00
60. 00	06000 LABORATORY			220, 151	0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				0	Ō	62. 00
65. 00	06500 RESPI RATORY THERAPY	(	o c	0	0	231, 654	65. 00
66. 00	06600 PHYSI CAL THERAPY	(	) c	0	0	-	
67. 00	06700 OCCUPATI ONAL THERAPY			0	0	0	1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY				0	0	68. 00 69. 00
	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY				0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS				0	Ō	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	(	o c	o	466, 953	0	73. 00
74. 00	07400 RENAL DIALYSIS		o c	0	0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS	1			_		
88. 00	08800 EAST ADAMS RHC 08801 48TH AND MAINE RHC			ή		0	
88. 01 88. 02	08801 481H AND MAINE RHC 08802 MT STERLING RHC				0	0	88. 01 88. 02
88. 03	08803 MAI N CAMPUS RHC				0	0	88. 03
88. 04	08804 BLESSING EXPRESS CLINIC				0	o o	88. 04
88. 05	08805 BLESSING WALK IN CLINIC	(	o  c	o o	0	0	88. 05
88. 06	08806 HANNI BAL MAIN RHC	(	) C	) C	0	0	88. 06
88. 07	08807 PALMYRA RHC		) C	0	0	0	88. 07
88. 08	08808 BOWLING GREEN RHC		y c		0	0	88. 08
90. 00 90. 01	09000 CLINIC 09001 OUTPATIENT INFUSION				0	0	90. 00 90. 01
90.01	04950 ONCOLOGY				0	0	90.01
	04951 HANNI BAL I NFUSI ON				0	0	90. 02
91. 00	09100 EMERGENCY				Ō	Ö	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
93. 99	09399 PARTI AL HOSPITALI ZATI ON PROGRAM	(	o  c	) c	0	0	93. 99

BLESSING HOSPITAL

Provider CCN: 14-0015 | Period: From 10. Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10
Worksheet B

GENERAL SERVICE SOCIE		l rovider of	F T	rom 10/01/2022 o 09/30/2023	Part I Date/Time Pre 12/29/2023 3:	
Cost Center Description	PARAMED ED	PARAMED ED	PARAMED ED	PARAMED ED	PARAMED ED	34 piii
occi conton boson per on					PRGM-RESPIRATO	
			Y		RY	
	23. 00	23. 01	23. 02	23. 03	23. 04	
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	601, 180	220, 151	466, 953	231, 654	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01 19301 DENMAN SERVICES	0	0	0	0	0	193. 01
193. 02 19302 UNUSED SPACE	0	0	0	0	0	193. 02
193. 03 19303 RENTED SPACE	0	0	0	0	0	193. 03
193. 04 19304 RETAIL PHARMACIES	0	0	0	0	0	193. 04
193. 05 19305 WELLNESS CENTER	0	0	0	0	0	193. 05
200.00 Cross Foot Adjustments	0	0	0	0	0	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	601, 180	220, 151	466, 953	231, 654	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0015

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

				Ť	o 09/30/2023 Date/Time P 12/29/2023	
	Cost Center Description	Subtotal	Intern &	Total	12,27,2320	5. 5. p
			Residents Cost & Post			
			Stepdown			
		24. 00	Adjustments 25.00	26. 00		
	GENERAL SERVICE COST CENTERS					
1. 00 1. 01	OO100  CAP REL COSTS-BLDG & FIXT  OO101  CAP REL COSTS-BUTLER BUILDING					1. 00
1. 01	00101 CAP REL COSTS-BUTER BUTEDING					1. 01
1.03	00103 CAP REL COSTS-NEW BLDG & FIXTURES					1. 03
1.04	00104 CAP REL COSTS -MOB					1. 04
1. 05 1. 06	OO105 CAP REL COSTS-OAK STREET MALL   OO106 CAP REL COSTS-BRCN AT 36TH ST					1. 05 1. 06
1. 07	00107 CAP REL COSTS-SURGERY CENTER					1. 07
1. 08	00108 CAP REL COSTS-48TH AND MAINE					1. 08
1. 09 2. 00	OO109 CAP REL COSTS-HANNI BAL   OO200 CAP REL COSTS-MVBLE EQUI P					1. 09 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL					5. 00
6. 00 8. 00	00600 MAI NTENANCE & REPAI RS					6.00
9. 00	O0800   LAUNDRY & LINEN SERVICE   O0900   HOUSEKEEPING					8. 00 9. 00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
13. 00 16. 00	O1300   NURSI NG ADMI NI STRATI ON   O1600   MEDI CAL RECORDS & LI BRARY					13. 00 16. 00
20. 00	02000 NURSI NG PROGRAM					20.00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD					21. 00
22. 00 23. 00	02200   1 &R SERVICES-OTHER PRGM COSTS APPRVD   02300   PARAMED ED PRGM					22. 00 23. 00
23. 00	02301 PARAMED ED PRGM-RADI OLOGY					23. 00
23. 02	02302 PARAMED ED PRGM-LABORATORY					23. 02
23. 03	02303 PARAMED ED PRGM-PHARMACY					23. 03
23. 04	O2304   PARAMED ED PRGM-RESPIRATORY   I NPATI ENT ROUTI NE SERVI CE COST CENTERS					23. 04
30.00	03000 ADULTS & PEDI ATRI CS	107, 458, 532	-3, 891, 018	103, 567, 514		30.00
31.00	03100 I NTENSI VE CARE UNI T	13, 782, 464	l	13, 661, 550		31.00
41. 00 43. 00	04100   SUBPROVI DER - I RF   04300   NURSERY	5, 619, 038 941, 563	1 1	5, 619, 038 912, 544		41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	5, 698, 924		5, 698, 924		44. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS    O5000   OPERATI NG ROOM	38, 529, 855	-19, 346	38, 510, 509		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 187, 836	1	2, 187, 836		52. 00
53. 00	05300 ANESTHESI OLOGY	1, 311, 806		1, 306, 970		53. 00
54. 00 55. 00	05400  RADI OLOGY-DI AGNOSTI C   05500  RADI OLOGY-THERAPEUTI C	13, 431, 608 2, 828, 723	1	13, 426, 772 2, 828, 723		54. 00 55. 00
57. 00	05700 CT SCAN	2, 283, 415	1	2, 283, 415		57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	983, 736	1 1	983, 736		58. 00
60.00	O6000   LABORATORY   O6200   WHOLE BLOOD & PACKED RED BLOOD CELLS	20, 616, 923		20, 607, 250		60.00
62. 00 65. 00	06500 RESPIRATORY THERAPY	1, 856, 506 4, 863, 529		1, 856, 506 4, 863, 529		62.00
66. 00	06600 PHYSI CAL THERAPY	2, 335, 121		2, 335, 121		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 469, 357		1, 469, 357		67. 00
68. 00 69. 00	O6800   SPEECH   PATHOLOGY   O6900   ELECTROCARDI OLOGY	367, 420 7, 020, 819	1	367, 420 6, 945, 853		68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 122, 556		1, 112, 883		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 542, 609		22, 542, 609		71.00
72. 00 73. 00	O7200   IMPL. DEV. CHARGED TO PATIENTS   O7300   DRUGS CHARGED TO PATIENTS	22, 022, 577 40, 176, 112		22, 022, 577 40, 176, 112		72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	1, 227, 249		1, 227, 249		74. 00
	OUTPATIENT SERVICE COST CENTERS		l al	1 100 507		
88. 00 88. 01	08800   EAST ADAMS RHC   08801   48TH AND MAINE RHC	1, 108, 587 2, 976, 581	0	1, 108, 587 2, 976, 581		88. 00 88. 01
88. 02	08802 MT STERLING RHC	721, 817	1 1	721, 817		88. 02
88. 03	08803 MAIN CAMPUS RHC	21, 172, 824	0	21, 172, 824		88. 03
88. 04 88. 05	08804   BLESSING EXPRESS CLINIC   08805   BLESSING WALK IN CLINIC	2, 086, 142 4, 325, 511	0	2, 086, 142 4, 325, 511		88. 04 88. 05
88. 06	08806 HANNI BAL MAIN RHC	4, 325, 511		4, 325, 511 4, 791, 561		88. 06
88. 07	08807 PALMYRA RHC	493, 054	1	493, 054		88. 07
88. 08	08808 BOWLING GREEN RHC	184, 996	1	184, 996		88. 08
90. 00 90. 01	O9000   CLI NI C   O9001   OUTPATI ENT   I NFUSI ON	16, 130, 057 932, 755	l I	16, 069, 600 932, 755		90. 00 90. 01
90. 01	04950 ONCOLOGY	1, 171, 058	1	1, 171, 058		90. 02
90. 03	04951 HANNI BAL I NFUSI ON	178, 016	O	178, 016		90. 03
91.00	O9100   EMERGENCY   O9200   OBSERVATION BEDS (NON-DISTINCT PART)	15, 571, 066	-101, 567 0	15, 469, 499		91. 00 92. 00
72.00	101200 ODDERVATION DEDO (NON-DISTINCI FARI)	<u> </u>	<u>ı</u> 9		I	1 72.00

Health Financial Systems	BLESSI NG	HOSPI TAL		In Lie	u of Form CMS-2552-1	0
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 14-0015	Peri od: From 10/01/2022 To 09/30/2023	Worksheet B Part I Date/Time Prepared: 12/29/2023 3:54 pm	
Cost Center Description	Subtotal	Intern & Residents Cost	Total			

					То	09/30/2023	Date/Time Pr 12/29/2023 3	repared: 3:54 pm
	Cost Center Description	Subtotal	Intern &	Total				
		F	Residents Cost					
			& Post					
			Stepdown					
			Adjustments					
		24.00	25. 00	26. 00				
93. 99 09399	PARTIAL HOSPITALIZATION PROGRAM	2, 004, 816	0	2, 004, 8	316			93. 99
	REIMBURSABLE COST CENTERS							
	HOME HEALTH AGENCY	6, 213, 268	0	6, 213, 2	268			101. 00
	AL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE							113. 00
116. 00 11600	HOSPI CE	4, 652, 123	0	4, 652, 1	123			116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	405, 392, 510	-4, 326, 305	401, 066, 2	205			118. 00
NONRE	MBURSABLE COST CENTERS							
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	191, 196	0	191, 1	196			190. 00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	12, 956, 170	0	12, 956, 1	170			192. 00
193.00 19300	NONPALD WORKERS	0	0		0			193. 00
193. 01 19301	DENMAN SERVICES	55, 968	0	55, 9	968			193. 01
193. 02 19302	UNUSED SPACE	1, 135, 247	0	1, 135, 2	247			193. 02
193. 03 19303	RENTED SPACE	1, 471, 973	0	1, 471, 9	973			193. 03
193. 04 19304	RETAIL PHARMACIES	27, 249, 806	0	27, 249, 8	306			193. 04
193. 05 19305	WELLNESS CENTER	914, 382	o	914, 3	382			193. 05
200. 00	Cross Foot Adjustments	o	o		0			200.00
201. 00	Negative Cost Centers	0	o		0			201.00
202. 00	TOTAL (sum lines 118 through 201)	449, 367, 252	-4, 326, 305	445, 040, 9	947			202. 00

| Peri od: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0015

				To	09/30/2023	Date/Time Pre 12/29/2023 3:	
				CAPITAL REL	ATED COSTS		
	Cost Center Description	Di rectly	BLDG & FIXT	BUTLER	OLD BLDG &	NEW BLDG &	
		Assigned New		BUI LDI NG	FI XTURES	FI XTURES	
		Capi tal Rel ated Costs					
	GENERAL SERVICE COST CENTERS	0	1. 00	1. 01	1. 02	1. 03	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 1. 02	OO101 CAP REL COSTS-BUTLER BUILDING   OO102 CAP REL COSTS-OLD BLDG & FIXTURES						1. 01 1. 02
1. 02	00103 CAP REL COSTS-NEW BLDG & FIXTURES						1. 02
1.04	00104 CAP REL COSTS-MOB						1.04
1. 05 1. 06	00105 CAP REL COSTS-OAK STREET MALL 00106 CAP REL COSTS-BRCN AT 36TH ST						1. 05 1. 06
1.07	00107 CAP REL COSTS-SURGERY CENTER						1. 07
1. 08 1. 09	00108 CAP REL COSTS-48TH AND MAINE 00109 CAP REL COSTS-HANNIBAL						1. 08 1. 09
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	20, 217 455, 562	0	0 13, 758	8, 372 158, 893	655, 083 1, 739, 586	4. 00 5. 00
6.00	00600 MAI NTENANCE & REPAI RS	629	0	1	104, 324	1, 106, 114	6. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	0	0	9, 760 20, 756	21, 136 40, 308	1
10. 00	01000 DI ETARY	490	0	0	20, 730	226, 289	1
11.00	01100 CAFETERI A	0	0	0	0	90, 001	1
13. 00 16. 00	01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY	20, 700	0	0	23, 116 1, 490	14, 338 30, 119	1
20. 00	02000 NURSI NG PROGRAM	417, 289	0	0	O	32, 350	20. 00
21. 00 22. 00	02100   &R SERVI CES-SALARY & FRINGES APPRVD 02200   &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0	0	0 1, 490	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM	0	0	Ō	0	0	23. 00
23. 01 23. 02	O2301   PARAMED ED PRGM-RADI OLOGY   O2302   PARAMED ED PRGM-LABORATORY	0	0	0	0	10, 902 8, 359	1
23. 03	02303 PARAMED ED PRGM-PHARMACY	Ö	0	0	Ö	0,007	23. 03
23. 04	O2304   PARAMED ED PRGM-RESPIRATORY     I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	461	23. 04
30. 00	03000 ADULTS & PEDIATRICS	159, 682	0		1, 078	2, 970, 790	
31. 00 41. 00	03100   INTENSIVE CARE UNIT   04100   SUBPROVI DER -   I RF	27, 216 73, 831	0	I	50, 514 23, 568	197, 181 71, 022	
43.00	04300 NURSERY	247	0	o o	23, 300	53, 055	1
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	101, 810	0	0	0	174, 558	44. 00
50. 00	05000 OPERATING ROOM	1, 099, 849	0	0	32, 194	419, 394	50. 00
52. 00 53. 00	O5200   DELI VERY ROOM & LABOR ROOM   O5300   ANESTHESI OLOGY	0 86, 774	0	0	38, 730 3, 194	0 10, 084	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	70, 533	0	o o	7, 751	228, 312	•
55. 00 57. 00	O5500   RADI OLOGY-THERAPEUTI C   O5700   CT   SCAN	0	0	0	0	169, 144	1
57.00	05700  CT SCAN   05800  MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	3, 036 0	15, 379 29, 584	1
	06000 LABORATORY	421, 522	0	0	3, 250	166, 928	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY	54, 821	0	0	4, 094		62. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	O	50, 541	66. 00
67. 00 68. 00		0	0	0	0	24, 423 8, 270	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	Ō	43, 144	68, 181	69. 00
	07000   ELECTROENCEPHALOGRAPHY   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	50, 357	0	0 30, 646	9, 368 0	0 108, 876	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	Ö	0	35, 087	ő	124, 478	72. 00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	0	2, 935 0	87, 249 0	ı
74.00	OUTPATIENT SERVICE COST CENTERS	0	0			0	74.00
	08800 EAST ADAMS RHC 08801 48TH AND MAINE RHC	49, 753	0	0	0	0	88. 00
88. 01 88. 02		91, 278	0	0	o	0	88. 01 88. 02
88. 03	1 1	0	0	0	o	0	
88. 04 88. 05	08804 BLESSING EXPRESS CLINIC 08805 BLESSING WALK IN CLINIC	166, 757 0	0	0	0 0	0 55, 182	
88. 06	08806 HANNI BAL MAIN RHC	24, 551	0	o	ō	0	88. 06
88. 07 88. 08	O8807   PALMYRA RHC   O8808   BOWLI NG GREEN RHC	56, 074 15, 824	0 0	0 0	0  0	0	
90.00	09000 CLI NI C	74, 808	Ö	O	Ö	19, 827	90.00
	O9001   OUTPATI ENT   I NFUSI ON   O4950   ONCOLOGY	0	0	0	0	52, 043 25, 836	90. 01 90. 02
90. 03	04951 HANNI BAL I NFUSI ON		0	0	o	0	90. 03
91. 00	09100  EMERGENCY	0	0	0	31, 971	221, 990	91.00

| Period: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS BLESSING HOSPITAL Provider CCN: 14-0015

			To	09/30/2023	Date/Time Pre   12/29/2023 3:	
			CAPITAL REL	ATED COSTS	1 . 2, 2 , 2020 0.	J
Cost Center Description	Di rectly Assigned New Capital Related Costs	BLDG & FIXT	BUTLER BUI LDI NG	OLD BLDG & FIXTURES	NEW BLDG & FIXTURES	
	0	1. 00	1. 01	1. 02	1. 03	
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART) 93. 99   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0	0	0	48, 102	92. 00 93. 99
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 H0SPI CE	220, 983		0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 761, 557	0	79, 491	583, 028	9, 428, 574	118. 00
NONREI MBURSABLE COST CENTERS		_	_			
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	16, 336		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	305, 798	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
193. 01 19301 DENMAN SERVICES	0	0	0	14 042	14, 874	
193. 02 19302 UNUSED SPACE 193. 03 19303 RENTED SPACE	0	0	0	14, 042	369, 627	
193. 04 19304 RETAIL PHARMACIES	38, 685	0	0	4, 242	230, 364	193. 03
193. 04 19304 RETAIL PHARWACIES 193. 05 19305 WELLNESS CENTER	34, 820		0	0		193. 04
200.00 Cross Foot Adjustments	34, 620	U	U	٩	U	200. 00
201.00 Negative Cost Centers		0	0	0	0	200.00
202.00 TOTAL (sum lines 118 through 201)	4, 140, 860	0	79, 491	617, 648		

		CAP	TAL RELATED CO	OSTS	12/29/2023 3:	54 pm
Cost Center Description	MOB	OAK STREET	BRCN AT 36TH	SURGERY CENTER	48TH AND MAINE	
	1.04	MALL 1. 05	ST 1. 06	1. 07	1. 08	
GENERAL SERVICE COST CENTERS	1.04	1.05	1.00	1.07	1.00	
1. 00	0 282, 285 0 0 0 3, 810 0 0 0 0 0	33, 929 487, 959 25, 738 0 338 0 48, 099 0 41, 782 0 0 19, 965 937	2, 403 0 0 0 0 0 0 100, 273 0 0 0 3, 607	0 170, 060 166, 571 0 5, 719 0 0 0 0 0 0	0 627, 634 27, 523 0 6, 922 22, 296 0 0 0 0	1. 00 1. 01 1. 02 1. 03 1. 04 1. 05 1. 06 1. 07 1. 08 1. 09 2. 00 4. 00 5. 00 6. 00 8. 00 9. 00 10. 00 11. 00 20. 00 21. 00 22. 00 23. 01 23. 02 23. 03
23. 04 02304 PARAMED ED PRGM-RESPIRATORY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	621	0	0	0	23. 04
30. 00 03000 ADULTS & PEDIATRICS	0	15, 586	31, 339	0	0	30. 00
31. 00   03100   NTENSI VE CARE UNI T	0	0	0	0	0	31.00
41. 00   04100   SUBPROVI DER -   RF 43. 00   04300   NURSERY	0	0	)   0	Ol	0	41. 00 43. 00
44.00 O4400 SKILLED NURSING FACILITY	0	0	0	Ō	0	44. 00
ANCILLARY SERVICE COST CENTERS	00.000			754 700		F0 00
50.00   05000   0PERATING ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM	88, 293 0	0	0	754, 722 0	0	50. 00 52. 00
53. 00   05300   ANESTHESI OLOGY	1, 954	0	Ö	Ö	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	86, 232	0	0	0	0	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
57. 00   05700   CT SCAN 58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0	)   0	0	0	57. 00 58. 00
60. 00   06000   LABORATORY	0	0	ő	o	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	o	0	62. 00
65. 00   06500   RESPI RATORY THERAPY 66. 00   06600   PHYSI CAL THERAPY	28, 527	0	0	0	0	65.00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	0	0	0	0	0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	ő	Ö	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	o	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS 72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS	0	0	0	ol Ol	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	ő	o	0	73. 00
74. 00 07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
OUTPATIENT SERVICE COST CENTERS  88. 00 08800 EAST ADAMS RHC		0	0	٥	0	00 00
88. 00   08800   EAST ADAMS RHC 88. 01   08801   48TH AND MAINE RHC	0	0	0	0	0 108, 009	88. 00 88. 01
88. 02   08802 MT STERLING RHC	0	0	ő	o	0	88. 02
88. 03 08803 MAIN CAMPUS RHC	483, 635	0	0	o	0	88. 03
88. 04   08804   BLESSI NG EXPRESS CLI NI C	0	0	0	0	0	88. 04
88. 05   08805   BLESSING WALK IN CLINIC 88. 06   08806   HANNIBAL MAIN RHC	0	0	)   0	0	0	88. 05 88. 06
88. 07   08807   PALMYRA RHC	0	0	ő	o	0	88. 07
88. 08   08808   BOWLI NG GREEN RHC	0	0	0	o	0	88. 08
90. 00   09000   CLINI C	350, 672	0	0	0	53, 596	90.00
90. 01   09001   0UTPATI ENT   INFUSI ON 90. 02   04950   ONCOLOGY		0	) O	0	0	90. 01 90. 02
90. 03   04951   HANNI BAL   I NFUSI ON		0	Ö	ő	0	90. 03
91. 00   09100   EMERGENCY	0	25, 302	0	o	0	91.00
92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART) 93.99   09399   PARTIAL HOSPITALIZATION PROGRAM	0	0	_		0	92. 00 93. 99
75. 77  07577  TANTIAL HOSFITALIZATION PROGRAM	ı o	0	<u> </u>	Ч	0	73. 77

| Period: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS BLESSING HOSPITAL Provider CCN: 14-0015

			1	0 09/30/2023	Date/IIme Prepared:   12/29/2023 3:54 pm
		CAP	ITAL RELATED CO	OSTS	, те, е, те, е, е, е, е, е, е, е, е, е, е, е, е, е
Cost Center Description	MOB	OAK STREET MALL	BRCN AT 36TH ST	SURGERY CENTER	48TH AND MAINE
	1. 04	1. 05	1.06	1. 07	1. 08
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY	0	22, 285	0	0	0 101. 00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113. 00
116. 00 11600 H0SPI CE	0	0	0	0	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 325, 408	722, 541	137, 622	1, 097, 072	845, 980 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	21, 558	0	0	0	683, 331 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
193. 01   19301   DENMAN SERVICES	0	0	0	0	0 193. 01
193. 02 19302 UNUSED SPACE	0	0	0	0	0 193. 02
193. 03 19303 RENTED SPACE	0	0	0	0	0 193. 03
193. 04 19304 RETAIL PHARMACIES	0	0	0	0	0 193. 04
193. 05 19305 WELLNESS CENTER	0	78, 150	0	0	0 193. 05
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00   TOTAL (sum lines 118 through 201)	1, 346, 966	800, 691	137, 622	1, 097, 072	1, 529, 311 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

						12/29/2023 3:	pareu: 54 pm
		CAPITAL REL	ATED COSTS				·
	Cost Center Description	HANNI BAL	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		1. 09	2. 00	2A	4. 00	5. 00	
1. 00 1. 01 1. 02 1. 03 1. 04 1. 05 1. 06 1. 07 1. 08 1. 09 2. 00 4. 00 5. 00 6. 00 8. 00 9. 00 10. 00 11. 00 13. 00 20. 00 21. 00	01300 NURSI NG ADMI NI STRATI ON 01600 MEDI CAL RECORDS & LI BRARY 02000 NURSI NG PROGRAM 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0 119, 219 16, 279 0 1, 098 0 0 10, 274	23, 323 7, 641, 509 240, 965 1, 296 285, 384 148, 441 0 1, 057, 370 5, 853 158, 352	740, 924 11, 698, 868 1, 688, 143 32, 192 360, 525 401, 326 90, 001 1, 163, 623 47, 736 750, 046	740, 924 46, 398 19, 091 206 17, 690 6, 432 10, 736 25, 551 0 17, 745 5, 608	11, 745, 266 489, 655 55, 525 246, 460 99, 958 138, 702 484, 056 319, 168 113, 427 45, 272	1. 00 1. 01 1. 02 1. 03 1. 04 1. 05 1. 06 1. 07 1. 08 1. 09 2. 00 4. 00 5. 00 6. 00 8. 00 9. 00 10. 00 11. 00 20. 00 21. 00 21. 00
22. 00 23. 00 23. 01 23. 02 23. 03 23. 04	02300 PARAMED ED PRGM 02301 PARAMED ED PRGM-RADI OLOGY 02302 PARAMED ED PRGM-LABORATORY 02303 PARAMED ED PRGM-PHARMACY	0 0 0 0 0	743 0 23, 676 3, 388 0 2, 259	2, 233 0 54, 543 16, 291 0 3, 341	0 0 2, 030 596 1, 415 776	12, 764 4, 203 11, 935	22. 00 23. 00 23. 01 23. 02 23. 03 23. 04
30. 00 31. 00 41. 00 43. 00 44. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04300 NURSERY	0 0 0 0	214, 499 148, 933 4, 990 12, 777 996	3, 392, 974 423, 844 173, 411 66, 079 277, 364	145, 885 20, 632 8, 433 1, 434 7, 757	252, 989 90, 158 15, 228	30. 00 31. 00 41. 00 43. 00 44. 00
50. 00 52. 00 53. 00 54. 00 55. 00 57. 00 60. 00 62. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DIAGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGING (MRI) 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 0 5,819 0 0 0 0 0 0 0 0	2, 823, 229 14, 951 124, 326 417, 225 163, 404 397, 357 141, 958 249, 051 11, 497 214, 053 5, 414 0 2, 786 491, 744 39, 178 81, 209	5, 217, 681 53, 681 226, 332 815, 872 332, 548 415, 772 171, 542 840, 751 17, 223 348, 868 55, 955 24, 423 11, 056 603, 069 98, 903 220, 731	49, 265 3, 267 959 20, 525 4, 498 2, 868 1, 482 15, 659 883 11, 472 6, 692 4, 330 11, 937 2, 162 5, 219	35, 418 29, 362 300, 082 59, 940 55, 888 23, 078 516, 234 47, 863 111, 504 56, 267 35, 838 8, 845 162, 562 26, 650 580, 354	62. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00
72. 00 73. 00 74. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 0UTPATIENT SERVICE COST CENTERS	0 4, 705 0	92, 835 694, 655 0	252, 400 789, 544 0	0 22, 394 0	565, 387 1, 026, 582 32, 077	72.00 73.00 74.00
88. 00 88. 01 88. 02 88. 03 88. 04 88. 05 88. 06 88. 07 88. 08 90. 00 90. 01 90. 02	08801 48TH AND MAINE RHC 08802 MT STERLING RHC 08803 MAIN CAMPUS RHC 08805 BLESSING EXPRESS CLINIC 08806 HANNIBAL MAIN RHC 08807 PALMYRA RHC 08808 BOWLING GREEN RHC 09000 CLINIC 09001 OUTPATIENT INFUSION 04950 ONCOLOGY 04951 HANNIBAL INFUSION	0 0 0 0 72,010 0 88,233 0 0 25,061	138 0 24, 765 52, 271 32, 522 19, 825 0 1, 857 573 336, 456 0	49, 891 108, 009 116, 043 535, 906 199, 279 75, 007 96, 561 57, 931 16, 397 923, 592 52, 043 25, 836 25, 061	2, 461 8, 044 1, 569 68, 223 5, 237 12, 020 13, 091 1, 153 467 30, 648 1, 587 2, 425	18, 867 494, 462 54, 527 106, 650 116, 638 12, 887 4, 835 358, 342 16, 197 24, 108 1, 660	88. 00 88. 01 88. 02 88. 03 88. 04 88. 05 88. 06 88. 07 88. 08 90. 00 90. 01 90. 02 90. 03
91. 00 92. 00	1 1		133, 934	413, 197 O	27, 162	311, 224	91. 00 92. 00

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provider CCN: 14-0015	Peri od: Worksheet B

ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 10/01/2022 o 09/30/2023	Part II Date/Time Pre	pared: 54 pm_
	CAPITAL REL	ATED COSTS				
Cost Center Description	HANNI BAL	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
	1.09	2. 00	2A	4. 00	5. 00	
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	14, 762	62, 864	4, 481	39, 498	93. 99
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	466	22, 751	13, 511	136, 294	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	7, 880	228, 863	9, 635	107, 803	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	342, 698	16, 565, 075	34, 889, 046	704, 872	10, 695, 357	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	28, 190			190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	39, 629	215, 502	1, 265, 818	25, 438		
193. 00 19300 NONPALD WORKERS	0	0	0	0	l	193. 00
193. 01 19301 DENMAN SERVICES	0	0	14, 874			193. 01
193. 02 19302 UNUSED SPACE	0	0	383, 669			193. 02
193. 03 19303 RENTED SPACE	40, 743	0	275, 349	-		193. 03
193. 04 19304 RETAIL PHARMACIES	686	90, 238	138, 057	9, 250	711, 848	193. 04
193. 05 19305 WELLNESS CENTER	0	44, 942	157, 912	1, 364		
200.00 Cross Foot Adjustments			0			200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	423, 756	16, 915, 757	37, 152, 915	740, 924	11, 745, 266	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0015

					09/30/2023	12/29/2023 3:	
	Cost Center Description	MAI NTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	,
		REPAI RS	LINEN SERVICE	2.22	40.00		
	CENEDAL CEDALCE COCT CENTEDS	6.00	8. 00	9. 00	10.00	11. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 CAP REL COSTS-BUTLER BUILDING						1. 00
1. 02	00102 CAP REL COSTS-OLD BLDG & FIXTURES						1. 02
1. 03	00103 CAP REL COSTS-NEW BLDG & FIXTURES						1. 03
1. 04	00104 CAP REL COSTS-MOB						1. 04
1. 05	00105 CAP REL COSTS-OAK STREET MALL						1. 05
1.06	00106 CAP REL COSTS-BRCN AT 36TH ST						1. 06
1. 07	00107 CAP REL COSTS-SURGERY CENTER						1. 07
1. 08	00108 CAP REL COSTS-48TH AND MAINE						1. 08
1.09	00109 CAP REL COSTS-HANNI BAL						1. 09
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS	2, 196, 889					6. 00
8.00	00800 LAUNDRY & LINEN SERVICE	9, 133	97, 056				8. 00
9.00	00900 HOUSEKEEPI NG	20, 436	983	646, 094			9. 00
10.00	01000 DI ETARY	45, 658	715	15, 213	569, 302		10.00
11.00	01100 CAFETERI A	16, 545	0	5, 513	0	261, 497	11. 00
13.00	01300 NURSING ADMINISTRATION	27, 138	0	9, 044	0	13, 010	13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	9, 819	0	3, 273	0	0	16. 00
20.00	02000 NURSI NG PROGRAM	80, 897	0	26, 953	0	7, 483	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	-	0	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	801	0	268	0	3, 159	22. 00
23. 00	02300 PARAMED ED PRGM	0	0	-	0	0	23. 00
23. 01	02301 PARAMED ED PRGM-RADI OLOGY	7, 016	0	2, 340	0	858	23. 01
23. 02	02302 PARAMED ED PRGM-LABORATORY	4, 091	0	,	0	196	23. 02
23. 03	02303 PARAMED ED PRGM-PHARMACY	0	0		0	488	23. 03
23. 04	02304 PARAMED ED PRGM-RESPIRATORY	241	0	79	0	366	23. 04
	INPATIENT ROUTINE SERVICE COST CENTERS		00 705	100 470	450 005	70 744	
30.00	03000 ADULTS & PEDI ATRI CS	570, 772	33, 705		452, 985	70, 746	30.00
31.00	03100 INTENSIVE CARE UNIT	63, 406	5, 439		44, 165	9, 117	31.00
41. 00	04100 SUBPROVI DER – I RF	25, 727	5, 278		35, 977	3, 828	41.00
43. 00	04300 NURSERY	9, 753	588		0 27 175	545	43.00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	32, 090	3, 869	10, 691	36, 175	3, 965	44. 00
50. 00	05000 OPERATING ROOM	183, 111	7, 711	61, 010	ol	24, 574	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	20, 822	2, 681	6, 935	0	1, 575	52. 00
53. 00	05300 ANESTHESI OLOGY	4, 121	2,001	· ·	0	826	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	72, 369	6, 792		0	10, 136	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	31, 095	3, 786		0	1, 422	55. 00
57. 00	05700 CT SCAN	4, 460	2, 601		0	1, 231	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	5, 439	610		0	645	58. 00
60. 00	06000 LABORATORY	32, 434	10		0	9, 397	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 053	0		0	526	62. 00
65. 00	06500 RESPIRATORY THERAPY	18, 935	0		o	5, 219	65. 00
66. 00	06600 PHYSI CAL THERAPY	9, 291	0	· ·	O	2, 698	66. 00
67.00	1	4, 490	0		O	1, 780	
68.00	1 1	1, 520	0	509	O	401	68. 00
69. 00	06900 ELECTROCARDI OLOGY	35, 729	3, 855		o	5, 196	69. 00
70.00		5, 037	29		o	1, 167	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 169	597	7, 050	o	1, 879	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	24, 199	683	8, 063	o	2, 340	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	19, 211	0	6, 400	o	8, 227	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 EAST ADAMS RHC	0	0		0	0	88. 00
88. 01	08801 48TH AND MAINE RHC	14, 465	0	4, 821	0	0	88. 01
88. 02	08802 MT STERLING RHC	0	0	0	0	0	88. 02
88. 03	08803 MAIN CAMPUS RHC	136, 057	0	45, 330	0	19, 844	88. 03
88. 04	08804 BLESSING EXPRESS CLINIC	0	0	0	0	0	88. 04
88. 05	08805 BLESSING WALK IN CLINIC	10, 144	0	3, 378	0	3, 074	88. 05
88. 06	08806 HANNI BAL MAIN RHC	24, 396	0	8, 126	0	0	88. 06
88. 07	08807 PALMYRA RHC	0	0	0	0	0	88. 07
88. 08	08808 BOWLING GREEN RHC	0	0	0	0	10.010	88. 08
90.00	09000 CLINIC	139, 365	0	46, 437	0	19, 918	90.00
90. 01	09001 OUTPATIENT INFUSION	9, 567	32		0	896	90. 01
90. 02	04950 ONCOLOGY	4, 750	0	1, 584	0	1, 191	90. 02
90. 03	04951 HANNI BAL I NFUSI ON	8, 490	0	2, 828	0	12 125	90. 03
91. 00	09100 EMERGENCY	64, 349	16, 774	21, 440	O	13, 135	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.040	^	2 040		2 242	92.00
93. 99	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	8, 843	0	2, 948	O	2, 348	93. 99
101 0	OTHER REIMBURSABLE COST CENTERS 0 10100 HOME HEALTH AGENCY	5, 594	0	1, 862	0	0	101. 00
101.00	PITOTOO HOWE HEALTH AUCITOT	0,094	0	1,002	υ <sub>l</sub>	0	1.01.00

Health Financial Systems	BLESSI NG 1	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B	
				From 10/01/2022	Part II	
				To 09/30/2023	Date/Time Pre 12/29/2023 3:	pared:
Cost Center Description	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	54 pili
cost center bescription		LINEN SERVICE	HUUSEKEEPING	DIETAKT	CAFETERIA	
	6. 00	8. 00	9. 00	10.00	11. 00	
SPECIAL PURPOSE COST CENTERS	0.00	0.00	7.00	10.00	11.00	
113. 00 11300   NTEREST EXPENSE						113.00
116. 00 11600 H0SPI CE	0	0		0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 844, 028	96, 738	604, 54	6 569, 302		
NONREI MBURSABLE COST CENTERS						1
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	10, 962	318	3, 65	1 0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	111, 002	0	36, 98	4 0	8, 091	192. 00
193. 00 19300 NONPALD WORKERS	0	0		0	0	193. 00
193. 01 19301 DENMAN SERVICES	2, 734	0	91	3 0	0	193. 01
193. 02 19302 UNUSED SPACE	75, 500	0	(	0 0	0	193. 02
103 03 10303 DENTED CDACE	121 250	1			۸ ا	102 02

131, 258

1, 786

19, 619

2, 196, 889

569, 302

0 193. 03

0 193. 04 0 193. 05

0 201.00

261, 497 202. 00

200.00

0

97, 056

0

0

646, 094

193. 04 19304 RETAIL PHARMACIES

Cross Foot Adjustments

Negative Cost Centers TOTAL (sum lines 118 through 201)

193. 05 19305 WELLNESS CENTER

193. 03 19303 RENTED SPACE

200.00

201.00

202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0015

						Date/lime Prep 12/29/2023 3:	
					INTERNS &	RESI DENTS	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	MEDI CAL RECORDS & LI BRARY	NURSI NG PROGRAM	SERVICES-SALAR Y & FRINGES	PRGM COSTS	
	CENEDAL SEDVICE COST CENTEDS	13. 00	16. 00	20. 00	21. 00	22.00	
1. 00 1. 01 1. 02 1. 03 1. 04 1. 05 1. 06 1. 07 1. 08 1. 09 2. 00 4. 00 6. 00 8. 00 9. 00 10. 00 11. 00 21. 00 22. 00 22. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT  00101 CAP REL COSTS-BLDG & FIXT  00102 CAP REL COSTS-BUDE & FIXTURES  00103 CAP REL COSTS-OLD BLDG & FIXTURES  00104 CAP REL COSTS-MEW BLDG & FIXTURES  00105 CAP REL COSTS-MOB  00105 CAP REL COSTS-MOB  00106 CAP REL COSTS-BRCN AT 36TH ST  00107 CAP REL COSTS-SURGERY CENTER  00108 CAP REL COSTS-SURGERY CENTER  00109 CAP REL COSTS-HANNI BAL  00200 CAP REL COSTS-MYBLE EQUI P  00400 EMPLOYEE BENEFITS DEPARTMENT  00500 ADMINISTRATIVE & GENERAL  00600 MAINTENANCE & REPAIRS  00800 LAUNDRY & LINEN SERVICE  00900 HOUSEKEEPING  01100 DI ETARY  01100 CAFETERIA  01300 NURSING ADMINISTRATION  01600 MEDICAL RECORDS & LIBRARY  02000 NURSING PROGRAM  02100 I &R SERVICES-SALARY & FRINGES APPRVD  02200 VARAMED ED PRGM-RADIOLOGY  02301 PARAMED ED PRGM-RADIOLOGY	1, 722, 422 0 0 0 0 0 0	379, 996 0 0 0 0 0 0	996, 55	1 50, 880	72, 240	1. 00 1. 01 1. 02 1. 03 1. 04 1. 05 1. 06 1. 07 1. 08 1. 09 2. 00 4. 00 5. 00 8. 00 9. 00 11. 00 11. 00 20. 00 21. 00 22. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00
23. 04	02304 PARAMED ED PRGM-RESPIRATORY INPATIENT ROUTINE SERVICE COST CENTERS	0	0				23. 04
30. 00	03000 ADULTS & PEDIATRICS	851, 377	301, 048				30. 00
31. 00 41. 00	03100   I NTENSI VE CARE UNI T   04100   SUBPROVI DER -   RF	109, 710 46, 064	29, 353 23, 909				31. 00 41. 00
43. 00	04300 NURSERY	6, 559	498				43. 00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	47, 718	24, 040				44. 00
50. 00	05000 OPERATING ROOM	295, 721	0				50. 00
52. 00 53. 00 54. 00 55. 00 57. 00 58. 00 60. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S OUTPATI ENT SERVICE COST CENTERS	295, 721 18, 955 9, 936 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000				50. 00 52. 00 53. 00 54. 00 55. 00 57. 00 58. 00 60. 00 62. 00 65. 00 66. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 00 74. 00
88. 01 88. 02 88. 03 88. 04 88. 05 88. 06 88. 07 89. 00 90. 01 90. 02 90. 03 91. 00	08801   48TH AND MAINE RHC   08802   MT STERLING RHC   08803   MAIN CAMPUS RHC   08804   BLESSING EXPRESS CLINIC   08805   BLESSING WALK IN CLINIC   08806   HANNIBAL MAIN RHC   08807   PALMYRA RHC   08808   BOWLING GREEN RHC   09000   CLINIC   09001   OUTPATIENT INFUSION	0 0 0 0 0 0 0 0 10, 789 14, 329 0 158, 061	0 0 0 0 0 0 0 0 0 0 0 0				88. 01 88. 02 88. 03 88. 04 88. 05 88. 06 88. 07 88. 08 90. 00 90. 01 90. 02 90. 03 91. 00 92. 00

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 14-0015	Peri od: Worksheet B

From 10/01/2022 Part II
To 09/30/2023 Date/Time Prepared: 12/29/2023 3:54 pm INTERNS & RESIDENTS NURSI NG MEDI CAL NURSI NG SERVI CES-SALAR SERVI CES-OTHER Cost Center Description ADMI NI STRATI ON RECORDS & PROGRAM Y & FRINGES PRGM COSTS LI BRARY 21.00 22.00 13.00 20.00 16.00 93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM 28, 255 93. 99 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 78, 029 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113. 00 116. 00 11600 HOSPI CE 46, 919 116. 00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 118.00 379, 996 1, 722, 422 0 0 118. 00 0 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 00 0 0 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 193. 00 19300 NONPALD WORKERS 0 193. 00 193. 01 19301 DENMAN SERVICES 0 193. 01 193. 02 19302 UNUSED SPACE 0 193. 02 193. 03 19303 RENTED SPACE 0 193. 03 193. 04 193. 04 19304 RETAIL PHARMACIES 0 193. 05 19305 WELLNESS CENTER 0 193. 05 Cross Foot Adjustments 50, 880 200.00 72, 240 200. 00 996, 551 201.00 Negative Cost Centers 0 201.00

1, 722, 422

379, 996

996, 551

50, 880

72, 240 202. 00

202.00

TOTAL (sum lines 118 through 201)

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 10/01/2022 | Part II |
| To 09/30/2023 | Date/Time Prepared: | 12/29/2023 3:54 pm

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Part		Cost Center Description						
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1. 00   00100 CAP REL COSTS-HANNI BAL		1						1.07
2. 0.0   00200   CAP REL COSTS-MARIE E GUIP   4. 0.0   00400   DIFFLOYEE BERKET IS DEPARTMENT   5. 0.0   00500   ADMIN INSTRATIVE & GENERAL   6. 0.0   00500   MAN TERMANCE & REPAIRS   6. 0.0   00500   MAN TERMANCE & REPAIRS   6. 0.0   01000   DIESTARY   7. 0.0   01000   01000   7. 0.0   01000   01000   7. 0.0   01000   01000   7. 0.0   01000   01000   7. 0.0   01000   01000   7. 0.0   01000   01000   7. 0.0   01000   01000   7. 0.0   01000   01000   7. 0.0   01000   01000   7. 0.0   01000   01000   7. 0.0   01000   01000   7. 0.0   01000   01000   7. 0.0   01000   01000   7. 0.0   01000   01000   7. 0.0   01000   01000   7. 0.0   01000   01000   7. 0.0   01000   01000   7. 0.0   01000   7. 0.0   01000   7. 0.0   01000   7. 0.0   01000   7. 0.0   01000   7. 0.0   01000   7. 0.0   01000   7. 0.0   01000		1						1. 08 1. 09
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IMPATI ENT ROUTINE SERVICE COST CENTERS   30.00   03000   ADULTS & PEDIATRICS   31.00   03100   INTERSI VE CARE UNIT   32.01   04100   SUBPROVIDER - I RF   44.00   04100   SUBPROVIDER - I RF   44.00   04400   SKI LLED NURSI NG FACI LITY   44.00   04400   SKI LLED NURSI NG FACI LITY   44.00   04400   SKI LLED NURSI NG FACI LITY   44.00   04400   SKI LLED NURSI NG FACI LITY   45.00   050000   05000   05000   05000   05000   05000   050000   050000						13, 838	1	23. 03 23. 04
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS 50. 00 5000 OPERATING ROOM 55. 00 05000 PERATING ROOM 55. 00 05200 DELIVERY ROOM & LABOR ROOM 55. 00 05200 DELIVERY ROOM & LABOR ROOM 56. 00 05400 RADIOLOGY-DIACNOSTIC 57. 00 05700 CT SCAN 58. 00 05500 RADIOLOGY-THERAPEUTIC 59. 00 05500 RADIOLOGY-THERAPEUTIC 59. 00 05500 RADIOLOGY-THERAPEUTIC 59. 00 05500 RADIOLOGY-THERAPEUTIC 59. 00 05600 RADIOLOGY-THERAPEUTIC 59. 00 05600 RADIOLOGY-THERAPEUTIC 59. 00 05600 RADIOLOGY-THERAPEUTIC 59. 00 05600 RADIOLOGY-THERAPEUTIC 59. 00 05600 RADIOLOGY-THERAPEUTIC 59. 00 05600 RADIOLOGY-THERAPEUTIC 59. 00 05600 RASING ROOM SEPIRATORY THERAPEY 50 00 05600 RESPIRATORY 23. 04	'					10, 371	23.04	
41.00   04100   SUBPROVI DER - I RF   44 43.00   04300   NURSERY   44 44.00   04400   SKI LLED NURSING FACILITY   44 45.00   04400   SKI LLED NURSING FACILITY   47 ANCILLARY SERVICE COST CENTERS  50.00   05000   OPERATING ROOM   55 50.00   05200   DELIVERY ROOM & LABOR ROOM   55 50.00   05300   ANESTHESI OLOGY   55 50.00   05300   ANESTHESI OLOGY   55 50.00   05500   RADI OLOGY-DI AGNOSTI C   55 50.00   05500   RADI OLOGY-DI AGNOSTI C   55 50.00   05500   RADI OLOGY-DI AGNOSTI C   55 50.00   05500   RADI OLOGY-DI AGNOSTI C   55 50.00   05500   MAGNETI C RESONANCE I MAGI NG (MRI )   56 60.00   06000   LABORATORY   66 60.00   06000   LABORATORY   66 61 62.00   06500   RESPI RATORY THERAPY   66 63.00   06500   RESPI RATORY THERAPY   67 64 65.00   06600   PHYSI CAL THERAPY   67 66 68.00   06600   SPECH PATHOLOGY   67 69.00   06700   CCUPATI ONAL THERAPY   67 69.00   06900   ELECTROCARDI OLOGY   67 69.00   06900   ELECTROCARDI OLOGY   67 70.00   07000   ELECTROCARDI OLOGY   7 70.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   7 72.00   07200   IMPL DEV. CHARGED TO PATIENTS   7 73.00   07300   DRUGS CHARGED TO PATIENTS   7 74.00   07400   RENAL DI ALYSI S   7 75 88.00   08800   EAST ADAMS RHC   88 89.00   08800   EAST ADAMS RHC   88 89.00   08800   BAEST ADAMS RHC   88 89.00   08800   BAEST ADAMS RHC   88 89.00   08800   BAEST ADAMS RHC   88 89.00   08800   BAEST ADAMS RHC   88 89.00   08800   BAEST ADAMS RHC   88 89.00   08800   BAEST ADAMS RHC   88 89.00   08800   BAEST ADAMS RHC   88 89.00   08800   BAEST NO WALK IN CLINIC   88 89.01   08800   BLESSING WALK IN CLINIC   88 89.01   08800   BLESSING WALK IN CLINIC   88 89.01   08800   BLESSING WALK IN CLINIC   88 89.01   08800   BLESSING WALK IN CLINIC   88 89.01   08800   BLESSING WALK IN CLINIC   88 89.01   08800   BLESSING WALK IN CLINIC   88	30.00							30. 00
43.00   04300   NURSERY   44.00   04400   SKILLED NURSING FACILITY   44.00   04400   SKILLED NURSING FACILITY   45.00   050000   05000   05000   05000	31.00	03100 INTENSIVE CARE UNIT						31. 00
44.00   04400   SKILLED NURSING FACILITY   ANCILLARY SERVICE COST CENTERS    50.00   05000   OPERATING ROOM   52.00   05200   DELIVERY ROOM & LABOR ROOM   55.00   05200   DELIVERY ROOM & LABOR ROOM   55.00   05300   ANESTHESI OLOGY   55.00   05500   RADI OLOGY-DI AGNOSTI C   55.00   05500   RADI OLOGY-THERAPEUTI C   57.00   05700   CT SCAN   57.00   05700   CT SCAN   56.00   05800   MAGNETI C RESONANCE I MAGING (MRI )   60.00   06000   LABORATORY   66.00   06000   LABORATORY   66.00   06500   RESPIRATORY THERAPY   66.00   06500   RESPIRATORY THERAPY   66.00   06600   PHYSI CAL THERAPY   67.00   06700   OCCUPATIONAL THERAPY   67.00   06700   OCCUPATIONAL THERAPY   67.00   06800   SPECEH PATHOLOGY   69.00   06900   ELECTROCARDIOLOGY   69.00   07000   ELECTROCARDIOLOGY   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   72.00   07200   MPLD LEV. CHARGED TO PATIENTS   73.00   07300   DRUGS CHARGED TO PATIENTS   74.00   07400   RENAL DIALYSIS   74.00   07400   RENAL DIALYSIS   74.00   07400   RENAL DIALYSIS   75.00   07400   RENAL DIALYSIS   75.00   08800   BEST ADAMS RHC   88.01   08801   48TH AND MAINE RHC   88.02   08802   MT STERLING RHC   88.03   08803   MAIN CAMPUS RHC   88.04   08804   BLESSING EXPRESS CLINIC   88.04   08804   BLESSING EXPRESS CLINIC   88.05   08805   BLESSING EXPRESS CLINIC   88.07   08805   BLESSING WALK IN CLINIC   88.07   08805   BLESSING WALK IN CLINIC   88.07   08805   BLESSING WALK IN CLINIC   88.07   08805   BLESSING WALK IN CLINIC   88.07   08805   BLESSING WALK IN CLINIC   88.07   08805   BLESSING WALK IN CLINIC   88.07   08805   BLESSING WALK IN CLINIC   88.07   08805   BLESSING WALK IN CLINIC   88.07   08805   BLESSING WALK IN CLINIC   88.07   08805   08805   BLESSING WALK IN CLINIC   88.07   08805   08805   BLESSING WALK IN CLINIC   88.07   08805		1						41.00
ANCILLARY SERVICE COST CENTERS								43. 00 44. 00
50. 00   05000  OPERATI ING ROOM   52. 00   05200   DELI VERY ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY   55. 00   05300   ANESTHESI OLOGY   55. 00   05400   RADI OLOGY-DI AGNOSTI C   55. 00   05500   RADI OLOGY-THERAPEUTI C   57. 00   05700   CT SCAN   58. 00   05800   MAGNETI C RESONANCE   IMAGI NG (MRI )   50. 0000   MAGNETI C RESONANCE   IMAGI NG (MRI )   50. 0000   MAGNETI C RESONANCE   IMAGI NG (MRI )   50. 0000   MAGNETI C RESONANCE   IMAGI NG (MRI )   50. 0000   MAGNETI C RESONANCE   IMAGI NG (MRI )   50. 0000   MAGNETI C RESONANCE   IMAGI NG (MRI )   50. 0000   MAGNETI C RESONANCE   IMAGI NG (MRI )   50. 0000   MAGNETI C RESONANCE   IMAGI NG (MRI )   50. 0000   MAGNETI C RESONANCE   IMAGI NG (MRI )   50. 0000   MAGNETI C RESONANCE   MAGI NG (MRI )   50. 00. 00. 0000   MAGNETI C RESONANCE   MAGI NG (MRI )   50. 00. 00. 0000   MAGNETI C RESONANCE   MAGI NG (MRI )   60. 00. 00. 00. 00. 00. 00. 00. 00. 00.	44.00							44.00
53. 00   05300   ANESTHESI OLOGY   55. 00   05500   RADI OLOGY-DI AGNOSTI C   55. 00   05500   RADI OLOGY-THERAPEUTI C   55. 00   05500   RADI OLOGY-THERAPEUTI C   55. 00   05500   RADI OLOGY-THERAPEUTI C   56. 00   05700   CT SCAN   58. 00   05800   MAGNETI C RESONANCE   IMAGI NG (MRI )   60. 00   06000   LABORATORY   62. 00   06200   WHOLE   BLOOD & PACKED   RED BLOOD CELLS   65. 00   06500   RESPI RATORY   THERAPY   66. 00   06500   RESPI RATORY   THERAPY   67. 00   06700   OCCUPATI ONAL   THERAPY   68. 00   06800   SPEECH   PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY   69. 00   06900   ELECTROCARDI OLOGY   69. 00   07000   ELECTROCARDI OLOGY   71. 00   07100   MEDI CAL   SUPPLIES CHARGED   TO PATI ENTS   72. 00   07200   IMPL. DEV. CHARGED   TO PATI ENTS   73. 00   07300   DRUGS CHARGED   TO PATI ENTS   74. 00   07400   RENAL   DI ALYSI S   74. 00   07400   RENAL   DI ALYSI S   74. 00   07400   RENAL   DI ALYSI S   75. 00   07500   LECTROCARDI OLOGY   75. 00   07500   LECTROCARDI OLOGY   75. 00   07500   DRUGS CHARGED   TO PATI ENTS   75. 00   07500   07500   07	50.00							50. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C   55. 00   RADI OLOGY - THERAPEUTI C   57. 00   05500   RADI OLOGY - THERAPEUTI C   57. 00   05700   CT SCAN   58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   58. 00   06600   LABORATORY   62. 00   06200   MIGHLE BLOOD & PACKED RED BLOOD CELLS   65. 00   06500   RESPI RATORY THERAPY   66. 00   06600   PHYSI CAL THERAPY   67. 00   06600   PHYSI CAL THERAPY   68. 00   06800   SPECH PATHOLOGY   69. 00   06800   SPECH PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY   69. 00   06900   ELECTROCARDI OLOGY   67. 00   07000   CLECTROENCEPHALOGRAPHY   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   77. 00   07300   DRUGS CHARGED TO PATI ENTS   77. 00   07400   RENAL DI ALYSI S   77. 00   07400		1						52. 00
55.00   05500   RADI OLOGY-THERAPEUTI C   55.00   05500   CT SCAN   55.00   05700   CT SCAN   55.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   55.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   56.00   06000   LABORATORY   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   66.00   06500   RESPI RATORY THERAPY   67.00   06500   RESPI RATORY THERAPY   67.00   06700   0CCUPATI ONAL THERAPY   67.00   06700   0CCUPATI ONAL THERAPY   67.00   06800   SPEECH PATHOLOGY   67.00   06800   SPEECH PATHOLOGY   67.00   07.000   CLECTROCARDI OLOGY   67.00   07.000   CLECTROENCEPHALOGRAPHY   71.00   07.000   CLECTROENCEPHALOGRAPHY   71.00   07.000   MEDI CAL SUPPLIES CHARGED TO PATIENTS   77.00   07.000   MUGS CHARGED TO PATIENTS   77.00   07.000   MUGS CHARGED TO PATIENTS   77.00   07.000   MUGS CHARGED TO PATIENTS   77.00   07.000   MUGS CHARGED TO PATIENTS   77.00   07.000   MEDI CAL SUPPLIES CHARGED TO PATIENTS   77.00   07.000   MEDI SCHARGED TO PATIENTS   77.000   07.000   MUGS CHARGED TO PATIENTS   77.000   07.000   MUGS CHARGED TO PATIENTS   77.000   07.000   MEDI CAL SUPPLIES CHARGED TO PATIENTS   77.000   07.000   MEDI CAL SUPPLIES CHARGED TO PATIENTS   77.000   07.000   MUGS CHARGED TO PATIENTS   77.000   07.000   MUGS CHARGED TO PATIENTS   77.000   07.000   MUGS CHARGED TO PATIENTS   77.000   07.000   MUGS CHARGED TO PATIENTS   77.000   07.000   MUGS CHARGED TO PATIENTS   77.000   07.000   MUGS CHARGED TO PATIENTS   77.000   07.000   MUGS CHARGED TO PATIENTS   77.000   07.000   MUGS CHARGED TO PATIENTS   77.000   07.000   MUGS CHARGED TO PATIENTS   77.000   07.000   MUGS CHARGED TO PATIENTS   77.000   07.000   MUGS CHARGED TO PATIENTS   77.000   07.000   MUGS CHARGED TO PATIENTS   77.000   07.000   MUGS CHARGED TO PATIENTS   77.000   07.000   MUGS CHARGED TO PATIENTS   77.000   07.000   MUGS CHARGED TO PATIENTS   77.000   07.000   MUGS CHARGED TO PATIENTS   77.000   07.000   07.000   MUGS CHARGED TO PATIENTS   77.000   07.000   07.000   07.000   07.000   07.000   07.000   07.000   07.000   07.000   0		1 1						53.00
57. 00   05700   CT SCAN   58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI )   56. 00   06000   LABORATORY   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   66. 00   06500   RESPIRATORY THERAPY   66. 00   06600   PHYSI CAL THERAPY   67. 00   06600   PHYSI CAL THERAPY   68. 00   06800   SPEECH PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY   69. 00   06900   ELECTROCARDI OLOGY   69. 00   07000   ELECTROCARDI OLOGY   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   77. 00   07200   IMPL DEV. CHARGED TO PATIENTS   77. 00   07300   DRUGS CHARGED TO PATIENTS   77. 00   07300   DRUGS CHARGED TO PATIENTS   77. 00   07400   RENAL DILALYSI S   77. 00   07400   RENAL DILALYSI S   77. 00   08800   EAST ADAMS RHC   88. 01   08801   48TH AND MAINE RHC   88. 02   08802   MT STERLING RHC   88. 03   08803   MAIN CAMPUS RHC   88. 04   08804   BLESSING WALK IN CLINIC   88. 05   08805   BLESSING WALK IN CLINIC   88		1 1						54. 00 55. 00
58. 00		1						57.00
62. 00		1						58. 00
65. 00		1						60. 00
66. 00		1						62.00
67. 00								65.00
68. 00		1						66. 00 67. 00
69. 00   06900   ELECTROCARDI OLOGY   6   70. 00   07000   ELECTROENCEPHALOGRAPHY   7   7   7   7   7   7   7   7   7		1						68. 00
71. 00		06900 ELECTROCARDI OLOGY						69. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   77   73. 00   07300   DRUGS CHARGED TO PATIENTS   77   74. 00   07400   RENAL DI ALYSI S   77   00   000								70. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS								71. 00 72. 00
74. 00								73.00
SECTION   SERVICE COST CENTERS								74. 00
88. 01   08801   48TH AND MAINE RHC   88. 02   08802   MT STERLING RHC   88. 03   08803   MAIN CAMPUS RHC   88. 04   08804   BLESSING EXPRESS CLINIC   88. 05   08805   BLESSING WALK IN CLINIC   88. 05   08805   BLESSING WALK IN CLINIC   88. 05   08805   BLESSING WALK IN CLINIC   88. 05   08805   BLESSING WALK IN CLINIC   88. 05   08805   BLESSING WALK IN CLINIC   88. 05   08805								
88. 02   08802   MT STERLING RHC 88. 03   08803   MAIN CAMPUS RHC 88. 04   08804   BLESSING EXPRESS CLINIC 88. 05   08805   BLESSING WALK IN CLINIC		1						88. 00
88. 03   08803   MAI N CAMPUS RHC   88. 04   08804   BLESSING EXPRESS CLINIC   88. 05   08805   BLESSING WALK IN CLINIC   88.								88. 01
88. 04   08804   BLESSING EXPRESS CLINIC   88. 05   08805   BLESSING WALK IN CLINIC   88. 05   08805   BLESSING WALK IN CLINIC   88. 05		1						88. 02 88. 03
88. 05 08805 BLESSING WALK IN CLINIC								88. 04
88. 06   08806   HANNI BAL MAI N RHC		l						88. 05
								88. 06
		1 1						88. 07
		1 1						88. 08
		1 1						90. 00 90. 01
		1						90.01
90. 03   04951   HANNI BAL   I NFUSI ON   9	90. 03	04951 HANNI BAL I NFUSI ON						90. 03
		1						91.00
								92. 00 93. 99
75. 77   07077  TRATTAE HOST FINE ENTION FROMING	73. 77	1979771 ARTIAL HOST TALL ZATION TROOKAW	I	1	I	I	I	1 73. 77

| Period: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS BLESSING HOSPITAL Provider CCN: 14-0015

				0 09/30/2023	Date/IIme Pre	
				1	12/29/2023 3:	54 pm
Cost Center Description	PARAMED ED	PARAMED ED	PARAMED ED	PARAMED ED	PARAMED ED	
	PRGM	PRGM-RADI OLOGY	PRGM-LABORATOR	PRGM-PHARMACY	PRGM-RESPI RATO	
			Υ		RY	
	23. 00	23. 01	23. 02	23. 03	23. 04	
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY						101. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE						116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	C	0	0	0	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES						192. 00
193. 00 19300 NONPALD WORKERS						193. 00
193. 01 19301 DENMAN SERVICES						193. 01
193. 02 19302 UNUSED SPACE						193. 02
193. 03 19303 RENTED SPACE						193. 03
193. 04 19304 RETALL PHARMACLES						193. 04
193. 05 19305 WELLNESS CENTER						193. 05
200.00 Cross Foot Adjustments	(	79, 551	26, 741	13, 838	10, 571	
201.00 Negative Cost Centers		77,001	20, 711	10,000		201.00
		70 551	24 741	12 020		
202.00   TOTAL (sum lines 118 through 201)	1	79, 551	26, 741	13, 838	10, 571	1202.00

| Peri od: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0015

				1	To 09/30/2023 Date/Time Pr 12/29/2023 3	
	Cost Center Description	Subtotal	Intern &	Total	1,12,12,12,232,3	, , , , , , , , , , , , , , , , , , ,
			Residents Cost & Post			
			Stepdown			
		24.00	Adjustments 25.00	26.00		
	GENERAL SERVICE COST CENTERS		1	1		
1. 00 1. 01	00100  CAP REL COSTS-BLDG & FLXT  00101  CAP REL COSTS-BUTLER BUILDING					1. 00
1. 01	00101 CAP REL COSTS-BUTLER BUTLETING					1. 02
1.03	00103 CAP REL COSTS-NEW BLDG & FIXTURES					1. 03
1.04	00104 CAP REL COSTS MOB					1. 04
1. 05 1. 06	00105 CAP REL COSTS-OAK STREET MALL 00106 CAP REL COSTS-BRCN AT 36TH ST					1. 05 1. 06
1. 07	00107 CAP REL COSTS-SURGERY CENTER					1. 07
1.08	00108 CAP REL COSTS-48TH AND MAINE					1. 08
1. 09 2. 00	OO109 CAP REL COSTS-HANNI BAL   OO200 CAP REL COSTS-MVBLE EQUI P					1. 09 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL					5. 00
6. 00 8. 00	OO6OO   MAINTENANCE & REPAIRS   OO8OO   LAUNDRY & LINEN SERVICE					6. 00
9. 00	00900 HOUSEKEEPING					8. 00 9. 00
10.00	01000 DI ETARY					10. 00
11.00	01100 CAFETERI A					11.00
13. 00 16. 00	O1300   NURSI NG ADMI NI STRATI ON   O1600   MEDI CAL RECORDS & LI BRARY					13. 00 16. 00
20. 00	02000 NURSI NG PROGRAM					20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD					21. 00
22. 00 23. 00	02200   I &R SERVICES-OTHER PRGM COSTS APPRVD   02300   PARAMED ED PRGM					22. 00 23. 00
23. 00	02301 PARAMED ED PRGM-RADI OLOGY					23. 00
23. 02	02302 PARAMED ED PRGM-LABORATORY					23. 02
23. 03	02303 PARAMED ED PRGM-PHARMACY					23. 03
23. 04	O2304   PARAMED ED PRGM-RESPIRATORY   I NPATI ENT ROUTI NE SERVI CE COST CENTERS					23. 04
30.00	03000 ADULTS & PEDIATRICS	7, 752, 585	0	7, 752, 585	5	30.00
31.00	03100 I NTENSI VE CARE UNI T	979, 780				31.00
41. 00 43. 00	04100   SUBPROVI DER - I RF   04300   NURSERY	421, 357 103, 931	0			41. 00 43. 00
44.00	04400 SKILLED NURSING FACILITY	534, 455	0			44. 00
50. 00	ANCILLARY SERVICE COST CENTERS    O5000   OPERATING ROOM	6, 670, 078	0	6, 670, 078	3	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	143, 334				52. 00
53. 00	05300 ANESTHESI OLOGY	272, 910		,		53. 00
54. 00 55. 00	05400  RADI OLOGY-DI AGNOSTI C   05500  RADI OLOGY-THERAPEUTI C	1, 249, 886 443, 650	l .			54. 00 55. 00
57. 00	05700 CT SCAN	484, 305	l .	,		57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	204, 606		204, 606	b	58. 00
60.00	06000 LABORATORY	1, 425, 292	_	1 ' '	_[	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY	67, 899 502, 309		67, 899 502, 309		62.00
66. 00	06600 PHYSI CAL THERAPY	133, 998				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	72, 356	l .	,		67. 00
68. 00 69. 00	O6800   SPEECH PATHOLOGY   O6900   ELECTROCARDI OLOGY	23, 361 834, 251	0	,		68. 00 69. 00
	07000 ELECTROENCEPHALOGRAPHY	135, 627		1		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	836, 999				71. 00
72. 00 73. 00	O7200   IMPL. DEV. CHARGED TO PATIENTS   O7300   DRUGS CHARGED TO PATIENTS	853, 072 1, 872, 358	l .			72. 00 73. 00
74.00	07400 RENAL DIALYSIS	32, 077				74.00
	OUTPATIENT SERVICE COST CENTERS		1	1		
88. 00 88. 01	O8800   EAST ADAMS RHC   O8801   48TH AND MAINE RHC	81, 328 208, 039	l .	81, 328 208, 039		88. 00 88. 01
88. 02	08802 MT STERLING RHC	136, 479	l .	1		88. 02
88. 03	08803 MAIN CAMPUS RHC	1, 299, 822	l .	1, 299, 822	2	88. 03
88. 04	08804 BLESSING EXPRESS CLINIC	259, 043				88. 04
88. 05 88. 06	O8805   BLESSING WALK IN CLINIC   O8806   HANNIBAL MAIN RHC	210, 273 258, 812				88. 05 88. 06
88. 07	08807 PALMYRA RHC	71, 971	Ö	1		88. 07
88. 08	08808 BOWLING GREEN RHC	21, 699	l .	,		88. 08
90. 00 90. 01	O9000   CLINIC   O9001   OUTPATIENT INFUSION	1, 518, 302 94, 300	l .	1, 518, 302 94, 300		90. 00 90. 01
90.01	04950 ONCOLOGY	74, 223	l .	1		90.01
90. 03	04951 HANNI BAL I NFUSI ON	38, 140	0	38, 140	D	90. 03
91.00	09100 EMERGENCY	1, 026, 490				91.00
92.00	09200  OBSERVATI ON BEDS (NON-DI STI NCT PART)	l	0	"	1	92. 00

Health Financial Systems	BLESSI NG	HUSDI TVI		Inlia	u of Form CMS-2	2552_10
ALLOCATION OF CAPITAL RELATED COSTS	DELOGINO	Provi der CO	N: 14_0015	Peri od:	Worksheet B	1332-10
ALLOCATION OF CALLIAL RELATED COSTS		Trovider co		From 10/01/2022		
				To 09/30/2023	Date/Time Pre	
					12/29/2023 3:	54 pm_
Cost Center Description	Subtotal	Intern &	Total			
		Residents Cost				
		& Post				

			Т	o 09/30/2023 Date/Time 12/29/2023	
Cost Center Description	Subtotal	Intern &	Total		
	F	Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
	24.00	25. 00	26. 00		
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	149, 237	0	149, 237		93. 99
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY	258, 041	0	258, 041		101. 00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE					113. 00
116. 00 11600 HOSPI CE	393, 220	0	393, 220		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	32, 149, 895	0	32, 149, 895		118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	44, 065	0	44, 065		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 742, 362	0	1, 742, 362		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0		193. 00
193. 01 19301 DENMAN SERVICES	19, 019	0	19, 019		193. 01
193. 02 19302 UNUSED SPACE	472, 014	0	472, 014		193. 02
193. 03 19303 RENTED SPACE	415, 825	0	415, 825		193. 03
193. 04 19304 RETAIL PHARMACIES	860, 941	0	860, 941		193. 04
193. 05 19305 WELLNESS CENTER	198, 422	0	198, 422		193. 05
200.00 Cross Foot Adjustments	1, 250, 372	0	1, 250, 372		200. 00
201.00 Negative Cost Centers	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	37, 152, 915	0	37, 152, 915		202. 00

Health Financial Systems	BLESSI NG	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		eriod: rom 10/01/2022	Worksheet B-1	
		CAD	ITAL RELATED CO	)STS	12/29/2023 3:	54 pm
		CAI	TIAL KLLATED O	5515		
Cost Center Description	BLDG & FIXT	BUTLER	OLD BLDG &	NEW BLDG &	MOB	
	(SQUARE FEET)	BUI LDI NG (SQUARE FEET)	FIXTURES (SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	
	1.00	1. 01	1. 02	1. 03	1. 04	
GENERAL SERVICE COST CENTERS			I			
1.00   00100   CAP REL COSTS-BLDG & FLXT 1.01   00101   CAP REL COSTS-BUTLER BUILDING	0	1, 092				1. 00 1. 01
1. 02   00102 CAP REL COSTS-OLD BLDG & FIXTURES		1, 092	1			1. 01
1.03 00103 CAP REL COSTS-NEW BLDG & FIXTURES	0	0	0	676, 612		1. 03
1. 04   00104   CAP REL COSTS-MOB	0	0	0	0	138, 583	1.04
1.05 OO105 CAP REL COSTS-OAK STREET MALL 1.06 OO106 CAP REL COSTS-BRCN AT 36TH ST	0	0	0	0	0	1. 05 1. 06
1. 07   00107   CAP   REL   COSTS SURGERY CENTER	0	Ö	ő	0	Ö	1. 07
1.08 O0108 CAP REL COSTS-48TH AND MAINE	0	0	0	0	0	1. 08
1. 09   00109 CAP REL COSTS-HANNI BAL 2. 00   00200 CAP REL COSTS-MVBLE EQUI P	0	0	0	0	0	1. 09 2. 00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT	0	0	1, 646	44, 043	o	4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	0	189		116, 957	29, 043	5. 00
6. 00 00600 MAI NTENANCE & REPAI RS	0	0		74, 367	0	6. 00
8. 00   00800   LAUNDRY & LINEN SERVICE 9. 00   00900   HOUSEKEEPING	0	0	1, 919 4, 081	1, 421 2, 710	0	8. 00 9. 00
10. 00   01000   DI ETARY	0	Ö	0	15, 214	392	
11. 00 01100 CAFETERI A	0	0		6, 051	0	11. 00
13. 00   01300   NURSI NG ADMINI STRATI ON 16. 00   01600   MEDI CAL RECORDS & LI BRARY	0	0	4, 545 293		0	13. 00 16. 00
20. 00   02000   NURSI NG PROGRAM			0	2, 175	o o	20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21. 00
22. 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	293	0	0	22. 00
23. 00   02300   PARAMED ED PRGM 23. 01   02301   PARAMED ED PRGM-RADI OLOGY	0		0	733	0	23. 00 23. 01
23. 02   02302   PARAMED ED   PRGM-LABORATORY	0	Ö	Ö	562	Ö	23. 02
23. 03 02303 PARAMED ED PRGM-PHARMACY	0	0	•	0	0	23. 03
23. 04 O2304 PARAMED ED PRGM-RESPIRATORY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	31	0	23. 04
30. 00   03000   ADULTS & PEDI ATRI CS	0	0	212	199, 734	0	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	9, 932		0	31.00
41. 00   04100   SUBPROVI DER -   RF 43. 00   04300   NURSERY	0	0	4, 634 0	4, 775 3, 567	0	41. 00 43. 00
44. 00 04400 SKILLED NURSING FACILITY	0			11, 736	Ö	44. 00
ANCI LLARY SERVI CE COST CENTERS	1	1		00.407		
50.00   05000   OPERATING ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	6, 330 7, 615		9, 084	50. 00 52. 00
53. 00   05300   ANESTHESI OLOGY	0	Ö	628		201	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1, 524	15, 350	8, 872	54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C 57. 00   05700   CT   SCAN	0	0	0 597	11, 372 1, 034	0	
57.00  05700 CT SCAN 58.00  05800 MAGNETIC RESONANCE IMAGING (MRI)			0		1	
60. 00   06000   LABORATORY	0	0	639	11, 223	0	60. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	385	1	62.00
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY	0		805 0	3, 185 3, 398		65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	1, 642	Ö	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	556	0	68. 00
69. 00   06900  ELECTROCARDI OLOGY 70. 00   07000  ELECTROENCEPHALOGRAPHY	0		8, 483 1, 842		0   0	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	421	0	7, 320	o o	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	482		8, 369	0	72. 00
73.00   07300   DRUGS CHARGED TO PATIENTS 74.00   07400   RENAL DIALYSIS	0	0	•	5, 866 0	0	73. 00 74. 00
OUTPATIENT SERVICE COST CENTERS					0	74.00
88. 00 08800 EAST ADAMS RHC	0	0		0	0	88. 00
88. 01   08801   48TH AND MAINE RHC	0	0	0	0	0	88. 01
88. 02   08802   MT   STERLI NG   RHC 88. 03   08803   MAI N   CAMPUS   RHC	0		0	0	0 49, 759	88. 02 88. 03
88. 04 08804 BLESSING EXPRESS CLINIC	0	o	Ö	0	0	88. 04
88. 05 08805 BLESSING WALK IN CLINIC	0	0	0	3, 710	0	88. 05
88. 06   08806   HANNI BAL MAI N RHC 88. 07   08807   PALMYRA RHC	0		0	0	0	88. 06 88. 07
88. 08   08808   BOWLI NG GREEN RHC	0	0	Ö	Ö	ő	88. 08
90. 00 09000 CLI NI C	0	0	0	1, 333		90. 00
90. 01   09001   0UTPATI ENT   INFUSI ON 90. 02   04950   ONCOLOGY	0	0	0	3, 499 1, 737	0	90. 01 90. 02
90. 02   04950   ONCOLOGY 90. 03   04951   HANNI BAL   NFUSI ON	0	0	0	1, /3/	0	90. 02
91. 00 09100 EMERGENCY	0	0	6, 286	14, 925	ō	91. 00
92. 00  09200  OBSERVATI ON BEDS (NON-DI STINCT PART)						92. 00

CAPITAL RELATED COSTS   COST Center Description   BLDG & FIXT   BUTLER   SULARE FEET)   CSUU				10	09/30/2023	12/29/2023 3:	
SQUARE FEET)   SQUARE FEET)   SQUARE FEET)   SQUARE FEET)   SQUARE FEET)   SQUARE FEET)			CAP	ITAL RELATED CO	STS		
SQUARE FEET)   SQUARE FEET)   SQUARE FEET)   SQUARE FEET)   SQUARE FEET)   SQUARE FEET)							
SQUARE FEET)   SQUARE FEET)   SQUARE FEET)   SQUARE FEET)   SQUARE FEET)	Cost Center Description						
93. 99   09399   PARTI AL HOSPITALIZATION PROGRAM   0   0   0   0   3, 234   0   93. 99   09399   PARTI AL HOSPITALIZATION PROGRAM   0   0   0   0   0   0   0   0   0		(SQUARE FEET)				(SQUARE FEET)	
93.99   PARTIAL HOSPITALIZATION PROGRAM   0   0   0   3, 234   0   93.99							
OTHER RELMBURSABLE COST CENTERS   O O O O O O O O O O O O O O O O O O							
101.00   10100   HOME   HEALTH AGENCY   SPECI AL PURPOSE COST CENTERS     113.00   11300   INTEREST EXPENSE     113.00   11600   HOSPI CE     0   0   0   0   0   0   116.00		0	0	0	3, 234	0	93. 99
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   0 0 0 0 0 0   0   116.00				T		Ι _	
113.00   11300   INTEREST EXPENSE   0   0   0   0   0   0   0   0   0		0	0	0	0	0	101. 00
116.00   1				Τ		Γ	
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   0   1,092   114,634   633,908   136,365   18.00						<b>l</b>	1
NONRE   MBURSABLE COST CENTERS   190. 00   19000   GIFT, ELOWER, COFFEE SHOP & CANTEEN   0   0   0   3,212   797   0   190. 00   190.		0	0	0	0		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 3, 212 797 0 190. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 0 2, 218 192. 00 193. 00 19300 NONPAID WORKERS 0 0 0 0 0 0 0 193. 01 193. 01 19301 DENMAN SERVI CES 0 0 0 0 0 1,000 0 193. 01 193. 01 19302 UNUSED SPACE 0 0 0 0 2, 761 24, 851 0 193. 02 193. 03 19303 RENTED SPACE 0 0 0 0 834 15, 488 0 193. 03 193. 03 19303 RENTED SPACE 0 0 0 0 834 15, 488 0 193. 03 193. 04 19304 RETAIL PHARMACIES 0 0 0 0 568 0 193. 04 193. 05 19305 WELLNESS CENTER 0 0 0 0 568 0 193. 04 193. 05 19305 WELLNESS CENTER 0 0 0 0 0 0 193. 05 200. 00 Cost to be allocated (per Wkst. B, Part I) 0.000000 72. 793956 5. 085992 14. 873725 9. 719562 203. 00 204. 00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 205. 00 NAHE unit cost multiplier (Wkst. D, 207. 00		0	1, 092	114, 634	633, 908	136, 365	118. 00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 0 193.00 193.							
193.00 19300 NONPAID WORKERS 193.01 19301 DENMAN SERVICES 0 0 0 0 1,000 0 193.01 193.02 19302 UNUSED SPACE 0 0 0 2,761 24,851 0 193.02 193.03 19303 RENTED SPACE 0 0 0 834 15,488 0 193.03 193.04 19304 RETAIL PHARMACIES 0 0 0 0 568 0 193.04 193.05 19305 WELLNESS CENTER 0 0 0 0 0 0 193.05 200.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 NAHE adjustment amount to be allocated (per Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 NAHE		0	0	3, 212	797		
193.01 19301 DENMAN SERVICES 0 0 0 1,000 0 193.01 193.02 19302 UNUSED SPACE 0 0 0 2,761 24,851 0 193.02 193.03 19303 RENTED SPACE 0 0 0 834 15,488 0 193.04 193.04 193.05 19305 19305 19305 200.00 Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part III) Unit cost m		0	0	0	0		
193.02 19302 UNUSED SPACE 0 0 0 2,761 24,851 0 193.02 193.03 19303 RENTED SPACE 0 0 0 834 15,488 0 193.03 193.04 19304 RETAIL PHARMACIES 0 0 0 0 568 0 193.04 193.04 193.05 193.05 WELLNESS CENTER 0 0 0 0 0 193.05 200.00 Cross Foot Adjustments Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) 0.00000 72.793956 5.085992 14.873725 9.719562 203.00 204.00 Unit cost multiplier (Wkst. B, Part III) 205.00 Unit cost multiplier (Wkst. B, Part III) NAHE adjustment amount to be allocated (per Wkst. B, Part III) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 207.00 207.00 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 207.0		0	0	0	0	l	
193.03 19303 RENTED SPACE 0 0 0 834 15,488 0 193.03 193.04 19304 RETAIL PHARMACIES 0 0 0 0 0 568 0 193.04 193.05 19305 WELLNESS CENTER 0 0 0 0 0 193.05 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 0.000000 72.793956 5.085992 14.873725 9.719562 203.00 204.00 Cost to be allocated (per Wkst. B, Part III) 205.00 Unit cost multiplier (Wkst. B, Part III) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part III) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00		0	0	0			
193.04 19304 RETAIL PHARMACIES  193.05 19305 WELLNESS CENTER  200.00 Cross Foot Adjustments  Negative Cost Centers  202.00 Cost to be allocated (per Wkst. B, Part I)  203.00 Unit cost multiplier (Wkst. B, Part II)  205.00 Unit cost multiplier (Wkst. B, Part II)  205.00 Unit cost multiplier (Wkst. B, Part II)  206.00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0				
193.05   19305   WELLNESS CENTER		0	0	834		l .	1
200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part III) 206.00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D,  Cross Foot Adjustments 200.00 201.00 201.00 79, 491 617, 648 10, 063, 741 1, 346, 966 202.00 72. 793956 5. 085992 14. 873725 9. 719562 203.00 204.00 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part III) 206.00 NAHE unit cost multiplier (Wkst. D, 207.00		0	0	0	568		
201.00 202.00     Negative Cost Centers     Cost to be allocated (per Wkst. B, Part I) 203.00 204.00     Unit cost multiplier (Wkst. B, Part I) 205.00     Walte adjustment amount to be allocated (per Wkst. B, Part II) 206.00     NAHE unit cost multiplier (Wkst. D, NAHE unit cost multiplier (Wkst. D, Part II) 207.00     NAHE unit cost multiplier (Wkst. D, Part II) 207.00     NAHE unit cost multiplier (Wkst. D, Part II) 207.00     NAHE unit cost multiplier (Wkst. D, Part III) 207.00		0	0	0	0	0	
202.00   Cost to be allocated (per Wkst. B, Part I)   0.000000   72.793956   5.085992   14.873725   9.719562   203.00   204.00   Cost to be allocated (per Wkst. B, Part II)   Unit cost multiplier (Wkst. B, Part III)   Unit cost multiplier (Wkst. B, Part III)   205.00   Unit cost multiplier (Wkst. B, Part III)   206.00   NAHE adjustment amount to be allocated (per Wkst. B-2)   NAHE unit cost multiplier (Wkst. D, 207.00   20	200.00 Cross Foot Adjustments						200. 00
Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part III)  205.00 WAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00	201.00 Negative Cost Centers						201. 00
203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 72.793956 5.085992 14.873725 9.719562 203.00		0	79, 491	617, 648	10, 063, 741	1, 346, 966	202. 00
204.00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 205.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00							
Part II) Unit cost multiplier (Wkst. B, Part II) 205.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00		0. 000000	72. 793956	5. 085992	14. 873725	•	1
205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00							204. 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00							
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00							205. 00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00							
207.00 NÄHE unit cost multiplier (Wkst. D, 207.00							206. 00
Parts III and IV)							207. 00
	Parts III and IV)						

Peri od: From 10/01/2022 To 09/30/2023 Date/Ti me Prepared: 12/29/2023 3:54 pm

			CAP	ITAL RELATED CO	OSTS	12/29/2023 3:	54 pm
	Cost Center Description	OAK STREET MALL	BRCN AT 36TH ST	SURGERY CENTER	48TH AND MAINE	HANNI BAL (SQUARE FEET)	
				(SQUARE FEET)	(SQUARE FEET)	(SQUARE TEET)	
	OFNEDAL CEDIU OF COCT OFNEDO	1. 05	1. 06	1. 07	1. 08	1. 09	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1. 00
1. 01	00101 CAP REL COSTS-BUTLER BUILDING						1. 01
1.02	00102 CAP REL COSTS-OLD BLDG & FIXTURES						1. 02
1.03	00103 CAP REL COSTS-NEW BLDG & FIXTURES 00104 CAP REL COSTS-MOB						1.03
1. 04 1. 05	00104 CAP REL COSTS-MOB	73, 512					1. 04 1. 05
1. 06	00106 CAP REL COSTS-BRCN AT 36TH ST	0	32, 356				1. 06
1.07	00107 CAP REL COSTS-SURGERY CENTER	0	0	,			1. 07
1. 08 1. 09	00108 CAP REL COSTS-48TH AND MAINE 00109 CAP REL COSTS-HANNIBAL	0	0	0	74, 902 0	52, 503	1. 08 1. 09
2.00	00200 CAP REL COSTS-MVBLE EQUI P			J o	O	52, 503	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 115	0	0	0	0	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	44, 800				l	5. 00
6. 00 8. 00	00600 MAINTENANCE & REPAIRS 00800 LAUNDRY & LINEN SERVICE	2, 363	0	5, 155 0	1, 348 0	2, 017 0	6. 00 8. 00
9. 00	00900 HOUSEKEEPING	31	0	177	339	136	9. 00
10.00	01000 DI ETARY	0	0	0	1, 092	0	10.00
11. 00	01100 CAFETERI A	0	0	0	0	0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	4, 416	0	0	0	0	13.00
16. 00 20. 00	01600 MEDICAL RECORDS & LIBRARY 02000 NURSING PROGRAM	3, 836	0 23, 575		0	1, 273 0	16. 00 20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0,000	20, 070	ő	0	ő	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM	1 022	0	0	0	0	23. 00
23. 01 23. 02	02301 PARAMED ED PRGM-RADIOLOGY 02302 PARAMED ED PRGM-LABORATORY	1, 833 86	848	0	0	0	23. 01 23. 02
23. 03	02303 PARAMED ED PRGM-PHARMACY	0	0		0	ő	23. 03
23. 04	02304 PARAMED ED PRGM-RESPIRATORY	57	0	0	0	0	23. 04
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1, 431	7, 368	0	0	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	1, 431	7, 300	0	0		31.00
41. 00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41. 00
43.00	04300 NURSERY	0	0	_	0	0	43.00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	44. 00
50. 00	05000 OPERATI NG ROOM	0	0	23, 357	0	0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00 54. 00
55. 00	05400  RADI OLOGY-DI AGNOSTI C   05500  RADI OLOGY-THERAPEUTI C	0	0	0	0	721 0	55. 00
57. 00	05700 CT SCAN	0	0	Ö	0	Ö	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	60.00
65. 00	06500 RESPIRATORY THERAPY	0	0	0	0		62. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	0	0	0	68. 00 69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		0	583 0	73. 00 74. 00
74.00	OUTPATIENT SERVICE COST CENTERS	U U	0	0	U	<u> </u>	74.00
88. 00	08800 EAST ADAMS RHC	0	0	0	0	0	88. 00
88. 01	08801 48TH AND MAINE RHC	0	0	0	5, 290	0	88. 01
88. 02 88. 03	08802 MT STERLING RHC 08803 MAIN CAMPUS RHC	0	0	0	0	0	88. 02 88. 03
88. 04	08804 BLESSING EXPRESS CLINIC	0	0	0	0	0	88. 04
88. 05	08805 BLESSING WALK IN CLINIC	0	0	0	0	0	88. 05
88. 06	08806 HANNI BAL MAI N RHC	0	0	0	0	8, 922	88. 06
88. 07 88. 08	08807 PALMYRA RHC 08808 BOWLI NG GREEN RHC	0	0	0	0	0	88. 07 88. 08
90.00	09000 CLINIC				2, 625	10, 932	90.00
90. 01	09001 OUTPATIENT INFUSION	O	0	o o	0	0	90. 01
90. 02	04950 ONCOLOGY	0	0	0	0	0	90. 02
90. 03 91. 00	04951 HANNI BAL I NFUSI ON 09100 EMERGENCY	0 2, 323	0	0	0	3, 105 0	90. 03 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 323			U		91.00
			•			•	· · · · · ·

			Т		Date/Time Pre 12/29/2023 3:	
		CAP	ITAL RELATED CO	OSTS		
Cost Center Description	OAK STREET MALL (SQUARE FEET)	BRCN AT 36TH ST (SQUARE FEET)	SURGERY CENTER (SQUARE FEET)	48TH AND MAINE (SQUARE FEET)	HANNI BAL (SQUARE FEET)	
	1. 05	1.06	1. 07	1. 08	1. 09	
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93. 99
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	2, 046	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 H0SPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	66, 337	32, 356	33, 952	41, 434	42, 460	118. 00
NONREI MBURSABLE COST CENTERS	1					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	١		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 193.00 19300 NONPALD WORKERS	0	0	0	33, 468		192. 00 193. 00
193. 00 19300 NONPALD WORKERS 193. 01 19301 DENMAN SERVICES	0	0	0	0		193. 00
193. 01 19301 DENIMAN SERVICES 193. 02 19302 UNUSED SPACE	0	0	0	0		193. 01
193. 03 19303 RENTED SPACE	0	0	0	0		193. 02
193. 04 19304 RETAIL PHARMACIES	0	0	١			193. 04
193. 05 19305 WELLNESS CENTER	7, 175	0	١			193. 05
200.00 Cross Foot Adjustments	,,,,,	Ŭ	Ĭ	١	ŭ	200.00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	800, 691	137, 622	1, 097, 072	1, 529, 311	423, 756	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	10. 891977	4. 253369	32. 312441	20. 417492	8. 071082	203 00
204.00 Cost to be allocated (per Wkst. B,	10. 071777	4. 233307	32. 312441	20. 417472	0.071002	204. 00
Part II)						204.00
205.00 Unit cost multiplier (Wkst. B, Part						205. 00
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)						207.00

11. 00 01100 (AFTERIA 0.0 0 2.447, 288 0 4.142, 970 6.051 16. 00 01600 MUSIS INCAMINI STRATI ON 1.067, 566 5.824, 284 014, 488, 503 9, 925 16. 00 01600 MUSIS INC PROGRAM 159, 979 0 0 9, 533, 385 3, 591 170 00 02000 MUSIS INC PROGRAM 159, 879 4, 044, 996 0 3, 387, 991 29, 586 2 10. 00 20100 1 8F SERVI CES-SALARY & FRINGES APPRVD 750 0 0 1, 94, 770 293 2 00 02200 1 8F SERVI CES-SALARY & FRINGES APPRVD 750 0 0 1, 94, 770 293 2 03. 00 02300 PARAMED ED PROM 0 0 0 0 0 1, 94, 770 293 2 03. 00 02300 PARAMED ED PROM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Heal th	Financial Systems	BLESSI NG H	OSPI TAL		In Lie	eu of Form CMS-	2552-10
CAPITAL   CAPI	COST A	LLOCATION - STATISTICAL BASIS		Provider C	CCN: 14-0015	Peri od:	Worksheet B-1	
Cest Center Description    RELIFED COSTS   REL								narod:
Cost Center Description						10 09/30/2023		
Cost Center Description								
COLLAR VALUE)   SERIETTS   S. CONTROL   CACCUM. COST)   COST)   COST		Coot Conton Decemintion		EMDL OVEE	Dogonoiliatio	ADMINI CTDATI VE	MAINTENANCE 0	
BINERAL SERVICE COST CENTERS		cost center bescription			Reconciliatio			
CEMERAL_SERVICE COST CENTERS			(DOLLAR VALUE)					
SELECTION COORT CENTERS						(ACCOM: COST)	(SQUARE TEET)	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BUTLER BUILD ING 1.01 100101 CAP REL COSTS-BUTLER BUILD ING 1.02 00100 CAP REL COSTS-BUTLER BUILD ING 1.04 00100 CAP REL COSTS-BUTLER BUILD ING 1.05 00105 CAP REL COSTS-BOR STREET MALL 1.06 00105 CAP REL COSTS-BOR STREET MALL 1.06 00105 CAP REL COSTS-BOR STREET MALL 1.06 00105 CAP REL COSTS-BOR STREET MALL 1.06 00105 CAP REL COSTS-BOR STREET MAIN RE 1.07 001010 CAP REL COSTS-BOR STREET MAIN RE 1.08 00105 CAP REL COSTS-BOR STREET MAIN RE 1.09 00105 CAP REL COSTS-BOR STREET MAIN RE 1.00 00105								
0.00   0.00			2.00	4. 00	5A	5. 00	6. 00	
1. 01 00101 CAP REL COSTS-BUTLER BUILDING 1. 02 00102 CAP REL COSTS-LOB BLOG & FIXTURES 1. 03 00103 CAP REL COSTS-LOB BLOG & FIXTURES 1. 04 00104 CAP REL COSTS-LOB BLOG & FIXTURES 1. 05 00105 CAP REL COSTS-LOB STREET MURL 1. 06 00106 CAP REL COSTS-LOB STREET MURL 1. 07 00107 CAP REL COSTS-LOB STREET MURL 1. 08 00106 CAP REL COSTS-LOB STREET MURL 2. 09 00200 CAP REL COSTS-LOB STREET MURL 2. 00 00200 CAP RE								
1.02   0.0102   CAP REL COSTS-LOR BUDG & FINTURES								1.00
1.03 00103 CAP REL COSTS-REW BLDG & FIXTURES 1.04 00104 CAP REL COSTS-ROBE STREET MALE 1.08 00105 CAP REL COSTS-ROBE STREET MALE 1.09 00105 CAP REL COSTS-ROBE AT 36TH AD MAIN RE 1.09 00105 CAP REL COSTS-ROBE AT 36TH AD MAIN RE 1.09 00105 CAP REL COSTS-ROBE STREET 1.09 00105 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.09 00105 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.09 00105 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS-ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP REL COSTS ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP RE ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP RE ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP RES ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP ROBE FOR A 36TH AD MAIN RE 1.00 00400 CAP ROBE FOR A 36TH AD MAIN RE								1. 01
1.04   00104 CAP REL COSTS-A0S STREET MALL   1.06   00105 CAP REL COSTS-SURGERY CENTER   1.07   00107 CAP REL								1. 02 1. 03
1.05								1.03
1.06   00106   CAP REL COSTS-SINGERY CENTER								1. 05
1.08 00108 [CAP REL COSTS-IMANI BAIN NO								1. 06
1.09	1.07	00107 CAP REL COSTS-SURGERY CENTER						1. 07
2.00								1. 08
4.00								1. 09
5.00   00500   ADMIN STRATIVE & CERIERIA   7,715,196   10,576,187   -99,538,476   350,828,776   8.00   00500   MAINTENANCE & REPAIRS   243,288   4,351,614   4,352,283   0   1,688,508   3,340   9,00   00900   LAILINDRY & L.I.NEN SERVICE   1,309   46,882   0   1,688,508   3,340   9,00   00900   LAILINDRY & L.I.NEN SERVICE   1,309   46,882   0   1,688,508   3,340   9,00   00900   LAILINDRY & L.I.NEN SERVICE   1,309   46,882   0   2,985,691   16,698   1,000   1,			1	1/0 007 07/	,			2.00
6.00   00000   MAINTRANCE & REPAIRS   243, 288   4, 351, 617   0   14, 625, 726   803, 452   9,00   00000   LAINDRY & LINEN SERVICE   1,309   46,982   0   1, 668, 608   3,340   00000   LAINDRY & LINEN SERVICE   1,309   46,082   0   2,985, 601   16,698   11,000   10000   LAINDRY & LINEN SERVICE   1,309   46,082   0   2,985, 601   16,698   11,000   10100   CAFETERI A   0   2,447,288   0   4,142,970   6,051   16,098   10,000   1,			1		1	250 020 774		4. 00 5. 00
0.000   0.0000   LAUNDRY & LINEN SERVICE		1 1					l .	
0.000 00000 HOUSEKEPING		1 1						
11.00   01100   CAFETERIA   0   2,447, 288   0   4,142,970   6,051     10.00   10500 MIRSI NG ADM IN STRATI ON   1,007,565   5,824, 284   0   14,488,503   9,925     10.00   01600 MIRSI NG PROGRAM   15,979   4,044,996   0   3,387,991   2,9586     21.00   02100   IAR SERVI CES-SALARY & FRINGES APPRVD   750   0   0   1,352,253   0   0     22.00   02200   RAS ESERVI CES-SALARY & FRINGES APPRVD   750   0   0   0   1,352,253   0   0     23.01   02230   PARAMED ED PROM   0   0   0   0   0   0   0     23.01   02230   PARAMED ED PROM   20,904   462,838   0   381,265   2,566     23.02   02302   PARAMED ED PROM   20,904   462,838   0   381,265   2,566     23.03   02303   PARAMED ED PROM   20,904   462,838   0   381,265   2,566     23.04   02304   PARAMED ED PROM   PARAMED ED PROM   20,904   22,904   462,838   0   381,265   2,566     23.03   02303   PARAMED ED PROM   PARAME			1	•	1			
13. 00 01300 NURSIN GAMIN ISTRATION 1, 0.67, 56.6 5, 82.4, 284 0 9, 9.525 99.9 10. 00 2000 NEDICAL RECORDS & LIBRARY 5, 909 0 0 9, 53.3, 385 3, 591 120. 00 2000 NURSING PROGRAM 159, 879 4, 0.44, 996 0 3, 387, 991 29, 586 21. 00 2010 1 RR SERVICES-SALARY & FRINGES APPRVD 0 0 1, 278, 372 0 1, 158, 253 3 0 22. 00 02200 1 RR SERVICES-SALARY & FRINGES APPRVD 750 0 0 1, 964, 770 293 3, 23. 00 2230 PARAMELE DE PROM COSTS APPRVD 750 0 0 0 1, 964, 770 293 3, 23. 00 2230 PARAMELE DE PROM LABORATORY 3, 421 135, 875 0 125, 545 1, 496 2, 23. 03 02302 PARAMELE DE PROM-LABORATORY 3, 421 135, 875 0 125, 545 1, 496 2, 23. 03 02302 PARAMELE DE PROM-LABORATORY 2, 281 176, 990 0 172, 297 88 2, 23. 04 02304 PARAMELE DE PROM-RESPIRATORY 2, 281 176, 990 0 172, 297 88 2, 23. 04 02304 PARAMELE DE PROM-RESPIRATORY 2, 281 176, 990 0 172, 297 88 2, 23. 04 02304 PARAMELE DE PROM-RESPIRATORY 2, 281 176, 990 0 172, 297 88 2, 23. 04 02304 PARAMELE DE PROM-RESPIRATORY 2, 281 176, 990 0 172, 297 88 2, 23. 04 02304 PARAMELE DE PROM-RESPIRATORY 2, 281 176, 990 0 172, 297 88 2, 23. 04 02304 PARAMELE DE PORTO-RESPIRATORY 2, 281 176, 990 0 172, 297 88 2, 23. 04 02304 PARAMELE DE PORTO-RESPIRATORY 2, 281 176, 990 0 172, 297 88 2, 23. 04 02304 PARAMELE DE PORTO-RESPIRATORY 2, 281 176, 990 0 172, 297 88 2, 24. 04 02, 692, 970 9, 409 0 0 0, 200 0	10.00	01000 DI ETARY	149, 872	1, 466, 148	3	0 2, 985, 691	16, 698	10.00
16. 00 01-000 NEDICAL RECORDS & LI BRARY 5. 909 0 0 9, 533, 385 3, 591 220 00 02000 NURSIN REPROBRAM 159, 879 4, 044, 996 0 3, 387, 991 29, 586, 210 00 02100 IRS REPRIVES-S-OTHER PROBLOSTS APPRVD 750 0 0, 0 0, 1, 964, 770 293 23 00 02300 PARAMED ED PROBLOSTS APPRVD 750 0 0 0, 9, 64, 770 293 23 00 02300 PARAMED ED PROBLOSTS APPRVD 750 0 0 0, 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11. 00		0	2, 447, 288	8	0 4, 142, 970	6, 051	11. 00
20. 00   02000   NURSING PROGRAM   159, 879   4, 044, 996   0   3, 387, 991   29, 586   22. 00   02200   18R SERVI CES-SALARY & FRINCES APPRVD   750   0   0   1, 964, 770   293   23, 200   22300   18R SERVI CES-SALARY & FRINCES APPRVD   750   0   0   1, 964, 770   293   23, 200   22300   PRAGNED ED PROM   0   0   0   0   0   0   0   0   0		1	i i	5, 824, 284	1			
21.00   02100   IAR SERVI CES-SALARY & FRINCES APPRVD   0   1, 278, 372   0   1, 352, 253   0   2   200   02200   IAR SERVI CES-OTHER PREGU COSTS APPRVD   750   0   0   0   0   0   0   0   0   0			1	(	-			
22.00   02200   IAS SERVICES-OTHER PROM COSTS APPRVD   750   0   0   1,964,770   293   23.00   23.00   02300   PARAMED ED PROM ADIOLOGY   23.904   46.2,838   0   381,265   2.566   23.02   02302   PARAMED ED PROM LABORATORY   3.421   135,875   0   125,545   1.496   23.03   02303   PARAMED ED PROM LABORATORY   0   322,517   0   356,502   0   2.201   20.00		1	1					
23.00   02300   PARAMED ED PROM   0   0   0   0   0   0   0   0   0			-		•			
23.01			750	(	-1	-,		
23. 02   02302   PARMED ED PRICK-LABORATORY   3, 421   135, 875   0   125, 545   0   356, 502   0   0   330, 303   PARAMED ED PRICK-PRIRIMACY   0   322, 517   0   356, 502   0   0   0   322, 517   0   356, 502   0   0   0   320, 517   0   356, 502   0   0   320, 517   0   356, 502   0   0   320, 517   0   356, 502   0   0   320, 517   0   356, 502   0   0   320, 517   0   320,			23, 904	462, 838	-1	-	_	
176, 960			l l					
INPATIENT ROUTINE SERVICE COST CENTERS	23. 03	02303 PARAMED ED PRGM-PHARMACY	0	322, 517	7	0 356, 502	0	23. 03
30.00   03000   ADULTS & PEDIATRICS   216, 567   33, 251, 114   0   52, 064, 021   208, 745   208, 745   210, 0010   INTENSI NYE CARE UNIT   150, 369   4, 703, 082   0   7, 556, 650   23, 189   41.00   04100   SUBPROVI DER - I RF   5, 038   1, 922, 164   0   2, 692, 970   9, 409   43.00   04300   NURSERY   12, 900   326, 853   0   454, 852   3, 567   44.00   04400   SKI LLED NURSI NG FACI LI TY   1, 000   1, 768, 150   0   2, 711, 737   11, 736   ANCI LLARY SERVICE COST CENTERS	23. 04		2, 281	176, 960	0	0 172, 297	88	23. 04
31.00   03100   INTENSIVE CARE UNIT   150, 369   4, 703, 082   0   7, 556, 650   23, 189   41.00   04100   SUBPROVI DER - I RF   5, 038   1, 922, 164   0   2, 692, 970   9, 409   44.00   04400   NURSERY   12, 900   326, 853   0   454, 852   3, 567   44.00   04400   SVILLED NURSI NG FACILITY   1, 006   1, 768, 150   0   2, 711, 737   11, 736   7			044 545		.1	50.044.004		
41.00   04100   SUBPROVI DER - IRF   5, 038   1, 922, 164   0   2, 992, 970   9, 409   43.00   04300   NURSERY   12, 900   326, 853   0   454, 852   3, 567   44.00   04400   SKI LLED NURSI NG FACILITY   1, 006   1, 768, 150   0   2, 711, 737   11, 736   736		1 1	1		1			
43.00   04300   NURSERY   12,900   326,853   0   454,852   3,567   44.00   04400   SKILLED NURSING FACILITY   1,006   1,768,150   0   2,711,737   11,736   736   748,000   748,000   744,762   744					•			
44.0   04400   SKI LLED NURSI NG FACILITY   1,006   1,768,150   0   2,711,737   11,736   ANCILLARY SERVI CE COST CENTERS			1		•			1
50.00	44.00	04400 SKILLED NURSING FACILITY	1, 006	1, 768, 150	o l	0 2, 711, 737	11, 736	44.00
52.00   05200   DELIVERY ROOM & LABOR ROOM   15,095   744,762   0   1,057,917   7,615   73.00   05300   ANESTHESI OLOGY   125,525   218,623   0   877,030   1,507   54.00   05400   RADI OLOGY-DI AGNOSTI C   421,248   4,678,549   0   8,963,278   26,467   55.00   05500   RADI OLOGY-THERAPEUTI C   164,980   1,025,273   0   1,790,374   11,372   55.00   05500   RADI OLOGY-THERAPEUTI C   164,980   1,025,273   0   1,790,374   11,372   55.00   05500   MAGNETI C RESONANCE I MAGI NG (MRI )   143,327   337,767   0   689,320   1,989   60.00   06000   LABORATORY   251,452   3,569,471   0   15,419,623   11,862   62.00   06200   MACNETI C RESONANCE I RED BLOOD CELLS   11,608   201,369   0   1,429,629   385   65.00   06500   RESPIRATORY THERAPY   216,117   2,614,975   0   3,330,552   6,925   66.00   06600   PHYSI CAL THERAPY   5,466   1,525,328   0   1,680,671   3,398   67.00   06700   OCUPATI I ONAL THERAPY   5,466   1,525,328   0   1,680,671   3,398   68.00   06800   SPEECH PATHOLOGY   2,813   234,775   0   264,186   556   69.00   06900   ELECTROCARDI OLOGY   496,485   2,720,973   0   4,855,647   13,067   70.00   07000   ELECTROCARDI OLOGY   496,485   2,720,973   0   4,855,647   13,067   70.00   07000   ELECTROCARDI OLOGY   496,485   2,720,973   0   4,855,647   13,067   70.00   07000   ELECTROCARDI OLOGY   496,485   2,720,973   0   4,855,647   13,067   70.00   07000   ELECTROCARDI OLOGY   496,485   2,720,973   0   4,855,647   13,067   70.00   07000   ELECTROCARDI OLOGY   496,485   2,720,973   0   4,855,647   13,067   70.00   07000   ELECTROCARDI OLOGY   496,485   2,720,973   0   4,855,647   13,067   70.00   70.00   ELECTROCARDI OLOGY   496,485   2,720,973   0   4,855,647   13,067   70.00   70.00   ELECTROCARDI OLOGY   496,485   2,720,973   0   4,855,647   13,067   70.00   70.00   ELECTROCARDI OLOGY   496,485   2,720,973   0   4,855,647   13,067   70.00   70.00   ELECTROCARDI OLOGY   496,485   2,720,973   0   4,855,647   13,067   0   4,850,485   0   4,850,485   0   4,850,485   0   4,850,485   0   4,850,485   0   4,850,485					-1		1	
53. 00   05300   ANESTHESI OLOGY   125, 525   218, 623   0   877, 030   1, 507   54. 00   05400   RADI OLOGY-DI AGNOSTI C   421, 248   4, 678, 549   0   8, 963, 278   26, 467   25. 00   05500   RADI OLOGY-THERAPEUTI C   164, 980   1, 025, 273   0   1, 790, 374   11, 372   57. 00   05700   CT   SCAN   401, 188   653, 721   0   1, 669, 355   1, 631   58. 00   05800   MAGNETI C   RESONANCE   IMAGI NG (MRI )   143, 327   337, 767   0   689, 320   1, 899   60. 00   06000   LABORATORY   251, 452   3, 569, 471   0   15, 419, 623   11, 862   62. 00   06200   WHOLE   BLOOD & PACKED RED   BLOOD CELLS   11, 608   201, 369   0   1, 429, 629   385   66. 00   06500   RESPI RATORY THERAPY   216, 117   2, 614, 975   0   3, 330, 552   6, 925   66. 00   06500   PHYSI CAL THERAPY   5, 466   1, 525, 328   0   1, 680, 671   3, 398   67. 00   06600   PHYSI CAL THERAPY   0   986, 980   0   1, 070, 477   1, 642   68. 00   06800   SPECCH PATHOLOGY   2, 813   234, 775   0   264, 186   556   69. 00   06900   ELECTROCARDI OLOGY   496, 485   2, 720, 973   0   4, 855, 647   13, 067   67. 00   07000   ELECTROCARDI OLOGY   496, 485   2, 720, 973   0   4, 855, 647   13, 067   67. 00   07000   ELECTROCARDI OLOGY   496, 485   2, 720, 973   0   4, 855, 647   13, 067   67. 00   07000   ELECTROCARDI OLOGY   496, 485   2, 720, 973   0   4, 855, 647   13, 067   67. 00   07000   ELECTROCARDI OLOGY   496, 485   2, 720, 973   0   4, 855, 647   13, 067   67. 00   07000   ELECTROCARDI OLOGY   496, 485   2, 720, 973   0   4, 855, 647   13, 067   67. 00   07000   ELECTROCARDI OLOGY   496, 485   2, 720, 973   0   4, 855, 647   13, 067   67. 00   07000   ELECTROCARDI OLOGY   496, 485   2, 720, 973   0   0, 958, 135   0   0   0   0   0   0   0   0   0					1			
54.00   05400   RADI OLOGY-DI AGNOSTI C   421, 248   4, 678, 549   0   8, 963, 278   26, 467   55.00   05500   RADI OLOGY-THERAPEUTI C   164, 980   1, 025, 273   0   1, 790, 374   11, 372   57.00   05700   CT SCAN   401, 188   653, 721   0   1, 669, 355   1, 631   58.00   05800   MAGNETI C RESONANCE   MAGI NG (MRI )   143, 327   337, 767   0   689, 320   1, 989   60.00   06000   LABORATORY   251, 452   3, 569, 471   0   15, 419, 623   11, 862   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   11, 608   201, 369   0   1, 429, 629   385   66.00   06500   RESPI RATORY   THERAPY   216, 117   2, 614, 975   0   3, 330, 552   6, 925   66.00   06500   RESPI RATORY   THERAPY   5, 466   1, 525, 328   0   1, 680, 671   3, 398   67.00   06700   0CCUPATI ONAL   THERAPY   5, 466   1, 525, 328   0   1, 680, 671   3, 398   69.00   06900   ELECTROCARDI OLOGY   2, 813   234, 775   0   264, 186   556   69.00   6900   ELECTROCARDI OLOGY   496, 485   2, 720, 973   0   4, 855, 647   13, 667   70.00   07000   ELECTROCARDI OLOGY   496, 485   2, 720, 973   0   4, 855, 647   13, 667   70.00   07000   MEDI CAL   SUPPLIES CHARGED TO PATI ENTS   81, 992   1, 189, 541   0   17, 334, 863   7, 742   77.00   07000   MEDI CAL   SUPPLIES CHARGED TO PATI ENTS   701, 353   5, 104, 667   0   30, 663, 464   7, 026   74.00   0   0   0   0   958, 135   0   0   0   0   958, 135   0   0   0   0   0   0   0   0   0								
55. 00   05500   RADI OLOGY-THERAPEUTI C   164, 980   1, 025, 273   0   1, 790, 374   11, 372   5   5   0   05700   CT SCAN   401, 188   653, 721   0   1, 669, 355   1, 631   5   6   0   0   0   0   0   0   0   0   0								
57. 00   05700   CT SCAN   401, 188   653, 721   0   1, 669, 355   1, 631   58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI)   143, 327   337, 767   0   689, 320   1, 989   58. 00   06000   LABORATORY   251, 452   3, 569, 471   0   15, 419, 623   11, 862   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   11, 608   201, 369   0   1, 429, 629   385   68. 00   06500   RESPI RATORY THERAPY   216, 117   2, 614, 975   0   3, 330, 552   6, 925   69. 00   06500   RESPI RATORY THERAPY   5, 466   1, 525, 328   0   1, 680, 671   3, 398   08800   SPECCH PATHOLOGY   2, 813   234, 775   0   264, 186   556   69. 00   06800   SPECCH PATHOLOGY   496, 485   2, 720, 973   0   4, 855, 647   13, 067   07. 00   07000   ELECTROCARDI OLOGY   496, 485   2, 720, 973   0   4, 855, 647   13, 067   07. 00   07000   ELECTROENCEPHALOGRAPHY   39, 556   492, 837   0   796, 010   1, 842   77. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   81, 992   1, 189, 541   0   17, 334, 863   7, 742   77. 00   07300   DRUGS CHARGED TO PATIENTS   93, 730   0   0   16, 887, 804   8, 850   77. 00   07400   RENAL DI ALYSI S   0   0   958, 135   0   0   0   958, 135   0   0   0   958, 135   0   0   0   0   958, 135   0   0   0   0   0   958, 135   0   0   0   0   0   0   0   0   0								
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)   143, 327   337, 767   0   689, 320   1, 989   60. 00   06000   LABORATORY   251, 452   3, 569, 471   0   15, 419, 623   11, 862   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   11, 608   201, 369   0   1, 429, 629   385   65. 00   06500   RESPI RATORY THERAPY   216, 117   2, 614, 975   0   3, 330, 552   6, 925   66. 00   06600   PHYSI CAL THERAPY   5, 466   1, 525, 328   0   1, 680, 671   3, 398   68. 00   06700   0CCUPATI ONAL THERAPY   0   0   986, 980   0   1, 070, 477   1, 642   68. 00   06800   SPEECH PATHOLOGY   2, 813   234, 775   0   264, 186   556   69. 00   06900   ELECTROCARDI OLOGY   496, 485   2, 720, 973   0   4, 855, 647   13, 067   67. 00   07000   ELECTROENCEPHALOGRAPHY   39, 556   492, 837   0   796, 010   1, 842   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   81, 992   1, 189, 541   0   17, 334, 863   7, 742   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   93, 730   0   0   16, 887, 804   8, 850   73. 00   07400   RENAL DI ALYSI S   0   0   0   958, 135   0   0   0   958, 135   0   0   0   958, 135   0   0   0   0   958, 135   0   0   0   0   958, 135   0   0   0   0   958, 135   0   0   0   0   958, 135   0   0   0   0   0   0   0   0   0		1 1						
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 11, 608 201, 369 0 1, 429, 629 385 6 65. 00 06500 RESPI RATORY THERAPY 216, 117 2, 614, 975 0 3, 330, 552 6, 925 6 66. 00 06600 PHYSI CAL THERAPY 5, 466 1, 525, 328 0 1, 680, 671 3, 398 6 7 7 7 7 7 7 7 7 8 7 8 7 8 7 8 7 8 8 7 8	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		337, 767	7	0 689, 320		
65. 00 06500 RESPIRATORY THERAPY 216.117 2, 614, 975 0 3, 330, 552 6, 925 66. 00 06600 PHYSI CAL THERAPY 5, 466 1, 525, 328 0 1, 680, 671 3, 398 670 0 06700 0CCUPATI ONAL THERAPY 0 986, 980 0 1, 070, 477 1, 642 68. 00 06800 SPEECH PATHOLOGY 2, 813 234, 775 0 264, 186 556 69. 00 06900 ELECTROCARDI OLOGY 496, 485 2, 720, 973 0 4, 855, 647 13, 067 70. 00 07000 ELECTROCARDI OLOGY 39, 556 492, 837 0 796, 010 1, 842 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 81, 992 1, 189, 541 0 17, 334, 863 7, 742 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 93, 730 0 0 16, 887, 804 8, 850 73. 00 07300 DRUGS CHARGED TO PATI ENTS 93, 730 0 0 16, 887, 804 8, 850 73. 00 07400 RENAL DI ALYSI S 0 0 0 0 958, 135 0 0 0 0 958, 135 0 0 0 0 0 958, 135 0 0 0 0 0 958, 135 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1						
66. 00		1	1		•			62. 00
67. 00		1	1					
68. 00   06800   SPEECH PATHOLOGY   2, 813   234, 775   0   264, 186   556   69. 00   06900   ELECTROCARDI OLOGY   496, 485   2, 720, 973   0   4, 855, 647   13, 067   67. 00   07000   ELECTROENCEPHALOGRAPHY   39, 556   492, 837   0   796, 010   1, 842   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   81, 992   1, 189, 541   0   17, 334, 863   7, 742   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   93, 730   0   0   16, 887, 804   8, 850   73. 00   07300   DRUGS CHARGED TO PATI ENTS   701, 353   5, 104, 667   0   30, 663, 464   7, 026   74. 00   07400   RENAL DI ALYSI S   0   0   0   958, 135   0   0   0   0   958, 135   0   0   0   0   0   0   0   0   0								
69. 00   06900   ELECTROCARDI OLOGY   496, 485   2, 720, 973   0   4, 855, 647   13, 067   670. 00   07000   ELECTROENCEPHALOGRAPHY   39, 556   492, 837   0   796, 010   1, 842   771. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   81, 992   1, 189, 541   0   17, 334, 863   7, 742   772. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   93, 730   0   0   16, 887, 804   8, 850   773. 00   07300   DRUGS CHARGED TO PATI ENTS   701, 353   5, 104, 667   0   30, 663, 464   7, 026   70, 200   000			-		•			
70. 00		1	I I					
72. 00		1	l l		•			
73. 00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	81, 992	1, 189, 541	1	0 17, 334, 863	7, 742	71. 00
74. 00			93, 730	(	0	0 16, 887, 804	8, 850	72. 00
SERVICE COST CENTERS   SERVICE COST COST CENTERS   SERVICE COST COST COST COST COST COST COST COST		1 1						1
88. 00	74. 00		0	(	0	0 958, 135	0	74. 00
88. 01     08801     48TH AND MAINE RHC     0     1,833,542     0     2,171,496     5,290     8       88. 02     08802     MT STERLING RHC     25,004     357,609     0     563,535     0     8       88. 03     08803     MAIN CAMPUS RHC     52,775     15,551,177     0     14,769,325     49,759     8       88. 04     08804     BLESSING EXPRESS CLINIC     32,836     1,193,803     0     1,628,688     0       88. 05     08805     BLESSING WALK IN CLINIC     20,016     2,739,897     0     3,185,580     3,710     8       88. 06     08806     HANNI BAL MAIN RHC     0     2,983,960     0     3,483,926     8,922     8       88. 07     08807     PALMYRA RHC     1,875     262,907     0     384,936     0     8       88. 08     08808     BOWLI NG GREEN RHC     579     106,415     0     144,430     0     0	88 00		130	561 06	7	0 865 403	1	88. 00
88. 02     08802 MT STERLING RHC     25,004     357,609     0 563,535     0 8       88. 03     08803 MAIN CAMPUS RHC     52,775     15,551,177     0 14,769,325     49,759     8       88. 04     08804 BLESSING EXPRESS CLINIC     32,836     1,193,803     0 1,628,688     0 8       88. 05     08805 BLESSING WALK IN CLINIC     20,016     2,739,897     0 3,185,580     3,710       88. 06     08806 HANNI BAL MAIN RHC     0 2,983,960     0 3,483,926     8,922     8       88. 07     08807 PALMYRA RHC     1,875     262,907     0 384,936     0 8       88. 08     08808 BOWLING GREEN RHC     579     106,415     0 144,430     0 144,430			1		•		l .	
88. 03     08803 MAIN CAMPUS RHC     52,775     15,551,177     0     14,769,325     49,759 8       88. 04     08804 BLESSING EXPRESS CLINIC     32,836     1,193,803     0     1,628,688     0     8       88. 05     08805 BLESSING WALK IN CLINIC     20,016     2,739,897     0     3,185,580     3,710 8       88. 06     08806 HANNI BAL MAIN RHC     0     2,983,960     0     3,483,926     8,922 8       88. 07     08807 PALMYRA RHC     1,875     262,907     0     384,936     0     8       88. 08     08808 BOWLING GREEN RHC     579     106,415     0     144,430     0     0			_					
88. 04   08804   BLESSING EXPRESS CLINIC   32,836   1,193,803   0   1,628,688   0   8   8   0   8   8   0   0   8   0   0			1					
88. 06   08806   HANNI BAL MAI N RHC   0   2, 983, 960   0   3, 483, 926   8, 922   8   88. 07   08807   PALMYRA RHC   1, 875   262, 907   0   384, 936   0   8   8. 08   08808   BOWLI NG GREEN RHC   579   106, 415   0   144, 430   0   8		08804 BLESSING EXPRESS CLINIC	32, 836	1, 193, 803	3	0 1, 628, 688	0	88. 04
88. 07   08807   PALMYRA RHC			1		1			
88. 08   08808   BOWLING GREEN RHC 579 106, 415 0 144, 430 0 8			_					
			1		1		l .	
90. 00   09000   CLI NI C   339, 700   6, 986, 076   0   10, 703, 491   50, 969   9			1		1		l .	
90. 01   09001   0UTPATI ENT   INFUSI ON 0 361, 705 0 483, 800 3, 499 9			1		1			
90. 02   04950   ONCOLOGY   0   552, 715   0   720, 105   1, 737   9			1					
90. 03   04951   HANNI BAL I NFUSI ON   0 23, 115   0 49, 569 3, 105   9	90. 03	04951  HANNI BAL I NFUSI ON	0					90. 03

Health Financial Systems	BLESSING H	OSPI TAL		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
				From 10/01/2022 To 09/30/2023	Date/Time Pre	narodi
				10 09/30/2023	12/29/2023 3:	
	CAPI TAL	<u> </u>				
	RELATED COSTS					
Cost Center Description	MVBLE EQUIP		Reconciliatio	n ADMI NI STRATI VE		
	(DOLLAR VALUE)	BENEFITS		& GENERAL	REPAI RS	
		DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	
		(GROSS SALARI ES)				
	2.00	4. 00	5A	5. 00	6. 00	
91. 00   09100   EMERGENCY	135, 225	6, 191, 553		0 9, 296, 097		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	100,220	0, 1, 1, 000		7,270,077	20,001	92. 00
93. 99 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	14, 904	1, 021, 443		0 1, 179, 779	3, 234	
OTHER REIMBURSABLE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,	•			
101.00 10100 HOME HEALTH AGENCY	470	3, 079, 669		0 4, 071, 028	2, 046	101. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	7, 956	2, 196, 230		0 3, 220, 006		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	16, 724, 803	160, 669, 962	-98, 538, 47	6 319, 468, 562	674, 403	118. 00
NONREI MBURSABLE COST CENTERS	1		1	00.400		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	5 700 550		0 28, 190		190.00
193. 00 19300 NONPALD WORKERS	217, 580	5, 798, 559		0 8, 812, 355 0 0		192. 00 193. 00
193. 00 19300 NONPALD WORKERS		0		0 14, 874		193. 00
193. 02 19302 UNUSED SPACE		0		0 383, 669		193. 02
193. 03 19303 RENTED SPACE	0	0		0 275, 349		193. 03
193. 04 19304 RETAIL PHARMACIES	91, 108	2, 108, 491	1	0 21, 262, 514		193. 04
193. 05 19305 WELLNESS CENTER	45, 375	310, 864		0 583, 263		193. 05
200.00 Cross Foot Adjustments	1	•				200.00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	16, 915, 757	9, 760, 521		98, 538, 476	18, 733, 698	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 990450	0. 057793		0. 280873		
204.00 Cost to be allocated (per Wkst. B,		740, 924		11, 745, 266	2, 196, 889	204.00
Part II)		0.004207		0.022470	2 724242	205 00
205.00 Unit cost multiplier (Wkst. B, Part		0. 004387		0. 033479	2. 734313	205.00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						200.00
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)	1					1

| Period: | Worksheet B-1 | From 10/01/2022 | To 09/30/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0015

					09/30/2023	Date/Time Prep 12/29/2023 3:	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	оч ріп
		LINEN SERVICE (POUNDS OF	(HOURS OF SERVICE)	(MEALS SERVED)	(MEALS SERVED)	ADMI NI STRATI ON	
		LAUNDRY)	OLIVI OL)			(DIRECT NURS.	
		8. 00	9. 00	10.00	11.00	HRS. ) 13. 00	
	NERAL SERVICE COST CENTERS	0.00	7. 00	10.00	11.00	10.00	
	0100 CAP REL COSTS-BLDG & FLXT						1.00
	0101 CAP REL COSTS-BUTLER BUILDING 0102 CAP REL COSTS-OLD BLDG & FIXTURES						1. 01 1. 02
	0103 CAP REL COSTS-NEW BLDG & FIXTURES						1. 03
	0104 CAP REL COSTS-MOB						1. 04
	0105 CAP REL COSTS-OAK STREET MALL 0106 CAP REL COSTS-BRCN AT 36TH ST						1. 05 1. 06
	0107 CAP REL COSTS-BROW AT 3011 31						1. 00
1.08 00	0108 CAP REL COSTS-48TH AND MAINE						1. 08
	0109 CAP REL COSTS HANNI BAL						1. 09
	0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
	D500 ADMINISTRATIVE & GENERAL						5. 00
	0600 MAINTENANCE & REPAIRS	4 500 704					6. 00
	D800 LAUNDRY & LINEN SERVICE	1, 503, 794 15, 224	123, 162				8. 00 9. 00
	1000 DI ETARY	11, 074	2, 900				10. 00
	1100 CAFETERI A	O	1, 051	0	,		11. 00
1	1300 NURSING ADMINISTRATION	0	1, 724 624	0	20, 263	1, 848, 825 0	13. 00 16. 00
1	1600 MEDICAL RECORDS & LIBRARY 2000 NURSING PROGRAM	0	5, 138	ľ	11, 655	0	20. 00
1	2100 I&R SERVICES-SALARY & FRINGES APPRVD	O	0	1	0	0	21. 00
	2200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	51	0	4, 920	0	22. 00
	2300 PARAMED ED PRGM 2301 PARAMED ED PRGM-RADIOLOGY	0	0 446	1	0 1, 336	0	23. 00 23. 01
	2302 PARAMED ED PRGM-LABORATORY	o	260			0	23. 01
	2303 PARAMED ED PRGM-PHARMACY	O	0			0	23. 03
	2304 PARAMED ED PRGM-RESPIRATORY IPATIENT ROUTINE SERVICE COST CENTERS	0	15	0	570	0	23. 04
	8000 ADULTS & PEDIATRICS	522, 239	36, 252	199, 176	110, 189	913, 857	30. 00
	3100 INTENSIVE CARE UNIT	84, 279	4, 027			·	31.00
	1100 SUBPROVI DER - I RF	81, 772	1, 634 619			49, 445	41.00
	1300 NURSERY 1400 SKILLED NURSING FACILITY	9, 117 59, 950	2, 038			7, 040 51, 220	43. 00 44. 00
AN	ICILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM 5200 DELIVERY ROOM & LABOR ROOM	119, 476 41, 535	11, 630 1, 322				50. 00 52. 00
	5300 ANESTHESI OLOGY	41, 535	262				53. 00
	7400 RADI OLOGY-DI AGNOSTI C	105, 236	4, 596				54.00
	5500 RADIOLOGY-THERAPEUTIC 5700 CT_SCAN	58, 662	1, 975		-,	0	55.00
	5700 CT SCAN 5800 MAGNETIC RESONANCE IMAGING (MRI)	40, 294 9, 445	283 345			0	57. 00 58. 00
60.00 06	6000 LABORATORY	148	2, 060				60.00
	5200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	67	0		0	62. 00
1	5500  RESPI RATORY THERAPY 5600  PHYSI CAL THERAPY	0	1, 203 590		8, 129 4, 202	0	65. 00 66. 00
1	5700 OCCUPATI ONAL THERAPY	o	285		2, 773	Ö	67. 00
	5800 SPEECH PATHOLOGY	0	97	•		0	68.00
	5900  ELECTROCARDI OLOGY 7000  ELECTROENCEPHALOGRAPHY	59, 732 455	2, 269 320		-,	0	69. 00 70. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 254	1, 344	1	2, 927	0	71. 00
1	7200 I MPL. DEV. CHARGED TO PATIENTS	10, 578	1, 537		3, 644	0	72. 00
	7300 DRUGS CHARGED TO PATIENTS 7400 RENAL DIALYSIS	0	1, 220 0			0	73. 00 74. 00
	ITPATIENT SERVICE COST CENTERS	<u> </u>				0	7 1. 00
	B800 EAST ADAMS RHC	0	0	0		0	88. 00
	3801 48TH AND MAINE RHC 3802 MT STERLING RHC	0	919 0	0	0	0	88. 01 88. 02
	38803 MAIN CAMPUS RHC	o o	8, 641	Ö	30, 907	Ö	88. 03
	BLESSING EXPRESS CLINIC	o	0	0	0	0	88. 04
	3805 BLESSING WALK IN CLINIC	0	644	0	4, 788	0	88. 05
	3806 HANNIBAL MAIN RHC 3807 PALMYRA RHC		1, 549 0		0	0	88. 06 88. 07
88. 08 08	B808 BOWLING GREEN RHC	o	0	0	Ō	0	88. 08
	9000 CLINIC	0	8, 852		31, 022	0	90.00
1	POO1 OUTPATIENT INFUSION 1950 ONCOLOGY	495 0	608 302		1, 396 1, 855	11, 581 15, 381	90. 01 90. 02
	1951 HANNI BAL I NFUSI ON	o	539		0	0	90. 03
1	9100 EMERGENCY	259, 902	4, 087	0	20, 457	169, 661	91.00
92. 00   09	9200 OBSERVATION BEDS (NON-DISTINCT PART)			l	<u> </u>		92. 00

Heal th Financial	Systems	BLESSING HOSPI	TAL		In Lieu	of Form CMS-2552-10
COST ALLOCATION	SIND INCIDITATE		Providor CCN: 14 0015	Pari ad:		Workshoot P 1

Health Financial Systems	BLESSING F	IOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co	F	eriod: rom 10/01/2022 o 09/30/2023	Worksheet B-1 Date/Time Pre	
					12/29/2023 3:	54 pm
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	(MEALS SERVED)	ADMI NI STRATI ON	
	(POUNDS OF	SERVI CE)			(D. DEOT 111DO	
	LAUNDRY)				(DI RECT NURS.	
	8. 00	9. 00	10.00	11.00	HRS. ) 13. 00	
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0.00	9.00				93. 99
OTHER REIMBURSABLE COST CENTERS	0	302	.[	3, 037	30, 320	93.99
101. 00 10100 HOME HEALTH AGENCY	0	355	il o	0	83 755	101. 00
SPECIAL PURPOSE COST CENTERS			,	<u> </u>	00, 700	101.00
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	0	0	0	50, 362	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 11	17) 1, 498, 867	115, 242	250, 320	394, 677	1, 848, 825	
NONREI MBURSABLE COST CENTERS	,					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 927	696	0	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	7, 050	0	12, 602		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
193. 01 19301 DENMAN SERVICES	0	174	0	0		193. 01
193. 02 19302 UNUSED SPACE	0	0	0	0		193. 02
193. 03 19303 RENTED SPACE	0	0	0	0		193. 03
193. 04 19304 RETAIL PHARMACIES	0	0	0	0		193. 04
193. 05 19305 WELLNESS CENTER	0	0	0	0	0	193. 05
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	2, 202, 215	9, 625, 870	4, 456, 500	5, 529, 848	19, 160, 785	202. 00
Part I) 203.00 Unit cost multiplier (Wkst. B, Part	1. 464439	78. 156168	17. 803212	13. 577543	10. 363763	202 00
204.00 Cost to be allocated (per Wkst. B,	97, 056	646, 094			1, 722, 422	
Part II)	77,030	040, 074	307, 302	201, 477	1, 722, 422	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 064541	5. 245888	2. 274297	0. 642059	0. 931631	205. 00
206.00 NAHE adjustment amount to be allocat	ted					206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)			I			l

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: Worksheet B-1 From 10/01/2022 To 09/30/2023 Date/Time Prepared: Provider CCN: 14-0015

						12/29/2023 3:	
				INTERNS &	RESI DENTS		
	Cost Center Description	MEDI CAL	NURSI NG	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	
		RECORDS &	PROGRAM	Y & FRINGES	PRGM COSTS	PRGM	
		LI BRARY	(ASSI GNED	(ASSI GNED	(ASSI GNED	(ASSI GNED	
		(TIME SPENT) 16.00	TI ME) 20. 00	TI ME) 21. 00	TI ME) 22. 00	TI ME) 23. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 1. 02	00101 CAP REL COSTS-BUTLER BUILDING 00102 CAP REL COSTS-OLD BLDG & FIXTURES						1. 01 1. 02
1. 03	00103 CAP REL COSTS-NEW BLDG & FIXTURES						1. 03
1.04	00104 CAP REL COSTS-MOB						1. 04
1. 05 1. 06	00105 CAP REL COSTS-OAK STREET MALL 00106 CAP REL COSTS-BRCN AT 36TH ST						1. 05 1. 06
1.00	00100 CAP REL COSTS-BROW AT 30TH 3T						1.00
1.08	00108 CAP REL COSTS-48TH AND MAINE						1. 08
1.09	00109 CAP REL COSTS-HANNI BAL						1. 09
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSING ADMINISTRATION	222 //7					13.00
16. 00 20. 00	01600 MEDICAL RECORDS & LIBRARY 02000 NURSING PROGRAM	223, 667	24, 244				16. 00 20. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0		21, 468			21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0			21, 468	0	22. 00
23. 00 23. 01	O2300   PARAMED ED   PRGM   O2301   PARAMED ED   PRGM-RADI OLOGY	0				0	23. 00 23. 01
23. 02	02302 PARAMED ED PRGM-LABORATORY	o o					23. 02
23. 03	02303 PARAMED ED PRGM-PHARMACY	0					23. 03
23. 04	O2304   PARAMED ED PRGM-RESPIRATORY     I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0					23. 04
30. 00	03000 ADULTS & PEDIATRICS	177, 198	17, 882	19, 308	19, 308	0	30. 00
31.00	03100   NTENSI VE CARE UNI T	17, 277	1, 263		600	0	1
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	14, 073 293	222 366		0 144	0	41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	14, 150	113		0	0	1
FO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	1 120	0/	0/	0	FO 00
50. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 138 1, 071		96 0	0	1
53.00	05300 ANESTHESI OLOGY	0	0		24	0	
54. 00	05400 RADI OLOGY - DI AGNOSTI C	0	0	24	24	0	
55. 00 57. 00	05500   RADI OLOGY-THERAPEUTI C   05700   CT   SCAN	0	0	0	0	0	55. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	
60.00	06000 LABORATORY	0	0		48		
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY	0	0	0	0	0	
66. 00	06600 PHYSI CAL THERAPY	0	0	Ö	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	1
68. 00 69. 00	06800  SPEECH PATHOLOGY 06900  ELECTROCARDI OLOGY	0	0 204	-	0 372	0	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	Ö	0	48	48	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	1
74. 00		0	0		0	0	
	OUTPATIENT SERVICE COST CENTERS			_	_		
88. 00 88. 01	08800 EAST ADAMS RHC 08801 48TH AND MAINE RHC	0	0	0	0	0	88. 00 88. 01
88. 02	08802 MT STERLING RHC	0	0	0	0	0	88. 02
88. 03	08803 MAIN CAMPUS RHC	0	0	0	0	0	88. 03
88. 04	08804 BLESSING EXPRESS CLINIC	0	100	_	0	0	
88. 05 88. 06	08805 BLESSING WALK IN CLINIC 08806 HANNIBAL MAIN RHC		188 0		0	0	88. 05 88. 06
88. 07	08807 PALMYRA RHC		0	0	0	0	88. 07
88. 08	08808 BOWLING GREEN RHC	0	0	0	0	0	88. 08
90. 00 90. 01	09000   CLI NI C   09001   OUTPATI ENT   I NFUSI ON	0	253 192		300 0	0	90. 00 90. 01
90. 02	04950 ONCOLOGY		0		0	0	90. 02
90. 03	04951 HANNI BAL I NFUSI ON	0	0	0	0	0	1
91. 00	09100  EMERGENCY	676	1, 042	504	504	0	91.00

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 14-0015	Period: Worksheet B-1 From 10/01/2022

COST ALLOCATION - S	ATISTICAL BASIS		Provi der C		'eri od:	Worksheet B-1	
					From 10/01/2022 To 09/30/2023	Date/Time Pre	nared·
				'	0 077 307 2023	12/29/2023 3:	
				INTERNS &	RESI DENTS		
Cost Cer	nter Description	MEDI CAL	NURSI NG		SERVI CES-OTHER		
		RECORDS &	PROGRAM	Y & FRINGES	PRGM COSTS	PRGM	
		LI BRARY	(ASSI GNED	(ASSI GNED	(ASSI GNED	(ASSI GNED	
		(TIME SPENT)	TIME)	TIME)	TIME)	TIME)	
		16. 00	20.00	21. 00	22. 00	23. 00	
	TION BEDS (NON-DISTINCT PART)						92. 00
	HOSPITALIZATION PROGRAM	0	45	(	0	0	93. 99
	SABLE COST CENTERS						
101.00 10100 HOME HE		0	240	)	0	0	101. 00
	SE COST CENTERS						
113. 00 11300 I NTERES	T EXPENSE						113. 00
116. 00 11600 HOSPI CE		0	25	5		0	116. 00
118.00 SUBTOTA	LS (SUM OF LINES 1 through 117)	223, 667	24, 244	21, 468	21, 468	0	118. 00
NONREI MBURSAB	LE COST CENTERS						1
190. 00 19000 GIFT, F	LOWER, COFFEE SHOP & CANTEEN	0	O	) (	0	0	190. 00
192. 00 19200 PHYSI CL	ANS' PRIVATE OFFICES	o	0	) (	0	0	192. 00
193. 00 19300 NONPAI D	WORKERS	o	0	) (	0	0	193. 00
193. 01 19301 DENMAN	SERVI CES	o	0	) (	0	0	193. 01
193. 02 19302 UNUSED	SPACE	o	0	) (	0	0	193. 02
193. 03 19303 RENTED	SPACE	o	Ō		0	0	193. 03
193. 04 19304 RETAI L	PHARMACI ES	o	Ō		0	0	193. 04
193. 05 19305 WELLNES	S CENTER	o	Ō		0	0	193. 05
200.00 Cross F	oot Adjustments						200.00
201.00 Negative	e Cost Centers						201.00
202.00 Cost to	be allocated (per Wkst. B,	12, 343, 554	5, 589, 240	1, 732, 064	2, 594, 241	0	202. 00
Part I)							
203.00 Unit co	st multiplier (Wkst. B, Part I)	55. 187193	230. 541165	80. 681200	120. 842230	0.000000	203. 00
204.00 Cost to	be allocated (per Wkst. B,	379, 996	996, 551	50, 880	72, 240	0	204.00
Part II			·		•		
205.00 Unit co	st multiplier (Wkst. B, Part	1. 698936	41. 105057	2. 370039	3. 365008	0. 000000	205. 00
	•						
206.00 NAHE ad	ustment amount to be allocated		0			0	206. 00
	st. B-2)						
207. 00 NAHE un	it cost multiplier (Wkst. D,		0. 000000			0. 000000	207.00
Parts I	II and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0015 

Control					1	0 09/30/2023	Date/lime Prepared:   12/29/2023 3:54 pm
CASSINED   CASSINED		Cost Center Description					
REMERIAL SERVICE COST CENTERS   TYPE   THE PT			PRGM-RADI OLOGY				
THEFT			(ASSLGNED		` .		
Children Schmidt Cost   Cent Birs					, , , , , , , , , , , , , , , , , , , ,		
1.00		I	23. 01	23. 02	23. 03	23. 04	
1.01   0.010  CAP REL COSTS-BUILTER BUILDING   1.01   0.010  CAP REL COSTS ON BIOLOGY AND STREET MALL   1.04   1.05   0.010  CAP REL COSTS ON BIOLOGY AND STREET MALL   1.04   1.05   0.010  CAP REL COSTS ON BIOLOGY CAP REL COSTS ON STREET MALL   1.04   1.05   0.010  CAP REL COSTS ON STREET MALL   1.04   1.05   0.010  CAP REL COSTS-BUILDING CAP REL COSTS ON STREET MALL   1.05   0.010  CAP REL COSTS-BUILDING CAP REL COSTS BUILDING CA	1 00				I		1 00
102   00102   CAP REL COSTS-ADD BLOS & FIXTURES     1 0.2		1 1					
0.0103   CAP REL COSTS-MEW RELDG & FIXTURES     1.03   1.03   1.05   1		1 1					
1.05   0.0105   CAP REL COSTS-SOR STREET WALL     1.05   1.07		1 t		•			
1.06   OTOLO   CAP REL COSTS-BRICH AT 26TH ST							
1.07   0107   CAP REL COSTS-SURGERY CENTER     1.08   1.09   1.09   1.00   1.							
1.08   ORDING CAP REL COSTS-HAMIN BAIN		l i					
1.09							
4. 00							
5.00	2.00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
0.000   00000   MAINTENNICE & REPAIRS							
8. 00 00600   LAUNDRY & LINEN SERVICE   9. 00 0000   10 1000   10 11 100   11 100							
9.00   009900   HOUSEKEEPING   9.00   11.00							
10 00   01000   DIETARY							
11.00							
16.00   01-000   MIRST IOS PROGRAM   2.00   2.00   2.00   2.00   02-000   IARS ESERVICES-SALARY & FETINGES APPRVD   2.10   2.20   2.00   2.00   1 AR SERVICES-SALARY & FETINGES APPRVD   2.20   2.20   2.20   2.20   2.00   2.00   1 AR SERVICES-SALARY & FETINGES APPRVD   2.20	11. 00						11. 00
20.00							
21.00   02.100   RR SERVI CES-SALARY & FRI NŒS APPRUD   22.00   22.00   02.300   PARAMÉE DE PREMI - ARDIOLOGY   100   23.00   23.00   23.00   PARAMÉE DE PREMI - ARDIOLOGY   100   23.00   2		1 1					
22.00							
23.00   02300   PARAMED ED PROM. ARDIOLOGY   100   23.00   2		l l					
23. 02   02302   PARAMED ED PROM-L-BADONATORY   100   23. 0. 02   23. 04   223.04   PARAMED ED PROM-PESTIRATORY   100   23. 0. 04   100   100   23. 0. 04   100		l l					
22.03   02303   PARAMED ED PROM-PHARMACY   0   23.04   23.04   23.04   23.04   23.04   23.04   23.04   23.04   23.04   23.00   PARAMED ED PROM-PESPI RATORY	23. 01	l l	100				
23.0 4				100			
INPATEENT ROUTINE SERVICE COST CENTERS		1 1			100		
30.00   030000   03000   03000   03000   03000   03000   03000   03000   030000   030000   030000   030000   030000   03000   03000   03000   03000   03000   03000   03000   03000	23. 04					100	23. 04
31.00   03100   INTENSIVE CARE UNIT	30 00		0	0	0	0	30.00
43. 00 04300 NURSERY 40. 00 1400 SKILLED NURSI NG FACILITY 9 0 0 0 0 44. 00  ANCILLARY SERVICE COST CENTERS  50. 00 5000 IOPERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 AWESTHESI OLOGY 9 0 0 0 0 0 0 0 0 0 52. 00 55. 00 05300 AWESTHESI OLOGY 9 0 0 0 0 0 0 0 0 53. 00 55. 00 05500 RADIOLOGY-DI AGNOSTIC 10 0 0 0 0 0 0 0 0 54. 00 55. 00 05500 RADIOLOGY-DI AGNOSTIC 10 0 0 0 0 0 0 0 0 55. 00 55. 00 05500 RADIOLOGY-DI AGNOSTIC 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l l	0	_	Ō		
44.00	41.00	04100 SUBPROVI DER - I RF	0	0	0	0	41. 00
ANCILLARY SERVICE COST CENTERS			-				
50. 00   05000   05000   05000   0   0   0	44. 00		0	0	0	0	44. 00
52.00   05.200   DELIVERY ROOM & LABOR ROOM   0   0   0   52.00	50 00		0	0	0	0	50.00
53. 00   05300   AMESTHESI OLOGY   0   0   0   53. 00   54. 00   05400   RADIO LOGY-DI AGNOSTIC   100   0   0   0   0   55. 00   05500   RADIO LOGY-THERAPEUTIC   0   0   0   0   0   55. 00   05500   RADIO LOGY-THERAPEUTIC   0   0   0   0   0   57. 00   05500   RADIO LOGY-THERAPEUTIC   0   0   0   0   0   58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)   0   0   0   0   0   0   60. 00   06000   LABORATORY   0   0   0   0   0   0   60. 00   06000   LABORATORY   0   0   0   0   0   61. 00   06000   RESPI RATORY THERAPY   0   0   0   0   0   62. 00   06000   RESPI RATORY THERAPY   0   0   0   0   0   63. 00   06500   RESPI RATORY THERAPY   0   0   0   0   0   64. 00   06500   RESPI RATORY THERAPY   0   0   0   0   0   65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   0   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   67. 00   06700   0CCUPATIONAL THERAPY   0   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   69. 00   06900   ELECTROCARDIO LOGY   0   0   0   0   0   69. 00   06900   ELECTROCARDIO LOGY   0   0   0   0   69. 00   06900   ELECTROCARDIO LOGY   0   0   0   0   69. 00   07000   ELECTROCARDIO LOGY   0   0   0   0   69. 00   07000   LELECTROCARDIO LOGY   0   0   0   69. 00   07000   07000   07000   07000   69. 00   07000   07000   07000   07000   69. 00   07000   07000   07000   07000   69. 00   07000   07000   07000   07000   69. 00   07000   07000   07000   07000   69. 00   07000   07000   07000   0   69. 00   07000   07000   07000   0   69. 00   07000   07000   07000   0   69. 00   07000   07000   07000   0   69. 00   07000   07000   07000   0   69. 00   07000   07000   07000   0   69. 00   07000   07000   07000   0   69. 00   07000   07000   07000   0   69. 00   07000   07000   07000   0   69. 00   07000   07000   07000   0   69. 00   07000   07000   07000   0   69. 00   07000   07000   07000   0   69. 00   07000   07000   07000   0   69. 00   07000   07000   07000   0   69. 00   07000   07000   07000   0   69. 00   07000   07000   07000   0   69. 00   07000   0							
55. 00   05500   RADI OLOGY-THERAPEUTIC	53.00	05300 ANESTHESI OLOGY	0	0	0	0	53. 00
57. 00   05700   CT SCAN   0   0   0   0   0   0   57. 00			100	0	0	0	
58.00   05800   MACNETIC RESONANCE I MAGING (MRI)			0	0	0	0	
60.00   06000   LABORATORY   0   100   0   60.00   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   65.00   06500   RESPIRATORY THERAPY   0   0   0   0   0   66.00   06600   PHYSI CAL THERAPY   0   0   0   0   0   66.00   06600   OFOTO   COCUPATI ONAL THERAPY   0   0   0   0   0   67.00   06700   COCUPATI ONAL THERAPY   0   0   0   0   0   68.00   06800   SPEECH PATHOLOGY   0   0   0   0   0   69.00   06900   CLECTROCARDIOLOGY   0   0   0   0   0   69.00   07000   CLECTROCARDIOLOGY   0   0   0   0   70.00   07000   CLECTROCARDIOLOGY   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   72.00   07200   MPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   88.00   08800   EAST ADAMS RHC   0   0   0   0   88.01   08801   AST ERLING RHC   0   0   0   0   88.02   08802   MI STERLING RHC   0   0   0   0   88.03   08803   MAI N CAMPUS RHC   0   0   0   0   88.04   08804   BLESSING EXPRESS CLINIC   0   0   0   88.05   08805   BLESSING EXPRESS CLINIC   0   0   0   88.06   08806   BALESSING WALK IN CLINIC   0   0   0   88.07   08807   PALMYRA RHC   0   0   0   0   88.08   08808   BOWLING GREEN RHC   0   0   0   0   89.09   00   00   0   0   80.00   09000   CLINIC   0   0   0   80.01   09001   UTPATIENT SINT SINT ON   0   0   0   80.02   04950   ONCOLOGY   0   0   0   80.03   04951   ANNIBAL INFUSION   0   0   0   80.04   09001   OUTPATIENT SINT SINT SINT SINT SINT SINT SINT SI			0	_	0	0	
62. 00   06-200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   62. 00   65. 00   06-500   RESPI RATORY THERAPY   0   0   0   0   0   0   66. 00   06-6000   06-6000   06-6000   06-6000   06-6000   06-6000   06-6000   06-6000			0		0	0	
65.00   06500   RESPIRATORY THERAPY   0   0   0   0   0   0   0   65.00   66.00   06600   PHYSI CAL THERAPY   0   0   0   0   0   0   0   67.00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   68.00   06800   SPECH PATHOLOGY   0   0   0   0   0   0   69.00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   70.00   07000   ELECTROCARDI OLOGY   0   0   0   0   0   71.00   07000   ELECTROCARDI OLOGY   0   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   74.00   07400   RENAL DI ALYSI S   0   0   0   0   001794TI ENT SERVI DE COST CENTERS  88.00   08800   EAST ADM/S RHC   0   0   0   0   88.01   08801   48TH AND MAINE RHC   0   0   0   0   88.02   08802   MT STERLI NG RHC   0   0   0   0   88.03   08803   MAIN CAMPUS RHC   0   0   0   0   88.04   08804   BLESSI NG EXPRESS CLINI C   0   0   0   0   88.05   08805   BLESSI NG WALK IN CLINI C   0   0   0   0   88.06   08807   PALMYRA RHC   0   0   0   0   88.07   08807   PALMYRA RHC   0   0   0   0   88.08   08808   BMIN BAL MIN RHC   0   0   0   0   88.07   08807   PALMYRA RHC   0   0   0   0   88.08   08808   BOWLI NG GREEN RHC   0   0   0   0   88.09   08809   BOWLI NG GREEN RHC   0   0   0   0   90.00   09000   CLIPATI ENT INFUSI ON   0   0   0   90.01   09001   OUTPATI ENT INFUSI ON   0   0   0   90.02   04950   ONCOLOGY   0   0   0   90.03   04951   HANNI BAL LINFUSI ON   0   0   0   90.01   09000   OUTPATI ENT INFUSI ON   0   0   0   90.02   04950   ONCOLOGY   0   0   0   90.03   09100   OUTPATI ENT INFUSI ON   0   0   0   90.03   09100   OUTPATI ENT INFUSI ON   0   0   0   90.00   09000   OUTPATI ENT INFUSI ON   0   0   0   90.01   09000   OUTPATI ENT INFUSI ON   0   0   0   90.02   04950   ONCOLOGY   0   0   0   90.03   09100   OUTPATI ENT INFUSI ON   0   0   0   90.01   09000   OUTPATI ENT INFUSI ON   0   0   0   90.02   04950   ONCOLOGY   0   0   0   90.03   09100   OUTPATI			-				
67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   67. 00   68. 00   06800   SPECEH PATHOLOGY   0   0   0   0   0   0   68. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   0   0			0	0	0	100	65. 00
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 69. 00 70. 00 07000 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 74. 00 0000 EAST ADAMS RHC 0 0 0 0 0 88. 01 88. 01 08801 487H AND MAINE RHC 0 0 0 0 0 88. 01 88. 02 08802 MT STERLING RHC 0 0 0 0 0 88. 02 88. 03 08803 MAIN CAMPUS RHC 0 0 0 0 0 88. 03 88. 04 08804 BLESSING EXPRESS CLINIC 0 0 0 0 0 88. 03 88. 06 08806 BLESSING WALK IN CLINIC 0 0 0 0 0 88. 04 88. 07 08807 PALMYRA RHC 0 0 0 0 0 0 88. 04 88. 08 08808 BUSSING GREEN RHC 0 0 0 0 0 0 0 88. 05 88. 08 08808 BOWLING GREEN RHC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l l	0	0	0	0	
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 69.00 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 70.00 70. 00 07000 ELECTROCARDI OLOGRAPHY 0 0 0 0 0 0 0 77.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 72. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 72. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 0 73. 00 0UTPATIENT SERVICE COST CENTERS  88. 00 08800 EAST ADAMS RHC 0 0 0 0 0 0 88. 00 88. 01 08801 48TH AND MAINE RHC 0 0 0 0 0 88. 01 88. 02 08802 MT STERLING RHC 0 0 0 0 0 88. 02 88. 03 08803 MAIN CAMPUS RHC 0 0 0 0 0 0 88. 03 88. 04 08804 BLESSING EXPRESS CLINIC 0 0 0 0 0 88. 03 88. 05 08805 BLESSING WALK IN CLINIC 0 0 0 0 0 88. 05 88. 06 08806 HANNI BAL MAIN RHC 0 0 0 0 0 0 88. 05 88. 06 08806 HANNI BAL MAIN RHC 0 0 0 0 0 0 88. 05 88. 07 08807 PALMYRA RHC 0 0 0 0 0 0 88. 06 88. 07 08807 PALMYRA RHC 0 0 0 0 0 0 88. 07 88. 08 08808 BOWLING GREEN RHC 0 0 0 0 0 0 0 88. 08 90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 t	0	0	0	0	
70.00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   0   0   0   0		1 1	0	0	0	0	
71. 00  07100		1 1	0	0	0	0	
73. 00		1 1	0	Ö	Ö	0	
74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   0   0   0   0	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72. 00
SB. 00   OBSOO   EAST ADAMS RHC   O   O   O   O   O   O   O   O   O			0	0		0	
88. 00   08800   EAST ADAMS RHC   0   0   0   0   0   88. 00   88. 01   08801   48TH AND MAINE RHC   0   0   0   0   0   0   88. 01   88. 02   08802   MT   STERLI NG RHC   0   0   0   0   0   0   0   88. 02   88. 03   08803   MAIN   CAMPUS RHC   0   0   0   0   0   0   0   88. 03   88. 04   08804   BLESSI NG EXPRESS CLINI C   0   0   0   0   0   0   0   88. 03   88. 05   08805   BLESSI NG WALK IN CLINI C   0   0   0   0   0   0   0   88. 05   88. 06   08806   HANNI BAL MAIN   RHC   0   0   0   0   0   0   88. 06   88. 07   08807   PALMYRA   RHC   0   0   0   0   0   0   88. 07   88. 08   08808   BOWLI NG   GREEN   RHC   0   0   0   0   0   0   0   88. 08   90.00   09000   CLINI C   0   0   0   0   0   90. 00   90. 01   09001   OUTPATI ENT   INFUSI ON   0   0   0   0   0   90. 02   90. 03   04951   HANNI BAL   INFUSI ON   0   0   0   0   0   91. 00   91. 00   09100   EMERGENCY   0   0   0   0   0   91. 00   0   0   0   0   0   0   0   0   0	74. 00		0	0	0	0	74. 00
88. 01   08801   48TH AND MAINE RHC   0   0   0   0   0   88. 01   88. 02   08802   MT STERLING RHC   0   0   0   0   0   88. 02   88. 03   08803   MAIN CAMPUS RHC   0   0   0   0   0   0   88. 03   88. 04   08804   BLESSING EXPRESS CLINIC   0   0   0   0   0   0   88. 04   88. 05   08805   BLESSING WALK IN CLINIC   0   0   0   0   0   0   88. 05   88. 06   08806   HANNI BAL MAIN RHC   0   0   0   0   0   0   88. 05   88. 07   08807   PALMYRA RHC   0   0   0   0   0   0   88. 07   88. 08   08808   BOWLING GREEN RHC   0   0   0   0   0   0   88. 08   09000   CLINIC   0   0   0   0   0   0   0   0   0	88 00		0	0	Γ ο	0	88 00
88. 02       08802 MT STERLING RHC       0       0       0       0       0       88. 02         88. 03       08803 MAIN CAMPUS RHC       0       0       0       0       0       88. 03         88. 04       08804 BLESSING EXPRESS CLINIC       0       0       0       0       0       88. 04         88. 05       08805 BLESSING WALK IN CLINIC       0       0       0       0       0       88. 05         88. 06       08806 HANNI BAL MAIN RHC       0       0       0       0       0       88. 06         88. 07       08807 PALMYRA RHC       0       0       0       0       0       88. 07         88. 08       08908 BOWLING GREEN RHC       0       0       0       0       0       88. 08         90. 00       09000 CLINIC       0       0       0       0       0       90. 00         90. 01       09001 OUTPATI ENT INFUSION       0       0       0       0       90. 01         90. 02       04950 ONCOLOGY       0       0       0       0       0       90. 02         90. 03       04951 HANNI BAL INFUSION       0       0       0       0       0       0       90. 03		l l	0	0	0	0	
88. 04   08804   BLESSING EXPRESS CLINIC   0   0   0   0   0   88. 04   88. 05   08805   BLESSING WALK IN CLINIC   0   0   0   0   0   88. 06   08806   HANNI BAL MAIN RHC   0   0   0   0   0   88. 07   08807   PALMYRA RHC   0   0   0   0   0   88. 08   08808   BOWLING GREEN RHC   0   0   0   0   88. 08   08808   BOWLING GREEN RHC   0   0   0   0   90. 00   09000   CLINIC   0   0   0   0   90. 01   09001   0UTPATIENT INFUSION   0   0   0   0   90. 02   04950   0NCOLOGY   0   0   0   0   90. 03   04951   HANNI BAL INFUSION   0   0   0   0   91. 00   09100   EMERGENCY   0   0   0   0   91. 00   09100   EMERGENCY   0   0   0   0   91. 00   09100   EMERGENCY   0   0   0   0   91. 00   09100   EMERGENCY   0   0   0   0   90. 01   00   0   0   0   91. 00   09100   EMERGENCY   0   0   0   0   90. 01   00   0   0   0   90. 02   09100   00   0   0   0   90. 01   00   0   0   0   90. 02   09100   00   00   0   90. 02   09100   00   00   00   90. 03   09100   00   00   00   90. 04   00   00   00   90. 05   00   00   00   90. 06   00   00   90. 07   00   00   00   90. 08   00   00   00   90. 08   00   00   00   90. 09   00   00			0	Ö	Ö	0	
88. 05   08805   BLESSING WALK IN CLINIC   0   0   0   0   0   88. 05   88. 06   08806   HANNI BAL MAIN RHC   0   0   0   0   0   88. 06   88. 07   08807   PALMYRA RHC   0   0   0   0   0   0   88. 07   88. 08   08808   BOWLING GREEN RHC   0   0   0   0   0   0   0   88. 08   90. 00   09000   CLINIC   0   0   0   0   0   0   90. 00   90. 01   09001   00TPATIENT INFUSION   0   0   0   0   0   90. 02   04950   0NCOLOGY   0   0   0   0   0   0   90. 02   090. 03   04951   HANNI BAL INFUSION   0   0   0   0   0   90. 03   91. 00   09100   EMERGENCY   0   0   0   0   0   91. 00	88. 03	08803 MAIN CAMPUS RHC	0	0	0	0	
88. 06   08806   HANNI BAL MAI N RHC   0 0 0 0 0 0 88. 06 88. 07   08807   PALMYRA RHC   0 0 0 0 0 0 0 88. 07 88. 08   08808   BOWLI NG GREEN RHC   0 0 0 0 0 0 0 88. 08   90. 00   09000   CLI NI C   0 0 0 0 0 0 0 90. 00   90. 00			0	0	0	0	
88. 07   08807   PALMYRA RHC   0 0 0 0 0 0 88. 07   88. 08   08808   BOWLI NG GREEN RHC   0 0 0 0 0 0   88. 08   90. 00   09000   CLI NI C   0 0 0 0 0 0   90. 00   90. 00   90. 01   09001   OUTPATI ENT I NFUSI ON   0 0 0 0 0 0   90. 01   90. 02   04950   ONCOLOGY   0 0 0 0 0 0   90. 02   90. 03   04951   HANNI BAL I NFUSI ON   0 0 0 0 0 0   90. 03   91. 00   09100   EMERGENCY   0 0 0 0 0 0   91. 00   91. 00			0	0	0	0	
88. 08     08808     BOWLING GREEN RHC     0     0     0     0     0     90. 00       90. 00     09000     CLINIC     0     0     0     0     0     90. 00       90. 01     09001     OUTPATIENT INFUSION     0     0     0     0     0     90. 01       90. 02     04950     ONCOLOGY     0     0     0     0     90. 02       90. 03     04951     HANNI BAL INFUSION     0     0     0     0     90. 03       91. 00     09100     EMERGENCY     0     0     0     0     91. 00			0	0	0	0	
90. 00   09000   CLINIC   0   0   0   0   90. 00   90. 01   90. 01   90. 01   90. 01   90. 02   04950   0NCOLOGY   0   0   0   0   0   90. 02   90. 03   04951   HANNI BAL I NFUSI ON   0   0   0   0   0   90. 03   91. 00   09100   EMERGENCY   0   0   0   0   0   91. 00   0   0   0   0   0   0   0   0   0				0	0	0	
90. 01   09001   0UTPATIENT INFUSION   0 0 0 0 90. 01   90. 02   90. 03   04951   HANNI BAL I NFUSION   0 0 0 0 90. 03   91. 00   09100   EMERGENCY   0 0 0 0 0 91. 00   0 0 0 91. 00   0 0 0 91. 00   0 0 0 0 0 91. 00   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0		0	
90. 02   04950   0NCOLOGY   0 0 0 0 0 90. 02   90. 03   04951   HANNI BAL   I NFUSI ON   0 0 0 0 0 91. 00   91. 00   09100   EMERGENCY   0 0 0 0 0 91. 00   91. 00			0	0	Ö	Ö	
91. 00   09100   EMERGENCY   0   0   0   91. 00			0	0	0	0	
			0	0	0	0	
72. 00  07200  003LN71110N DLD3 (NON-DI311NCT FART)			0	0	0	0	
	72. UU	10/200 ODSERVATION DEDS (NON-DISTINCT PART)	1	1	l		92.00

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 14-0015	Peri od: Worksheet B-1

Health Financial Systems	BLESSING H	OSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		eri od:	Worksheet B-1
				rom 10/01/2022	
			T	o 09/30/2023	Date/Time Prepared:
	5454455 55	D1011150 50	5454455 55	5454455 55	12/29/2023 3:54 pm
Cost Center Description	PARAMED ED	PARAMED ED	PARAMED ED	PARAMED ED	
	PRGM-RADI OLOGY				
	(400101150	Υ (1001 0115)	(ASSI GNED	RY	
	(ASSI GNED	(ASSI GNED	TIME)	(ASSI GNED	
	TIME)	TIME)	22.22	TIME)	
	23. 01	23. 02	23. 03	23. 04	
93. 99 O9399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0	0	0	93. 99
OTHER REIMBURSABLE COST CENTERS				T	
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE					113. 00
116. 00 11600 HOSPI CE	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 11	7) 100	100	100	100	118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	193. 00
193. 01 19301 DENMAN SERVICES	0	0	0	0	193. 01
193. 02 19302 UNUSED SPACE	o	0	0	o	193. 02
193. 03 19303 RENTED SPACE	o	0	0	o	193. 03
193. 04 19304 RETALL PHARMACLES	o	0	0	ol	193. 04
193. 05 19305 WELLNESS CENTER	ol	0	0	ol	193. 05
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers					201. 00
202.00 Cost to be allocated (per Wkst. B,	601, 180	220, 151	466, 953	231, 654	202. 00
Part I)	0017100	220/ 101	100,700	201,001	202.00
203.00 Unit cost multiplier (Wkst. B, Part	1) 6, 011. 800000	2, 201. 510000	4, 669. 530000	2, 316. 540000	203. 00
204.00 Cost to be allocated (per Wkst. B,	79, 551	26, 741			204.00
Part II)	,		,		
205.00 Unit cost multiplier (Wkst. B, Part	795. 510000	267. 410000	138. 380000	105. 710000	205. 00
11)					
206.00 NAHE adjustment amount to be allocat	ed l ol	0	l o	l	206. 00
(per Wkst. B-2)			]	]	
207.00 NAHE unit cost multiplier (Wkst. D,	0. 000000	0. 000000	0. 000000	0. 000000	207. 00
Parts III and IV)		2. 223000		1.113000	
1 1	ı	'	1	1	1

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od:	Worksheet C	Worksheet C	
					From 10/01/2022	Part I	
					To 09/30/2023	Date/Time Pre 12/29/2023 3:	parea: 54 nm
-			Title	XVIII	Hospi tal	PPS	оч рііі
			11 21 0	7,111	Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	<b>'</b>	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				.1		
30.00	03000 ADULTS & PEDI ATRI CS	103, 567, 514		103, 567, 51		103, 601, 378	
31.00	03100 I NTENSI VE CARE UNI T	13, 661, 550		13, 661, 55			
41.00	04100 SUBPROVI DER - I RF 04300 NURSERY	5, 619, 038 912, 544		5, 619, 03 912, 54		5, 633, 416 912, 544	
43. 00 44. 00	04400 SKILLED NURSING FACILITY	5, 698, 924		5, 698, 92		5, 698, 924	1
44.00	ANCI LLARY SERVI CE COST CENTERS	3, 070, 724		3, 070, 72	+j U	5, 070, 724	44.00
50. 00	05000 OPERATING ROOM	38, 510, 509		38, 510, 50	9 17, 160	38, 527, 669	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 187, 836		2, 187, 83		2, 187, 836	1
53. 00	05300 ANESTHESI OLOGY	1, 306, 970		1, 306, 97		1, 306, 970	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	13, 426, 772		13, 426, 77		13, 426, 772	1
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 828, 723		2, 828, 72		2, 828, 723	
57.00	05700 CT SCAN	2, 283, 415		2, 283, 41	5 0	2, 283, 415	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	983, 736		983, 73	6 0	983, 736	58. 00
60.00	06000 LABORATORY	20, 607, 250		20, 607, 25		20, 607, 250	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 856, 506		1, 856, 50		1, 856, 506	1
65.00	06500 RESPI RATORY THERAPY	4, 863, 529	0			4, 869, 086	1
66. 00	06600 PHYSI CAL THERAPY	2, 335, 121	0			2, 335, 121	
67.00	06700 OCCUPATI ONAL THERAPY	1, 469, 357	0			1, 469, 357	
68. 00	06800 SPEECH PATHOLOGY	367, 420	0			367, 420	
69. 00	06900 ELECTROCARDI OLOGY	6, 945, 853		6, 945, 85		6, 962, 234	1
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 112, 883 22, 542, 609		1, 112, 88		1, 117, 280	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	22, 542, 609		22, 542, 60 22, 022, 57		22, 542, 609 22, 022, 577	
73. 00	07300 DRUGS CHARGED TO PATIENTS	40, 176, 112		40, 176, 11		40, 176, 112	
	07400 RENAL DIALYSIS	1, 227, 249		1, 227, 24		1, 227, 249	
7 1. 00	OUTPATIENT SERVICE COST CENTERS	1,227,217		1,22,,21	71 01	1,221,217	7 1. 00
88. 00	08800 EAST ADAMS RHC	1, 108, 587		1, 108, 58	7 0	1, 108, 587	88. 00
88. 01	08801 48TH AND MAINE RHC	2, 976, 581		2, 976, 58			
88. 02	08802 MT STERLING RHC	721, 817		721, 81		721, 817	
88. 03	08803 MAIN CAMPUS RHC	21, 172, 824		21, 172, 82	4 0	21, 172, 824	88. 03
88. 04	08804 BLESSING EXPRESS CLINIC	2, 086, 142		2, 086, 14	2 0	2, 086, 142	88. 04
88. 05	08805 BLESSING WALK IN CLINIC	4, 325, 511		4, 325, 51	1 0	4, 325, 511	88. 05
88. 06	08806 HANNI BAL MAIN RHC	4, 791, 561		4, 791, 56		4, 791, 561	1
88. 07	08807 PALMYRA RHC	493, 054		493, 05		493, 054	1
88. 08	08808 BOWLING GREEN RHC	184, 996		184, 99		184, 996	1
90.00	09000 CLI NI C	16, 069, 600		16, 069, 60		16, 070, 000	1
90. 01	09001 OUTPATIENT INFUSION	932, 755		932, 75		932, 755	
90. 02	04950 ONCOLOGY	1, 171, 058		1, 171, 05		1, 171, 058	
90. 03	04951 HANNI BAL I NFUSI ON 09100 EMERGENCY	178, 016 15, 469, 499		178, 01 15, 469, 49		178, 016 15, 577, 316	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 383, 467		8, 383, 46		8, 383, 467	
	09399 PARTIAL HOSPITALIZATION PROGRAM	2, 004, 816		2, 004, 81			
75. 77	OTHER REIMBURSABLE COST CENTERS	2,004,010		2,004,01	<u> </u>	2,004,010	73. 77
101.00	10100 HOME HEALTH AGENCY	6, 213, 268		6, 213, 26	8	6, 213, 268	101. 00
101100	SPECIAL PURPOSE COST CENTERS	0/210/200		0,210,20		0,210,200	
113. 00	11300   I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	4, 652, 123		4, 652, 12	3	4, 652, 123	
200.00	Subtotal (see instructions)	409, 449, 672	0				
201.00	Less Observation Beds	8, 383, 467		8, 383, 46	7	8, 383, 467	201. 00
202.00	Total (see instructions)	401, 066, 205	0	401, 066, 20	5 223, 550	401, 289, 755	202. 00

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 10/01/2022 To 09/30/2023	Worksheet C Part I Date/Time Pre 12/29/2023 3:	pared: 54 pm
				XVIII	Hospi tal	PPS	
			Charges		_		
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6   + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	167, 219, 984		167, 219, 98	4		30. 00
31.00	03100 I NTENSI VE CARE UNI T	61, 804, 906		61, 804, 90	6		31.00
41.00	04100 SUBPROVI DER - I RF	9, 141, 477		9, 141, 47	7		41. 00
43.00	04300 NURSERY	4, 237, 406		4, 237, 40	6		43. 00
44.00	04400 SKILLED NURSING FACILITY	7, 497, 957		7, 497, 95	7		44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	64, 202, 145	128, 546, 973	192, 749, 11	8 0. 199796	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	11, 915, 687	389, 989	12, 305, 67	6 0. 177791	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	21, 215, 646	33, 840, 610	55, 056, 25	6 0. 023739	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	23, 248, 552	61, 132, 747	84, 381, 29	9 0. 159120	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	991, 175	18, 320, 843	19, 312, 01	0. 146475	0.000000	55. 00
57.00	05700 CT SCAN	59, 872, 257	85, 260, 553	145, 132, 81	0. 015733	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	11, 898, 058	8, 815, 002	20, 713, 06	0. 047494	0.000000	58. 00
60.00	06000 LABORATORY	110, 824, 607	134, 466, 651	245, 291, 25	0. 084011	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	7, 047, 823	3, 673, 948	10, 721, 77	0. 173153	0.000000	62. 00
65.00	06500 RESPIRATORY THERAPY	24, 296, 533	7, 182, 183			0.000000	1
66. 00	06600 PHYSI CAL THERAPY	5, 978, 783	466, 147			0.000000	
67. 00	06700 OCCUPATI ONAL THERAPY	5, 158, 018	448, 844			0. 000000	•
68. 00	06800 SPEECH PATHOLOGY	1, 622, 020	236, 562			0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY	57, 832, 932	71, 814, 124			0. 000000	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 004, 873	4, 003, 634			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	84, 612, 014	98, 234, 313			0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	49, 965, 542	94, 460, 571			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	161, 444, 252	267, 055, 760			0. 000000	1
74. 00	07400 RENAL DIALYSIS	2, 440, 193	0			0. 000000	1
7 1. 00	OUTPATIENT SERVICE COST CENTERS	2, 110, 170		2, 110, 17	0.002701	0.000000	7 1. 00
88. 00	08800 EAST ADAMS RHC	0	1, 098, 603	1, 098, 60	3		88. 00
88. 01	08801 48TH AND MAINE RHC	o	2, 550, 377				88. 01
88. 02	08802 MT STERLING RHC	ol	373, 097				88. 02
88. 03	08803 MAIN CAMPUS RHC	l ő	26, 551, 995				88. 03
88. 04	08804 BLESSING EXPRESS CLINIC	O	2, 473, 655				88. 04
88. 05	08805 BLESSING WALK IN CLINIC	l ő	4, 207, 125				88. 05
88. 06	08806 HANNI BAL MAIN RHC	o o	5, 640, 357				88. 06
88. 07	08807 PALMYRA RHC	l ől	403, 369				88. 07
88. 08	08808 BOWLING GREEN RHC	l ől	118, 368				88. 08
90.00	09000 CLINIC	61, 331	35, 358, 706			0. 000000	•
90. 01	09001 OUTPATIENT INFUSION	24, 397	2, 929, 746			0. 000000	1
90. 01	04950 ONCOLOGY	14, 763	3, 105, 215			0.000000	
90. 02	04951 HANNI BAL I NFUSI ON	14, 703	84, 833			0.000000	1
91. 00	09100 EMERGENCY	23, 410, 107	48, 828, 263				
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 577, 864	14, 095, 879			l e	
	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	1, 601	3, 255, 129				
73. 77	OTHER REIMBURSABLE COST CENTERS	1,001	3, 233, 129	3, 250, 75	0.013392	0.00000	73.77
101 00	10100 HOME HEALTH AGENCY	O	6, 553, 346	6, 553, 34	6		101. 00
101.00	SPECIAL PURPOSE COST CENTERS	l ol	0, 333, 340	0, 333, 34	טן		1101.00
113 00	11300   INTEREST EXPENSE						113. 00
	111600 HOSPI CE	423, 506	6, 192, 940	6, 616, 44	6		116. 00
200.00			1, 182, 170, 457				200. 00
200.00		702, 700, 409	1, 102, 170, 437	2, 100, 100, 00			200.00
201.00		982 986 400	1, 182, 170, 457	2 165 156 86	6		202.00
202.00	Total (See Histiactions)	702, 700, 407	1, 102, 170, 407	1 2, 100, 100, 00	<u>- ا</u>	I	1202.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES BLESSING HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 14-0015

Peri od: Worksheet C From 10/01/2022 Part I To 09/30/2023 Date/Ti me Prepared: 12/29/2023 3:54 pm

IMPATIENT ROUTINE SERVICE COST CENTERS   11.00					12/29/2023 3:54 pm
INPATIENT ROUTINE SERVICE COST CENTERS   11.00			Title XVIII	Hospi tal	PPS
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   300.00   300.01   301.00	Cost Center Description	PPS Inpatient			
INPATI ENT ROUTINE SERVICE COST CENTERS   30,00   310,0		Ratio			
30.00		11. 00			
31.00   03100   INTENSIVE CARE LINIT	INPATIENT ROUTINE SERVICE COST CENTERS				
11. 00   04100   SUBPROVIDER - I BF	30. 00   03000   ADULTS & PEDI ATRI CS				30.00
33. 00   04300   NURSERY	31.00 03100 INTENSIVE CARE UNIT				31.00
44. 00   04400   SKILLED NURSING FACILITY	41. 00   04100   SUBPROVI DER - 1 RF				41.00
MICH LLARY SERVICE COST CENTERS   50. 00   50. 00   50.00   0FEATIN ROOM   0.199885   50. 00   50.00   0FEATIN ROOM   0.177791   52. 00   50.00   50.00   0FEATIN ROOM   0.177791   52. 00   50.00   50.00   0FEATIN ROOM   0.177791   53. 00   50.00   50.00   0FEATIN ROOM   0.177791   53. 00   50.00   0FEATIN ROOM   0.1000   0.199825   50.00   50.00   0FEATIN ROOM   0.1000   0.199120   54. 00   55.00   0FEATIN ROOM   0.1000					43. 00
MICH LLARY SERVICE COST CENTERS   50. 00   50. 00   50.00   0FEATIN ROOM   0.199885   50. 00   50.00   0FEATIN ROOM   0.177791   52. 00   50.00   50.00   0FEATIN ROOM   0.177791   52. 00   50.00   50.00   0FEATIN ROOM   0.177791   53. 00   50.00   50.00   0FEATIN ROOM   0.177791   53. 00   50.00   0FEATIN ROOM   0.1000   0.199825   50.00   50.00   0FEATIN ROOM   0.1000   0.199120   54. 00   55.00   0FEATIN ROOM   0.1000	44.00 04400 SKILLED NURSING FACILITY				44.00
S2 00   05200   05200   05200   05200   05200   05200   05200   05300   05300   05300   05300   05300   05300   05300   05300   05300   0550		<u> </u>			
53.0   0.530   0.530   AIRSTHESI OLOGY   0.023739   53.0   0.0540   ADD   COCY-DIACNOSTI C   0.159120   55.0   0.0550   RADI DLOGY-THERAPEUTI C   0.146475   55.0   0.0570   CT SCAN   0.015733   57.00   57.0   0.0570   CT SCAN   0.015733   57.00   58.0   0.05800   MAGRETI C RESONANCE I MAGING (MRI)   0.047494   58.0   0.0500   MAGRETI C RESONANCE I MAGING (MRI)   0.047494   60.0   0.00   0.	50. 00 05000 OPERATI NG ROOM	0. 199885			50. 00
54.00   05400   RADI OLOCY-DI ACMOSTIC   0.159120   55.00   05500   RADI OLOCY-THERAPEUTIC   0.146475   55.50   05700   CT SCAN   0.07373   57.00   05700   CT SCAN   58.00   05800   MACHETIC RESONANCE I MAGI NG (MRI )   0.047494   58.60   06.00   0.0000   LABORATORY   0.084011   0.084011   0.09	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 177791			52. 00
54.00   05400   RADI OLOCY-DI ACMOSTIC   0.159120   55.00   05500   RADI OLOCY-THERAPEUTIC   0.146475   55.50   05700   CT SCAN   0.07373   57.00   05700   CT SCAN   58.00   05800   MACHETIC RESONANCE I MAGI NG (MRI )   0.047494   58.60   06.00   0.0000   LABORATORY   0.084011   0.084011   0.09	53. 00 05300 ANESTHESI OLOGY	0. 023739			53. 00
55. 00   05.00   RADIOLOGY-THERAPEUTIC   0.146475   55. 00	l	1			54.00
57. 00   05700   CT SCAN   57. 00   58. 00   05600   AGNETIC RESONANCE IMAGING (MRI )   0. 047494   6.0 00   0.0000   LABORATORY   0. 084011   0.0 00   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000   0.000000   0.0000000   0.00000000		1			
58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI )   0. 047494   0. 064001   0. 064001   0. 064000   0. 064000   LABORATORY   0. 084011   0. 084011   0. 06500   0. 06500   0. 06500   NESPI RATORY T HERAPY   0. 154679   0. 65. 00   0. 06500   RESPI RATORY T HERAPY   0. 362319   0. 06700   0. 0700   0. 0CUPATI ONAL THERAPY   0. 262064   0. 0700   0. 0700   0. 0CUPATI ONAL THERAPY   0. 262064   0. 0700	I I				
60.00   06000   LABIORATORY   0.084011   60.00   62.00   62.00   62.00   66.00		1			
62. 00   06200   MOLLE BLOOD & PACKED RED BLOOD CELLS   0. 173153   65. 00		1			<b>I</b>
65.00   06500   RSSPI RATORY THERAPY   0. 154679   66. 00		1			<b>I</b>
66. 00   06600   DRYSI CAL THERAPY   0. 362319   66. 00   06700   06700   06700   06700   06700   06700   06700   06700   06700   06800   SPEECH PATHOLOGY   0. 197688   68. 00   06900   06800   SPEECH PATHOLOGY   0. 053701   69. 00   07000   07000   ELECTROCARDI OLOGY   0. 053701   70. 00   70. 00   70. 00   07000   ELECTROCARDI OLOGY   0. 053701   70. 00   70. 00   70. 00   07100   ELECTROCARDI OLOGY   0. 233076   70. 00   70. 00   71. 00   07100   ELECTROCARDI OLOGRAPHY   0. 223076   71. 00   07100   ELECTROCARDI OLOGRAPHY   0. 123287   71. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 152483   72. 00   73. 00   07300   ROUGS CHARGED TO PATIENTS   0. 093760   73. 00   07300   ROUGS CHARGED TO PATIENTS   0. 093760   73. 00   074. 00   07400   ETAIL DIALYSIS   0. 502931   74. 00   0017PATIENT SERVICE COST CENTERS   88. 00   08800   EAST ADAMS RHC   88. 03   08801   48174 AND MAINE RHC   88. 01   08801   48184 AND MAINE RHC   88. 02   08802   MIT STERLING RHC   88. 03   08803   MIN TO AMPUS RHC   88. 03   08804   BLESSI NO EXPRESS CLINIC   88. 04   08804   BLESSI NO EXPRESS CLINIC   88. 05   08805   BLESSI NO EXPRESS CLINIC   88. 05   08805   BLESSI NO WALK IN CLINIC   88. 05   08806   BOWLIN ING GREEN RHC   88. 05   08808   BOWLIN ING GREEN RHC   88. 05   08808   BOWLIN ING GREEN RHC   89. 00   09000   0017PATIENT INFUSION   0. 315745   90. 01   09000   0017PATIENT INFUSION   0. 315745   90. 01   09000   0017PATIENT INFUSION   0. 315745   90. 01   09000   0017PATIENT INFUSION   0. 315745   90. 01   09000   0017PATIENT INFUSION   0. 315745   90. 01   09000   0017PATIENT INFUSION   0. 315745   90. 01   09000   0017PATIENT INFUSION   0. 315745   90. 01   09000   0017PATIENT INFUSION   0. 315745   90. 01   09000   0017PATIENT INFUSION   0. 315745   90. 01   09000   0017PATIENT INFUSION   0. 315745   90. 01   09000   0017PATIENT INFUSION   0. 315745   90. 01   09000   0017PATIENT INFUSION   0. 315745   90. 01   09000   0017PATIENT INFUSION   0. 315745   90. 01   09000   0017PATIENT INFUSION   0. 315745   90. 01					
67. 00 66700 DCCUIPATI ONAL THERAPY 0. 262064 68. 00 6800 SPEECH PATHOLOGY 0. 197688 68. 00 6800 SPEECH PATHOLOGY 0. 053701 69. 00 0700 DELECTROCARDI OLOGY 0. 053701 70. 00 07000 ELECTROCARDI OLOGY 0. 053701 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 123287 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 152483 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 152483 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 053701 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 093760 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 093760 74. 00 07400 RENAL DI ALYSIS 0. 502931 74. 00 07400 RENAL DI ALYSIS 0. 50	· · · · · · · · · · · · · · · · · · ·				
68. 00   06800   SPEECH PATHOLOCY   0. 197688   68. 00   06900   CLECTROCARDIOLOGY   0. 053701   0. 053701   0. 07000   CLECTROCARDIOLOGY   0. 053701   0. 07000   CLECTROENCEPHALOGRAPHY   0. 223076   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 123287   72. 00   72. 00   10PL DEV. CHARGED TO PATIENTS   0. 152483   72. 00   07300   DRUGS CHARGED TO PATIENTS   0. 093760   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 093760   73. 00   07400   RENAL DI ALYSIS   0. 502931   74. 00   07400   RENAL DI ALYSIS   0. 502931   74. 00   07400   RENAL DI ALYSIS   0. 502931   74. 00   07400   RENAL DI ALYSIS   0. 502931   74. 00   07400   RENAL DI ALYSIS   0. 502931   74. 00   07400   RENAL DI ALYSIS   0. 502931   74. 00   07400   RENAL DI ALYSIS   0. 502931   74. 00   07400   RENAL DI ALYSIS   0. 502931   74. 00   07400   RENAL DI ALYSIS   0. 502931   0. 50					
69.00   06900   ELECTROCARDI OLOGY   0.053701   70.00		1			ı
70. 00   07000   ELECTROENCEPHALOGRAPHY   0. 223076   71. 00   07100	· · · · · · · · · · · · · · · · · · ·				ı
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0. 123287   72. 00   772. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 152483   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 093760   74. 00   07400   RENAL DIALYSIS   0. 502931   74. 00   07400   RENAL DIALYSIS   0. 502931   74. 00   07400   RENAL DIALYSIS   88. 00   08800   EAST ADAMS RHC   88. 01   88.00   EAST ADAMS RHC   88. 01   88.00		1			ı
72. 00   07200   MPL DEV. CHARGED TO PATIENTS   0. 152.483   72. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   74. 0					
73. 00   07300   DRUGS CHARGED TO PATIENTS   0.093760   0.502931   74.00   07400   RENAL DIALYSIS   0.502931   74.00   07400   RENAL DIALYSIS   0.502931   74.00   07400   RENAL DIALYSIS   74.00   07400   RENAL DIALYSIS   74.00   07400   RENAL DIALYSIS   74.00   07400   RENAL DIALYSIS   74.00   07400   RENAL DIALYSIS   74.00   07400   RENAL DIALYSIS   74.00   07400   RENAL DIALYSIS   74.00   07400   RENAL DIALYSIS   74.00   07400   RENAL DIALYSIS   88.00   88.01   88.01   88.01   88.01   88.01   88.01   88.01   88.01   88.02   RENAL DIALYSIS   88.02   88.03   88.03   MAIN CAMPUS RHC   88.03   88.04   88.04   88.05					
74. 00   07400   RENAL DI ALYSIS   0.502931   74. 00   00TPATI ENT SERVICE COST CENTERS   88. 00   88. 01   88. 01   88. 01   88. 01   88. 01   88. 01   88. 01   88. 01   88. 01   88. 01   88. 01   88. 01   88. 01   88. 01   88. 01   88. 01   88. 01   88. 01   88. 01   88. 02   88. 03   88. 04   88. 04   88. 04   88. 05   88. 05   88. 06   88. 06   88. 06   88. 06   88. 06   88. 06   88. 07   88. 08   88.		1			ı
OUTPATI ENT SERVICE COST CENTERS   88. 00		1			ı
88. 00   08800   EAST ADAMS RHC   88. 00   88. 01   08801   48TH AND MAINE RHC   88. 01   08802   MSTERLING RHC   88. 02   08803   MAIN CAMPUS RHC   88. 03   08804   MSTERLING EXPRESS CLINIC   88. 04   08805   BLESSING EXPRESS CLINIC   88. 04   08806   BLESSING WALK IN CLINIC   88. 05   08806   HANNI BAL MAIN RHC   88. 06   08806   HANNI BAL MAIN RHC   88. 06   08807   PALMYRA RHC   88. 07   08807   PALMYRA RHC   88. 08   09000   CLINIC   0. 453698   09000   0179ATIENT INFUSION   0. 315745   090. 01   09001   0UTPATIENT INFUSION   0. 315745   090. 01   09001   0UTPATIENT INFUSION   0. 315745   090. 01   09001   0UTPATIENT INFUSION   0. 375342   090. 03   04951   HANNI BAL INFUSION   0. 275342   090. 03   04951   HANNI BAL INFUSION   0. 215638   091. 00   09100   EMERGENCY   0. 215638   091. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0. 474346   092. 00   09399   PARTIAL HOSPITALIZATION PROGRAM   0. 615592   07100   00100   HOME HEALTH AGENCY   0. 1300   00100   HOME HEALTH AGENCY   0. 1300   00100   HOME HEALTH AGENCY   0. 1300   00100   HOME HEALTH AGENCY   0. 1300   00100   HOME HEALTH AGENCY   0. 1300   00100   HOSPICE   00000   00000   00000   00000   000000		0. 502931			74.00
88. 01 08801 48TH AND MAINE RHC 88. 02 08802 MT STERLING RHC 88. 02 88. 03 08803 MAIN CAMPUS RHC 88. 03 88. 04 08804 BLESSING EXPRESS CLINIC 88. 04 88. 05 08805 BLESSING WALK IN CLINIC 88. 05 08805 BLESSING WALK IN CLINIC 88. 05 08806 HANNIBAL MAIN RHC 88. 06 08806 HANNIBAL MAIN RHC 88. 07 08807 PALMYRA RHC 88. 07 08807 PALMYRA RHC 88. 08 0808 BOWLING GREEN RHC 90. 00 09000 CLINIC 0.453698 90. 01 09001 UITPATI ENT INFUSION 0.315745 90. 01 09001 UITPATI ENT INFUSION 0.375342 90. 02 90. 03 04951 HANNIBAL INFUSION 2. 098429 90. 02 90. 03 04951 HANNIBAL INFUSION 2. 098429 90. 03 91. 00 09000 EMERGENCY 0. 215638 91. 00 09000 EMERGENCY 0. 215638 91. 00 09000 EMERGENCY 0. 215638 91. 00 09000 EMERGENCY 0. 215638 91. 00 09000 EMERGENCY 0. 215638 91. 00 09000 EMERGENCY 0. 215638 91. 00 09000 EMERGENCY 0. 215638 91. 00 09000 IMPORTING BEDS (NON-DISTINCT PART) 0. 474346 92. 00 09000 IM					00.00
88. 02 08802 MT STERLING RHC 88. 02 88. 03 08803 MAIN CAMPUS RHC 88. 04 88. 04 08804 BLESSING EXPRESS CLINIC 88. 05 88. 06 08805 BLESSING WALK IN CLINIC 88. 05 88. 07 08807 PALMYRA RHC 88. 06 88. 07 08807 PALMYRA RHC 88. 06 89. 00 09000 CLINIC 0. 453698 99. 00 90. 01 09001 0UTPATIENT INFUSION 0. 315745 99. 00 90. 02 04950 ONCOLOGY 0. 375342 99. 02 90. 03 04951 HANNI BAL INFUSION 2. 098429 99. 03 91. 00 09100 EMERGENCY 0. 215638 99. 03 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 474346 99. 09. 09399 PARTIAL HOSPITALIZATION PROGRAM 0. 615592 99. 07 101. 00 1000 INTEREST EXPENSE 113. 00 116. 00 11300 INTEREST EXPENSE 113. 00 200. 00 200. 00 Subtractions Beds 201. 00 201. 00 Less Observation Beds 201. 00					
88. 03					<b>I</b>
88. 04					<b>I</b>
88. 05					
88. 06					
88. 07					
88. 08 0808 BOWLING GREEN RHC					
90. 00   09000   CLINI C   0. 453698   90. 00   90. 01   09001   0UTPATI ENT INFUSION   0. 315745   90. 01   90. 02   04950   ONCOLOGY   0. 375342   90. 02   90. 03   04951   HANNI BAL INFUSION   2. 098429   90. 03   91. 00   09100   EMERGENCY   0. 215638   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0. 474346   92. 00   93. 99   OTHER REIMBURSABLE COST CENTERS   101. 00   10100   HOME   HEALTH   AGENCY   90. 03   90. 0					
90. 01	l				
90. 02 04950 0NCOLOGY 0. 375342 90. 02 90. 03 04951 HANNI BAL I NFUSI ON 2. 098429 90. 03 91. 00 09100 EMERGENCY 0. 215638 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0. 474346 92. 00 93. 99 OTHER REI MBURSABLE COST CENTERS  101. 00 10100 HOME HEALTH AGENCY 90. 01 101. 00 10100 I NTEREST EXPENSE 113. 00 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00	I I	1			
90. 03	l				
91. 00					
92. 00		1			
93. 99   OTHER REIMBURSABLE COST CENTERS   93. 99   OTHER REIMBURSABLE COST CENTERS   101. 00   10100   HOME   HEALTH   AGENCY   101. 00   SPECIAL   PURPOSE   COST   CENTERS   113. 00   11300   INTEREST   EXPENSE   116. 00   116.00   HOSPI   CE   116. 00   200. 00   Subtotal   (see instructions)   200. 00   201. 00   Less Observation   Beds   201. 00		1			<b>I</b>
OTHER REI MBURSABLE COST CENTERS  101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS  113.00 11300 INTEREST EXPENSE 116.00 11600 HOSPI CE 200.00 Subtotal (see instructions) Less Observation Beds  113.00 11600 COST CENTERS 200.00 Subtotal (see instructions) 200.00 COST CENTERS 200.00 Subtotal (see instructions) 200.00 COST CENTERS 200.					
101. 00   10100   HOME HEALTH AGENCY   101. 00   SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   116. 00   11600   HOSPI CE   116. 00   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00		0. 615592			93. 99
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   116.00   11600   HOSPI CE   116.00   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00		,			
113. 00   113. 00   113. 00   116. 00   116. 00   200. 00   201. 00   Less Observation Beds   113. 00   113. 00   113. 00   113. 00   114. 00   115. 00   116. 00   116. 00   116. 00   116. 00   116. 00   117. 00   118. 00   119. 00   11					101. 00
116. 00       116.00         200. 00       Subtotal (see instructions)         201. 00       Less Observation Beds         116. 00         200. 00         201. 00					
200. 00       Subtotal (see instructions)       200. 00         201. 00       Less Observation Beds       201. 00					
201.00 Less Observation Beds 201.00					
202.00   Total (see instructions)	+ I				
	202.00   Total (see instructions)				202. 00

COMPU	TATION OF RATIO OF COSTS TO CHARGES		Provider Co	CN: 14-0015	Peri od:	Worksheet C	
					From 10/01/2022 To 09/30/2023	Part     Date/Time Pre	narod:
					10 09/30/2023	12/29/2023 3:	54 pm
			Titl	e XIX	Hospi tal	Cost	
	·				Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	0.00	2.00	4.00	F 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1. 00	2. 00	3.00	4. 00	5. 00	
30. 00	03000 ADULTS & PEDIATRICS	103, 567, 514		103, 567, 51	4 33, 864	103, 601, 378	30.00
31. 00	03100 I NTENSI VE CARE UNI T	13, 661, 550		13, 661, 55		13, 685, 146	
41. 00	04100 SUBPROVI DER - I RF	5, 619, 038		5, 619, 03		5, 633, 416	
43. 00	04300 NURSERY	912, 544		912, 54		912, 544	
44. 00	04400 SKILLED NURSING FACILITY	5, 698, 924		5, 698, 92		5, 698, 924	
	ANCILLARY SERVICE COST CENTERS	27 2 . 27 . 2 .			-	97 9 1 9 1 9 1	1
50.00	05000 OPERATING ROOM	38, 510, 509		38, 510, 50	9 17, 160	38, 527, 669	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 187, 836		2, 187, 83	6 0	2, 187, 836	52.00
53.00	05300 ANESTHESI OLOGY	1, 306, 970		1, 306, 97		1, 306, 970	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	13, 426, 772		13, 426, 77		13, 426, 772	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 828, 723		2, 828, 72		2, 828, 723	
57. 00	05700 CT SCAN	2, 283, 415		2, 283, 41		2, 283, 415	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	983, 736		983, 73		983, 736	1
60.00	06000 LABORATORY	20, 607, 250		20, 607, 25		20, 607, 250	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 856, 506		1, 856, 50		1, 856, 506	
65. 00	06500 RESPI RATORY THERAPY	4, 863, 529	0	.,	· ·	4, 869, 086	
66.00	06600 PHYSI CAL THERAPY	2, 335, 121	0	,		2, 335, 121	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1, 469, 357 367, 420	0	1, 469, 35 367, 42		1, 469, 357 367, 420	
69. 00	06900 ELECTROCARDI OLOGY	6, 945, 853	U	6, 945, 85		6, 962, 234	
70.00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	1, 112, 883		1, 112, 88		1, 117, 280	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 542, 609		22, 542, 60	·	22, 542, 609	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	22, 022, 577		22, 022, 57		22, 022, 577	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	40, 176, 112		40, 176, 11		40, 176, 112	
74.00	07400 RENAL DIALYSIS	1, 227, 249		1, 227, 24			
	OUTPATIENT SERVICE COST CENTERS	<u> </u>				· · ·	1
88. 00	08800 EAST ADAMS RHC	1, 108, 587		1, 108, 58	7 0	1, 108, 587	88. 00
88. 01	08801 48TH AND MAINE RHC	2, 976, 581		2, 976, 58	1 0	2, 976, 581	88. 01
88. 02	08802 MT STERLING RHC	721, 817		721, 81	7 0	721, 817	88. 02
88. 03	08803 MAIN CAMPUS RHC	21, 172, 824		21, 172, 82		21, 172, 824	
88. 04	08804 BLESSING EXPRESS CLINIC	2, 086, 142		2, 086, 14		2, 086, 142	
88. 05	08805 BLESSING WALK IN CLINIC	4, 325, 511		4, 325, 51		4, 325, 511	
88. 06	08806 HANNI BAL MAIN RHC	4, 791, 561		4, 791, 56		4, 791, 561	
88. 07	08807 PALMYRA RHC	493, 054		493, 05		493, 054	
88. 08 90. 00	08808 BOWLING GREEN RHC	184, 996		184, 99 16, 069, 60		184, 996	
90.00	09000   CLINIC   09001   OUTPATIENT INFUSION	16, 069, 600 932, 755		932, 75		16, 070, 000 932, 755	
90. 01	04950 ONCOLOGY	1, 171, 058		1, 171, 05		1, 171, 058	1
90. 02	04951 HANNI BAL I NFUSI ON	171,038		171,03		171, 038	1
	09100 EMERGENCY	15, 469, 499		15, 469, 49			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 383, 467		8, 383, 46		8, 383, 467	
	09399 PARTIAL HOSPITALIZATION PROGRAM	2, 004, 816		2, 004, 81			
	OTHER REIMBURSABLE COST CENTERS	, , , , , , ,		, , , , ,		, , , , , , ,	
101.00	10100 HOME HEALTH AGENCY	6, 213, 268		6, 213, 26	8	6, 213, 268	101. 00
	SPECIAL PURPOSE COST CENTERS			•			
113.00	11300 INTEREST EXPENSE						113. 00
	11600 H0SPI CE	4, 652, 123		4, 652, 12		4, 652, 123	
200.00		409, 449, 672	0			409, 673, 222	
201.00		8, 383, 467		8, 383, 46		8, 383, 467	
202.00	Total (see instructions)	401, 066, 205	0	401, 066, 20	5 223, 550	401, 289, 755	J202. 00

	ATION OF RATIO OF COSTS TO CHARGES	BEESSI NO 1	Provider CO	-	Period: From 10/01/2022 Fo 09/30/2023	Date/Time Pre 12/29/2023 3:	pared:
				e XIX	Hospi tal	Cost	
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	167, 219, 984		167, 219, 98	4		30.00
31.00	03100 INTENSIVE CARE UNIT	61, 804, 906		61, 804, 906	5		31. 00
41.00	04100 SUBPROVI DER - I RF	9, 141, 477		9, 141, 47	7		41.00
43.00	04300 NURSERY	4, 237, 406		4, 237, 400	5		43.00
44.00	04400 SKILLED NURSING FACILITY	7, 497, 957		7, 497, 95			44.00
	ANCILLARY SERVICE COST CENTERS					<u>'</u>	1
50.00	05000 OPERATI NG ROOM	64, 202, 145	128, 546, 973	192, 749, 118	0. 199796	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	11, 915, 687	389, 989				1
53. 00	05300 ANESTHESI OLOGY	21, 215, 646					
54. 00	05400 RADI OLOGY-DI AGNOSTI C	23, 248, 552	61, 132, 747				
55. 00	05500 RADI OLOGY-THERAPEUTI C	991, 175	18, 320, 843				
57. 00	05700 CT SCAN	59, 872, 257	85, 260, 553				
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	11, 898, 058	8, 815, 002				
60.00	06000 LABORATORY	110, 824, 607				0.000000	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		134, 466, 651				1
65. 00		7, 047, 823					1
	06500 RESPI RATORY THERAPY	24, 296, 533					
66.00	06600 PHYSI CAL THERAPY	5, 978, 783	466, 147				
67. 00	06700 OCCUPATI ONAL THERAPY	5, 158, 018	448, 844				
68. 00	06800 SPEECH PATHOLOGY	1, 622, 020	236, 562				
69. 00	06900 ELECTROCARDI OLOGY	57, 832, 932	71, 814, 124				
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 004, 873	4, 003, 634				
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	84, 612, 014	98, 234, 313			0. 000000	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	49, 965, 542	94, 460, 571				1
73.00	07300 DRUGS CHARGED TO PATIENTS	161, 444, 252					
74. 00	07400 RENAL DI ALYSI S	2, 440, 193	0	2, 440, 193	0. 502931	0. 000000	74. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 EAST ADAMS RHC	0	1, 098, 603				
88. 01	08801 48TH AND MAINE RHC	0	2, 550, 377				
88. 02	08802 MT STERLING RHC	0	373, 097				
88. 03	08803 MAIN CAMPUS RHC	0	26, 551, 995	26, 551, 99!			
88. 04	08804 BLESSING EXPRESS CLINIC	0	2, 473, 655	2, 473, 65			
88. 05	08805  BLESSING WALK IN CLINIC	0	4, 207, 125	4, 207, 12	1. 028139	0.000000	
88. 06	08806 HANNI BAL MAIN RHC	0	5, 640, 357	5, 640, 35	0. 849514	0.000000	88. 06
88. 07	08807  PALMYRA RHC	0	403, 369	403, 369	9 1. 222340	0.000000	88. 07
88. 08	08808 BOWLI NG GREEN RHC	0	118, 368	118, 368	1. 562889	0.000000	88. 08
90.00	09000  CLI NI C	61, 331	35, 358, 706		7 0. 453687	0.000000	90.00
90. 01	09001 OUTPATIENT INFUSION	24, 397	2, 929, 746	2, 954, 143	0. 315745	0.000000	90. 01
90. 02	04950 ONCOLOGY	14, 763	3, 105, 215			0.000000	90. 02
90. 03	04951 HANNI BAL I NFUSI ON	o	84, 833			0.000000	90. 03
91.00	09100 EMERGENCY	23, 410, 107	48, 828, 263	72, 238, 370	0. 214145	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 577, 864					
	09399 PARTIAL HOSPITALIZATION PROGRAM	1, 601	3, 255, 129				1
	OTHER REIMBURSABLE COST CENTERS	, 1					
101.00	10100 HOME HEALTH AGENCY	0	6, 553, 346	6, 553, 340	5		101. 00
101100	SPECIAL PURPOSE COST CENTERS	٩,	0,000,010	0,000,01	~		1.000
113 00	11300   I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	423, 506	6, 192, 940	6, 616, 446	5		116. 00
200.00			1, 182, 170, 457				200.00
201.00	, ,	, , , , , , , , , , , , , , , ,	, ,	,,,			201. 00
202.00		982, 986, 409	1, 182, 170, 457	2, 165, 156, 866	5		202. 00
50	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		, ,	, , , , , , , , , , , , , , , , , , , ,	- (	ı	

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES BLESSING HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 14-0015

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

				10 077 007 2020	12/29/2023 3:	54 pm
			Title XIX	Hospi tal	Cost	•
Cost Cent	er Description	PPS Inpatient		<u> </u>		
	•	Ratio				
		11. 00				
I NPATI ENT ROUTI	NE SERVICE COST CENTERS					
30. 00 03000 ADULTS &	PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE						31.00
41. 00 04100 SUBPROVI D						41.00
43. 00 04300 NURSERY						43.00
44. 00   04400   SKI LLED N	URSING FACILITY					44. 00
	CE COST CENTERS					1 00
50. 00 05000 OPERATI NG		0. 000000				50.00
	ROOM & LABOR ROOM	0. 000000				52. 00
53. 00   05300 ANESTHESI		0. 000000				53.00
54. 00   05400 RADI OLOGY		0. 000000				54.00
55. 00   05500 RADI OLOGY		0. 000000				55.00
57. 00   05700 CT SCAN	- ITIERAL EUTIC	0. 000000				57.00
	RESONANCE IMAGING (MRI)	0. 000000				58.00
60. 00   06000 LABORATOR		0. 000000				60.00
	OD & PACKED RED BLOOD CELLS	0. 000000				62.00
65. 00   06500   RESPI RATO		0. 000000				65.00
		1				
66. 00   06600 PHYSI CAL		0.000000				66.00
67. 00 06700 0CCUPATI 0		0.000000				67. 00
68. 00 06800 SPEECH PA		0.000000				68. 00
69. 00 06900 ELECTROCA		0. 000000				69. 00
70. 00   07000   ELECTROEN		0. 000000				70.00
	UPPLIES CHARGED TO PATIENTS	0. 000000				71.00
	. CHARGED TO PATIENTS	0. 000000				72. 00
	RGED TO PATIENTS	0. 000000				73. 00
74. 00 07400 RENAL DIA		0. 000000				74. 00
	ICE COST CENTERS					
88. 00   08800   EAST   ADAM		0. 000000				88. 00
88. 01   08801   48TH   AND		0. 000000				88. 01
88. 02   08802 MT STERLI		0. 000000				88. 02
88. 03   08803   MAIN CAMP		0. 000000				88. 03
88. 04   08804   BLESSI NG		0. 000000				88. 04
88. 05   08805   BLESSI NG		0. 000000				88. 05
88. 06   08806   HANNI BAL		0. 000000				88. 06
88. 07   08807   PALMYRA R		0. 000000				88. 07
88. 08   08808   BOWLI NG G	REEN RHC	0. 000000				88. 08
90. 00  09000  CLI NI C		0. 000000				90. 00
90. 01  09001   OUTPATI EN	T INFUSION	0. 000000				90. 01
90. 02  04950  ONCOLOGY		0. 000000				90. 02
90. 03  04951 HANNI BAL	I NFUSI ON	0. 000000				90. 03
91. 00   09100   EMERGENCY		0. 000000				91.00
92. 00   09200   0BSERVATI	ON BEDS (NON-DISTINCT PART)	0. 000000				92.00
	OSPITALIZATION PROGRAM	0. 000000				93. 99
	BLE COST CENTERS					
101.00 10100 HOME HEAL	TH AGENCY					101. 00
SPECIAL PURPOSE						
113. 00 11300 I NTEREST	EXPENSE					113. 00
116. 00 11600 HOSPI CE						116. 00
200. 00 Subtotal	(see instructions)					200. 00
201.00 Less Obse	rvation Beds					201. 00
202.00 Total (se	e instructions)					202. 00

Health Financial Systems	BLESSI NG I	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der (	CCN: 14-0015	Peri od: From 10/01/2022 To 09/30/2023		pared: 54 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cos			
	Part II, col.		(col . 1 - co	١.		
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	7, 752, 585		0 7, 752, 5			
31.00 INTENSIVE CARE UNIT	979, 780		979, 7	5, 809	168. 67	31.00
41. 00   SUBPROVI DER - I RF	421, 357		0 421, 3			41.00
43. 00 NURSERY	103, 931		103, 9	31 2, 065	50. 33	43.00
44.00 SKILLED NURSING FACILITY	534, 455		534, 4	55 4, 765	112. 16	44. 00
200.00 Total (lines 30 through 199)	9, 792, 108		9, 792, 1	08 80, 887		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				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	20, 926		•			30. 00
31.00 INTENSIVE CARE UNIT	2, 139					31. 00
41. 00   SUBPROVI DER - I RF	2, 790	1	•			41. 00
43. 00 NURSERY	0		0			43. 00
44.00 SKILLED NURSING FACILITY	3, 297		•			44.00
200.00 Total (lines 30 through 199)	29, 152	3, 534, 53	7			200. 00

Health Financial Systems	BLESSI NG 1	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 14-0015	Peri od: From 10/01/2022 To 09/30/2023	Worksheet D Part II Date/Time Pre 12/29/2023 3:	pared: 54 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	Ŭ	Í	
	26)	,	,			
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	6, 670, 078			24, 881, 630	861, 029	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	143, 334	12, 305, 676	0. 01164	.8	0	52.00
53. 00 05300 ANESTHESI OLOGY	272, 910	55, 056, 256	0.00495	7 8, 045, 492	39, 882	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 249, 886	84, 381, 299	0. 01481	9, 617, 041	142, 448	54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C	443, 650	19, 312, 018	0. 02297	3 471, 510	10, 832	55. 00
57. 00  05700 CT SCAN	484, 305	145, 132, 810	0.00333	7 24, 599, 417	82, 088	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	204, 606	20, 713, 060	0. 00987	8 4, 807, 449	47, 488	58. 00
60. 00   06000   LABORATORY	1, 425, 292	245, 291, 258	0. 00581	1 43, 225, 411	251, 183	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	67, 899	10, 721, 771	0.00633	3 2, 655, 676	16, 818	62.00
65. 00 06500 RESPIRATORY THERAPY	502, 309	31, 478, 716	0. 01595	7 10, 082, 957	160, 894	65. 00
66. 00   06600 PHYSI CAL THERAPY	133, 998				30, 435	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	72, 356				13, 149	67.00
68.00 06800 SPEECH PATHOLOGY	23, 361				6, 402	68. 00
69. 00 06900 ELECTROCARDI OLOGY	834, 251				145, 035	•
70. 00 07000 ELECTROENCEPHALOGRAPHY	135, 627				11, 295	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	836, 999				141, 022	•
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	853, 072				152, 005	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 872, 358				259, 736	1
74. 00 07400 RENAL DIALYSIS	32,077				14, 117	74. 00
OUTPATIENT SERVICE COST CENTERS	02/0//	2/ 1.0/ 1.70	0.0.0.	1,0,0,,12	,	,
88. 00 08800 EAST ADAMS RHC	81, 328	1, 098, 603	0. 07402	9 0	0	88. 00
88. 01   08801   48TH   AND   MAI NE   RHC	208, 039				Ö	88. 01
88. 02   08802 MT STERLING RHC	136, 479				ő	88. 02
88. 03   08803   MAI N CAMPUS RHC	1, 299, 822		1		Ö	88. 03
88. 04 08804 BLESSING EXPRESS CLINIC	259, 043		1	1	ő	88. 04
88. 05 08805 BLESSING WALK IN CLINIC	210, 273		1		Ö	88. 05
88. 06   08806   HANNI BAL   MAI N   RHC	258, 812		•		0	88. 06
88. 07   08807   PALMYRA RHC	71, 971				0	88. 07
88. 08   08808   BOWLING GREEN RHC	21, 699		•		0	88. 08
90. 00   09000   CLI NI C	1, 518, 302		l .		1, 256	
90. 01   09001   0UTPATI ENT   INFUSI ON	94, 300				338	90.00
90. 02   04950  ONCOLOGY	74, 223				234	90.01
90. 03   04951   HANNI BAL   I NFUSI ON	38, 140				234	90.02
91. 00   09100   EMERGENCY	1, 026, 490				121, 933	
						1
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART) 93.99   09399   PARTIAL HOSPITALIZATION PROGRAM	627, 343				34, 020 0	92. 00 93. 99
	149, 237	3, 256, 730 1, 902, 085, 344		280, 970, 653	-	
200.00   Total (lines 50 through 199)	22, 333, 809	1, 902, 000, 344	I	200, 910, 003	2, 343, 039	<sub>1</sub> 200.00

Health Financial Systems	BLESSI NG 1	INT ID201		In lie	eu of Form CMS-	2552_10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA				Period: From 10/01/2022 To 09/30/2023	Worksheet D Part III	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdow Adjustments	h Allied Health Cost	All Other Medical Education Cost	
INPATIENT ROUTINE SERVICE COST CENTERS	1A	1.00	2A	2.00	3. 00	
30.00   03000   ADULTS & PEDIATRICS   31.00   03100   INTENSIVE CARE UNIT   41.00   04100   SUBPROVIDER - IRF   43.00   04300   NURSERY   44.00   04400   SKI LLED NURSING FACILITY   200.00   Total (Lines 30 through 199)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4, 122, 537 291, 173 51, 180 84, 378 26, 051 4, 575, 319		0 0 0 0 0 0 0 0 0 0 0 0	0 0	31. 00 41. 00
Cost Center Description		Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	200.00
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   03000   ADULTS & PEDIATRICS   31.00   03100   INTENSIVE CARE UNIT   41.00   04100   SUBPROVIDER - IRF   43.00   04300   NURSERY   44.00   04400   SKILLED   NURSING FACILITY   200.00   Total (lines 30 through 199)	0	4, 122, 537 291, 173 51, 180 84, 378 26, 051 4, 575, 319	5, 80 4, 63 2, 06 4, 76	50. 12 30 11. 05 55 40. 86 55 5. 47	2, 139 2, 790 0 3, 297	31. 00 41. 00 43. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	., 5.5, 617	33,00		27,102	
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   03000   ADULTS & PEDIATRICS   31.00   03100   INTENSIVE CARE UNIT   41.00   04100   SUBPROVIDER - IRF   43.00   04300   NURSERY   44.00   04400   SKILLED NURSING FACILITY   200.00   Total (lines 30 through 199)	1, 356, 005 107, 207 30, 830 0 18, 035 1, 512, 077					30. 00 31. 00 41. 00 43. 00 44. 00 200. 00

Health Financial Systems	BLESSING HOS	PITAL	In Lie	u of Form CMS-2552-10
ADDODEL ONMENT OF LADATIENT (OUTDATIENT	ANGLILADY CEDVICE OTHER DACC	D: -I CCN 14 0015	D!!	Wasaliaka a + D

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Period: From 10/01/2022 To 09/30/2023 | Period: Part IV Date/Time Prepared: 12/29/2023 3:54 pm

					0 09/30/2023	Date/Time Pre 12/29/2023 3:	pared: 54 nm
			Ti tl e	xVIII	Hospi tal	PPS	0 1 piii
	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 OPERATI NG ROOM	0	0	,		0	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	246, 910	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	Ü		0	0	53. 00
54.00	05400 RADI OLOGY -DI AGNOSTI C	0	Ü		0	601, 180	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	Ü			0	55. 00
57. 00	05700 CT SCAN	0	U			0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	58. 00
60. 00 62. 00	06000  LABORATORY  06200  WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			220, 151 0	60. 00 62. 00
65. 00	06500 RESPIRATORY THERAPY		0			231, 654	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0			231,034	66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0	0			0	67. 00
68. 00	06800 SPEECH PATHOLOGY		0			0	68. 00
69. 00	06900 ELECTROCARDI OLOGY		0	47, 030		0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY		0	47,030		0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0			Ö	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0			0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0		0	466, 953	73. 00
74. 00	07400 RENAL DIALYSIS		Ö	1		0	74. 00
, 00	OUTPATIENT SERVICE COST CENTERS	٥,					7 11 00
88. 00	08800 EAST ADAMS RHC	0	C	C	0	0	88. 00
88. 01	08801 48TH AND MAINE RHC	o	0	l c	0	0	88. 01
88. 02	08802 MT STERLING RHC	o	0	ol c	0	0	88. 02
88. 03	08803 MAIN CAMPUS RHC	o	0	) c	0	0	88. 03
88. 04	08804 BLESSING EXPRESS CLINIC	0	0	C	0	0	88. 04
88. 05	08805 BLESSING WALK IN CLINIC	0	0	43, 342	0	0	88. 05
88. 06	08806 HANNI BAL MAIN RHC	0	0	) c	0	0	88. 06
88. 07	08807 PALMYRA RHC	0	0	) C	0	0	88. 07
88. 08	08808 BOWLI NG GREEN RHC	0	0	) C	0	0	88. 08
90. 00	09000  CLI NI C	0	0	58, 327		0	90. 00
90. 01	09001 OUTPATIENT INFUSION	0	0	44, 264	0	0	90. 01
90. 02	04950 ONCOLOGY	0	0	<u> </u>	0	0	90. 02
90. 03	04951 HANNI BAL I NFUSI ON	0	0	0.40 0.00	0	0	90. 03
91.00	09100 EMERGENCY	0	O	240, 224		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		333, 595		0	92.00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0			1 510 029	93. 99
200.00	Total (lines 50 through 199)	ı U	0	1, 286, 422	2 0	1, 519, 938	<sub>1</sub> 200.00

Health Financial Systems	BLESSI NG HOSI	PITAL		In Lieu of Form CMS-2552-10
ADDODEL ONMENT OF LANDATI ENT COUTDATI ENT	T ANCILL ADV CEDVICE OTHER DACC	D	D!I	Mandada D

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-0015 From 10/01/2022 To 09/30/2023 Part IV THROUGH COSTS Date/Time Prepared: 12/29/2023 3:54 pm Title XVIII Hospi tal Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (from Wkst. C, (sum of cols Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. l(col. 5 ÷ col 4) col s. 2, 3, 8) 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 262, 356 262, 356 192, 749, 118 0.001361 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 246, 910 246, 910 12, 305, 676 0.020065 52.00 52.00 05300 ANESTHESI OLOGY 0 0 0 55, 056, 256 0.000000 53.00 53.00 84, 381, 299 05400 RADI OLOGY-DI AGNOSTI C 601, 180 601, 180 0 007125 54 00 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C C C 19, 312, 018 0.000000 55.00 57.00 05700 CT SCAN 145, 132, 810 0.000000 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 20, 713, 060 0.000000 58 00 0 58 00 60.00 06000 LABORATORY 220, 151 220, 151 245, 291, 258 0.000898 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 10, 721, 771 0.000000 62.00 65.00 06500 RESPIRATORY THERAPY 00000000 231, 654 231, 654 31, 478, 716 0.007359 65.00 06600 PHYSICAL THERAPY 6, 444, 930 0.000000 66 00 66 00 C 67.00 06700 OCCUPATI ONAL THERAPY 0 5, 606, 862 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 1, 858, 582 68.00 06900 ELECTROCARDI OLOGY 47,030 129, 647, 056 69.00 47.030 0.000363 69.00 5, 008, 507 70 00 07000 ELECTROENCEPHALOGRAPHY C 0 0.000000 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS C 0 182, 846, 327 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 144, 426, 113 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0 466, 953 466, 953 428, 500, 012 0.001090 73.00 73.00 07400 RENAL DIALYSIS 0 74.00 0 2, 440, 193 0.000000 74.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 EAST ADAMS RHC 1, 098, 603 0.000000 88.00 0 08801 48TH AND MAINE RHC 2, 550, 377 88.01 0 0.000000 88.01 0 08802 MT STERLING RHC 0 88.02 C 373, 097 0.000000 88 02 08803 MAIN CAMPUS RHC 0 26, 551, 995 0.000000 88.03 88.03 0000000000000 0 08804 BLESSING EXPRESS CLINIC 2, 473, 655 0.000000 88.04 88.04 88.05 08805 BLESSING WALK IN CLINIC 4, 207, 125 0.010302 88.05 43, 342 43, 342 88.06 08806 HANNI BAL MAIN RHC C 5, 640, 357 0.000000 88.06 08807 PALMYRA RHC 0.000000 88.07 403, 369 88.07 88. 08 08808 BOWLING GREEN RHC 0 118, 368 0.000000 88.08 09000 CLINIC 58, 327 90 00 58, 327 35, 420, 037 0.001647 90 00 90.01 09001 OUTPATIENT INFUSION 44, 264 44, 264 2, 954, 143 0.014984 90.01 90. 02 04950 ONCOLOGY 0 3, 119, 978 0.000000 90.02 04951 HANNIBAL INFUSION 84, 833 0.000000 90.03 90.03 0 91.00 09100 EMERGENCY 240, 224 240, 224 72, 238, 370 0.00332591.00

333, 595

2, 806, 360

10.374

333, 595

10.374

2, 806, 360 1, 902, 085, 344

17, 673, 743

3, 256, 730

92.00

93.99

200.00

0.018875

0.003185

92.00

200.00

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-10
ADDODTI ONMENT OF INDATIENT/OUTDATIENT	ANCILLARY SERVICE OTHER DASS   Provider CCN: 14 0015	Pariod: Warkshoot D

Peri od: From 10/01/2022 To 09/30/2023 Part IV THROUGH COSTS Date/Time Prepared: 12/29/2023 3:54 pm Title XVIII Hospi tal Cost Center Description Outpati ent Inpatient Inpati ent Outpati ent Outpati ent Program Ratio of Cost Program Program Program to Charges Pass-Through Pass-Through Charges Charges  $(col. 6 \div col$ Costs (col. 8 Costs (col. x col. 10) x col. 12) 7) 11.00 9.00 10.00 12.00 13.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.001361 46. 471 50.00 24, 881, 630 33, 864 34, 144, 602 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.020065 0 52.00 05300 ANESTHESI OLOGY 0.000000 8, 045, 492 8, 816, 943 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.007125 9, 617, 041 14, 322, 145 54.00 68.521 102.045 54.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 471, 510 9, 599, 573 55.00 Λ 55.00 57.00 05700 CT SCAN 0.000000 24, 599, 417 0 19, 042, 236 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 4, 807, 449 1, 951, 722 0 58.00 43, 225, 411 0.000898 10. 943. 239 60 00 06000 LABORATORY 38, 816 9 827 60 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0.000000 2, 655, 676  $\cap$ 1, 183, 203 Ω 62.00 65.00 06500 RESPIRATORY THERAPY 0.007359 10, 082, 957 74, 200 2, 225, 881 16, 380 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 1, 463, 852 17,825 0 66.00 0 06700 OCCUPATIONAL THERAPY 1, 018, 878 12, 407 67 00 0.000000 O 67 00 0 68.00 06800 SPEECH PATHOLOGY 0.000000 509, 358 0 6, 620 0 68.00 06900 ELECTROCARDI OLOGY 69.00 0.000363 22, 538, 530 8, 181 26, 864, 172 9, 752 69.00 07000 ELECTROENCEPHALOGRAPHY 417, 125 70 00 0.000000 755 526 70 00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 30, 804, 380 0 31, 131, 065 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 25, 733, 011 0 32, 433, 098 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.001090 59, 436, 071 64, 785 76, 794, 287 83, 706 73.00 07400 RENAL DIALYSIS 74.00 0.000000 1, 073, 942 74.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 EAST ADAMS RHC 0.000000 0 88.00 88. 01 08801 48TH AND MAINE RHC 0.000000 0 0 0 0 88.01 08802 MT STERLING RHC 0.000000 0 88 02 88 02 0 0 88. 03 08803 MAIN CAMPUS RHC 0.000000 0 88.03 08804 BLESSING EXPRESS CLINIC 0.000000 0 0 88.04 88.04 0 0 08805 BLESSING WALK IN CLINIC 88.05 0.010302 0 0 0 88.05 0 08806 HANNI BAL MAIN RHC 0.000000 88.06 Ω 0 88.06 88.07 08807 PALMYRA RHC 0.000000 0 0 0 0 88.07 08808 BOWLING GREEN RHC 88.08 0.000000 0 0 88.08 90.00 09000 CLI NI C 0.001647 29, 301 48 6, 853, 188 11, 287 90.00 09001 OUTPATIENT INFUSION 90.01 0.014984 10, 579 159 1, 030, 434 15, 440 90 01 04950 ONCOLOGY 0.000000 978, 007 90.02 90.02 9,853 0 04951 HANNIBAL INFUSION 90. 03 0.000000 0 39, 130 Ω 90.03 7, 965, 271 09100 EMERGENCY 8, 580, 782 91.00 0.003325 28.531 26, 485 91.00 92.00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART) 0.018875 958, 408 18, 090 2, 401, 654 45, 331 92.00

0.003185

280, 970, 653

156, 101

289, 668, 329

335, 195

497

367, 221 200. 00

93.99

93.99

200.00

09399 PARTIAL HOSPITALIZATION PROGRAM

Total (lines 50 through 199)

	TINDICIAL SYSTEMS	DLESSING		CN. 14 001E		Washabaat D	2332-10
APPURI	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 14-0015	Peri od: From 10/01/2022	Worksheet D Part V	
					To 09/30/2023	Date/Time Pre	pared:
						12/29/2023 3:	54 pm_
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	·	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 199796	34, 144, 602		0 0	6, 821, 955	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 177791	0	1	0 0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 023739	8, 816, 943		0 0	209, 305	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 159120	14, 322, 145		0 0	2, 278, 940	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 146475			0 0	1, 406, 097	55. 00
57. 00	05700 CT SCAN	0. 015733			0 0	299, 591	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 047494			0 0	92, 695	1
	1 1			1	0 0	1	1
60.00	06000 LABORATORY	0. 084011				919, 352	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 173153		1	0	204, 875	1
65. 00	06500 RESPI RATORY THERAPY	0. 154502		1	0	343, 903	1
66. 00	06600 PHYSI CAL THERAPY	0. 362319		1	0	6, 458	1
67. 00	06700 OCCUPATI ONAL THERAPY	0. 262064		1	0	3, 251	1
68. 00	06800 SPEECH PATHOLOGY	0. 197688		)	0	1, 309	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 053575	26, 864, 172		0	1, 439, 248	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 222199	755, 526	,	0 0	167, 877	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 123287	31, 131, 065		0 0	3, 838, 056	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 152483	32, 433, 098		0 0	4, 945, 496	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 093760		1	0 103, 951	7, 200, 232	1
74. 00	07400 RENAL DIALYSIS	0. 502931		1	0 0		1
	OUTPATIENT SERVICE COST CENTERS		-		-		1
88. 00	08800 EAST ADAMS RHC						88. 00
88. 01	08801 48TH AND MAINE RHC						88. 01
88. 02	08802 MT STERLING RHC						88. 02
88. 03	08803 MAIN CAMPUS RHC						88. 03
88. 04	08804 BLESSING EXPRESS CLINIC						88. 04
88. 05	08805 BLESSING WALK IN CLINIC						88. 05
							88. 06
88. 06	08806 HANNI BAL MAIN RHC						
88. 07	08807 PALMYRA RHC						88. 07
88. 08	08808 BOWLING GREEN RHC						88. 08
90. 00	09000 CLI NI C	0. 453687			0	-,,	1
90. 01	09001 OUTPATIENT INFUSION	0. 315745			0	325, 354	1
90. 02	04950 ONCOLOGY	0. 375342		1	0	367, 087	90. 02
90. 03	04951 HANNI BAL I NFUSI ON	2. 098429	39, 130	1	0	82, 112	90. 03
91.00	09100 EMERGENCY	0. 214145	7, 965, 271	1	0	1, 705, 723	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 474346	2, 401, 654		0	1, 139, 215	92.00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0. 615592	156, 101	1	0 0	96, 095	93. 99
200.00	Subtotal (see instructions)		289, 668, 329	1	0 103, 951	37, 003, 428	200.00
201.00					0 0	l	201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		289, 668, 329	1	0 103, 951	37, 003, 428	202. 00
		•	•	•	*	-	

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 14-0015 Peri od: Worksheet D From 10/01/2022 Part V 09/30/2023 Date/Time Prepared: 12/29/2023 3:54 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7.00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 000000000000000000 0 52.00 53. 00 05300 ANESTHESI OLOGY 0 53 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 58.00 60.00 06000 LABORATORY 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 62.00 06500 RESPIRATORY THERAPY 0 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 06900 ELECTROCARDI OLOGY 0 69 00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 9,746 73.00 73.00 74.00 07400 RENAL DIALYSIS 74.00 OUTPATIENT SERVICE COST CENTERS 08800 EAST ADAMS RHC 88.00 88.00 08801 48TH AND MAINE RHC 88. 01 88.01 88.02 08802 MT STERLING RHC 88.02 08803 MAIN CAMPUS RHC 88. 03 88.03 08804 BLESSING EXPRESS CLINIC 88.04 88.04 08805 BLESSING WALK IN CLINIC 88.05 88.05 08806 HANNI BAL MAIN RHC 88.06 88.06 08807 PALMYRA RHC 88.07 88.07 08808 BOWLING GREEN RHC 88 08 88.08 90.00 09000 CLI NI C 90.00 09001 OUTPATIENT INFUSION 90. 01 00000000 90.01 04950 ONCOLOGY 90.02 0 90.02 04951 HANNIBAL INFUSION 90.03 0 90.03 91.00 09100 EMERGENCY 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 09399 PARTIAL HOSPITALIZATION PROGRAM 93.99 93.99 200.00 Subtotal (see instructions) 9,746 200.00 201.00 Less PBP Clinic Lab. Services-Program 201.00

9.746

202. 00

Only Charges

Net Charges (line 200 - line 201)

202.00

	Financial Systems	BLESSI NG I				u of Form CMS-2	2552-10
APP0R1	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C	CN: 14-0015	Peri od:	Worksheet D	
			Component	CCN: 14-T015	From 10/01/2022 To 09/30/2023	Part II Date/Time Pre	nared:
			Component	CON. 14 1015	10 07/30/2023	12/29/2023 3:	54 pm
			Ti tl e	: XVIII	Subprovi der -	PPS	•
					IRF		
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	·	(col . 1 ÷ col	l. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	2.00	2.00	4.00	Г 00	
	ANCILL ADV. CEDVI CE. COCT. CENTEDO	1. 00	2. 00	3.00	4. 00	5. 00	
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	/ /70 070	192, 749, 118	0. 03460	) E1 EE7	1 704	50.00
50.00	05200 DELIVERY ROOM & LABOR ROOM	6, 670, 078		1	·	1, 784	
52.00		143, 334				0	
53. 00 54. 00	05300 ANESTHESI OLOGY	272, 910				13	
55. 00	05400   RADI OLOGY-DI AGNOSTI C   05500   RADI OLOGY-THERAPEUTI C	1, 249, 886		1	·	2, 750	1
57. 00	05700 CT SCAN	443, 650 484, 305		1		0 327	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	204, 606				434	
60.00	06000 LABORATORY	1, 425, 292				4, 698	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	67, 899				177	
65. 00	06500 RESPIRATORY THERAPY	502, 309		1		3, 114	
66. 00	06600 PHYSI CAL THERAPY	133, 998		1		25, 590	
67. 00	06700 OCCUPATI ONAL THERAPY	72, 356				15, 915	
68. 00	06800 SPEECH PATHOLOGY	23, 361		1		3, 436	
69. 00	06900 ELECTROCARDI OLOGY	834, 251				102	
70.00	07000 ELECTROENCEPHALOGRAPHY	135, 627				109	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	836, 999		1		378	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	853, 072		1	·	62	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 872, 358				6, 363	
74. 00	07400 RENAL DIALYSIS	32,077		1		184	1
	OUTPATIENT SERVICE COST CENTERS	<u> </u>		,			
88. 00	08800 EAST ADAMS RHC	81, 328	1, 098, 603	0. 07402	29 0	0	88. 00
88. 01	08801 48TH AND MAINE RHC	208, 039	2, 550, 377	0. 0815	72 0	0	88. 01
88. 02	08802 MT STERLING RHC	136, 479	373, 097	0. 36580	00	0	88. 02
88. 03	08803 MAIN CAMPUS RHC	1, 299, 822	26, 551, 995	0. 0489	54 0	0	88. 03
88. 04	08804 BLESSING EXPRESS CLINIC	259, 043	2, 473, 655			0	88. 04
88. 05	08805 BLESSING WALK IN CLINIC	210, 273	4, 207, 125	0. 04998	80 0	0	88. 05
88. 06	08806 HANNI BAL MAIN RHC	258, 812		1		0	
88. 07	08807 PALMYRA RHC	71, 971				0	
88. 08	08808 BOWLING GREEN RHC	21, 699		1		0	
90. 00	09000 CLI NI C	1, 518, 302				0	
90. 01	09001 OUTPATIENT INFUSION	94, 300				0	
90. 02	04950 ONCOLOGY	74, 223				0	
90. 03	04951 HANNI BAL I NFUSI ON	38, 140				0	1
	09100 EMERGENCY	1, 026, 490				0	
47 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	17. 673. 743	0.0000	0.0	0	92.00

0

149, 237 3, 256, 730 21, 706, 526 1, 902, 085, 344

17, 673, 743

0 0

5, 734, 023

0 92.00

65, 436 200. 00

0 93.99

0.000000

0.045824

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
93.99 09399 PARTIAL HOSPITALIZATION PROGRAM
200.00 Total (lines 50 through 199)

	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	BLESSI NG		N 14 0015		u of Form CMS-:	2552-10
	TONMENT OF INPATTENT/OUTPATTENT ANCIELARY SEF	WICE UIHER PAS	S Provider CO	JN: 14-0015	Peri od: From 10/01/2022	Worksheet D Part IV	
11111000	11 00313		Component (	CCN: 14-T015	To 09/30/2023		pared: 54 pm
			Title	XVIII	Subprovi der -	PPS	оч рііі
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown	Ü	Adjustments		
			Adjustments				
		1.00	2A	2. 00	3A	3. 00	
	ANCI LLARY SERVI CE COST CENTERS	Τ	1				
50.00	05000 OPERATING ROOM	0		262, 35		0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	l .	246, 91		0	52.00
53. 00	05300 ANESTHESI OLOGY	0	_		0	0	
54. 00	05400 RADI OLOGY - DI AGNOSTI C	0	_		0	601, 180	1
55. 00	O5500  RADI OLOGY-THERAPEUTI C		0		0	0	
57. 00	05700 CT SCAN				0	0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	_	_		0 0	0	
60.00	06000 LABORATORY	0	_		0	220, 151	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY		_		0 0	0	
65. 00 66. 00	06600 PHYSI CAL THERAPY					231, 654 0	1
67. 00	06700 OCCUPATI ONAL THERAPY		_		0 0	0	
68. 00	06800 SPEECH PATHOLOGY		0			0	68. 00
69. 00	06900 ELECTROCARDI OLOGY			47, 03	0 0	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY		0	47,00	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS					0	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0			0	72.00
	07300 DRUGS CHARGED TO PATIENTS		, and the second		0 0	466, 953	1
	07400 RENAL DIALYSIS				0 0	'	1
7 1. 00	OUTPATIENT SERVICE COST CENTERS				<u> </u>		7 1. 00
88. 00	08800 EAST ADAMS RHC	0	0		0 0	0	88. 00
88. 01	08801 48TH AND MAINE RHC	0	0		0 0	0	1
88. 02	08802 MT STERLING RHC	0	0		0 0	0	88. 02
88. 03	08803 MAIN CAMPUS RHC	0	0		0 0	0	88. 03
88. 04	08804 BLESSING EXPRESS CLINIC	0	0		0 0	0	88. 04
88. 05	08805 BLESSING WALK IN CLINIC	0	0	43, 34	12 0	0	88. 05
88. 06	08806 HANNI BAL MAIN RHC	0	0		0 0	0	88. 06
88. 07	08807 PALMYRA RHC	0	0		0 0	0	88. 07
88. 08	08808 BOWLING GREEN RHC	0	0		0 0	0	88. 08
90.00	09000  CLI NI C	0	0	58, 32	27 0	0	90.00
90. 01	09001 OUTPATIENT INFUSION	0	0	44, 26	0	0	90. 01
90. 02	04950 ONCOLOGY	0	0		0	0	90. 02
90. 03	04951 HANNI BAL I NFUSI ON	0	0		0	0	90. 03
91.00	09100 EMERGENCY	0	0	240, 22	24 0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	1 - 1 - 0 - 0
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	10, 37	74 0	0	93. 99

10, 374 952, 827

0 93. 99 1, 519, 938 200. 00

93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM 200. 00 Total (lines 50 through 199)

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S HROUGH COSTS	SERVICE OTHER PAS			Period: From 10/01/2022 To 09/30/2023	Worksheet D Part IV Date/Time Pre 12/29/2023 3:	pared:
		Title	: XVIII	Subprovider -	12/29/2023 3: PPS	54 pm
Cost Center Description	All Other	Total Cost	Total	IRF Total Charges	Datio of Cost	1
cost center bescription	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
	Ludcati on cost	4)	col s. 2, 3,	8)	7)	
		'/	and 4)		(see	
			und 1)		instructions)	
	4.00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS		0.00	5. 55		5.55	
0. 00 O5000 OPERATI NG ROOM	0	262, 356	262, 35	6 192, 749, 118	0. 001361	50.00
2.00 05200 DELIVERY ROOM & LABOR ROOM	0		246, 91		0. 020065	
3. 00   05300   ANESTHESI OLOGY	0	0		0 55, 056, 256	0. 000000	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	601, 180	601, 18		0. 007125	
5. 00   05500 RADI OLOGY-THERAPEUTI C	0	0		0 19, 312, 018	0. 000000	
7. 00   05700 CT SCAN	0	0		0 145, 132, 810	0. 000000	
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 20, 713, 060	0. 000000	
0. 00   06000   LABORATORY	0	220, 151	220, 15		0. 000898	
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	Ö	0		0 10, 721, 771	0. 000000	
5. 00 06500 RESPIRATORY THERAPY	0	231, 654	231, 65		0. 007359	65. 0
6. 00 06600 PHYSI CAL THERAPY	0	0	1	0 6, 444, 930	0. 000000	
7. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 5, 606, 862	0. 000000	
8. 00 06800 SPEECH PATHOLOGY	0	0		0 1, 858, 582	0. 000000	
9. 00 06900 ELECTROCARDI OLOGY	0	47, 030	47, 03		0. 000363	
0. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 5, 008, 507	0. 000000	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 182, 846, 327	0. 000000	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	Ö	0		0 144, 426, 113	0. 000000	
3. 00 07300 DRUGS CHARGED TO PATIENTS	o		466, 95		0. 001090	
4. 00 07400 RENAL DIALYSIS	0			0 2, 440, 193	0. 000000	
OUTPATIENT SERVICE COST CENTERS				2, 110, 170	0.000000	/ 1. 0
8. 00 08800 EAST ADAMS RHC	0	0		0 1, 098, 603	0.000000	88. 0
8. 01   08801   48TH   AND   MAI NE   RHC	Ö			0 2, 550, 377	0. 000000	
8. 02   08802 MT STERLING RHC	0	0		0 373, 097	0. 000000	
8. 03   08803   MAI N CAMPUS RHC	0	0		0 26, 551, 995	0. 000000	
8. 04 08804 BLESSING EXPRESS CLINIC	Ö	0		0 2, 473, 655	0. 000000	
8. 05   08805   BLESSING WALK IN CLINIC	0	43, 342	43, 34	-,,	0. 010302	
8. 06   08806   HANNI BAL MAI N RHC	Ö	0		0 5, 640, 357	0. 000000	
8. 07   08807   PALMYRA RHC	0	0		0 403, 369	0. 000000	
8. 08   08808   BOWLI NG GREEN RHC	0	0		0 118, 368	0. 000000	
0. 00   09000   CLI NI C	0	58, 327	58, 32	-	0.001647	90.0
0. 01   09001   0UTPATI ENT   NFUSI ON	0	44, 264	44, 26		0. 014984	
0. 02 04950 ONCOLOGY	0	0		0 3, 119, 978	0.000000	
0. 03   04951   HANNI BAL   NFUSI ON	0			0 84, 833	0. 000000	
1. 00   09100   EMERGENCY	0	240, 224			0. 003325	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 17, 673, 743	0. 000000	
3. 99   09399   PARTIAL HOSPITALIZATION PROGRAM	0				0. 003185	

Health Financial Systems	DI ESSINO HO	ISDI TAI		ln lio	u of Form CMS	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	BLESSING HO RVICE OTHER PASS	Provider C	CN: 14-0015	Peri od:	u of Form CMS-: Worksheet D	2552-10
THROUGH COSTS		Component	CCN: 14-T015	From 10/01/2022 To 09/30/2023	Part IV Date/Time Pre 12/29/2023 3:	pared: 54 pm
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges (col. 6 ÷ col.	Charges	Pass-Through Costs (col.		Pass-Through Costs (col. 9	
	7)		x col . 10)	0	x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	71.00	101.00		12.00	10.00	
50. 00 05000 OPERATING ROOM	0. 001361	51, 557	7	0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 020065	0		0 0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	2, 662		0 0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 007125	185, 665	1, 32	23 0	0	54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55. 00
57. 00   05700   CT   SCAN	0. 000000	98, 098		0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	43, 949		0	0	58. 00
60. 00  06000   LABORATORY	0. 000898	808, 471	72		0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	27, 999		0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 007359	195, 180	1, 43		0	65. 00
66. 00   06600   PHYSI CAL THERAPY	0. 000000	1, 230, 811		0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 233, 256		0 0	0	
68. 00 06800 SPEECH PATHOLOGY	0.000000	273, 368		0 0	0	
69. 00   06900   ELECTROCARDI OLOGY 70. 00   07000   ELECTROENCEPHALOGRAPHY	0. 000363 0. 000000	15, 875		6 0	0	
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	4, 009 82, 527		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	10, 523		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.001090	1, 456, 074			0	
74. 00   07400   RENAL DI ALYSI S	0. 000000	13, 999		0 0	0	
OUTPATIENT SERVICE COST CENTERS	0.000000	10, ,,,		<u> </u>		1 00
88. 00 08800 EAST ADAMS RHC	0. 000000	0		0 0	0	88. 00
88. 01   08801   48TH AND MAINE RHC	0. 000000	0		0 0	0	88. 01
88. 02   08802   MT   STERLI NG   RHC	0. 000000	0		0	0	88. 02
88. 03   08803   MAI N CAMPUS RHC	0. 000000	0		0	0	88. 03
88. 04   08804   BLESSING EXPRESS CLINIC	0. 000000	0		0	0	88. 04
88.05 08805 BLESSING WALK IN CLINIC	0. 010302	0		0	0	
88. 06   08806   HANNI BAL MAIN RHC	0. 000000	0		0	0	
88. 07   08807   PALMYRA RHC	0. 000000	0		0	0	
88. 08   08808   BOWLI NG GREEN RHC	0. 000000	0		0 0	0	88. 08
90. 00   09000   CLI NI C	0. 001647	0		0	0	90.00
90. 01   09001   0UTPATI ENT   INFUSI ON 90. 02   04950   ONCOLOGY	0. 014984	0		0 0	0	
90. 02   04950   0NCOLOGY 90. 03   04951   HANNI BAL   I NFUSI ON	0. 000000 0. 000000	0		0 0	0	
91. 00   09100   EMERGENCY	0. 003325	0		0 0	0	
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	0. 003323	0			0	1
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 003185	0		0 0	0	
200.00 Total (lines 50 through 199)	0.000100	5, 734, 023		-		200. 00
, ,				•		

near tir i mancrar systems		DLL331NG 1103F	TIAL	III LI CI	1 01 1 01 III CW3-2332-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES A	AND VACCINE COST	Provider CCN: 14-0015	Peri od:	Worksheet D
				From 10/01/2022	
			Component CCN: 14-T015	To 09/30/2023	Date/Time Prepared:
					12/29/2023 3:54 pm
			Title XVIII	Subprovi der -	PPS
				IDE	

						12/29/2023 3:	54 pm
			Title	: XVIII	Subprovi der -	PPS	
					I RF		
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	·	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	,	
		Part I, col. 9	,	Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
	05000 OPERATING ROOM	0. 199796	0		0 0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 177791			0 0		52.00
1		1		•	0 0		
	05300 ANESTHESI OLOGY	0. 023739	0			-	53. 00
	05400 RADI OLOGY - DI AGNOSTI C	0. 159120	0		0	0	54. 00
	05500 RADI OLOGY-THERAPEUTI C	0. 146475	0		0	0	55. 00
	05700 CT SCAN	0. 015733	0	1	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 047494	0		0	0	58. 00
60.00	06000 LABORATORY	0. 084011	0		0	0	60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 173153	0		0	0	62.00
65. 00	06500 RESPI RATORY THERAPY	0. 154502	0		0 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 362319	0		0 0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0. 262064	l o		0 0	0	67. 00
1	06800 SPEECH PATHOLOGY	0. 197688	0		0 0		68. 00
	06900 ELECTROCARDI OLOGY	0. 053575	0		0 0	-	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0. 222199	١		0 0	Ö	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 123287			0 0	Ö	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 123287			0 0	0	72.00
		1			-		
	07300 DRUGS CHARGED TO PATIENTS	0. 093760	•		0 462	0	73. 00
	07400 RENAL DI ALYSI S	0. 502931	0		0 0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS		ı	1			
	08800 EAST ADAMS RHC						88. 00
4	08801 48TH AND MAINE RHC						88. 01
	08802 MT STERLING RHC						88. 02
88. 03	08803 MAIN CAMPUS RHC						88. 03
88. 04	08804 BLESSING EXPRESS CLINIC						88. 04
88. 05	08805 BLESSING WALK IN CLINIC						88. 05
88. 06	08806 HANNI BAL MAIN RHC						88. 06
88. 07	08807 PALMYRA RHC						88. 07
	08808 BOWLING GREEN RHC						88. 08
	09000 CLINI C	0. 453687	0		0 0	0	90.00
	09001 OUTPATIENT INFUSION	0. 315745	0	1	0 0	ő	90. 01
1	04950 ONCOLOGY	0. 375342	0	1	0 0	-	90.02
	04951 HANNI BAL I NFUSI ON	1		•	0 0	0	90.02
		2. 098429			-	_	
	09100 EMERGENCY	0. 214145	-			0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 474346	l e		0		92.00
1	09399 PARTIAL HOSPITALIZATION PROGRAM	0. 615592	0	1	0 0		93. 99
200.00	Subtotal (see instructions)		0		0 462	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		0	1	0 462	0	202. 00

Health Financial Systems	BLESSING HOS	PITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0015 Component CCN: 14-T015	From 10/01/2022	
		Title XVIII	Subprovi der -	PPS

		Ti tl e	XVIII	Subprovi der - I RF	PPS	оч рііі
	Cost	ts		TIM		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
		Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.) 7.00				
ANCILLARY SERVICE COST CENTERS	6. 00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53. 00   05300   ANESTHESI OLOGY	o	0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	0				54. 00
55. 00   05500 RADI OLOGY-THERAPEUTI C	o	0				55. 00
57. 00   05700 CT SCAN	0	0				57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	o	o				58. 00
60. 00   06000   LABORATORY	O	o				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62. 00
65. 00 06500 RESPIRATORY THERAPY	O	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68.00   06800   SPEECH PATHOLOGY	0	0				68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	43				73. 00
74. 00 07400 RENAL DIALYSIS	0	0				74. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00   08800   EAST ADAMS RHC						88. 00
88. 01   08801   48TH AND MAINE RHC						88. 01
88. 02   08802 MT STERLING RHC						88. 02
88. 03   08803   MAI N CAMPUS RHC 88. 04   08804   BLESSI NG EXPRESS CLI NI C						88. 03
88. 04   08804   BLESSING EXPRESS CLINIC 88. 05   08805   BLESSING WALK IN CLINIC						88. 04 88. 05
88. 06   08806   HANNI BAL MAIN RHC						88. 06
88. 07   08807   PALMYRA RHC						88. 07
88. 08   08808   BOWLI NG   GREEN   RHC						88. 08
90. 00   09000   CLINI C	0	0				90.00
90. 01   09001   0UTPATIENT   NFUSION	o o	0				90. 01
90. 02 04950 ONCOLOGY	0	0				90. 02
90. 03   04951   HANNI BAL   NFUSI ON	0	0				90. 03
91. 00   09100   EMERGENCY	0	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
93. 99 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0				93. 99
200.00 Subtotal (see instructions)	0	43				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0	İ				201. 00
Only Charges						
202.00   Net Charges (line 200 - line 201)	0	43				202. 00

Heal th Financial	Systems		BLESSING F	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTI ONMENT OF	I NPATI ENT/OUTPATI ENT	ANCI LLARY SEI	RVICE OTHER PASS	Provi der C	CN: 14-0015	Peri od:	Worksheet D	
THROUGH COSTS						From 10/01/2022		
				Component	CCN: 14-5643	To 09/30/2023		
							12/29/2023 3:	54 pm_
				Title	e XVIII	Skilled Nursing	PPS	
						Facility Pacility		
Cost	Center Description		Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
			Anestheti st	Program	Program	Post-Stepdown		

Non Physician   Anesthetist   Cost   Non Physician   Anesthetist   Cost   Program   Program   Aliied Health   Post-Stepdown   Adjustments   Aliied Health   Post-Stepdown   Adjustments   Aliied Health   Post-Stepdown   Adjustments   Aliied Health   Post-Stepdown   Adjustments   Aliied Health   Post-Stepdown   Adjustments   Program   Program   Program   Aliied Health   Post-Stepdown   Adjustments   Program   Program   Program   Aliied Health   Post-Stepdown   Adjustments   Program   Program   Program   Aliied Health   Post-Stepdown   Adjustments   Program   Program   Aliied Health   Post-Stepdown   Adjustments   Program   Program   Program   Aliied Health   Post-Stepdown   Adjustments   Program   Program   Program   Aliied Health   Post-Stepdown   Adjustments   Program   Prog
Anesthetist   Cost
Cost
Adjustments
ANCI LLARY SERVI CE COST CENTERS
ANCILLARY SERVICE COST CENTERS   50.00   05000   DERATI NG ROOM   0   0   0   262,356   0   0   50.00   52.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   0   52.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   0   0   53.00   53.00   05300   ANESTHESI OLOGY   0   0   0   0   0   0   0   0   0
52. 00         05200         DELIVERY ROOM & LABOR ROOM         0         0         246,910         0         0         52. 00           53. 00         05300         ANESTHESI OLOGY         0         0         0         0         0         0         0         53. 00         0         53. 00         0         0         0         0         0         0         53. 00         0         0         0         0         0         0         64. 00         <
52. 00         05200 DELIVERY ROOM & LABOR ROOM         0         0         246,910         0         0         52. 00           53. 00         05300 ANESTHESI OLOGY         0         0         0         0         0         0         0         53. 00           54. 00         05400 RADI OLOGY-DI AGNOSTI C         0         0         0         0         0         601,180         54. 00         55. 00         0         0         0         0         601,180         54. 00         55. 00         0         0         0         0         0         0         0         0         55. 00         0         0         0         0         0         0         0         0         55. 00         0         0         0         0         0         0         55. 00         0         0         0         0         0         0         57. 00         0 <td< td=""></td<>
53. 00         05300         ANESTHESI OLOGY         0         0         0         0         0         53. 00           54. 00         O5400         RADI OLOGY-DI AGNOSTI C         0         0         0         0         0         601, 180         54. 00           55. 00         O5500         RADI OLOGY-THERAPEUTI C         0         0         0         0         0         55. 00           57. 00         O5700         CT SCAN         0         0         0         0         0         57. 00           58. 00         O5800         MAGNETI C RESONANCE I MAGI NG (MRI)         0         0         0         0         0         57. 00           60. 00         O6000         LABORATORY         0         0         0         0         220, 151         60. 00           62. 00         O6200         WHOLE BLOOD & PACKED RED BLOOD CELLS         0         0         0         0         0         220, 151         60. 00           65. 00         O6500         RESPI RATORY THERAPY         0         0         0         0         231, 654         65. 00         0         0         231, 654         65. 00         0         0         0         0         66. 00
55. 00         05500         RADI OLOGY-THERAPEUTI C         0         0         0         0         0         55. 00           57. 00         05700         CT SCAN         0         0         0         0         0         55. 00           58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         0         0         0         0         0         55. 00           60. 00         06000         LABORATORY         0         0         0         0         220, 151         60. 00           62. 00         06200         WHOLE BLOOD & PACKED RED BLOOD CELLS         0         0         0         0         0         0         0         0         62. 00           65. 00         06500         RESPI RATORY THERAPY         0         0         0         0         0         0         231, 654         65. 00           66. 00         06500         RESPI RATORY THERAPY         0         0         0         0         0         0         65. 00           66. 00         06600         PHYSI CAL THERAPY         0         0         0         0         0         0         0         65. 00           67. 00         06700         OCCUPATI ONAL THER
55. 00         05500         RADI OLOGY-THERAPEUTI C         0         0         0         0         0         55. 00           57. 00         05700         CT SCAN         0         0         0         0         0         0         57. 00           58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         0         0         0         0         0         0         55. 00           60. 00         06500         LABORATORY         0         0         0         0         220, 151         60. 00           62. 00         06200         WHOLE BLOOD & PACKED RED BLOOD CELLS         0         0         0         0         0         0         220, 151         60. 00           65. 00         06500         RESPI RATORY THERAPY         0         0         0         0         0         231, 654         65. 00           66. 00         06600         PHYSI CAL THERAPY         0         0         0         0         0         0         66. 00           67. 00         06700         OCCUPATI ONAL THERAPY         0         0         0         0         0         0         0         0         0         0         0         0         66. 0
57. 00
60. 00
60. 00
62. 00
65. 00
66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   0   67. 00   68. 00   06800   SPECH PATHOLOGY   0   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   47, 030   0   0   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   74. 00   00TPATI ENT SERVI CE COST CENTERS    88. 00   08800   EAST ADAMS RHC   0   0   0   0   0   88. 01   08801   48TH AND MAINE RHC   0   0   0   0   0   88. 01
67. 00
68. 00
69. 00
70. 00
71. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   72. 00   07300   07300   07300   07400
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   466, 953   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   74. 00   0   0   0   0   0   0   0   0   0
74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   74. 00
OUTPATIENT SERVICE COST CENTERS           88. 00         08800 EAST ADAMS RHC         0         0         0         0         0         88.00           88. 01         08801 48TH AND MAINE RHC         0         0         0         0         0         0         0         88.01
88. 00   08800   EAST ADAMS RHC   0   0   0   0   88. 00   88. 01   08801   48TH AND MAINE RHC   0   0   0   0   88. 01
88. 02   08802   MT STERLI NG RHC   0   0   0   0   88. 02
88. 03   08803   MAI N CAMPUS RHC   0   0   0   88. 03
88. 04   08804   BLESSING EXPRESS CLINIC   0   0   0   88. 04
88.05   08805   BLESSING WALK IN CLINIC   0   0   43,342   0   0   88.05
88. 06   08806   HANNI BAL MAI N RHC   0   0   0   88. 06
88. 07   08807   PALMYRA RHC   0   0   0   88. 07
88. 08   08808   BOWLING GREEN RHC   0   0   0   88. 08
90. 00   09000  CLI NI C   0   0   58, 327   0   0   90. 00
90. 01   09001   0UTPATI ENT   I NFUSI ON   0   44, 264   0   0   90. 01
90. 02   04950  0NC0L0GY   0   0   0   0   90. 02
90. 03   04951   HANNI BAL I NFUSI ON 0 0 0 90. 03
91. 00   09100   EMERGENCY   0   0   240, 224   0   0   91. 00
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   0   92. 00
93. 99   09399   PARTIAL HOSPITALIZATION PROGRAM 0 0 10, 374 0 0 93. 99
200.00   Total (lines 50 through 199)   0   952,827   0   1,519,938   200.00

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE HROUGH COSTS	RVICE OTHER PASS			Period: From 10/01/2022 To 09/30/2023	Worksheet D Part IV Date/Time Pre 12/29/2023 3:	pared: 54 pm
		Title	· XVIII	Skilled Nursing Facility	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	F 00	/ 00	7.00	instructions)	
ANGLEL ADV. CEDVI CE COCT CENTEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS		2/2 25/	2/2.25	/ 100 740 110	0.0012/1	
0. 00 05000 OPERATING ROOM	0					50.00
2. 00   05200   DELI VERY ROOM & LABOR ROOM	0		1		0. 020065	
3. 00   05300   ANESTHESI OLOGY	0		1	0 55, 056, 256	0.000000	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	,	1		0. 007125	
5. 00   05500   RADI OLOGY-THERAPEUTI C	0	0		0 19, 312, 018	0.000000	
7. 00   05700 CT SCAN	0	0		0 145, 132, 810	0. 000000	
8.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0 20, 713, 060	0. 000000	
0. 00   06000   LABORATORY	0	220, 151	1		0. 000898	
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0 10, 721, 771	0. 000000	
5. 00 06500 RESPI RATORY THERAPY	0	231, 654	1		0. 007359	
6. 00 06600 PHYSI CAL THERAPY	0	0		0 6, 444, 930	0. 000000	
7. 00 06700 OCCUPATI ONAL THERAPY	0	· -		0 5, 606, 862	0. 000000	
8. 00 06800 SPEECH PATHOLOGY	0	0		0 1, 858, 582	0. 000000	
9. 00 06900 ELECTROCARDI OLOGY	0	47, 030			0. 000363	
0. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 5, 008, 507	0. 000000	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 182, 846, 327	0. 000000	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 144, 426, 113	0. 000000	
3.00 07300 DRUGS CHARGED TO PATIENTS	0				0. 001090	
4. 00 07400 RENAL DI ALYSI S	0	0		0 2, 440, 193	0. 000000	74.0
OUTPATIENT SERVICE COST CENTERS	_	_	1			
8. 00 08800 EAST ADAMS RHC	0	-		0 1, 098, 603	0. 000000	
8. 01   08801   48TH   AND   MAI NE   RHC	0		•	0 2, 550, 377	0.000000	
8. 02   08802 MT STERLING RHC	0	1		0 373, 097	0. 000000	
8. 03   08803   MAI N CAMPUS RHC	0	0	1	0 26, 551, 995	0. 000000	
8. 04   08804   BLESSING EXPRESS CLINIC	0			0 2, 473, 655	0. 000000	
8.05 08805 BLESSING WALK IN CLINIC	0		1		0. 010302	
8. 06   08806   HANNI BAL MAIN RHC	0			0 5, 640, 357	0. 000000	
8.07   08807   PALMYRA RHC	0	0		0 403, 369	0. 000000	
8. 08   08808   BOWLING GREEN RHC	0	0		0 118, 368	0. 000000	
0. 00  09000   CLI NI C	0				0. 001647	90.0
0. 01   09001   0UTPATIENT   INFUSION	0	1, == .	1		0. 014984	90.0
0. 02   04950   0NCOLOGY	0	-		0 3, 119, 978	0. 000000	
0. 03   04951   HANNI BAL   I NFUSI ON	0			0 84, 833	0. 000000	
1. 00   09100   EMERGENCY	0					
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		•	0 17, 673, 743		
3.99 09399 PARTIAL HOSPITALIZATION PROGRAM	0		·		0. 003185	
00.00   Total (lines 50 through 199)	0	2, 472, 765	2, 472, 76	5 1, 902, 085, 344		200.00

ealth Financial Systems	BLESSING HO	_	ON 14 0015		u of Form CMS-1	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE UTHER PASS	Provi der C		Peri od: From 10/01/2022	Worksheet D Part IV	
THROUGH COSTS		Component		To 09/30/2023	Date/Time Pre	pared:
		·			12/29/2023 3:	54 pm
		Title	XVIII	Skilled Nursing	PPS	
	I a I	<u> </u>		Facility		
Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges (col. 6 ÷ col.	Charges	Pass-Through Costs (col. 8		Pass-Through Costs (col. 9	
	7)		x col. 10)		x col . 12)	
	9.00	10.00	11.00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
60. 00   05000   OPERATING ROOM	0. 001361	78, 390	10	7 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 020065	0		ol ol	0	
33. 00   05300   ANESTHESI OLOGY	0. 000000	0		o o	0	
64. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 007125	196, 955			0	
55. 00   05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		ol ol	0	
67. 00 05700 CT SCAN	0. 000000	0		o o	0	
88.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		ol ol	0	
0. 00   06000   LABORATORY	0. 000898	1, 339, 979	1, 20		0	
22.00 O6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	44, 628		ol ol	0	
55. 00 06500 RESPIRATORY THERAPY	0. 007359	517, 818			0	
66. 00   06600 PHYSI CAL THERAPY	0. 000000	745, 370		ol ol	0	
57. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	798, 425		ol ol	0	67.00
8. 00 06800 SPEECH PATHOLOGY	0. 000000	38, 579		ol ol	0	68.00
9. 00 06900 ELECTROCARDI OLOGY	0. 000363	30, 050		1 0	0	69.00
0.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	5, 346		o o	0	70.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	134, 091		o o	0	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		o o	0	72.00
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 001090	2, 677, 039	2, 91	8 0	0	73.00
74. 00 07400 RENAL DIALYSIS	0. 000000	121, 324		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00   08800   EAST ADAMS RHC	0. 000000	0		0 0	0	
88.01  08801 48TH AND MAINE RHC	0. 000000	0		0 0	0	
88. 02   08802   MT   STERLING   RHC	0. 000000	0		0 0	0	
88. 03   08803   MAIN CAMPUS RHC	0. 000000	0		0 0	0	
88.04 08804 BLESSING EXPRESS CLINIC	0. 000000	0		0 0	0	
88.05 08805 BLESSING WALK IN CLINIC	0. 010302	0		0 0	0	
88. 06   08806   HANNI BAL MAIN RHC	0. 000000	0		0 0	0	
88.07   08807   PALMYRA RHC	0. 000000	0		0 0	0	
88. 08   08808   BOWLI NG GREEN RHC	0. 000000	0		0 0	0	
0. 00  09000   CLI NI C	0. 001647	0		0 0	0	
O. 01 O9001 OUTPATIENT INFUSION	0. 014984	0		0	0	
0. 02   04950   ONCOLOGY	0. 000000	0		0 0	0	
0. 03   04951   HANNI BAL   NFUSI ON	0. 000000	0		0	0	
01. 00   09100   EMERGENCY	0. 003325	0		0 0	0	
22. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	
23. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 003185	0		0 0	0	
.00.00   Total (lines 50 through 199)		6, 727, 994	9, 45	3 0	0	200.00

| Nursing | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | PDS | Peri od: From 10/01/2022 To 09/30/2023 Provider CCN: 14-0015 Component CCN: 14-5643

			Title	XVIII	Skilled Nursing Facility	PPS	<u> </u>
				Charges	Taciffty	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	out contain baser per an	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(222 11121)	
		Part I, col. 9	,	Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 199796	0		0	0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 177791	0		0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0. 023739	0		0	0	53. 00
54. 00	05400  RADI OLOGY-DI AGNOSTI C	0. 159120	0		0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 146475	0		0	0	55. 00
57. 00	05700 CT SCAN	0. 015733	0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 047494	0		0	0	58. 00
60. 00	06000 LABORATORY	0. 084011	0		0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 173153	0		0	0	62. 00
65. 00	06500 RESPI RATORY THERAPY	0. 154502	0		0 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 362319	0		0 0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 262064	0		0 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 197688	0		0 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 053575	0		0 0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 222199	0		0 0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 123287	0		0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 152483	0		0 0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 093760	0		0 12, 364	0	73. 00
74. 00	07400 RENAL DIALYSIS	0. 502931	0		0 0	0	74. 00
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
88. 00	08800 EAST ADAMS RHC						88. 00
88. 01	08801 48TH AND MAINE RHC						88. 01
88. 02	08802 MT STERLING RHC						88. 02
88. 03	08803 MAIN CAMPUS RHC						88. 03
88. 04	08804 BLESSING EXPRESS CLINIC						88. 04
88. 05	08805 BLESSING WALK IN CLINIC						88. 05
88. 06	08806 HANNI BAL MAIN RHC						88. 06
88. 07	08807 PALMYRA RHC						88. 07
88. 08	08808 BOWLING GREEN RHC	0.450/07	•				88. 08
90.00	09000 CLINIC	0. 453687	0		0	0	90.00
90. 01	09001 OUTPATIENT INFUSION	0. 315745	0		0	0	90. 01
90. 02	04950 ONCOLOGY	0. 375342	0		0	0	90. 02
90. 03	04951 HANNI BAL I NFUSI ON	2. 098429	0		0	0	90. 03
91.00	09100 EMERGENCY	0. 214145	0		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 474346	0		0	0	92.00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0. 615592	0		0 0	0	93. 99
200.00	1 /		0		0 12, 364	0	200. 00
201.00							201. 00
202.00	Only Charges (Line 200 Line 201)		0		12 244	_	202 00
202.00	Net Charges (line 200 - line 201)	1 1	0	I	0 12, 364	U	202. 00

Health Financial Systems	BLESSING HOS	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0015 Component CCN: 14-5643	From 10/01/2022	
		Title XVIII	Skilled Nursing	PPS

			Title	: XVIII	Skilled Nursing	PPS	оч рііі
		Cos	·+c		Facility		
Cost Center Desc	crintion	Cost	Cost	<u> </u>			
COST CONTON DESC	ST P CT OII	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
ANCILLARY SERVICE COS	T CENTERS						
50. 00  05000 OPERATING ROOM		0	0				50. 00
52. 00  05200   DELI VERY ROOM &	LABOR ROOM	0	0	1			52. 00
53. 00   05300   ANESTHESI OLOGY		0	0				53. 00
54. 00   05400   RADI OLOGY-DI AGNO		0	0				54. 00
55. 00   05500   RADI OLOGY-THERAI	PEUTI C	0	0				55. 00
57.00  05700 CT SCAN		0	0				57. 00
58.00 05800 MAGNETIC RESONAL	NCE IMAGING (MRI)	0	0	•			58. 00
60. 00   06000   LABORATORY		0	0				60.00
62. 00   06200   WHOLE BLOOD & PA		0	0				62. 00
65. 00   06500   RESPI RATORY THE		0	0				65. 00
66. 00   06600   PHYSI CAL THERAP		0	0	•			66. 00
67. 00   06700   0CCUPATI ONAL THE		0	0	•			67. 00
68. 00   06800   SPEECH PATHOLOGY		0	0	1			68. 00
69. 00   06900   ELECTROCARDI OLO		0	0				69. 00
70. 00   07000   ELECTROENCEPHALO		0	0	1			70.00
71. 00   07100   MEDI CAL SUPPLIES		0	0				71.00
72. 00   07200   IMPL. DEV. CHARGE		0	1 150				72. 00
73. 00   07300   DRUGS CHARGED TO	J PATIENTS	0	1, 159	1			73.00
74. 00 07400 RENAL DIALYSIS	CT CENTEDS	0	0				74. 00
88. 00 08800 EAST ADAMS RHC	SI CENTERS						88. 00
88. 01   08801   48TH   AND   MAI NE   F	DUC						88. 01
88. 02   08802 MT STERLING RHC	RIC						88. 02
88. 03   08803 MAI N CAMPUS RHC							88. 03
88. 04   08804   BLESSING EXPRESS	SCLINIC						88. 04
88. 05   08805   BLESSING WALK II							88. 05
88. 06   08806   HANNI BAL MAIN RI							88. 06
88. 07   08807   PALMYRA RHC							88. 07
88. 08   08808   BOWLING GREEN RI	4C						88. 08
90. 00   09000   CLINIC	10	o	0				90.00
90. 01   09001   0UTPATI ENT   I NFUS	SLON		0	•			90. 01
90. 02   04950   ONCOLOGY	31 314		0	1			90. 02
90. 03   04951   HANNI BAL   INFUSI (	NC		0	1			90. 03
91. 00   09100   EMERGENCY	-		0	1			91. 00
92. 00 09200 OBSERVATI ON BEDS	S (NON-DISTINCT PART)	l ol	0	1			92. 00
93. 99   09399   PARTI AL HOSPI TAI	,	l o	0	•			93. 99
200.00 Subtotal (see in		o	1, 159	1			200.00
1 1	Lab. Services-Program	O	,				201. 00
Only Charges	3						
	ne 200 - line 201)	o	1, 159				202. 00

Health Financial Systems	BLESSING HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-0015	Peri od: From 10/01/2022	Worksheet D-1	
			Date/Time Pre 12/29/2023 3:	
	Title XVIII	Hospi tal	PPS	
Cost Center Description	· ·			
· ·			1. 00	
DART I _ ALL DROVEDED COMPONENTS		-		

		Title XVIII	Hospi tal	PPS	34 piii
	Cost Center Description	THE XVIII	nospi tui	113	
	<u> </u>			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			63, 618	1.00
2.00	Inpatient days (including private room days, excluding swing-le Private room days (excluding swing-bed and observation bed day		vota room dava	63, 618 0	2.00
3. 00	do not complete this line.	(S). IT you have only pri	vate room days,	Ü	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		58, 470	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period	3 .			
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		04 6 11		7.00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through becember	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) area becomes of	01 1110 0031	· ·	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	20, 926	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days)	0	10. 00
11 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or	II ons)		0	11 00
11. 00	December 31 of the cost reporting period (if calendar year, er		oom days) arter	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
	through December 31 of the cost reporting period	y (			
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
	after December 31 of the cost reporting period (if calendar ye			_	
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	lays)	0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			0	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
	reporting period	g			
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s 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 th	na cost	0.00	20. 00
20.00	reporting period	s arter becomber 51 or tr	10 0031	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions	s)		103, 601, 378	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporti	ng period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	na neriod (line	0	24. 00
24.00	7 x line 19)	or the cost reportin	ig perrou (Trile	O	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)				
	Total swing-bed cost (see instructions)	(II		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		103, 601, 378	27.00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation hed cha	rnes)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	and observation bed ene	11 903)	0	29. 00
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 -	- line 28)		0.000000	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir		i ons)	0.00	
35.00	Average per diem private room cost differential (line 34 x line)	ne 31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	0 103, 601, 378	36. 00 37. 00
57.00	27 minus line 36)	and private room cost dir	renential (Title	103, 001, 370	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	*		1, 628. 49	
39. 00	Program general inpatient routine service cost (line 9 x line	•		34, 077, 782	39. 00
40.00	Medically necessary private room cost applicable to the Program general inpatient routine service cost (Line 20)	•		24 077 792	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ ITHE 40)	l	34, 077, 782	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	BLESSING H		CCN: 14-0015	Peri od:		worksheet D-1	
					From 10/07 To 09/30	1/2022 0/2023	Date/Time Prep 12/29/2023 3:	
				e XVIII	Hospi t		PPS	
	Cost Center Description	Total Inpatient Cost	Total npatient Day	Average Pes Diem (col. col. 2)		Days	Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4.00		5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0 0	. 00	0	0	42.00
43.00	INTENSIVE CARE UNIT	13, 685, 146	5, 80	9 2, 355	. 85	2, 139	5, 039, 163	1
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT							44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT							46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description							47. 00
	·						1. 00	
48. 00 48. 01	Program inpatient ancillary service cost (Wk			III line 1	0 column 1)		31, 391, 246 0	48. 00 48. 01
49. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				u, corumn r)	)	70, 508, 191	
FO 00	PASS THROUGH COST ADJUSTMENTS			14/1 L D	6.5.		4 074 000	
50. 00	Pass through costs applicable to Program inp	atient routine	services (Tro	m WKST. D, S	um or Parts	ı and	4, 374, 039	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Part	ts II	2, 878, 834	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)					7, 252, 873	52. 00
53.00	Total Program inpatient operating cost exclu	ding capital re	lated, non-ph	ysician anes	thetist, and	t	63, 255, 318	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)						1
54.00	Program di scharges							54. 00
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge						0.00	55. 00 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				>		0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (	line 56 minu	s line 53)		0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost rep	orting perio	d ending 199	96,		59.00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	m prior year	cost report	undated by	tho	0.00	60.00
00.00	market basket)	01 11110 33 1101	ii piroi yeai	cost report,	updated by	tric	0.00	00.00
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les						0	61.00
	53) are less than expected costs (lines 54 x							
62. 00	enter zero. (see instructions) Relief payment (see instructions)							62.00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)					63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine cos	ts through Daca	mber 31 of th	e cost renor	ting period	(Soo	0	64. 00
04.00	instructions)(title XVIII only)	Ü		•	0 .	,		
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reporti	ng period (S	See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XV	III only); f	for	0	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost	renortina ne	eri od		67. 00
07.00	(line 12 x line 19)	3						
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost re	porting peri	od	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient						0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil				7)			70.00
71. 00	Adjusted general inpatient routine service c	ost per diem (I		•	• ,			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(lino 14 v l	ino 25)				72. 00 73. 00
74. 00	Total Program general inpatient routine serv							74.00
75. 00	Capital -related cost allocated to inpatient	routine service	costs (from	Worksheet B,	Part II, co	ol umn		75. 00
76. 00	26, line 45)  Per diem capital-related costs (line 75 ÷ li	ne 2)						76. 00
77. 00	Program capital-related costs (line 9 x line	76)						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovider recor	ds)				78. 00 79. 00
80. 00	Total Program routine service costs for comp				inus line 79	9)		80.00
81.00	Inpatient routine service cost per diem limi		`					81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (							82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	structions)						84. 00
85.00	Utilization review - physician compensation							85. 00 86. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS:		ougn ob)					00.00
	Total observation bed days (see instructions						5, 148	87. 00
87. 00 88. 00	Adjusted general inpatient routine cost per		line 2)				1, 628. 49	00 00

Health Financial Systems	BLESSING H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2022 To 09/30/2023	Date/Time Prep 12/29/2023 3:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	7, 752, 585	103, 601, 378	0. 07483	1 8, 383, 467	627, 343	90.00
91.00 Nursing Program cost	4, 122, 537	103, 601, 378	0. 03979	2 8, 383, 467	333, 595	91.00
92.00 Allied health cost	0	103, 601, 378	0.00000	8, 383, 467	0	92.00
93.00 All other Medical Education	0	103, 601, 378	0. 000000	8, 383, 467	0	93. 00

Health Financial Systems	BLESSING HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-0015	Peri od: From 10/01/2022	Worksheet D-1
	Component CCN: 14-T015	To 09/30/2023	Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	Subprovi der -	PPS

		litle XVIII	I RF	PPS	
	Cost Center Description		110	1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			4, 630	1. 00
2.00	Inpatient days (including private room days, excluding swing-			4, 630	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation by	ed days)		4, 630	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 ro	om days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
7.00	reporting period	" days) trii dagii becember	31 of the cost	O	7.00
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)			0.700	0.00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swing-bed and	2, 790	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days)	0	10. 00
	through December 31 of the cost reporting period (see instruc	tions)	,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, endowng-bed NF type inpatient days applicable to titles V or XI.		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	a compared and privat	c room days)	G	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar y			0	14. 00
15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	-)		5, 633, 416	21. 00
21.00	Swing-bed cost applicable to SNF type services through December		ina period (line	0, 033, 410	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	na period (line	0	24. 00
2 00	7 x line 19)	. or or the east report.		Ü	2 00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
26 00	x line 20) 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)		5, 633, 416	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 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	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00 35. 00	Average per diem private room charge differential (line 32 mil Average per diem private room cost differential (line 34 x li		tions)	0. 00 0. 00	•
36. 00	Private room cost differential adjustment (line 3 x line 35)	10 01)		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	5, 633, 416	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 216. 72	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			3, 394, 649	39. 00
40.00	Medically necessary private room cost applicable to the Program general inputions routing service cost (Line 30)	,		2 204 640	
41.00	Total Program general inpatient routine service cost (line 39	+ ITTIE 40)	I	3, 394, 649	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	BLESSI NG F	Provider ( Component	CCN: 14-0015 CCN: 14-T015 e XVIII	Peri od: From 10/01/2022 To 09/30/2023 Subprovi der -		pared:
	Cost Center Description	Total Inpatient Cost		col . 2)	÷	Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00 00 0	5.00	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	l ol		0 0.0	00 0	0	43.00
44. 00 45. 00 46. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						44. 00 45. 00 46. 00 47. 00
	Cost Center Description			•		1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			1, 126, 768	48. 00
	Program inpatient cellular therapy acquisition total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS				, column 1)	0 4, 521, 417	
50. 00	Pass through costs applicable to Program inp	atient routine	servi ces (fro	m Wkst. D, sur	m of Parts I and	284, 748	50.00
51. 00	Pass through costs applicable to Program inpand IV)		y services (f	rom Wkst. D, s	sum of Parts II	70, 584	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu- medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	ding capital re	lated, non-ph	ysician anestl	hetist, and	355, 332 4, 166, 085	
54. 00	Program discharges					0	54.00
	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				0. 00 0. 00	
56. 00	Target amount (line 54 x sum of lines 55, 55	. 01, and 55. 02)				0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (	line 56 minus	line 53)	0	
	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost rep	orting period	endi ng 1996,	0.00	
60. 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 market basket)					0.00	60. 00
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of t	he amount by	which operation	ng costs (line	0	61.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost report	ing period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	ll onlv): for	0	66. 00
	CAH, see instructions	`		, ,	3,		
	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	0				0	
68. 00 69. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20) Total title V or XIX swing-bed NF inpatient			·	orting period	0	
	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY	, AND ICF/IID	ONLY	`		1
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	•		,	)		70.00
	Program routine service cost (line 9 x line		70 - 11110	_/			72. 00
	Medically necessary private room cost applic		•				73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital -related cost allocated to inpatient	•		•	Part II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
	Inpatient routine service cost (line 74 minumagnes to beneficiaries for excess		rovi don mass	rde)			78. 00 79. 00
	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 79)		80.00
81. 00	Inpatient routine service cost per diem limi	tati on			/		81.00
	Inpatient routine service cost limitation (I		•				82.00
	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		S)				83. 00 84. 00
	Utilization review - physician compensation		ns)				85. 00
86. 00	Total Program inpatient operating costs (sum		rough 85)				86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	   87. 00
87. 00						. 0	, -,

Health Financial S	systems	BLESSI NG 1	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF INF	PATIENT OPERATING COST					Worksheet D-1	
			Component (		From 10/01/2022 To 09/30/2023	Date/Time Pre 12/29/2023 3:	pared: 54 pm_
			Title	XVIII	Subprovi der -	PPS	
					I RF		
Cost (	Center Description						
						1. 00	
89.00 Observation	bed cost (line 87 x line 88) (se	e instructions)				0	89. 00
Cost	Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
			(from line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
		1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATI ON	OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capi tal -rel	ated cost	421, 357	5, 633, 416	0. 07479	6 0	0	90. 00
91.00 Nursing Pro	gram cost	51, 180	5, 633, 416	0. 00908	5 0	0	91. 00
92.00 Allied heal	th cost	0	5, 633, 416	0. 00000	0 0	0	92. 00
93.00 All other M	ledical Education	0	5, 633, 416	0. 00000	0	0	93. 00

Health Financial Systems	BLESSING HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-0015	Peri od: From 10/01/2022	Worksheet D-1
	Component CCN: 14-5643	To 09/30/2023	Date/Time Prepared: 12/29/2023 3:54 pm
	Title XVIII	Skilled Nursing	PPS

Day:			Title XVIII	Skilled Nursing Facility	PPS	
PART 1 - ALL PROVIDER COMPONENTS		Cost Center Description			1.00	
Inpatt int days (Including private room days and swing-bed days, excluding neeborn)		PART I - ALL PROVIDER COMPONENTS			1.00	
Impattent days (including private room days, excluding swing-bed and neberon days)   4,765   2,00		I NPATI ENT DAYS				
Private room days (excluding swing-bed and observation bed days). If you have only private room days. do not complete this it sked using swing-bed and observation bed days).  5.00 Sell-private room days (excluding swing-bed and observation bed days).  5.00 Room of the cost reporting period (it called and private room days) through December 31 of the cost reporting period (it called and reporting period (it call						
do not complete this line.  4. 00 Semi-private room days (sexcluding swing-bed and observation bed days) through December 31 of the cost						
5.00 Total swing-bed SF type inpatient days (including private room days) after December 31 of the cost proporting period of the swing-bed SF type inpatient days (including private room days) after December 31 of the cost proporting period of the swing-bed SF type inpatient days (including private room days) after December 31 of the cost proporting period of the swing-bed NF type inpatient days (including private room days) after December 31 of the cost proporting period of the swing-bed NF type inpatient days (including private room days) after December 31 of the cost proporting period of the calledar year, enter 0 on this 11 na) private room days including private room days after December 31 of the cost proporting period of the cost proporting period of the cost reporting period of cost instructions) and the cost reporting period of cost instructions after the cost reporting period of cost inters volve the cost period by the cost reporting period of cost inters volve the cost period by the cost reporting period of cost inters volve the cost period by the cost reporting period of cost inters volve the cost period by the	3.00		ys). If you have only pr	rivate room days,	0	3.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 reporting period (if calendar year, enter 0 on this line)  8.01 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8.02 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.03 For a swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10.03 Swing-bed SNF type inpatient days (applicable to the Program (excluding swing-bed and nowborn days) (see instructions)  11.00 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days)  12.00 Swing-bed SNF type inpatient days applicable to the swing-type type inpatient days applicable to the swing-type type inpatient days applicable to the swing-type type inpatient days applicable to the swing-type type inpatient days applicable to the swing-type type inpatient days applicable to the swing-type type inpatient days applicable to the swing-type type inpatient days applicable to the swing-type type inpatient days applicable to the swing-type type inpatient days applicable to the swing-type type inpatient days applicable to the swing-type type inpatient days applicable to the swing-type type inpatient days applicable to swing-type type inpatient days applicable to swing-type inpatient days applicable to swing-type inpatient days applicable to swing-type inpatient days applicable to swing-type inpatient days applicable to swing-type inpatient days applicable to swing-type inpatient days applicable to swing-type inpatient days applicable to swing-type inpatient days applicable to swing-type inpatient days applicable to swing-type inpatient days applicable to swing-type inpatient days applicable to s	4 00	!	ed days)		4 765	4 00
reporting period (				er 31 of the cost		
reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed NF type inpatient days (including private room days) shrough December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12. 00 Swing-bed Swing-bed Swing-bed Swing-bed (if calendar year, enter 0 on this line) 13. 00 Swing-bed Swing-bed Swing-bed Swing-bed (if calendar year, enter 0 on this line) 14. 00 Swing-bed Swi					_	
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line)   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line)   Total inpatient days including private room days applicable to the Program (excluding swing-bed and private room days)   Total inpatient days including private room days applicable to title XVIII only (including private room days)   Total proporting period (see instructions)   Total	6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
Reporting period   Section   Secti						
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)   10.00	7. 00		m days) through December	131 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after on through becember 31 of the cost reporting period (see instructions)  12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after on through becember 31 of the cost reporting period  13. 00 Swing-bed NF type Inpatient days applicable to titles V or XIX only (including private room days)  14. 00 Swing-bed NF type Inpatient days applicable to titles V or XIX only (including private room days)  15. 00 Swing-bed NF type Inpatient days applicable to titles V or XIX only (including private room days)  16. 00 Swing-bed NF type Inpatient days applicable to titles V or XIX only (including private room days)  17. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  18. 00 Nursery days (title V or XIX only)  18. 00 Nursery days	8 00	1	m days) after December (	R1 of the cost	0	8 00
Total inpatient days including private room days applicable to the Program (excluding swing-bed and and and and applicable to title XVIII only (including private room days)   0.00	0.00		ii days) ai tei becembei .	of the cost	O	0.00
10.00   Swing-bed SNF type Inpatient days applicable to title XVIII only (Including private room days)   10.00   11.00   11.00   11.00   11.00   12.00   11.	9.00		o the Program (excluding	swing-bed and	3, 297	9. 00
through December 31 of the cost reporting period (see instructions)  1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.14.00 Medically necessary private room days applicable to the Program (excluding Swing-bed days)  1.14.00 Medically necessary private room days applicable to the Program (excluding Swing-bed days)  1.15.00 Novery days (title V or XIX only)  1.17.00 Novery days (title V or XIX only)  1.18.00 Novery days (title V or XIX only)  1.19.00 Novery days (title V			-			
11.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type Inpatient days applicable to titles V or XIX only (Including private room days) 13.00 Swing-bed NF type Inpatient days applicable to titles V or XIX only (Including private room days) 14.00 Swing-bed NF type Inpatient days applicable to titles V or XIX only (Including private room days) 15.00 Into Into Incress and Into the cost reporting period (if calendar year, enter 0 on this line) 16.00 Nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Swing Bed ADUSIWENT 17.00 Red care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period or swing-bed SNF services applicable to services after December 31 of the cost reporting period or swing-bed NF services applicable to services through December 31 of the cost 18.00 Program period or swing-bed NF services applicable to services after December 31 of the cost 18.00 Nedicaid rate for swing-bed NF services applicable to services after December 31 of the cost 18.00 Nedicaid rate for swing-bed NF services applicable to services after December 31 of the cost 18.00 Nedicaid rate for swing-bed NF services applicable to services after December 31 of the cost 18.00 Nedicaid rate for swing-bed NF services applicable to services after December 31 of the cost 18.00 Nedicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17) 18.00 Nedicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 x line 18) 18.00 Nedicaid rate for swing-bed NF services after December 31 of the cost reporting period (line 6 x line 18) 18.00 Nedicaid rate for swing-bed to NF type services after December 31 of the cost reporting period (line 6 x line 18) 18.00 Nedicaid rate for swing-bed cost applic	10. 00			room days)	0	10. 00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)   12. 00   12. 00   12. 00   13. 00   13. 00   14. 00   14. 00   15. 00	11 00	through December 31 of the cost reporting period (see instructions and SNE type inpatient days applicable to title VVIII of	tions) nly (including private i	soom dovs) after	0	11 00
12.00 Swing-bed NF type Inpatient days applicable to titles V or XIX only (Including private room days) 13.00 Swing-bed NF type Inpatient days applicable to titles V or XIX only (Including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (Including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Total general inpatient routine service cost (see instructions) 19.00 Total general inpatient routine service cost (see instructions) 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 2 2 0 0 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1	11.00	December 31 of the cost reporting period (if calendar year e	nter 0 on this line)	oolii days) ai tei	U	11.00
through December 31 of the cost reporting period  13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15. 00  16. 00  17. 00 Total nursery days (title V or XIX only)  17. 00 Medicaler rate for swing-bed SNF services applicable to services through December 31 of the cost  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services after December 31 of the cost reporting period (line 5 5,698,924 21.00  19. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 2 2.00  19. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 2 2.00  19. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 2 2.00  19. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 2 2.00  19. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 2 2.00  19. 00 Swi	12. 00			te room davs)	0	12. 00
after December' 31 of the cost reporting period (if calendar year, enter 0 on this line)   14, 00   14, 00   15.00   10   10   10   10   10   10   10		through December 31 of the cost reporting period	3 ( 3 )	, ,		
14.00   Modically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   0   15.00   16.00   0   15.00   0   15.00   0   15.00   0   15.00   0   15.00   0   15.00   0   15.00   0   15.00   0   15.00   0   15.00   0   15.00   0   15.00   0   15.00   0   15.00   0   15.00   0   0   0   0   0   0   0   0   0	13. 00				0	13.00
15.00 Total nursery days (title V or XIX only)  16.00 Nesery days (title V or XIX only)  17.00 SWING BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line of reporting period of reporting period of reporting period of reporting period of least of reporting period of least of reporting period of least of reporting period of least of reporting period of least of lea	44.00					44.00
16.00   Nursery days (title V or XIX only)   17.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   19.00			am (excluding swing-bed	days)	-	
SWING BED ADJUSTMENT  17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period period reporting reporting reporting reporting reporting reporting reporting reporting reporting reporting reporting period reporting repor						
17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 18.00 reporting period medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 0.00 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 reporting period or reporting period Proporting period Proporting period Proporting period Proporting period Proporting period Proporting Pro	10.00					10.00
18.00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   19.00   19.	17. 00		es through December 31 (	of the cost	0.00	17. 00
reporting period Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period reporting period Properting period Properting period Properting period Properting period Properting period Properting period Properting period Properting period Properting period Properting	40.00		6. 5			40.00
19.00   Medical d rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   2	18.00		es after December 31 of	the cost	0.00	18.00
reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 + line 3)  31.00 Average per diem private room per diem charge (line 30 + line 4)  32.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  33.00 Average per diem private room cost differential (line 32 minus line 33)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)	19. 00		s through December 31 of	f the cost	0.00	19. 00
reporting period Total general inpatient routine service cost (see instructions)  22.00  Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  25.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00  Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00  Total swing-bed cost (see instructions)  Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges)  Semi-private room charges (excluding swing-bed charges)  Ceneral inpatient routine service cost/charge ratio (line 27 + line 28)  Comparison of the cost reporting period (line 8 x line 3)  Comparison of the cost reporting period (line 8 x line 3)  Comparison of the cost reporting period (line 8 x line 3)  Comparison of the cost reporting period (line 8 x line 3)  Comparison of the cost reporting period (line 8 x line 3)  Comparison of the cost reporting period (line 8 x line 3)  Comparison of the cost reporting period (line 8 x line 3)  Comparison of the cost reporting period (line 8 x line 3)  Comparison of the cost reporting period (line 9 x line 3)  Comparison of the cost reporting period (line 9 x line 3)  Comparison of the cost reporting period (line 9 x line 3)  Comparison of the cost reporting period (line 9 x line 3)  Comparison of the cost reporting period (line 9 x line 3)  Comparison of the cost reporting period (line 9 x line 3)  Comparison of the cost reporting						
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5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost net of service charges (excluding swing-bed and observation bed charges)  31.00 General inpatient routine service cost net of service charges (excluding swing-bed and observation bed charges)  31.00 Semi-private room charges (excluding swing-bed charges)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average perivate room per diem charge (line 29 + line 3)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 698, 924)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				ting period (line		
x line 18)  24.00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  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)  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Somi-private room charges (excluding swing-bed charges)  Somi-private room charges (excluding swing-bed charges)  Somi-private room charges (excluding swing-bed charges)  Somi-private room charges (excluding swing-bed charges)  Average private room per diem charge (line 29 + line 3)  Average perivate room per diem charge (line 30 + line 4)  Average per diem private room cost differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Coeneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 698, 924)  PRATI II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost per diem (see instructions)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  Adough Medically necessary private room cost applicable to the Program (line 14 x line 35)				3   1   1   1		
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7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ± line 28)  32.00 Average private room per diem charge (line 29 ± line 3)  33.00 Average semi-private room per diem charge (line 30 ± line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 34)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 698, 924)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00	24.00	· · · · · · · · · · · · · · · · · · ·	r 21 of the cost managet:	ng poriod (line	0	24.00
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26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average semi-private room per diem charge (line 30 ÷ line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Frivate room cost differential adjustment (line 3 x line 35)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 698, 924)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 698, 924)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 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)  40.00	25. 00	,	31 of the cost reporting	g period (line 8	0	25. 00
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35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 698, 924)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  35.00 36.00 37.00  37.00 37.00 37.00			nuc lino 22\(coo i mo+	ations)		
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	41. 00	1 1				41. 00

	Financial Systems	BLESSI NG 1		20N 14 001F		eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CCN: 14-0015	Peri od: From 10/01/2022	Worksheet D-1	
			Component	CCN: 14-5643	To 09/30/2023	Date/Time Pre	
			Title	e XVIII	Skilled Nursing	12/29/2023 3: PPS	54 pm
		ı		_	Facility -		
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	impatrent bays	col. 2)	7	(col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)					<u> </u>	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT			1		I	43. 00
	CORONARY CARE UNIT						44. 00
	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
	·					1. 00	
	Program inpatient ancillary service cost (Wk			111 1: 10	1 1)		48. 00
	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				corumn 1)		48. 01 49. 00
50	PASS THROUGH COST ADJUSTMENTS		., (555 111511 40				1
50.00	Pass through costs applicable to Program inp	atient routine	services (from	m $\overline{Wkst.}$ D, sum	of Parts I and		50.00
51. 00	  Pass through costs applicable to Program inp	atient ancillar	v services (f	rom Wkst D a	sum of Parts II		51.00
51.00	and IV)	acront and Hal	y Scrvices (II	OIII WAST. D, S	oun or rarts II		] 31.00
52. 00	Total Program excludable cost (sum of lines						52. 00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-phy	ysician anesth	etist, and		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					1
	Program di scharges						54.00
	Target amount per discharge						55. 00
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)					55. 0° 55. 0°
	Target amount (line 54 x sum of lines 55, 55						56. 00
	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	line 56 minus	line 53)		57.00
	Bonus payment (see instructions)	on line EE from	+bo ooo+ ron		anding 100/		58. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)		the cost repo	orting period	ending 1996,		59. 00
60.00	Expected costs (lesser of line 53 ÷ line 54,		m prior year o	cost report, ι	pdated by the		60.00
(1.00	<pre>market basket) Continuous improvement bonus payment (if lin</pre>	o E2 . Lino E4	ic loca than t	the lowest of	Lines EE plus		(1.00
61. 00	55.01, or line 59, or line 60, enter the les						61.00
	53) are less than expected costs (lines 54 x						
(2.00	enter zero. (see instructions)						(2.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)				62.00
	PROGRAM INPATIENT ROUTINE SWING BED COST	(000 1110 11					1
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reporti	ng period (See		64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the d	cost reporting	period (See		65.00
	instructions)(title XVIII only)				, , , , , , , , , , , , , , , , , , , ,		
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	65)(title XVII	I only); for		66.00
67. 00	CAH, see instructions  Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 d	of the cost re	porting period		67.00
	(line 12 x line 19)						
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	orting period		68.00
69. 00	(line 13 x line 20)  Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + line	e 68)			69.00
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY			
	Skilled nursing facility/other nursing facil					5, 698, 924	1
	Adjusted general inpatient routine service c Program routine service cost (line 9 x line	, ,	ine /U = IINe	۷)		1, 196. 00 3, 943, 212	
73.00	Medically necessary private room cost applic		(line 14 x li	ine 35)		0	73.00
74.00	Total Program general inpatient routine serv				loot III	3, 943, 212	
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	COSIS (From V	worksneet B, F	art II, COIUMN	0	75.00
	Per diem capital-related costs (line 75 ÷ li	ne 2)				0.00	76.00
	Program capital -related costs (line 9 x line					0	
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi den recon	45)		0 0	
80.00	Total Program routine service costs for comp				nus line 79)	0	1
81. 00	Inpatient routine service cost per diem limi	tati on		•	,	0.00	81.00
82.00	Inpatient routine service cost limitation (I		* .			0 2 042 212	
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		5)			3, 943, 212 1, 065, 687	
	Utilization review - physician compensation		ns)			0	85.00
86.00	Total Program inpatient operating costs (sum	of lines 83 th	rough 95)			5, 008, 899	86.00

> 0 87.00 0.00 88.00

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

87.00 Total observation bed days (see instructions)

88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)

Health Financial Systems	BLESSING F	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 14-0015 Peri od:			Worksheet D-1	
		Component (	CCN: 14-5643	From 10/01/2022 To 09/30/2023		
		Title	XVIII	Skilled Nursing	PPS	
				Facility -		
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH O	OST					
90.00 Capital -related cost	0	0	0.00000	0 0	0	90. 00
91.00 Nursing Program cost	0	o	0. 00000	0 0	0	91. 00
92.00 Allied health cost	0	o	0. 00000	0 0	0	92. 00
93.00 All other Medical Education	0	o	0. 00000	0 0	0	93. 00

Health Financia	al Systems BLE	SSING HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCI	LLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 14-0015	Peri od:	Worksheet D-3	
				From 10/01/2022	D . /T' D	
				To 09/30/2023		
		Ti +l c	e XVIII	Hospi tal	12/29/2023 3: PPS	34 piii
Co	ost Center Description	11 11 6	Ratio of Cos		Inpati ent	
	ost center bescription		To Charges	Program	Program Costs	
			10 charges	Charges	(col. 1 x col.	
				onal goo	2)	
			1.00	2. 00	3. 00	
I NPATI EN	NT ROUTINE SERVICE COST CENTERS					
30. 00 03000 AD	DULTS & PEDIATRICS			58, 647, 995		30.00
31.00 03100 I N	NTENSIVE CARE UNIT			23, 973, 709		31. 00
41. 00 04100 SU	UBPROVIDER - IRF			0		41.00
43. 00 04300 NU	JRSERY					43.00
ANCI LLAF	RY SERVICE COST CENTERS					
50. 00 05000 OF	PERATING ROOM		0. 19988	24, 881, 630	4, 973, 465	50.00
52. 00   05200 DE	ELIVERY ROOM & LABOR ROOM		0. 17779	0 0	0	52.00
53. 00   05300 AN	NESTHESI OLOGY		0. 02373	8, 045, 492	190, 992	53.00
54.00 05400 RA	ADI OLOGY-DI AGNOSTI C		0. 15912	9, 617, 041	1, 530, 264	54.00
55. 00   05500 RA	ADI OLOGY-THERAPEUTI C		0. 14647	<sup>75</sup> 471, 510	69, 064	55. 00
57. 00   05700 CT	Γ SCAN		0. 01573	24, 599, 417	387, 023	57. 00
58. 00   05800 MA	AGNETIC RESONANCE IMAGING (MRI)		0.04749	4, 807, 449	228, 325	58. 00
60.00 06000 LA	ABORATORY		0. 08401	1 43, 225, 411	3, 631, 410	60.00
62.00 06200 WH	HOLE BLOOD & PACKED RED BLOOD CELLS		0. 17315	2, 655, 676	459, 838	62. 00
65. 00 06500 RE	ESPIRATORY THERAPY		0. 15467	10, 082, 957	1, 559, 622	65. 00
	HYSI CAL THERAPY		0. 36231	9 1, 463, 852	530, 381	66. 00
67. 00 06700 00	CCUPATI ONAL THERAPY		0. 26206	1, 018, 878	267, 011	67. 00
68. 00   06800 SP	PEECH PATHOLOGY		0. 19768	509, 358	100, 694	68. 00
	LECTROCARDI OLOGY		0. 05370		1, 210, 342	69. 00
70. 00   07000 EL	LECTROENCEPHALOGRAPHY		0. 22307	76 417, 125	93, 051	70. 00
71. 00 07100 ME	EDICAL SUPPLIES CHARGED TO PATIENTS		0. 12328	30, 804, 380	3, 797, 780	71. 00
72.00 07200 I N	MPL. DEV. CHARGED TO PATIENTS		0. 15248	25, 733, 011	3, 923, 847	72. 00
	RUGS CHARGED TO PATIENTS		0. 09376		5, 572, 726	73. 00
	ENAL DIALYSIS		0. 50293	1, 073, 942	540, 119	74. 00
	ENT SERVICE COST CENTERS					
	AST ADAMS RHC		0.00000		0	88. 00
1 1	8TH AND MAINE RHC		0.00000		0	88. 01
	T STERLING RHC		0.00000		0	88. 02
	AIN CAMPUS RHC		0.00000		0	88. 03
	LESSING EXPRESS CLINIC		0.00000		0	88. 04
	LESSING WALK IN CLINIC		0.00000		0	88. 05
	ANNI BAL MAIN RHC		0.00000		0	88. 06
	ALMYRA RHC		0.00000		0	88. 07
	OWLING GREEN RHC		0.00000		0	88. 08
90. 00   09000 CL			0. 45369		13, 294	90.00
1 1	UTPATIENT INFUSION		0. 31574		3, 340	90. 01
90. 02 04950 ON			0. 37534		3, 698	
	ANNI BAL I NFUSI ON		2. 09842		0	90. 03
	MERGENCY		0. 21563		1, 850, 343	1
	BSERVATION BEDS (NON-DISTINCT PART)		0. 47434		454, 617	92.00
	ARTIAL HOSPITALIZATION PROGRAM	ıb 00)	0. 61559		0	93. 99
1 1	otal (sum of lines 50 through 94 and 96 through	•		280, 970, 653	31, 391, 246	1
	ess PBP Clinic Laboratory Services-Program onlet charges (line 200 minus line 201)	y charges (Title of)		280, 970, 653		201. 00 202. 00
202.00    NE	st charges (Title 200 millius Title 201)		I	200, 970, 003	I	1202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider Component		Peri od: From 10/01/2022 To 09/30/2023	Worksheet D-3 Date/Time Pre 12/29/2023 3:	pare
	Ti tl e	: XVIII	Subprovi der -	PPS	<u> </u>
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS					30.
31. 00   03100   NTENSI VE CARE UNI T					31.
41. 00   04100   SUBPROVI DER -   RF			5, 508, 340		41.
3. 00   04300 NURSERY			, , , , , , , , , , , , , , , , , , , ,		43
ANCILLARY SERVICE COST CENTERS					1
50. 00 05000 OPERATING ROOM		0. 19988	51, 557	10, 305	50.
2.00   05200   DELIVERY ROOM & LABOR ROOM		0. 17779	0 0	0	52
3. 00   05300   ANESTHESI OLOGY		0. 02373	2, 662	63	53
4. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 15912	185, 665	29, 543	54
5. 00   05500   RADI OLOGY-THERAPEUTI C		0. 14647	75 0	0	55
7. 00  05700   CT   SCAN		0. 01573	98, 098	1, 543	57
8.00   05800   MAGNETIC RESONANCE I MAGING (MRI)		0. 04749		2, 087	58
0. 00   06000   LABORATORY		0. 08401		67, 920	
2.00  06200  WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 17315		4, 848	
5. 00 06500 RESPI RATORY THERAPY		0. 15467			
6. 00   06600   PHYSI CAL THERAPY		0. 36231	1 ' '	445, 946	
7. 00   06700   OCCUPATI ONAL THERAPY		0. 26206	1 ' '		
8. 00   06800   SPEECH PATHOLOGY		0. 19768		54, 042	
9. 00   06900   ELECTROCARDI OLOGY		0.05370		l .	
0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 22307		l e	
1. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 12328		10, 175	
2.00   07200   IMPL. DEV. CHARGED TO PATIENTS 3.00   07300   DRUGS CHARGED TO PATIENTS		0. 15248 0. 09376			72
4. 00   07400   RENAL DI ALYSI S		0. 50293	1 ' '	136, 521 7, 041	
OUTPATIENT SERVICE COST CENTERS		0. 30243	13, 777	7,041	′4
8. 00 08800 EAST ADAMS RHC		0.00000	10	0	88
8. 01   08801   48TH   AND   MAI NE   RHC		0. 00000		Ö	88
8. 02   08802   MT   STERLING   RHC		0. 00000		Ö	88
8. 03   08803   MAI N CAMPUS RHC		0. 00000		Ö	88
8. 04   08804   BLESSI NG EXPRESS CLI NI C		0. 00000		o o	88
8.05 08805 BLESSING WALK IN CLINIC		0. 00000		Ō	88
8. 06   08806   HANNI BAL MAIN RHC		0.00000		0	88
8. 07 08807 PALMYRA RHC		0. 00000		0	88
8. 08 08808 BOWLING GREEN RHC		0.00000		0	88
00. 00   09000   CLI NI C		0. 45369	0 8	0	90
PO. 01 09001 OUTPATIENT INFUSION		0. 31574	5 0	0	90
00. 02   04950   0NCOLOGY		0. 37534		0	90
PO. 03   04951   HANNI BAL I NFUSI ON		2. 09842			90
91 00 09100 FMERGENCY		0 21563	.al n	l n	01

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0. 215638

0. 474346

0. 615592

5, 734, 023

91. 00 09100 EMERGENCY

202.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

92.00 | 09200| 085ERVATION BEDS (NON-DISTINCT FART)
93.99 | 09399 | PARTIAL HOSPITALIZATION PROGRAM
200.00 | Total (sum of lines 50 through 94 and 96 through 98)
201.00 | Less PBP Clinic Laboratory Services-Program only charges (line 61)

	ESSING HOSPITAL			eu of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CO	:N: 14-0015	Peri od: From 10/01/2022	Worksheet D-3	3
	Component (	CCN: 14-5643	To 09/30/2023	Date/Time Pre 12/29/2023 3:	pare 54 p
	Title	XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1. 00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
30. 00 03000 ADULTS & PEDIATRICS					30.
B1. 00 03100 INTENSIVE CARE UNIT					31.
41. 00   04100   SUBPROVI DER -   I RF					41.
13. 00   04300   NURSERY					43.
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 19988	78, 390	15, 669	50.
2.00   05200   DELIVERY ROOM & LABOR ROOM		0. 17779	91 0	0	52.
3. 00 05300 ANESTHESI OLOGY		0. 02373	39 0	0	53.
4. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 15912	20 196, 955	31, 339	54.
5. 00   05500   RADI OLOGY-THERAPEUTI C		0. 14647	75 0	0	55.
57.00  05700 CT SCAN		0. 01573		0	1
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 04749		0	58.
00. 00   06000   LABORATORY		0. 08401			1
52. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 17315			
55. 00   06500   RESPI RATORY THERAPY		0. 15467			1
06. 00   06600   PHYSI CAL THERAPY		0. 36231			
57. 00   06700  OCCUPATI ONAL THERAPY 58. 00   06800  SPEECH PATHOLOGY		0. 2620 <i>6</i> 0. 19768			1
99. 00   06900   SPEECH PATHOLOGY		0. 05370			1
70. 00   07000   ELECTROENCEPHALOGRAPHY		0. 22307			1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 12328		16, 532	
22.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 15248		0	1
73. OO O7300 DRUGS CHARGED TO PATIENTS		0. 09376			
74. 00   07400   RENAL DIALYSIS		0. 50293			
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 EAST ADAMS RHC		0. 00000	00	0	88.
8.01   08801   48TH AND MAINE RHC		0.00000	00	0	88.
8. 02   08802   MT   STERLI NG   RHC		0.00000	00	0	88.
8. 03   08803   MAIN CAMPUS RHC		0.00000		0	88.
88. 04 08804 BLESSING EXPRESS CLINIC		0. 00000		0	
88. 05   08805   BLESSING WALK IN CLINIC		0.00000		0	
38. 06   08806   HANNI BAL MAI N RHC		0. 00000		0	1
88. 07   08807   PALMYRA RHC		0. 00000		0	
38. 08   08808   BOWLI NG GREEN RHC		0.00000		0	1 00.
90. 00   09000  CLINI C 20. 01   09001  OUTPATI ENT. I NEUSLON		0. 45369 0. 3157/			
JO OF IOGOTIOHERALIENT INFINION		0 3 15 7/	ומו ()	i ()	1 40

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202. 00

0.315745

0. 375342

2. 098429

0. 215638

0.474346

0. 615592

6, 727, 994

6, 727, 994

91. 00 09100 EMERGENCY

04950 ONCOLOGY

09001 OUTPATIENT INFUSION

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM
200. 00 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)

04951 HANNIBAL INFUSION

90.01

90. 02

90. 03

201.00

202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0015	Peri od: From 10/01/2022 To 09/30/2023	Worksheet E Part A Date/Time Prepared: 12/29/2023 3:54 pm
	T: +1 a V/// / /	Hooni tol	DDC

October 1 (see Instructions)   0.00		Title XVIII Hospital	12/29/2023 3: PPS	54 pm
AND THE PROPERTY AS SERVICES UNDER FINS  1.00 BROK Aments of their than outlier payments for discharges accurring prior to October 1 (see			1 00	
1.00   NOC Amounts Other than Outlier payments for discharges occurring prior to October 1 (see   44, 149, 548   1.02		PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	1.00	
Instructions   1.02   Refine autilitier payments for discharges occurring on an after October 1 (seen   48, 149, 548   1.02   Refine autilities pacific operating payment for Model 4 BPCI for discharges occurring on or after   0.103   1.03		DRG Amounts Other than Outlier Payments	1	
1.0.2   Dist amounts other than outlier payments for discharges occurring on or after october 1 (see   48,149,348   1.0.2	1. 01		0	1. 01
1.000   1.00	1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	48, 149, 548	1. 02
1.04   BRG for Federal specific operating payment for Woole 4 BRCI for discharges occurring on or after   0   1.04	1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to Octob	er 0	1. 03
2.00   Outlier payments for discharges (see instructions)   0.2.00	1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after	0	1. 04
2.02   2.03	2.00			2. 00
2.03   Outlier payments for discharges occurring prior to October 1 (see instructions)   1,931,923   2.04   Outlier payments for discharges occurring on or after October 1 (see Instructions)   1,931,923   2.04   2.04   Outlier payments for discharges occurring on or after October 1 (see Instructions)   274,90   4.00   Outlier of Managed Care Simulated Payments   23,918,488   3.00   Outlier of Managed Care Simulated Payments   23,918,488   3.00   Outlier of Managed Care Simulated Payments   23,918,488   3.00   Outlier of Managed Care Simulated Payments   23,918,488   3.00   Outlier of Managed Care Simulated Payments   23,918,488   3.00   Outlier of Managed Care Simulated Payments   23,918,488   3.00   Outlier of Managed Care Simulated Payments   23,918,488   3.00   Outlier of Managed Care Simulated Payments   3,918,488   3.00   Outlier of Managed Care Simulated Payments   3,918,488   3.00   Outlier of Managed Care Simulated Payments   3,918,488   3,918,488   3.00   Outlier of Managed Care Simulated Payments   3,918,488				
2.04   Out   Ler   payents for discharges occurring on or after October 1 (See Instructions)   1,931,823   204				
Managed Care Simulated Payments   294.90   4.00			-	
Indirect Medical Education Adjustment   1.00   1.				
FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/19/96, (see instructions)   5.01	4.00		294. 90	4. 00
FTE cap adjustment for qualifing hospitals under \$131 of the CAA 2021 (see instructions)   5.00   5.00	5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending	on 13.16	5. 00
FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	5 O1		0.00	5.01
1.00		FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap f	l l	
MAM Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the	6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 o	f 0.00	6. 26
cost report straddles July 1, 2011 then see instructions.  7.02 Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413,75(b) and 87 FR 49075 (August 10, 2022) (see instructions)  8.00 Adjustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 FFR 413,75(b), 413,79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).  8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.  8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)  8.11 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see Instructions)  8.21 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see Instructions)  8.20 Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or Sum of lines 5 and 5.01, plus line 6, plus lines 8.01 through 6.49, minus lines 7 and 7.01, plus or Sum of lines 5 and 5.01, plus line 6, plus lines 8.01 through 6.49, minus lines 7 and 7.01, plus or Sum of lines 1 and postelle FTE court for all opathic and osteopathic programs in the current year from your records  9.00 TEE court for all opathic and osteopathic programs in the current year from your records  10.00 TEE court for all opathic and osteopathic programs.  10.00 TEE court for all opathic fire court for the prior year.  11.01 The amount of increase of the prior year.  12.01 The amount of increase of the prior year.  13.16 12.00 Teach all lowable FTE court for the prior year.  13.16 12.00 Teach all lowable FTE court for the prior year.  13.16 12.00 Teach year all owable free court for the prior year.  13.16 12.00 Teach year.  13.1	7.00		0.00	7. 00
track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)  8.00 Adjustment (Increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(v), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).  8.01 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.  8.02 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost under \$ 5506 of ACA. (see instructions)  8.10 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions)  8.21 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see Instructions)  9.00 Sum of lines S and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)  10.00 FTE count for residents in dental and podiatric programs.  10.01 FTE count for residents in dental and podiatric programs.  10.02 Courrent year all owable FTE (see instructions)  10.03 In 10.04 allowable FTE count for the prior year.  10.04 Courrent year slowable FTE count for the prior year.  10.05 Sum of lines 12 through 14 divided by 3.  10.06 Adjustment for residents displaced by program or hospital closure  10.00 Adjustment for residents displaced by program or hospital closure  10.00 Current year resident to bed ratio (see instructions)  10.00 Current year resident to bed ratio (see instructions)  10.00 Current year resident to bed ratio (see instructions)  10.00 Current year resident to bed ratio (see instructions)  10.00 Current year resident to bed ratio (see instructions)  10.00 Current year resident to bed ratio (see instructions)  10.00 Current year resident to bed rat	7. 01		e 0.00	7. 01
Adjustment (increase or decrease) to the FTE count for all lopathic and osteopathic programs for a fiffiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	7. 02	track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b)		7. 02
1998), and 67 FR 50069 (August 1, 2002).	8. 00		0.00	8. 00
report straddles July 1, 2011, see instructions.   0.00   8.02   1.00				
under § 5506 of ACA. (see instructions)	8. 01		st 0.00	8. 01
instructions	8. 02		0.00	8. 02
minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)   18.25   10.00   11.00   11.00   12.00	8. 21		0.00	8. 21
11.00   FTE count for residents in dental and podiatric programs.   0.00   11.00   Current year allowable FTE (see instructions)   13.16   12.00   13.00   Total allowable FTE count for the prior year.   13.16   13.00   Total allowable FTE count for the prior year.   13.16   13.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, or 13.16   14.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, or 13.16   14.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, or 13.16   14.00   Total allowable FTE count for residents displaced by 3.   13.16   15.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   Adjustment resident to bed ratio (line 18 divided by line 4).   0.044625   19.00   0.00	9. 00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	13. 16	
12.00   Current year allowable FTE (see instructions)   13.16   12.00   13.00   Total allowable FTE count for the prior year.   13.16   13.00   10.0		, , , , , , , , , , , , , , , , , , , ,	l l	
13.10   Total allowable FTE count for the prior year.   13.16   13.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,   13.16   14.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,   13.16   14.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,   13.16   14.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,   13.16   15.00   Total allowable FTE count for residents in initial years of the program (see instructions)   0.00   16.00   16.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   16.00   18.00   18.00   0.00   18.00   0.			1	
14.00				1
15.00   Sum of lines 12 through 14 divided by 3.   13.16   15.00   16.00   Adjustment for residents in initial years of the program (see instructions)   0.00   16.00   17.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   18.00   19.00		Total allowable FTE count for the penultimate year if that year ended on or after September 30, 199		
17.00	15.00	Sum of lines 12 through 14 divided by 3.	13. 16	15. 00
18.00   Adjusted rolling average FTE count   13.16   18.00   19.00				
19.00   Current year resident to bed ratio (line 18 divided by line 4).   0.044625   19.00   20.00   Prior year resident to bed ratio (see instructions)   0.044517   20.00   21.00   Enter the lesser of lines 19 or 20 (see instructions)   1.156, 793   22.00   IME payment adjustment (see instructions)   1.156, 793   22.00   IME payment adjustment - Managed Care (see instructions)   776, 452   22.01   IME payment adjustment - Managed Care (see instructions)   776, 452   22.01   IME payment adjustment for the Add-on for § 422 of the MMA   23.00   (f)(1)(iv)(c).   24.00   IME FTE Resident Count Over Cap (see instructions)   5.09   24.00   IME FTE Resident Count Over Cap (see instructions)   5.09   24.00   IME FTE Resident to bed ratio (divide line 25 by line 4)   0.000000   25.00   IME payments adjustment factor. (see instructions)   0.000000   27.00   IME payments adjustment factor. (see instructions)   0.000000   27.00   IME payments adjustment amount (see instructions)   0.000000   27.00   0.000000   27.00   IME payments adjustment amount (see instructions)   0.000000   27.00   0.00000000			i i	
20.00   Prior year resident to bed ratio (see instructions)   0.044517   20.00   21.00   Enter the lesser of lines 19 or 20 (see instructions)   1.156, 793   22.00   1ME payment adjustment (see instructions)   1.156, 793   22.00   1ME payment adjustment - Managed Care (see instructions)   776, 452   22.01   1ME payment adjustment - Managed Care (see instructions)   776, 452   22.01   1ME payment adjustment - Managed Care (see instructions)   776, 452   22.01   1ME payment adjustment for the Add-on for § 422 of the MMA   776, 452   22.01   776, 452   22.01   776, 452   22.01   776, 452   22.01   776, 452   22.01   776, 452   22.01   776, 452   22.01   776, 452   22.01   776, 452   22.01   776, 452   22.01   776, 452   23.00   776, 452			1	1
21.00   Enter the lesser of lines 19 or 20 (see instructions)   0.044517   21.00   1ME payment adjustment (see instructions)   1,156,793   22.00   1ME payment adjustment - Managed Care (see instructions)   776,452   22.01   1 mid rect Medical Education Adjustment for the Add-on for § 422 of the MMA   23.00   Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105   0.00   23.00   (f)(1)(iv)(C).   24.00   IME FTE Resident Count Over Cap (see instructions)   5.09   24.00   1 mstructions   24.00   1 mstructions   25.00   1 mstructions   25.00   1 mstructions   26.00   Resident to bed ratio (divide line 25 by line 4)   0.000000   25.00   1 mstructions   26.00   1 mstructions   26.00   1 mstructions   26.00   27.00   1 mstructions   28.00   1 mstructions   28.00   1 mstructions   28.00   1 mstructions   28.00   1 mstructions   28.00   1 mstructions   28.00   28			l l	1
22. 01   IME payment adjustment - Managed Care (see instructions)   776, 452   22. 01   Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA   23. 00   Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 105   0. 00   23. 00 (f) (1) (iv) (C) .     (f) (1) (iv) (C) .   (f) (f) (f) (f) (f) (f) (f) (f) (f) (f)			l l	1
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 (f)(1)(iv)(C).  24.00 IME FTE Resident Count Over Cap (see instructions) 5.09 24.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 instructions)  26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 25.00 instructions)  28.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.28.01 IME add-on adjustment amount (see instructions) 0.28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 IO Total IME payment (sum of lines 22 and 28) 1,156,793 29.00 IO Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 776,452 29.01 IO Instructionate Share Adjustment Operationate Share Operationate Share Operationate Share Operationate Share Operationate Share Operationate Share Operationate Share Operationate Share Operationate Share Operationate Sh				
(f)(1)(iv)(C).  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  33.00 Allowable disproportionate share percentage (see instructions)  34.00 IME amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  5.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0		Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  0.00 instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  1 ME payments adjustment amount (see instructions)  28.00 IME add-on adjustment amount - Managed Care (see instructions)  29.00 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  17.156, 793  29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  33.00 Image of the disproportionate share percentage (see instructions)  33.00 Image of lines 30 and 31  29.94 32.00		(f)(1)(iv)(C).		
26. 00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26. 00         27. 00       IME payments adjustment factor. (see instructions)       0.000000       27. 00         28. 00       IME add-on adjustment amount (see instructions)       0       28. 00         29. 01       IME add-on adjustment amount - Managed Care (see instructions)       0       28. 01         29. 01       Total IME payment (sum of lines 22 and 28)       1, 156, 793       29. 00         29. 01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)       776, 452       29. 01         Disproportionate Share Adjustment       29. 01         30. 00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       5. 11       30. 00         31. 00       Percentage of Medicaid patient days (see instructions)       24. 83       31. 00         32. 00       Sum of lines 30 and 31       29. 94       32. 00         33. 00       Allowable disproportionate share percentage (see instructions)       13. 92       33. 00		If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see	1	
28. 00 IME add-on adjustment amount (see instructions)  28. 01 IME add-on adjustment amount - Managed Care (see instructions)  29. 00 Total IME payment (sum of lines 22 and 28)  29. 01 Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  31. 00 Sum of lines 30 and 31  32. 00 Allowable disproportionate share percentage (see instructions)  32. 00 Allowable disproportionate share percentage (see instructions)  33. 00 Allowable disproportionate share percentage (see instructions)  34. 00 Sum of lines 30 and 31  35. 00 Allowable disproportionate share percentage (see instructions)  38. 00 Sum of lines 30 and 31  39. 00 Allowable disproportionate share percentage (see instructions)		Resident to bed ratio (divide line 25 by line 4)	1	
28. 01 IME add-on adjustment amount - Managed Care (see instructions)  29. 00 Total IME payment (sum of lines 22 and 28)  Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  33. 00 Allowable disproportionate share percentage (see instructions)  33. 00 IME add-on adjustment amount - Managed Care (see instructions)  1, 156, 793			1	1
29.00 Total IME payment (sum of lines 22 and 28)  Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  1, 156, 793 29.00  776, 452 29.01  30.00  9ercentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  24.83 31.00  32.00 Allowable disproportionate share percentage (see instructions)  13.92 33.00		, ,	1	1
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  776, 452 29. 01  Disproportionate Share Adjustment  Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  33. 00 Allowable disproportionate share percentage (see instructions)  34. 00 Sum of lines 30 and 31  35. 00 Allowable disproportionate share percentage (see instructions)  36. 00 Sum of lines 30 and 31  37. 00 Sum of lines 30 and 31		, , ,		1
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  5. 11 30.00  31.00 Percentage of Medicaid patient days (see instructions)  24.83 31.00  32.00 Sum of lines 30 and 31  31.00 Allowable disproportionate share percentage (see instructions)  31.00 Sum of lines 30 and 31  32.00 Allowable disproportionate share percentage (see instructions)  32.00 Sum of lines 30 and 31		Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		
32.00 Sum of lines 30 and 31 29.94 32.00 Allowable disproportionate share percentage (see instructions) 13.92 33.00		Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	l l	
33.00 Allowable disproportionate share percentage (see instructions) 13.92 33.00			l l	
			i i	
1,010,001 01.00		, , , , , , , , , , , , , , , , , , , ,	1	

	Financial Systems BLESSING HOS			u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015	Peri od: From 10/01/2022	Worksheet E Part A	
			To 09/30/2023	Date/Time Pre	pared:
				12/29/2023 3:	
	<u> </u>	Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	Illustration of Court December 1 Additional transfer of Court December 1 Additional tr		1. 00	2. 00	
35. 00	Uncompensated Care Payment Adjustment Total uncompensated care amount (see instructions)			6, 874, 403, 459	35. 00
35. 00	Factor 3 (see instructions)		0. 000000000		
35. 01	Hospital UCP, including supplemental UCP (If line 34 is zero,	enter zero on this line			
00.02	(see instructions)	circal zero on tili s i i lie	,	2, 102, 770	00.02
35. 03	Pro rata share of the hospital UCP, including supplemental UC	P (see instructions)	0	2, 152, 778	35. 03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		2, 152, 778		36. 00
	Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 throu			
40. 00	Total Medicare discharges (see instructions)		0		40. 00
			Before 1/1	On/After 1/1	
41 00	Total FCDD Madigara disabangsa (ass instructions)		1.00	1. 01	41 00
41. 00 41. 01	Total ESRD Medicare discharges (see instructions) Total ESRD Medicare covered and paid discharges (see instruct	ions)	0	0	41. 00 41. 01
42. 00	Divide line 41 by line 40 (if less than 10%, you do not quali		0.00	U	42.00
43. 00	Total Medicare ESRD inpatient days (see instructions)	Ty Tor day detiment)	0.00		43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44. 00
	days)	3			
45.00	Average weekly cost for dialysis treatments (see instructions		0.00	0.00	45. 00
46. 00	Total additional payment (line 45 times line 44 times line 41	. 01)	0		46. 00
47. 00	Subtotal (see instructions)		55, 066, 546		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, s	mall rural hospitals	57, 670, 154		48. 00
	only. (see instructions)			Amount	
				1. 00	
49. 00	Total payment for inpatient operating costs (see instructions	5)		58, 446, 606	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I an			3, 901, 829	50. 00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt.	III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		711, 733	52. 00
53.00	Nursing and Allied Health Managed Care payment			399, 680	
54.00	Special add-on payments for new technologies			258, 570	
54. 01	Islet isolation add-on payment	0)		0	54. 01
55. 00 55. 01	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cellular therapy acquisition cost (see instructions)	19)		0	55. 00 55. 01
56. 00	Cost of physicians' services in a teaching hospital (see intr	ructions)		0	56. 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35).	1, 463, 212	
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.			335, 195	
59.00	Total (sum of amounts on lines 49 through 58)			65, 516, 825	59. 00
60.00	Primary payer payments			3, 400	60. 00
61. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		65, 513, 425	
62. 00	Deductibles billed to program beneficiaries			5, 336, 608	
63. 00	Coinsurance billed to program beneficiaries			99, 692	•
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			646, 973 420, 532	
66. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		645, 489	66. 00
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	ructions)		60, 497, 657	67. 00
68. 00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions)	00, 177, 007	68. 00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	69. 00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70. 00
70. 50	Rural Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see	instructions)	0	70. 50
70. 75	N95 respirator payment adjustment amount (see instructions)			0	70. 75
70. 87	Demonstration payment adjustment amount before sequestration			0	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)	rustians)		0	70. 88
70. 89	Pioneer ACO demonstration payment adjustment amount (see inst	ructions)		_	70.89
70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	70. 90 70. 91
70. 91	Bundled Model 1 discount amount (see instructions)			0	70. 91
70. 92	HVBP payment adjustment amount (see instructions)			0	70. 92
70. 94	, , , , , , , , , , , , , , , , , , , ,			-111, 338	
70. 95	Recovery of accelerated depreciation				70. 95

					12/29/2023 3:	54 pm_
		Ti tl	e XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70. 96	3 (3333)	column 0		0	0	70. 96
70.07	the corresponding federal year for the period prior to 10/1)					70.07
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70. 97
70.00	the corresponding federal year for the period ending on or after	er 10/1)		0		70.00
70. 98	Low Volume Payment-3			0	0	
70. 99 71. 00	HAC adjustment amount (see instructions) Amount due provider (line 67 minus lines 68 plus/minus lines 6	0 % 70)				
71.00	Sequestration adjustment (see instructions)	9 & 70)			60, 386, 319 1, 207, 726	1
71. 01	Demonstration payment adjustment amount after sequestration				1, 207, 720	1
71. 02	Sequestration adjustment-PARHM pass-throughs				0	71.02
71.03	Interim payments				60, 669, 960	1
72. 00	Interim payments  Interim payments-PARHM				00,009,900	72.00
73. 00	Tentative settlement (for contractor use only)				0	1
73. 00	Tentative settlement (for contractor use only)				0	73.00
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02	72 and			-1, 491, 367	1
74.00	73)	, 72, and			-1, 471, 307	74.00
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordance	ce with			1, 727, 117	1
73.00	CMS Pub. 15-2, chapter 1, §115.2	CC WI til			1, 727, 117	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1			1
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum o	f 2.03			0	90.00
	plus 2.04 (see instructions)					
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instru	ctions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruct				0	93.00
94.00	The rate used to calculate the time value of money (see instru	ctions)			0.00	94. 00
95.00	Time value of money for operating expenses (see instructions)	,			0	95. 00
96.00		i ons)			0	96.00
			•	Prior to 10/1	On/After 10/1	
				1. 00	2. 00	
	HSP Bonus Payment Amount			1.00	2.00	
100.00	HSP bonus amount (see instructions)			1.00		100. 00
	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1.00	0	]
101.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			1.00	0. 0000000000	101. 00
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	Title XVIII Hospital	PPS	0 1 p
	FART S. APRILAN. AND OTHER VEH THE OFFICE	1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES  Medical and other services (see instructions)	9, 746	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	36, 636, 207	2.00
3. 00	OPPS or REH payments	34, 737, 438	1
4.00	Outlier payment (see instructions)	275, 544	4. 00
4. 01	Outlier reconciliation amount (see instructions)	0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5. 00
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6	0.00	6. 00 7. 00
8. 00	Transitional corridor payment (see instructions)	0.00	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	367, 221	9. 00
10. 00	Organ acqui si ti ons	0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	9, 746	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES  Reasonable charges		
12. 00	Ancillary service charges	103, 951	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	103, 951	14. 00
45.00	Customary charges		1 45 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17. 00
18. 00	Total customary charges (see instructions)	103, 951	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	94, 205	19. 00
20. 00	instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
20.00	instructions)		20.00
21. 00	Lesser of cost or charges (see instructions)	9, 746	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)  COMPUTATION OF REIMBURSEMENT SETTLEMENT	35, 380, 203	24. 00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	201, 319	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5, 586, 563	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	29, 602, 067	27. 00
20.00	instructions)	220 452	20.00
28. 00 28. 50	Direct graduate medical education payments (from Wkst. E-4, line 50) REH facility payment amount	339, 453	28. 00 28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29. 00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	29, 941, 520	1
31. 00	Pri mary payer payments	2, 514	1
32. 00	Subtotal (line 30 minus line 31)	29, 939, 006	32. 00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)  Composite rate ESRD (from Wkst. I-5, line 11)	0	33. 00
34. 00	Allowable bad debts (see instructions)	152, 442	
35. 00	Adjusted reimbursable bad debts (see instructions)	99, 087	35. 00
	Allowable bad debts for dual eligible beneficiaries (see instructions)	152, 394	1
	Subtotal (see instructions)	30, 038, 093	
38. 00 39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-98 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	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)	30, 038, 191 600, 764	40. 00 40. 01
40. 01	Demonstration payment adjustment amount after sequestration	000, 704	40. 01
40. 03	Sequestration adjustment-PARHM pass-throughs		40. 03
41.00	Interim payments	29, 615, 180	41.00
41. 01	Interim payments-PARHM	_	41. 01
42. 00	Tentative settlement (for contractors use only)	0	
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)	-177, 753	42. 01 43. 00
43. 01	Balance due provider/program-PARHM (see instructions)		43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	1
	§115. 2		
00.00	TO BE COMPLETED BY CONTRACTOR		00.00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)	0	90. 00 91. 00
91.00	The rate used to calculate the Time Value of Money	0.00	1
93. 00	· · · · · · · · · · · · · · · · · · ·	0	1
94. 00	Total (sum of lines 91 and 93)	0	94. 00

Health Financial Systems	BLESSING HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015	Peri od:	Worksheet E	
		From 10/01/2022	Part B	
		To 09/30/2023	Date/Time Pre	pared:
			12/29/2023 3:	54 pm_
	Title XVIII	Hospi tal	PPS	
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200. 00

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Period: Worksheet E From 10/01/2022 Part B
		To 09/30/2023 Date/Time Prepared:

12/29/2023 3:54 pm Title XVIII Subprovi der -1.00 PART B - MEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 43 Medical and other services reimbursed under OPPS (see instructions) 2.00 0 2.00 OPPS or REH payments 3 00 3 00 0 4.00 Outlier payment (see instructions) 0 4.00 4.01 Outlier reconciliation amount (see instructions) 4.01 5.00 Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.00 Line 2 times line 5 6.00 0 6.00 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 0.00 7.00 8.00 Transitional corridor payment (see instructions) 0 8.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 9 00 9 00 0 10.00 Organ acquisitions 0 10.00 11.00 Total cost (sum of lines 1 and 10) (see instructions) 43 11.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 462 12.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 13.00 13 00 14.00 Total reasonable charges (sum of lines 12 and 13) 14.00 462 Customary charges Aggregate amount actually collected from patients liable for payment for services on a charge basis 15.00 15.00 0 Amounts that would have been realized from patients liable for payment for services on a chargebasis 16.00 0 16.00 had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 17 00 17 00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (see instructions) 462 18.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 419 19.00 instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 20.00 0 20.00 instructions) 21.00 21.00 Lesser of cost or charges (see instructions) 43 Interns and residents (see instructions) 22.00 0 22.00 23.00 Cost of physicians' services in a teaching hospital (see instructions) 0 23.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 24.00 0 24.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions) 25.00 0 25.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 26.00 26 00 0 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 27.00 43 27.00 instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 REH facility payment amount 28.50 28.50 29 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29 00 30.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 43 30.00 31.00 Primary payer payments 0 31.00 Subtotal (line 30 minus line 31) 43 32.00 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 34.00 Adjusted reimbursable bad debts (see instructions) 35.00 0 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 Subtotal (see instructions) 37.00 43 37.00 38. 00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 N95 respirator payment adjustment amount (see instructions) 39. 75 Demonstration payment adjustment amount before sequestration 39.97 39.97 0 39 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 0 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 Subtotal (see instructions) 43 40.00 Sequestration adjustment (see instructions)

40. 01	sequestration adjustment (see instructions)	l l	40. 01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	215	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-173	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44.00
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
MCRL F3	2 - 21. 2. 177. 1		
	22		

Health Financial Systems	BLESSING HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0015	Peri od:	Worksheet E	
		From 10/01/2022		
	Component CCN: 14-T015	To 09/30/2023	Date/Time Pre	
			12/29/2023 3:	54 pm
	Title XVIII	Subprovi der -	PPS	
		I RF		
			1.00	
94.00 Total (sum of lines 91 and 93)			0	94. 00
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			·	200. 00

Title XVIII Skilled Nursing

	litle XVIII   Skilled Nursing   Facility	PPS	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
. 00	Medical and other services (see instructions)	1, 159	1. 0
. 00	Medical and other services reimbursed under OPPS (see instructions)	0	2. 0
. 00	OPPS or REH payments		3. 0
. 00	Outlier payment (see instructions)		4. 0
01	Outlier reconciliation amount (see instructions)  Enter the hospital specific payment to cost ratio (see instructions)		4. C 5. C
00	Line 2 times line 5	0	6. 0
00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7. C
00	Transitional corridor payment (see instructions)	0	8. 0
00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9. (
0. 00	Organ acqui si ti ons	0	10. (
1. 00	Total cost (sum of lines 1 and 10) (see instructions)	1, 159	11. (
	COMPUTATION OF LESSER OF COST OR CHARGES		
2. 00	Reasonable charges Ancillary service charges	12, 364	12. (
3. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13. 0
	Total reasonable charges (sum of lines 12 and 13)	12, 364	
	Customary charges	,	
5. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.0
6. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16. 0
7 00	had such payment been made in accordance with 42 CFR §413.13(e)	0.000000	17 /
7. 00 3. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	
9. 00	Total customary charges (see instructions)  Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	12, 364 11, 205	
. 00	instructions)	11, 203	17.
0. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20. (
	instructions)		
1.00	Lesser of cost or charges (see instructions)	1, 159	
	Interns and residents (see instructions)	0	22.
	Cost of physicians' services in a teaching hospital (see instructions)  Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	23. 24.
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	0	24.
. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.
. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		26. (
7. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	1, 159	27. (
	instructions)		20
3. 00 3. 50	Direct graduate medical education payments (from Wkst. E-4, line 50) REH facility payment amount	0	28. 28.
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	
0.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	1, 159	
1. 00	Primary payer payments	0	31.
2. 00	Subtotal (line 30 minus line 31)	1, 159	32.
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
3.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33. 34.
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	0	34. 35.
	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	
	Subtotal (see instructions)	1, 159	
. 00	MSP-LCC reconciliation amount from PS&R		38.
00 .	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.
. 50	Pioneer ACO demonstration payment adjustment (see instructions)		39.
75	N95 respirator payment adjustment amount (see instructions)	0	39.
. 97	Demonstration payment adjustment amount before sequestration	0	39.
). 98 ). 99	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 39.
. 99	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)	1, 159	
. 01	Sequestration adjustment (see instructions)	23	
. 02	Demonstration payment adjustment amount after sequestration	0	40.
. 03	Sequestration adjustment-PARHM pass-throughs		40.
. 00	Interim payments	12, 364	41.
	Interim payments-PARHM		41.
	Tentative settlement (for contractors use only)	0	42.
2. 01	Tentative settlement-PARHM (for contractor use only)	11 000	42.
. 00	Balance due provider/program (see instructions)	-11, 228	
3. 01 I. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	43. 44.
r. 00	S115. 2	۷	74.
	TO BE COMPLETED BY CONTRACTOR		
. 00	Original outlier amount (see instructions)		90.
	Outlier reconciliation adjustment amount (see instructions)		91.
. 00	T	ı	
. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)		92. 93.

Health Financial Systems	BLESSING HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0015	Peri od:	Worksheet E	
	Component CCN: 14-5643	From 10/01/2022 To 09/30/2023		narod:
	Component Con. 14-3043	10 09/30/2023	12/29/2023 3:	54 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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 10/01/2022 Part I
To 09/30/2023 Date/Time Prepared: 12/29/2023 3:54 pm Provider CCN: 14-0015

					12/29/2023 3: 5	54 pm
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider	11.00	61, 912, 962		29, 753, 195	1. 00
2. 00	Interim payments payable on individual bills, either		01, 712, 702		27, 700, 170	2. 00
2.00	submitted or to be submitted to the contractor for		٦		Ĭ	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		l .			
3. 01	ADJUSTMENTS TO PROVIDER		C	01/31/2023	37, 973	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER		Ö		37, 773	3. 02
3. 03						3. 03
3. 04						3. 04
3. 05						3. 02
3.03	Provider to Program				<u> </u>	3. 00
3. 50	ADJUSTMENTS TO PROGRAM	01/31/2023	337, 359	05/31/2023	175, 988	3. 50
3. 51	ADJUSTIMENTS TO FROGRAM	05/31/2023	905, 643		175, 400	3. 51
3. 52		03/31/2023	905, 643			3. 52
3. 52		+	1 0			3. 52
3. 54			i c		0	3. 54
3. 99	Subtatal (sum of lines 2 01 2 40 minus sum of lines		l ~		1	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-1, 243, 002		-138, 015	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)	}	60, 669, 960		29, 615, 180	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		00, 009, 900		29, 013, 100	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR	I				
5.00	List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		С		0	5. 01
5. 02	TENTAL TO TROVIDER		ĺ		l ő	5. 02
5. 03			ĺ		l ő	5. 03
0.00	Provider to Program					0.00
5.50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51					0	5. 51
5. 52			l o		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		Ö		0	5. 99
5. //	5. 50-5. 98)		٦			5. 77
6. 00	Determined net settlement amount (balance due) based on					6. 00
5.00	the cost report. (1)					0. 00
6. 01	SETTLEMENT TO PROVIDER				0	6. 01
6. 02	SETTLEMENT TO PROGRAM		1, 491, 367		177, 753	6. 02
7. 00	Total Medicare program liability (see instructions)		59, 178, 593		29, 437, 427	7. 00
7.50	1.01a. modrodro program rrabirity (300 motractions)		57, 170, 373	Contractor	NPR Date	, . 00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	The state of the s	1		t .	1 1	50

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: From 10/01/2022 Part I To 09/30/2023 Date/Time Prepared: 12/29/2023 3:54 pm Subprovi der - PPS Provider CCN: 14-0015 Component CCN: 14-T015 Title XVIII

		Title	XVIII	Subprovi der - I RF	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		8, 225, 813 0		215	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER	05/31/2023	86, 978		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		86, 978		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  TO BE COMPLETED BY CONTRACTOR		8, 312, 791		215	4. 00
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					5. 00
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TERMINE TO THOMBEN		Ö		0	5. 02
5. 03			0		0	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 the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		10, 626		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		173	6. 02
7.00	Total Medicare program liability (see instructions)		8, 323, 417		42	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1. 00	2.00	
8.00	Name of Contractor					8. 00
	•					

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 14-0015 Component CCN: 14-5643 Title XVIII Skilled Nursing

		litie	XVIII	Killed Nursing Facility	PPS	
		I npati en	t Part A		t B	
		,				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 891, 925		12, 364	1. 00
2.00	Interim payments payable on individual bills, either		C	)	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		·	"		
3.01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3.02			C	)	0	3. 02
3.03			C	)	0	3. 03
3.04			C	)	0	3.04
3.05			C		0	3. 05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51			C		0	3. 51
3. 52			O		0	3. 52
3.53			O		0	3. 53
3. 54 3. 99	Subtatal (sum of lines 2 01 2 40 minus sum of lines					3. 54 3. 99
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		_		ا	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 891, 925		12, 364	4. 00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		1,071,720		12,001	1. 00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	ı				
5. 01	TENTATI VE TO PROVI DER		O		0	5. 01
5. 02			C		0	5. 02
5. 03	Provider to Program		C	1	U	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		C	1	0	5. 50
5. 51	TENTATIVE TO TROOKAW		Ö			5. 51
5. 52			Ö		l ől	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		ď		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		27, 488		0	6. 01
6.02	SETTLEMENT TO PROGRAM		0		11, 228	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 919, 413		1, 136	7. 00
				Contractor	NPR Date	
		(	`	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	(	)	1. 00	2.00	8. 00
3.00	Inamic of Contractor	I		1	l l	0.00

Heal th	Financial Systems BLESSING HOS	SPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0015	Peri od:	Worksheet E-	
			From 10/01/2022 To 09/30/2023		narod:
			10 09/30/2023	12/29/2023 3:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				_
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1. 00
2. 00	Medicare days (see instructions)				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l				6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified 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 LIPPS & 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 l	ine 31) (see instruction	ıs)		32. 00

Health Financial Systems	BLESSING HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-T015	From 10/01/2022	
	Title XVIII	Subprovi der -	PPS

		litle XVIII	Subprovider -	PPS	
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			8, 128, 932	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0469	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			312, 964	3. 00
4.00	Outlier Payments			68, 592	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent count to November 15, 2004 (see instructions)	ost reporting period en	ding on or prior	0. 00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE coun- program or hospital closure, that would not be counted without CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0. 00	5. 01	
6.00	New Teaching program adjustment. (see instructions)			0. 00	•
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in teaching program" (see instructions)	the new program growth p	eriod of a "new	0. 00	7. 00
8.00	Current year's unweighted I&R FTE count for residents within teaching program" (see instructions)	eriod of a "new	0. 00	8. 00	
9.00	Intern and resident count for IRF PPS medical education adjus	tment (see instructions)		0.00	9. 00
10.00	Average Daily Census (see instructions)			12. 684932	1
11. 00	Teaching Adjustment Factor (see instructions)			0. 000000	1
12.00	Teaching Adjustment (see instructions)			0 510 400	12.00
13. 00 14. 00	Total PPS Payment (see instructions)	(an)		8, 510, 488 0	13. 00 14. 00
15. 00	Nursing and Allied Health Managed Care payments (see instruction Organ acquisition (DO NOT USE THIS LINE)	i dii)		٥	15. 00
16. 00	Cost of physicians' services in a teaching hospital (see insti	ructions)		0	1
17. 00	Subtotal (see instructions)	4011 0113)		8, 510, 488	ł
18. 00	Primary payer payments			0	18.00
19.00	Subtotal (line 17 less line 18).			8, 510, 488	1
20.00	Deducti bl es			20, 580	20.00
21.00	Subtotal (line 19 minus line 20)			8, 489, 908	21. 00
22. 00	Coi nsurance			42, 778	22. 00
23. 00	Subtotal (line 21 minus line 22)			8, 447, 130	
24. 00	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		15, 654	
25. 00	Adjusted reimbursable bad debts (see instructions)			10, 175	1
26. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		15, 654	1
27. 00	Subtotal (sum of lines 23 and 25)	40)		8, 457, 305	1
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ne 49)		0	28. 00
29. 00 30. 00	Other pass through costs (see instructions)			35, 978 0	29. 00 30. 00
31. 00	Outlier payments reconciliation OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	31.50
31. 98	Recovery of accelerated depreciation.	3)		0	31. 98
31. 99	Demonstration payment adjustment amount before sequestration			0	1
32.00	Total amount payable to the provider (see instructions)			8, 493, 283	32. 00
32.01	Sequestration adjustment (see instructions)			169, 866	32. 01
32. 02	Demonstration payment adjustment amount after sequestration			0	32. 02
33.00	Interim payments			8, 312, 791	33. 00
34.00	Tentative settlement (for contractor use only)			0	34.00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02	•		10, 626	1
36. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2,	chapter 1,	48, 774	36. 00
50. 00	TO BE COMPLETED BY CONTRACTOR  Original outlier amount from Wkst. E-3, Pt. III, line 4			68, 592	50.00
51. 00	Outlier reconciliation adjustment amount (see instructions)			06, 592	51.00
52. 00	The rate used to calculate the Time Value of Money			0. 00	1
53. 00	Time Value of Money (see instructions)			0.00	1
55. 66	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND THE COVID-19 PHE)	BEGINNING ON OR BEFORE	MAY 11, 2023 (THE		33.00
99. 00	Teaching Adjustment Factor for the cost reporting period immed	diately preceding Februa	ry 29, 2020.	0.000000	99. 00
	Calculated Teaching Adjustment Factor for the current year. (	<b>3</b> .		0. 000000	

Health Financial Systems	In Lieu of Form CMS-2552-1			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0015 Per		Worksheet E-3	
		From 10/01/2022	Part VI	
	Component CCN: 14-5643	To 09/30/2023	Date/Time Pre	pared:
	'		12/29/2023 3:	
	Title XVIII	Skilled Nursing	PPS	
		Facility		
			1. 00	
PART VI - CALCULATION OF REIMBURSEMENT SETTLE	EMEMENT - ALL OTHER HEALTH SERVICES FOR TI	ITLE XVIII PART A	PPS SNF	

		1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART /	A PPS SNF	
	SERVI CES SERVI CES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	2, 041, 621	1. 00
2.00	Routine service other pass through costs	18, 035	2. 00
3.00	Ancillary service other pass through costs	9, 453	3. 00
4.00	Subtotal (sum of lines 1 through 3)	2, 069, 109	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, Part B. This line is now shaded.)		5. 00
6.00	Deducti bl e	0	6. 00
7.00	Coi nsurance	111, 085	7. 00
8.00	Allowable bad debts (see instructions)	0	8. 00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9. 00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1, 958, 024	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14. 50
14. 98	Recovery of accelerated depreciation.	0	14. 98
14. 99	Demonstration payment adjustment amount before sequestration	0	14. 99
15.00	Subtotal (see instructions	1, 958, 024	15. 00
15. 01	Sequestration adjustment (see instructions)	38, 611	15. 01
15. 02	Demonstration payment adjustment amount after sequestration	0	15. 02
15. 75	Sequestration for non-claims based amounts (see instructions)	0	15. 75
16.00	Interim payments	1, 891, 925	16. 00
17.00	J	0	17. 00
18. 00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	27, 488	18. 00
19. 00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19. 00

Heal th	Financial Systems BLESSING HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS	Provider CC	CN: 14-0015	Peri od: From 10/01/2022 To 09/30/2023	Worksheet E-4	pared:
		Title	XVIII	Hospi tal	PPS	<u> р</u>
					1. 00	
1 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT	-			40.50	1 00
1. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost reporti	ng perioas	19. 50	1. 00
1. 01	FTE cap adjustment under §131 of the CAA 2021 (see instruction	ons)			0.00	1. 01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CF				0.00	2. 00
2. 26	Rural track program FTE cap limitation adjustment after the c the CAA 2021 (see instructions)	d under §127 of	0. 00	2. 26		
3.00	Amount of reduction to Direct GME cap under section 422 of MN	MΑ			0. 00	3.00
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance		§413.79 (m).	(see	0. 00	3. 01
0.00	instructions for cost reporting periods straddling 7/1/2011)		( ) 6		0.00	0.00
3. 02	Adjustment (increase or decrease) to the hospital's rural track Medicare GME affiliation agreemen				0. 00	3. 02
	49075 (August 10, 2022) (see instructions)	it ili accorda	nce with 415.	75(b) and 07 1K		
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and		programs due	to a Medicare	0. 00	4. 00
4 01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)				0.00	4 01
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instantial straddling 7/1/2011)	Tructions for	cost reporti	ng perrous	0. 00	4. 01
4.02	ACA Section 5506 number of additional direct GME FTE cap slot	ts (see inst	ructions for	cost reporting	0.00	4. 02
	periods straddling 7/1/2011)					
4. 21	The amount of increase if the hospital was awarded FTE cap slinstructions)	ots under §1:	26 of the CAA	A 2021 (see	0. 00	4. 21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lin	nes 2.26 thro	uah 2.49. mir	nus lines 3 and	19. 50	5. 00
	3.01, plus or minus line 3.02, plus or minus line 4, plus lin					
6.00	Unweighted resident FTE count for allopathic and osteopathic	programs for	the current	year from your	18. 25	6. 00
7. 00	records (see instructions) Enter the lesser of line 5 or line 6				18. 25	7. 00
7.00	Litter the resser of Time 5 of Time 6		Primary Car	e Other	Total	7.00
			1 00	0.00		
			1. 00	2. 00	3. 00	
8. 00	Weighted FTE count for physicians in an allopathic and osteop	oathi c	1.00			8. 00
	program for the current year.		18. :	0. 00	18. 25	
8. 00 9. 00		vi se		0. 00	18. 25	
	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amount for cost reporting periods beginning on or after October 1	vise ount on line	18. :	0. 00	18. 25	
9. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amount for cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions.	vise ount on line 1, 2022, or	18. :	0. 00 25 0. 00	18. 25 18. 25	9. 00
9. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions.  Weighted dental and podiatric resident FTE count for the curr	vise bunt on line 1, 2022, or cent year	18. :	0. 00 25 0. 00 0. 00	18. 25 18. 25	9. 00
9. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amount for cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions.	vise bunt on line 1, 2022, or cent year	18. :	0. 00 25 0. 00 0. 00 0. 00	18. 25 18. 25	9. 00
9. 00 10. 00 10. 01	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the currunweighted dental and podiatric resident FTE count for the currotal weighted FTE count	vise Dunt on line 1, 2022, or Tent year Jurrent year	18. : 18. :	0.00 25 0.00 0.00 0.00 0.00	18. 25 18. 25	9. 00 10. 00 10. 01
9. 00 10. 00 10. 01 11. 00 12. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curr Unweighted dental and podiatric resident FTE count for the currotal weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)	vise bunt on line 1, 2022, or rent year urrent year ng year (see	18. : 18. : 18. :	0.00 0.00 0.00 0.00 0.00 0.00 0.00	18. 25 18. 25	9. 00 10. 00 10. 01 11. 00 12. 00
9. 00 10. 00 10. 01 11. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amount for cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the currular unweighted dental and podiatric resident FTE count for the currular weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost resident FTE count for the	vise bunt on line 1, 2022, or rent year urrent year ng year (see	18. : 18. : 18. :	0.00 0.00 0.00 0.00 0.00 0.00 0.00	18. 25 18. 25	9. 00 10. 00 10. 01 11. 00
9. 00 10. 00 10. 01 11. 00 12. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curr Unweighted dental and podiatric resident FTE count for the currotal weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)	vise punt on line 1, 2022, or rent year urrent year ng year (see	18. : 18. : 18. :	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	18. 25 18. 25	9. 00 10. 00 10. 01 11. 00 12. 00
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current line of the current line of the current line of the resident FTE count for the current line of the resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost respectively ear (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	vise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3).	18. : 18. : 17. ( 17. ( 17. (	0.00 0.00	18. 25 18. 25	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current long the dental and podiatric resident FTE count for the current long the dental and podiatric resident FTE count for the current long the dental and podiatric resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost respectively average for the penultimate cost respectively graves and programs for residents in initial years of new programs. Unweighted adjustment for residents in initial years of new programs.	vise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). brograms	18. : 18. : 17. ( 17. ( 0. ( 0. (	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	18. 25 18. 25	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions.  Weighted dental and podiatric resident FTE count for the cur Unweighted dental and podiatric resident FTE count for the cur Total weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost responsively ear (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs  Unweighted adjustment for residents in initial years of new padjustment for residents displaced by program or hospital closes.	vise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). brograms bsure	18. : 18. : 17. · 17. · 17. · 0. · 0. ·	0.00 0.00	18. 25 18. 25	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current long the dental and podiatric resident FTE count for the current long the dental and podiatric resident FTE count for the current long the dental and podiatric resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost respectively average for the penultimate cost respectively average for the penultimate cost respectively average for the penultimate cost respectively average for the penultimate cost respectively average for the penultimate cost respectively average for the penultimate cost respectively average for the penultimate cost respectively average for the penultimate cost respectively.	vise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). brograms bsure	18. : 18. : 17. ( 17. ( 0. ( 0. (	0.00 0.00	18. 25 18. 25	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions.  Weighted dental and podiatric resident FTE count for the curr Unweighted dental and podiatric resident FTE count for the curr Unweighted FTE count  Total weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost respect (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new padjustment for residents displaced by program or hospital cloud Unweighted adjustment for residents displaced by program or hospital cloud ustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted residents displaced by program or hospital cloud unweighted residents displaced by program or hospital cloud unweighted residents displaced by program or hospital cloud unweighted residents displaced by program or hospital cloud unweighted residents displaced by program or hospital cloud unweighted residents displaced by program or hospital cloud unweighted residents displaced by program or hospital cloud unweighted residents displaced by program or hospital cloud unweighted residents displaced by program or hospital cloud unweighted residents dental and podiatric residents dental and program and the program and the program and the program and the progr	vise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). brograms bsure	18. : 18. : 18. : 17. ( 17. ( 0. ( 0. ( 0. (	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	18. 25 18. 25	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 01 17. 00 18. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions.  Weighted dental and podiatric resident FTE count for the curr Unweighted dental and podiatric resident FTE count for the currotal weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost respect (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new padjustment for residents displaced by program or hospital cloud Unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweigh	vise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). brograms bsure	18. : 18. : 18. : 17. ( 17. ( 0. ( 0. ( 0. ( 17. : 103, 488. (	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	18. 25 18. 25	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the cur Unweighted dental and podiatric resident FTE count for the cur Total weighted FTE count  Total weighted resident FTE count for the prior cost reportin instructions)  Total weighted resident FTE count for the penultimate cost reyear (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new padjustment for residents displaced by program or hospital clouweighted adjustment for residents displaced by program or hospital clouweighted adjustment for residents displaced by program or hospital clouweighted adjustment for residents displaced by program or hospital clouweighted adjustment for residents displaced by program or hospital clouweighted adjustment for residents displaced by program or hospital clouweighted adjustment for residents displaced by program or hospital clouweighted adjustment for residents displaced by program or hospital clouweighted resident amount under §131 of the CAA 2021	vise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). brograms bsure	18. 18. 18. 18. 18. 17. 4 17. 4 17. 4 17. 6 0. 6 0. 6 17. 103, 488. 0. 6	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	18. 25 18. 25	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 00
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions.  Weighted dental and podiatric resident FTE count for the curr Unweighted dental and podiatric resident FTE count for the currotal weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost respect (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new padjustment for residents displaced by program or hospital cloud Unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweigh	vise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). brograms bsure	18. : 18. : 18. : 17. ( 17. ( 0. ( 0. ( 0. ( 17. : 103, 488. (	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	18. 25 18. 25	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 00
9. 00  10. 00 10. 01 11. 00 12. 00  13. 00  14. 00 15. 01 16. 00 16. 01  17. 00 18. 01 19. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions.  Weighted dental and podiatric resident FTE count for the curr Unweighted dental and podiatric resident FTE count for the currotal weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost responsively experience of the penultimate of the penultimate cost responsively experience of the penultimate of the penu	vise punt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). programs psure nospital	18. : 18. : 18. : 17. ( 17. ( 0. ( 0. ( 0. ( 17. 103, 488. 0. ( 1, 837, 9)	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	18. 25 18. 25 1, 837, 964	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 01 17. 00 18. 00 19. 00
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 19. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions.  Weighted dental and podiatric resident FTE count for the curr Unweighted dental and podiatric resident FTE count for the curr Unweighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost resident weighted resident FTE count for the penultimate cost resident weighted resident for the penultimate cost resident weighted resident for the penultimate cost resident weighted adjustment for residents in initial years of new programs. Unweighted adjustment for residents in initial years of new padjustment for residents displaced by program or hospital closure.  Adjusted rolling average FTE count  Per resident amount  Per resident amount under §131 of the CAA 2021  Approved amount for resident costs.  Additional unweighted allopathic and osteopathic direct GME F	vise punt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). programs psure nospital	18. : 18. : 18. : 17. ( 17. ( 0. ( 0. ( 0. ( 17. 103, 488. 0. ( 1, 837, 9)	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	18. 25 18. 25	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 01 17. 00 18. 00 19. 00
9. 00  10. 00 10. 01 11. 00 12. 00  13. 00  14. 00 15. 01 16. 00 16. 01  17. 00 18. 00 18. 01 19. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions.  Weighted dental and podiatric resident FTE count for the curr Unweighted dental and podiatric resident FTE count for the currotal weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost respect of the penultimate cost respect	vise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). brograms brosure nospital	18. : 18. : 18. : 17. ( 17. ( 0. ( 0. ( 0. ( 17. 103, 488. 0. ( 1, 837, 9)	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	18. 25 18. 25 1, 837, 964 1. 00 0. 00	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00
9. 00  10. 00 10. 01 11. 00 12. 00  13. 00  14. 00 15. 01 16. 00 16. 01  17. 00 18. 01 19. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions.  Weighted dental and podiatric resident FTE count for the curr Unweighted dental and podiatric resident FTE count for the curr Unweighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost resident weighted resident FTE count for the penultimate cost resident weighted resident for the penultimate cost resident weighted resident for the penultimate cost resident weighted adjustment for residents in initial years of new programs. Unweighted adjustment for residents in initial years of new padjustment for residents displaced by program or hospital closure.  Adjusted rolling average FTE count  Per resident amount  Per resident amount under §131 of the CAA 2021  Approved amount for resident costs.  Additional unweighted allopathic and osteopathic direct GME F	vise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). brograms brograms brograms brospital	18. : 18. : 18. : 17. ( 17. ( 0. ( 0. ( 0. ( 17. 103, 488. 0. ( 1, 837, 9)	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	18. 25 18. 25 1. 837, 964 1. 00 0. 00	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 01 17. 00 18. 00 19. 00
9. 00  10. 00 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 17. 00 18. 01 19. 00  20. 00 21. 00 22. 00 23. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions.  Weighted dental and podiatric resident FTE count for the curr Unweighted dental and podiatric resident FTE count for the curr Unweighted FTE count  Total weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost reyear (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs  Unweighted adjustment for residents in initial years of new programs  Unweighted adjustment for residents displaced by program or hospital clo  Unweighted adjustment for residents displaced by program or hospital clo  Unweighted adjustment for residents displaced by program or hospital clo  Unweighted rolling average FTE count  Per resident amount  Per resident amount under §131 of the CAA 2021  Approved amount for resident costs  Additional unweighted allopathic and osteopathic direct GME F  Sec. 413.79(c)(4)  Direct GME FTE unweighted resident count over cap (see instru  Allowable additional direct GME FTE Resident Count (see instru  Enter the locality adjustment national average per resident and	vise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). brograms bure hospital  FTE resident of uctions)	18.1 18.1 17.9 17.0 17.0 0.0 0.0 103,488.9 0.1,837,96	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	18. 25 18. 25 18. 25 1. 837, 964 1. 00 0. 00 0. 00 0. 00 0. 00	9. 00  10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 16. 01 17. 00 18. 01 19. 00  20. 00 21. 00 22. 00 23. 00
9. 00  10. 00 10. 01 11. 00 12. 00  13. 00  14. 00 15. 01 16. 00 16. 01  17. 00 18. 00 19. 00  20. 00  21. 00 22. 00 23. 00 24. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions.  Weighted dental and podiatric resident FTE count for the curr Unweighted dental and podiatric resident FTE count for the curr Unweighted FTE count  Total weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost reyear (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs Unweighted adjustment for residents displaced by program or hospital cloure Adjusted rolling average FTE count  Per resident amount  Per resident amount under §131 of the CAA 2021  Approved amount for resident costs  Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)  Direct GME FTE unweighted resident count over cap (see instruations)	vise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). brograms bure hospital  FTE resident of uctions)	18.1 18.1 17.9 17.0 17.0 0.0 0.0 103,488.9 0.1,837,96	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	18. 25 18. 25 1. 837, 964 1. 00 0. 00 0. 00 0. 00	9. 00  10. 00 10. 01 11. 00 12. 00  13. 00  14. 00 15. 01 16. 00 16. 01  17. 00 18. 01 19. 00  20. 00  21. 00 22. 00 23. 00 24. 00

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CO		Peri od:	Worksheet E-4	
EDI CA	AL EDUCATION COSTS			From 10/01/2022 To 09/30/2023	Date/Time Prep 12/29/2023 3:5	
		Title	XVIII	Hospi tal	PPS	
		Inpatient Part	Managed Care	Managed Care	Total	
		A	Prior to 1/1	On or after 1/1		
		1. 00	2. 00	2. 01	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
6. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	25, 855	3, 37	6 11, 004		26. (
7. 00	Total Inpatient Days (see instructions)	69, 530	69, 53	0 69, 530		27. (
8. 00	Ratio of inpatient days to total inpatient days	0. 371854				28. (
9. 00	Program direct GME amount	683, 454	89, 24	2 290, 882	1, 063, 578	29. (
9. 01	Percent reduction for MA DGME		3. 2	6 3. 26		29. (
0. 00	Reduction for direct GME payments for Medicare Advantage		2, 90	9, 483	12, 392	30. (
1. 00	Net Program direct GME amount				1, 051, 186	31.
					1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - T	TITLE XVIII ONLY	(NURSLING PRO	GRAM AND PARAMET		
	EDUCATION COSTS)	TILL AVIII ONLI	(NONSTNO TRO	OITHWI AND I AITHWILL	/I CAL	
2. 00	Renal dialysis direct medical education costs (from Wkst.	B. Pt. I. sum o	f col. 20 and	23. lines 74	0	32.
	and 94)					
. 00	Renal dialysis and home dialysis total charges (Wkst. C, F			4 and 94)	2, 440, 193	33.
. 00	Ratio of direct medical education costs to total charges (	line 32 ÷ line	33)		0.000000	34.
5. 00	Medicare outpatient ESRD charges (see instructions)				0	35.
. 00			5)		0	36.
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XV	III ONLY				
	Part A Reasonable Cost					
7. 00					81, 041, 929	
	Organ acquisition and HSCT acquisition costs (see instruct				0	38.
		nstructions)			0	39.
. 00	Primary payer payments (see instructions)				3, 400	40.
. 00 . 00	Total Part A reasonable cost (sum of lines 37 through 39 m	inus iine 40)			81, 038, 529	41.
0. 00 0. 00	D   D D       0				00 (50 (00	
0. 00 0. 00 . 00	Part B Reasonable Cost					
. 00 . 00 . 00	Reasonable cost (see instructions)				38, 653, 609	
. 00 . 00 . 00 . 00	Reasonable cost (see instructions) Primary payer payments (see instructions)				3, 200	43.
2. 00 0. 00 . 00 2. 00 3. 00 4. 00	Reasonable cost (see instructions) Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43)				3, 200 38, 650, 409	43. 44.
2. 00 2. 00 3. 00 4. 00 5. 00	Reasonable cost (see instructions) Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43) Total reasonable cost (sum of lines 41 and 44)	lino 41 · lino	45)		3, 200 38, 650, 409 119, 688, 938	43. 44. 45.
2. 00 2. 00 3. 00 4. 00 5. 00 5. 00	Reasonable cost (see instructions) Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43) Total reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (				3, 200 38, 650, 409 119, 688, 938 0. 677076	43. 44. 45. 46.
2. 00 2. 00 3. 00 4. 00 5. 00 5. 00	Reasonable cost (see instructions) Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43) Total reasonable cost (sum of lines 41 and 44)	line 44 ÷ line			3, 200 38, 650, 409 119, 688, 938	43. 44. 45. 46.
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Reasonable cost (see instructions) Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43) Total reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (Ratio of Part B reasonable cost to total reasonable cost (	line 44 ÷ line			3, 200 38, 650, 409 119, 688, 938 0. 677076	43. 44. 45. 46. 47.
	Reasonable cost (see instructions) Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43) Total reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (Ratio of Part B reasonable cost to total reasonable cost (ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND	line 44 ÷ line PART B	45)		3, 200 38, 650, 409 119, 688, 938 0. 677076 0. 322924	43. 44. 45. 46. 47.

Heal th	u of Form CMS-2	552-10			
OUTLI E	Worksheet E-5				
			From 10/01/2022 To 09/30/2023	Date/Time Prep 12/29/2023 3:5	
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instr	uctions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instruc	tions)		0	4.00
5.00	0.00	5.00			
6.00		0	6.00		
7.00	0	7. 00			

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

Provider CCN: 14-0015

Endowment Fund General Fund Speci fi c Plant Fund Purpose Fund 1.00 3.00 4.00 2.00 CURRENT ASSETS 1.00 1.00 Cash on hand in banks 72, 308, 306 0 0 0 160, 622, 404 0 0 2.00 Temporary investments 0 2.00 0 3.00 Notes receivable 0 0 3.00 461, 997, 429 0 4 00 Accounts receivable 0 4 00 0 5.00 Other receivable 24, 339, 814 0 0 5.00 6.00 Allowances for uncollectible notes and accounts receivable -358, 892, 594 6.00 0 7.00 Inventory 12, 080, 841 0 0 7.00 0 8.00 Prepaid expenses 8, 313, 278 0 8.00 0 9.00 Other current assets 254, 914 0 9.00 10 00 Due from other funds 1, 025, 976 0 0 0 10 00 382, 050, 368 Total current assets (sum of lines 1-10) 0 0 11.00 0 11 00 FIXED ASSETS 12.00 Land 16, 905, 128 0 0 0 12.00 Land improvements 0 0 13.00 13, 522, 538 13.00 0 0 14.00 Accumulated depreciation -6, 973, 169 0 14.00 15.00 Bui I di ngs 350, 341, 319 0 0 0 0 0 0 0 0 0 0 0 0 0 15.00 16.00 Accumulated depreciation -120, 161, 634 0 16.00 0 Leasehold improvements 17.00 17.00 0 0 18 00 Accumulated depreciation Λ 18 00 Fi xed equipment 19.00 19.00 0 20.00 Accumulated depreciation 0 20.00 0 21.00 Automobiles and trucks C 0 21.00 22.00 Accumulated depreciation 0 22.00 23.00 Major movable equipment 253, 242, 146 0 23.00 Accumulated depreciation 24.00 -166, 317, 945 0 24.00 0 25.00 Mi nor equi pment depreci abl e Λ 25, 00 26.00 Accumulated depreciation 0 0 26.00 C 27.00 HIT designated Assets 0 0 0 27.00 0 28.00 Accumulated depreciation 0 0 28.00 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 30.00 Total fixed assets (sum of lines 12-29) 340, 558, 383 0 30.00 OTHER ASSETS 31 00 23, 102, 263 O 0 0 31 00 Investments 0 0 32.00 Deposits on Leases 0 32.00 Due from owners/officers 0 0 0 33.00 33.00 0 34.00 Other assets 16, 208, 163 0 34.00 0 Total other assets (sum of lines 31-34) 0 35.00 39, 310, 426 0 35, 00 Total assets (sum of lines 11, 30, and 35) 36.00 761, 919, 177 0 0 0 36.00 CURRENT LIABILITIES 37 00 27 839 883 O 0 n 37 00 Accounts payable 0 38.00 Salaries, wages, and fees payable 33, 460, 539 0 0 38.00 1, 534, 491 Payroll taxes payable 0 39.00 39.00 0 0 5, 146, 236 0 40.00 40.00 Notes and Loans payable (short term) 0 Deferred income 0 41 00 41 00 1, 795, 978 0 42.00 Accelerated payments C 42.00 43.00 Due to other funds 0 0 0 43.00 Other current liabilities 29, 155, 555 0 44.00 0 44.00 0 Total current liabilities (sum of lines 37 thru 44) 0 0 45.00 98, 932, 682 0 45.00 ONG TERM LIABILITIES 46.00 Mortgage payable 129, 866, 390 0 46.00 0 0 Notes payable 0 47.00 47.00 48 00 Unsecured Loans 0 0 0 48 00 Other long term liabilities 39, 765, 196 0 0 49.00 49.00 0 50 00 Total long term liabilities (sum of lines 46 thru 49) 169, 631, 586 0 0 0 50.00 268, 564, 268 Total liabilities (sum of lines 45 and 50) 51.00 0 0 0 51.00 CAPITAL ACCOUNTS 493, 354, 909 52.00 General fund balance 52.00 53.00 Specific purpose fund 0 53.00 Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted 54.00 0 54.00 55.00 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 57.00 0 58.00 0 58.00 replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 493, 354, 909 0 59.00 Total liabilities and fund balances (sum of lines 51 and 60.00 761, 919, 177 0 0 0 60.00

BLESSING HOSPITAL

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 14-0015

					To 09/30/2023		
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) TRANSFER OF CLINIC ASSETS OTHER  Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) RELEASED FROM RESTRICTIONS ADOPTION OF ASC 842  Total deductions (sum of lines 12-17)	17, 179, 328 501 0 0 0 0 1, 559, 768 751, 952 0 0 0	452, 758, 567 25, 728, 233 478, 486, 800 17, 179, 829 495, 666, 629		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		493, 354, 909			1	19. 00
		Endowment Fund	PI ant	Fund			
		6.00	7. 00	8. 00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) TRANSFER OF CLINIC ASSETS OTHER	0	0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) RELEASED FROM RESTRICTIONS ADOPTION OF ASC 842  Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0		0 0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-0015

		Т	0 09/30/2023	Date/Time Pre 12/29/2023 3:	
	Cost Center Description	Inpati ent	Outpati ent	Total	
	'	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services	_			
1.00	Hospi tal	176, 982, 503		176, 982, 503	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF	9, 395, 964		9, 395, 964	3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	0		0	5. 00
6.00	Swing bed - NF	0		0	
7. 00	SKILLED NURSING FACILITY	7, 519, 805		7, 519, 805	7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	193, 898, 272		193, 898, 272	10. 00
	Intensive Care Type Inpatient Hospital Services	1 /5 75 / 000		/	
11. 00	INTENSIVE CARE UNIT	65, 754, 380		65, 754, 380	1
12.00	CORONARY CARE UNIT				12.00
	BURN INTENSIVE CARE UNIT				13.00
14. 00	SURGICAL INTENSIVE CARE UNIT				14.00
15. 00 16. 00	OTHER SPECIAL CARE (SPECIFY)	/E 7E4 200		/E 7E4 200	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	65, 754, 380		65, 754, 380	16. 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	259, 652, 652		259, 652, 652	17. 00
18. 00	Ancillary services	775, 234, 123		2, 025, 501, 042	
19. 00	Outpatient services	773, 234, 123		0	19. 00
20. 00	EAST ADAMS RHC	Ö	_		1
20. 01	48TH AND MAINE RHC	0	2, 550, 377	2, 550, 377	20. 01
	MT STERLING RHC	Ö	390, 917		
20. 03	MAIN CAMPUS RHC	l o	27, 734, 135	27, 734, 135	1
	BLESSING EXPRESS CLINIC	0	2, 473, 655		1
20.05	BLESSING WALK IN CLINIC	0		4, 587, 347	1
20.06	HANNI BAL MAIN RHC	0	5, 680, 371	5, 680, 371	20. 06
20. 07	PALMYRA RHC	0	403, 369	403, 369	20. 07
20.08	BOWLING GREEN RHC	0	134, 164	134, 164	20. 08
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21. 00
22.00	HOME HEALTH AGENCY		6, 553, 346	6, 553, 346	22. 00
23.00	AMBULANCE SERVI CES				23. 00
24.00	CMHC				24. 00
25.00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE	423, 506			1
27. 00	NURSERY	4, 592, 006		4, 592, 006	•
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	1, 039, 902, 287	1, 308, 066, 143	2, 347, 968, 430	28. 00
	G-3, line 1)				
20.00	PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200)	1	616, 826, 317		20.00
29. 00 30. 00	ADD (SPECIFY)	0			29. 00 30. 00
31. 00	ADD (SPECIFY)				31.00
32. 00					32.00
33. 00					33. 00
34. 00					34. 00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)	0	-		37. 00
38. 00		1 0			38. 00
39. 00		0			39. 00
40. 00		Ö			40. 00
41. 00		Ö			41. 00
42. 00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		616, 826, 317		43. 00
	to Wkst. G-3, line 4)				

Heal th	Financial Systems BLESSI	NG HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 14-0015	Peri od:	Worksheet G-3	
			From 10/01/2022 To 09/30/2023	Date/Time Pre 12/29/2023 3:	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3			2, 347, 968, 430	•
2.00	Less contractual allowances and discounts on patients' a	accounts		1, 785, 949, 030	•
3.00	Net patient revenues (line 1 minus line 2)			562, 019, 400	
4.00	Less total operating expenses (from Wkst. G-2, Part II,			616, 826, 317	
5. 00	Net income from service to patients (line 3 minus line	4)		-54, 806, 917	5. 00
, 00	OTHER I NCOME				, ,,
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			16, 103, 546	
8.00	Revenues from telephone and other miscellaneous communic	cation services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase discounts			0	10. 00 11. 00
11.00	· ·			-	12.00
12. 00 13. 00				0	13.00
	Revenue from meals sold to employees and quests				
	Revenue from rental of living quarters			2, 067, 173 0	1
	Revenue from sale of medical and surgical supplies to o	than than nationts		0	16.00
17. 00	9	ther than patrents		0	17. 00
18. 00				121, 089	
	Tuition (fees, sale of textbooks, uniforms, etc.)			4, 608, 507	
	Revenue from gifts, flowers, coffee shops, and canteen			4, 000, 307	20.00
	Rental of vending machines			0	21.00
22. 00				2, 368, 645	
23. 00	· ·			2, 300, 043	23. 00
24. 00				24, 621, 920	
24. 01				7, 098, 582	
24. 02				21, 769, 289	•
24. 50				1, 776, 399	•
	Total other income (sum of lines 6-24)			80, 535, 150	
	Total (line 5 plus line 25)			25, 728, 233	
	OTHER EXPENSES (SPECIFY)			0	•
	Total other expenses (sum of line 27 and subscripts)			0	28 00

0 28.00 25, 728, 233 29.00

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

3, 878, 352

-8. 058l

3, 870, 294

24.00

24.00 Total (sum of lines 1-23)

Heal th	Financial Systems		BLESSING HO	OSPI TAI		In Lie	eu of Form CMS-	2552-10
	LLOCATION - HHA GENERAL SERVICE	COST	DEESSI NO IN		CN: 14-0015	Peri od:	Worksheet H-1	
				HHA CCN:	14-7031	From 10/01/2022 To 09/30/2023		epared:
						Home Health	PPS	54 piii
			Capital Rela	ated Costs		Agency I		
			Capital Rela	ateu costs				
		Net Expenses	BI dgs &	Movabl e	Plant	Transportati or		
		for Cost Allocation	Fixtures	Equi pment	Operation &		(cols. 0-4)	
		(from Wkst. H,			ar rreariarios			
		col . 10)	1.00	2.00	2.00	4.00	44.00	
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	3.00	4. 00	4A. 00	
1.00	Capital Related - Bldg. &	0	0				C	1.00
2.00	Fixtures							2 00
2. 00	Capital Related - Movable Equipment	0		(	)		C	2.00
3.00	Plant Operation & Maintenance	0	0	(		0	C	3.00
4.00	Transportation	0	0	(	1	0	1	4. 00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	571, 641	0	(	)	0 (	571, 641	5. 00
6. 00	Skilled Nursing Care	1, 366, 966	0	(		0 0	1, 366, 966	6.00
7.00	Physical Therapy	1, 101, 920	0	(	1	0 0		
8. 00 9. 00	Occupational Therapy Speech Pathology	358, 724 79, 277	0	(	1	0 0	358, 724 79, 277	
10. 00	Medical Social Services	99, 464		(	1	0	99, 464	1
11. 00	Home Health Aide	292, 302	0	(		0 0	292, 302	
12. 00 13. 00	Supplies (see instructions)	0	0	(	1	0		
14. 00	Drugs DME	0 0	0	(		0 0		
00	HHA NONREIMBURSABLE SERVICES	, ,	3		1	<u> </u>	·1	1 00
15. 00	Home Dialysis Aide Services	0	0	(	•	0		1
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0	(	1	0 0		
18. 00	Clinic		o	(	1	0		1
19. 00	Health Promotion Activities	0	0	(	1	0	) c	
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	(	1	0 0	) C	
21.00	Homemaker Service		0	(	1	0 0		1
23. 00	All Others (specify)	O	O	Ć	1	0 0		1
23. 50	Tel emedi ci ne	0	0	(		0	1	
24.00	Total (sum of lines 1-23)	3, 870, 294 Admi ni strati ve	Total (cols.	(	<u>/ </u>	0 0	3, 870, 294	24.00
		& General	4A + 5)					
	CENEDAL CEDALCE COCT CENTEDO	5. 00	6. 00					
1. 00	GENERAL SERVICE COST CENTERS  Capital Related - Bldg. &							1.00
	Fixtures							
2.00	Capital Related - Movable							2. 00
3.00	Equipment Plant Operation & Maintenance							3. 00
4.00	Transportati on							4. 00
5. 00	Administrative and General	571, 641						5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	236, 890	1, 603, 856					6. 00
7.00	Physi cal Therapy	190, 957	1, 292, 877					7. 00
8.00	Occupational Therapy	62, 165	420, 889					8. 00
9. 00 10. 00	Speech Pathology Medical Social Services	13, 738 17, 237	93, 015 116, 701					9. 00 10. 00
11. 00	Home Health Aide	50, 654	342, 956					11. 00
12.00	Supplies (see instructions)	0	0					12.00
13. 00 14. 00	Drugs DMF	0 0	0					13. 00 14. 00
00	HHA NONREIMBURSABLE SERVICES	,						1 55
15.00	Home Dialysis Aide Services	0	0					15.00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0					16. 00 17. 00
18. 00	Clinic		o					18. 00
19. 00	Health Promotion Activities	0	O					19. 00
20. 00	Day Care Program Home Delivered Meals Program	0	0					20.00
21.00	Homemaker Service		0					21.00
23. 00	All Others (specify)	0	O					23. 00
23. 50		0	2 970 204					23. 50
∠4. 00	Total (sum of lines 1-23)	1 1	3, 870, 294					24. 00

Hoal th	Financial Systems		BLESSI NG I	HOSDI TAI		In lie	eu of Form CMS-:	2552_10
	ALLOCATION - HHA STATISTICAL BAS	SI S	DLE331 NO 1		CN: 14-0015	Peri od: From 10/01/2022	Worksheet H-1	
				HHA CCN:	14-7031	To 09/30/2023		pared: 54 pm
						Home Health	PPS	<u> </u>
						Agency I		
		Capital Re	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportati	on Reconciliation	Admi ni strati ve	1
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Maintenance (SQUARE FEET)			(ACCUM. COST)	
		1.00	2.00	3. 00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	11.00	2.00	0.00		07.1. 00	0.00	
1.00	Capital Related - Bldg. &	0				0		1. 00
2. 00	Fixtures Capital Related - Movable		0			0		2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	· ·	C	1	0		3. 00
4.00	Transportation (see	0	0	C	)	0		4. 00
F 00	instructions)					0 574 (44	0.000 (50	F 00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	0	0	C	ή	0 -571, 641	3, 298, 653	5. 00
6. 00	Skilled Nursing Care	0	0	С		0 0	1, 366, 966	6.00
7. 00	Physical Therapy				1	0 0	1, 101, 920	
8. 00	Occupational Therapy		0	1	1	0 0	358, 724	1
9. 00	Speech Pathology		0	1	1	0 0	79, 277	
10.00	Medical Social Services		0	1	1		99, 464	
11. 00	Home Heal th Aide	0	0	Ĭ	1	0 0	292, 302	1
12. 00	Supplies (see instructions)	0	0	Č		0 0	0	1
13. 00	Drugs	Ö	0	ĺ		0	Ō	
14. 00	DME	0	0	l c		0 0	0	1
	HHA NONREIMBURSABLE SERVICES	•			•			Ī
15.00	Home Dialysis Aide Services	0	0	C	)	0 0	0	15. 00
16.00	Respiratory Therapy	0	0	C		0 0	0	16. 00
17. 00	Private Duty Nursing	0	0	C	)	0	0	17. 00
18. 00	Clinic	0	0	C	)	0	0	18. 00
19. 00	Health Promotion Activities	0	0	C	)	0	0	19. 00
20.00	Day Care Program	0	0			0	0	20. 00
	1	0	0	1	1	0	0	21. 00
22. 00	Homemaker Service	0	0	C		0	0	22. 00
	All Others (specify)	0	0	[ C	2	0	0	23. 00
23. 50	Tel emedi ci ne	0	0	[ C	<u>'</u>	0	0 000 150	23. 50
24. 00	Total (sum of lines 1-23)		0		'[	0 -571, 641		1
25. 00	Cost To Be Allocated (per		0	C	ή	U	571, 641	25. 00

0. 000000

0.000000

0.000000

0.000000

0. 173295 26. 00

25.00 Cost To Be Allocated (per Worksheet H-1, Part I)
26.00 Unit Cost Multiplier

From 10/01/2022 Part I HHA CCN: 14-7031 09/30/2023 Date/Time Prepared: 12/29/2023 3:54 pm Home Health PPS Agency I CAPI TAL RELATED COSTS HHA Trial BUTLER OLD BLDG & NEW BLDG & MOB Cost Center Description BLDG & FIXT Bal ance (1) BUI LDI NG **FIXTURES** FI XTURES 1.00 0 1.01 1.02 1. 03 1.04 1.00 Administrative and General 1. 00 00000000000000000000 1, 603, 856 0 2.00 2.00 Skilled Nursing Care C 0 0 1, 292, 877 3.00 Physical Therapy 3.00 4.00 Occupational Therapy 420, 889 0 0 4.00 Speech Pathology 5.00 93, 015 5.00 116, 701 0 0 6.00 6.00 Medical Social Services O 0 7.00 Home Health Aide 342, 956 0 7.00 8.00 Supplies (see instructions) 8.00 Drugs o 0 0 9.00 9 00 0 0 0 10.00 DMF 10.00 11.00 Home Dialysis Aide Services 11.00 0 12.00 Respiratory Therapy 0 0 12.00 0 0 0 13.00 Private Duty Nursing 13 00 14.00 Clinic 0 14.00 15.00 Health Promotion Activities 0 15.00 Day Care Program 0 16.00 16,00 0 0 17.00 Home Delivered Meals Program 0 17.00 18.00 Homemaker Service 0 0 0 18.00 All Others (specify) 19.00 19.00 Tel emedi ci ne 0 0 0 19.50 19.50 0 Total (sum of lines 1-19) (2) 3, 870, 294 20.00 20.00 Unit Cost Multiplier: column 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places CAPI TAL RELATED COSTS Cost Center Description OAK STREET BRCN AT 36TH SURGERY CENTER 48TH AND MAINE HANNI BAL MVBLE EQUIP MALL ST 1. 05 1.06 1.07 1.08 1. 09 2.00 1.00 Administrative and General 22, 285 0 466 1.00 0 2.00 Skilled Nursing Care 0 0 2.00 3.00 Physical Therapy 0 0000000000000000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 3.00 0 0 0 0 4 00 O Occupational Therapy 4 00 5.00 Speech Pathology 0 0 5.00 Medical Social Services 6.00 6.00 0 0 7.00 Home Health Aide 0 0 7.00 0 0 8.00 Supplies (see instructions) 0 0 8.00 9.00 Drugs 0 0 9.00 0 0 10.00 10.00 Home Dialysis Aide Services 0 0 0 11.00 11.00 0 Respiratory Therapy 0 12.00 12.00 0 13.00 Private Duty Nursing 0 0 13.00 14.00 Clinic 14.00 Health Promotion Activities 0 0 0 15.00 15.00 0 0 0 16.00 Day Care Program 16.00 Home Delivered Meals Program 17.00 17.00 Homemaker Service All Others (specify) 0 18.00 0 0 18.00 19.00 19.00 0 0 0 0 0 19.50 Tel emedi ci ne 0 19.50 20.00 20.00 Total (sum of lines 1-19) (2) 22, 285 466 Unit Cost Multiplier: column 21.00 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to

6 decimal places.

<sup>(1)</sup> Column 0, line 20 must agree with Wkst. A, column 7, line 101.

<sup>(2)</sup> Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Worksheet H-2 Part I Date/Time Prepared: 12/29/2023 3:54 pm Provider CCN: 14-0015 Peri od: From 10/01/2022 To 09/30/2023 HHA CCN: 14-7031

							12/29/2023 3:	54 pm
						Home Health Agency I	PPS	
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		4. 00	4A	5. 00	6. 00	8. 00	9. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	177, 983 177, 983 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	200, 734 1, 603, 856 1, 292, 877 420, 889 93, 015 116, 701 342, 956 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	56, 381 450, 481 363, 134 118, 216 26, 125 32, 778 96, 327 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	47, 700		27, 745 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00
	of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON		NURSI NG PROGRAM	I NTERNS & RESI DENTS SERVI CES-SALAR Y & FRI NGES	
		10.00	11. 00	13.00	16. 00	20.00	21. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	000000000000000000000000000000000000000	000000000000000000000000000000000000000	868, 017		55, 330 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 20. 00 21. 00

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

Health Financial Systems	BLESSING HOSPITAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS	Provi der CCN: 14-0015	Peri od:	Worksheet H-2
		From 10/01/2022	Part I
	HHA CCN: 14-7031	To 09/30/2023	Date/Time Prepared:
			12/29/2023 3:54 pm
		Home Health	PPS
		A 1	

						Home Health Agency I	PPS	•
		INTERNS &				Agency 1		
	Cost Center Description	RESI DENTS SERVI CES-OTHER	PARAMED ED	PARAMED ED	PARAMED ED	PARAMED ED	PARAMED ED	
	dost deliter bescription	PRGM COSTS	PRGM				PRGM-RESPI RATO	
		22.00	22.00	22.01	Y 23. 02	22.02	RY 23. 04	
1. 00	Administrative and General	22. 00	23. 00	23. 01		23. 03		1. 00
2.00	Skilled Nursing Care	0	C	1		0	O	2. 00
3. 00	Physical Therapy	0	C	1	C	0	0	3. 00
4. 00 5. 00	Occupational Therapy Speech Pathology	0	C	0		0	0	4. 00 5. 00
6. 00	Medical Social Services	0		1		0	0	6.00
7.00	Home Health Aide	0	C	1	C	0	0	7. 00
8.00	Supplies (see instructions)	0	C			-	0	
9. 00 10. 00	Drugs DME	0	C		1	_	0	9. 00 10. 00
11. 00	Home Dialysis Aide Services	0	C	ł			Ö	11. 00
12. 00	Respiratory Therapy	0	C		1		0	12.00
13. 00 14. 00	Private Duty Nursing Clinic	0	C			0	0	13. 00 14. 00
15. 00	Health Promotion Activities	0	_		1	Ö	Ö	15. 00
16. 00	Day Care Program	0	C		1	-	0	16. 00
17. 00 18. 00	Home Delivered Meals Program Homemaker Service	0	C	l .			0	17. 00 18. 00
19. 00	All Others (specify)				1	_	0	19.00
19. 50	Tel emedi ci ne	0	C	o	C	0	0	19. 50
20. 00	Total (sum of lines 1-19) (2)	0	C	0	C	0	0	20.00
21. 00	Unit Cost Multiplier: column 26, line 1 divided by the sum							21. 00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.  Cost Center Description	Subtotal	Intern &	Subtotal	Allocated HHA	Total HHA		
	· ·		Residents Cost		A&G (see Part	Costs		
			& Post Stepdown		11)			
			Adjustments					
1 00	Administratives and Consumb	24. 00	25. 00	26.00	27. 00	28. 00		1 00
1. 00 2. 00	Administrative and General Skilled Nursing Care	1, 255, 913 2, 054, 337	C			2, 574, 792		1. 00 2. 00
3. 00	Physi cal Therapy	1, 656, 011	C		419, 539			3. 00
4.00	Occupational Therapy	539, 105		539, 105				4. 00
5. 00 6. 00	Speech Pathology Medical Social Services	119, 140 149, 479	C	119, 140 149, 479		·		5. 00 6. 00
7. 00	Home Health Aide	439, 283		1				7. 00
8. 00	Supplies (see instructions)	0	C	1	C	0		8. 00
9. 00 10. 00	Drugs DME	0	C	0		0		9. 00 10. 00
11. 00	Home Dialysis Aide Services	0		Ö		0		11. 00
12.00	Respiratory Therapy	0	C	0	C	0		12. 00
	Private Duty Nursing	0	C	0	O	0		13.00
14. 00 15. 00	Clinic Health Promotion Activities	0	C	0	l o	0		14. 00 15. 00
	Day Care Program	0	C	Ö	C	0		16. 00
	Home Delivered Meals Program	0	C	0	C	0		17. 00
18.00	Homemaker Service All Others (specify)	0	C			0		18. 00 19. 00
	Tel emedi ci ne	0	Č	-	Ö	Ö		19. 50
20.00	Total (sum of lines 1-19) (2)	6, 213, 268	C	6, 213, 268				20. 00
21. 00	Unit Cost Multiplier: column 26, line 1 divided by the sum				0. 253343			21. 00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.	1		I	l	l		

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

HHA CCN: Home Health PPS

						Agency I	PPS	
		CAPI TAL				7.901.07		
		RELATED COSTS						
	Cost Center Description	BLDG & FIXT	BUTLER	OLD BLDG &	NEW BLDG &	MOB	OAK STREET	
		(SQUARE FEET)	BUI LDI NG	FI XTURES	FI XTURES	(SQUARE FEET)	MALL	
			(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)		(SQUARE FEET)	
		1. 00	1. 01	1. 02	1. 03	1. 04	1. 05	
1. 00	Administrative and General	0	0			_	2, 046	1. 00
2. 00	Skilled Nursing Care	0	0	1	1		0	2. 00
3.00	Physical Therapy	0	0	•	) c	0	0	3. 00
4. 00	Occupational Therapy	0	0	1	) C	0	0	4. 00
5. 00	Speech Pathology	0	0	0	O C	0	0	5. 00
6. 00	Medical Social Services	0	0	0		0	0	6. 00
7.00	Home Heal th Ai de	0	0	0		0	0	7. 00
8.00	Supplies (see instructions)	0	0		C	0	0	8. 00
9.00	Drugs	0	0	1		0	0	9. 00
10.00	DME	0	0		C	_	0	10.00
11. 00	Home Dialysis Aide Services	0	0		0	_	0	11.00
12. 00 13. 00	Respiratory Therapy Private Duty Nursing		0		0	0	0	12.00
14. 00	Clinic		0	0		0	0	13. 00 14. 00
15. 00	Health Promotion Activities		0			0	0	15. 00
16. 00	Day Care Program		0			0	0	16. 00
17. 00	Home Delivered Meals Program		0			0	0	17. 00
18. 00	Homemaker Service	0	0	0	l o	0	Ö	18. 00
19. 00	All Others (specify)	0	0	0		0	0	19. 00
19. 50	Tel emedi ci ne	0	0	0	d	0	0	19. 50
20.00	Total (sum of lines 1-19)	0	0	0	ol c	0	2, 046	20. 00
21. 00	Total cost to be allocated	0	0	0	o c	0	22, 285	21. 00
22. 00	Unit cost multiplier	0. 000000	0. 000000	0.000000	0.000000	0.000000	10. 891984	22. 00
			CAP	ITAL RELATED CO	OSTS			
				1				
	Cost Center Description		SURGERY CENTER	48TH AND MAINE		MVBLE EQUIP	EMPLOYEE	
	Cost Center Description	ST			HANNI BAL (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	BENEFI TS	
	Cost Center Description		SURGERY CENTER (SQUARE FEET)				BENEFITS DEPARTMENT	
	Cost Center Description	ST					BENEFITS DEPARTMENT (GROSS	
	Cost Center Description	ST (SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS DEPARTMENT (GROSS SALARIES)	
1.00	Cost Center Description  Administrative and General	ST		(SQUARE FEET)	(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS DEPARTMENT (GROSS	1. 00
1. 00 2. 00	,	ST (SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS DEPARTMENT (GROSS SALARIES) 4.00	1. 00
	Administrative and General	ST (SQUARE FEET)	(SQUARE FEET)  1.07	(SQUARE FEET)	(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS DEPARTMENT (GROSS SALARIES) 4.00 3,079,669	
2. 00	Administrative and General Skilled Nursing Care	ST (SQUARE FEET)	(SQUARE FEET)  1.07	(SQUARE FEET)	(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS DEPARTMENT (GROSS SALARI ES) 4. 00 3, 079, 669 0	2. 00
2. 00 3. 00	Administrative and General Skilled Nursing Care Physical Therapy	ST (SQUARE FEET)	(SQUARE FEET)  1.07	(SQUARE FEET)  1.08  0 0 0 0	(SQUARE FEET)	(DOLLAR VALUE)	BENEFI TS DEPARTMENT (GROSS SALARI ES) 4. 00 3, 079, 669 0	2. 00 3. 00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	ST (SQUARE FEET)	1.07 0 0 0 0	(SQUARE FEET)  1.08  0 0 0 0 0	(SQUARE FEET)	(DOLLAR VALUE)	BENEFI TS DEPARTMENT (GROSS SALARI ES) 4. 00 3, 079, 669 0 0	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	ST (SQUARE FEET)	1.07 0 0 0 0 0	(SQUARE FEET)  1.08  0 0 0 0 0 0	(SQUARE FEET)	2.00 470 0 0 0	BENEFI TS DEPARTMENT (GROSS SALARI ES) 4. 00 3, 079, 669 0 0	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	ST (SQUARE FEET)	1.07 0 0 0 0 0	1.08 0 0 0 0 0 0	1.09	2.00 470 0 0 0	BENEFI TS DEPARTMENT (GROSS SALARI ES) 4.00 3,079,669 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	ST (SQUARE FEET)	1.07 0 0 0 0 0 0	(SQUARE FEET)  1.08  0 0 0 0 0 0 0 0 0 0 0	1.09	2. 00 470 0 0 0 0 0 0	BENEFI TS DEPARTMENT (GROSS SALARI ES) 4.00 3,079,669 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	ST (SQUARE FEET)	(SQUARE FEET)  1.07  0 0 0 0 0 0 0 0 0 0	(SQUARE FEET)  1.08  0 0 0 0 0 0 0 0 0 0 0	(SQUARE FEET)	2. 00 470 0 0 0 0 0 0	BENEFI TS DEPARTMENT (GROSS SALARI ES) 4.00 3,079,669 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	ST (SQUARE FEET)	(SQUARE FEET)  1.07  0 0 0 0 0 0 0 0 0 0	(SQUARE FEET)  1.08  0 0 0 0 0 0 0 0 0 0 0	(SQUARE FEET)	2. 00 470 0 0 0 0 0 0	BENEFI TS DEPARTMENT (GROSS SALARI ES) 4.00 3,079,669 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	ST (SQUARE FEET)	1.07 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.08 1.08 0 0 0 0 0 0 0 0 0 0 0 0 0	(SQUARE FEET)	2. 00 470 0 0 0 0 0 0	BENEFI TS DEPARTMENT (GROSS SALARI ES) 4. 00 3, 079, 669 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	ST (SQUARE FEET)  1.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.07 0 0 0 0 0 0 0 0 0 0 0 0	1.08 00 00 00 00 00 00 00 00 00 00 00 00 0	1.09	2. 00 470 0 0 0 0 0 0 0 0 0 0 0 0	BENEFI TS DEPARTMENT (GROSS SALARI ES) 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	ST (SQUARE FEET)	1.07 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.08 00 00 00 00 00 00 00 00 00 00 00 00 0	(SQUARE FEET)	2. 00 470 0 0 0 0 0 0 0 0 0 0 0 0	BENEFI TS DEPARTMENT (GROSS SALARI ES) 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	ST (SQUARE FEET)  1.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 07 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(SQUARE FEET)  1.08  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.09  1.09  CO CO CO CO CO CO CO CO CO CO CO CO CO	2. 00 470 0 0 0 0 0 0 0 0 0 0 0 0 0 0	BENEFI TS DEPARTMENT (GROSS SALARI ES) 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	ST (SQUARE FEET)  1.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.07 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.08  1.08  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.09	2. 00 470 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	BENEFI TS DEPARTMENT (GROSS SALARI ES) 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	ST (SQUARE FEET)  1.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 07 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.08  1.08  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.09  1.09  CO CO CO CO CO CO CO CO CO CO CO CO CO	2. 00 470 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	BENEFI TS DEPARTMENT (GROSS SALARI ES) 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	ST (SQUARE FEET)  1.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.07 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.08  1.08  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.09	2. 00 470 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	BENEFI TS DEPARTMENT (GROSS SALARI ES) 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	ST (SQUARE FEET)  1.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.07 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.08  1.08  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.09	2. 00 470 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	BENEFI TS DEPARTMENT (GROSS SALARI ES) 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	ST (SQUARE FEET)  1.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.07 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(SQUARE FEET)  1.08  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.09	2. 00  470 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	BENEFI TS DEPARTMENT (GROSS) 4.00 3,079,669 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19)	ST (SQUARE FEET)  1.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 07  1. 07  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(SQUARE FEET)  1.08  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.09	2. 00  470 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	BENEFI TS DEPARTMENT (GROSS SALARI ES) 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	ST (SQUARE FEET)  1.06  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 07  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(SQUARE FEET)  1.08  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 09  1. 09  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00  470 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	BENEFI TS DEPARTMENT (GROSS SALARI ES) 4.00 3,079,669 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00

Peri od: From 10/01/2022 To 09/30/2023 BASIS HHA CCN: 14-7031

						Home Health Agency I	PPS	<u> </u>
	Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	REPAI RS	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DIETARY (MEALS SERVED)	
		5A	5. 00	6. 00	8. 00	9. 00	10.00	
1. 00 2. 00 3. 00	Administrative and General Skilled Nursing Care Physical Therapy	0 0	200, 734 1, 603, 856 1, 292, 877	,	0	355 0 0	0 0 0	1. 00 2. 00 3. 00
4. 00 5. 00 6. 00	Occupational Therapy Speech Pathology Medical Social Services	0 0	420, 889 93, 015 116, 701	0	0	0 0 0	0 0 0	4. 00 5. 00 6. 00
7. 00 8. 00 9. 00	Home Health Aide Supplies (see instructions) Drugs	0 0	342, 956 0 0	0 0	Ō	0 0 0	0 0 0	7. 00 8. 00 9. 00
10. 00 11. 00 12. 00	DME Home Dialysis Aide Services Respiratory Therapy	0 0	0	0 0	Ō	0	0	10. 00 11. 00 12. 00
13. 00 14. 00 15. 00	Private Duty Nursing Clinic Health Promotion Activities	0 0	0	0 0	0	0	0 0	13. 00 14. 00 15. 00
16. 00 17. 00 18. 00	Day Care Program Home Delivered Meals Program Homemaker Service	0	0	0	0	0	0	16. 00 17. 00 18. 00
19. 00 19. 50 20. 00	All Others (specify) Telemedicine Total (sum of lines 1-19)	0	4, 071, 028			0 355	0 0	19. 00 19. 50 20. 00
21. 00 22. 00	Total cost to be allocated Unit cost multiplier		1, 143, 442 0. 280873	l		27, 745 78. 154930 I NTERNS & RESI DENTS	0. 000000	21. 00 22. 00
	Cost Center Description	CAFETERIA (MEALS SERVED)	NURSI NG ADMI NI STRATI ON	MEDI CAL RECORDS & LI BRARY	NURSI NG PROGRAM (ASSI GNED		SERVI CES-OTHER PRGM COSTS (ASSI GNED	
		11. 00	(DI RECT NURS. HRS.) 13.00	(TIME SPENT)	TI ME)	TI ME) 21. 00	TI ME) 22. 00	
1.00	Administrative and General	0	83, 755			0	0	1. 00
2.00	Skilled Nursing Care	0	0	i e	0	0	0	2. 00
3.00	Physi cal Therapy	0	0	0	0	0	0	3. 00
4.00	Occupational Therapy	0	0	0	0	0	0	4. 00
5.00	Speech Pathology	0	0	0	0	0	0	5. 00
6.00	Medical Social Services	0	0	0	0	0	0	6. 00
7. 00	Home Health Aide	0	0	0	0	0	0	7. 00
8.00	Supplies (see instructions)	0	0	0	_	0	0	8. 00
9. 00 10. 00	Drugs DME	0	0	0	1	0	0	9. 00 10. 00
11. 00	Home Dialysis Aide Services		0			0	0	11. 00
12. 00	Respiratory Therapy	0	0		0	0	0	12. 00
13. 00	Private Duty Nursing	0	0		0	0	0	13. 00
14. 00	Clinic	0	0	0	0	0	ő	14. 00
15. 00	Health Promotion Activities	0	0	0	0	0	Ö	
16. 00	Day Care Program	0	0	O	0	0	0	16. 00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17. 00
18.00	Homemaker Servi ce	0	0	0	0	0	0	18. 00
19. 00	All Others (specify)	0	0	0	0	0	0	19. 00
19. 50	Tel emedi ci ne	0	0	0	1	0	0	19. 50
20.00	Total (sum of lines 1-19)	0	83, 755			0	0	20. 00
21. 00 22. 00	Total cost to be allocated Unit cost multiplier	0. 000000	868, 017 10. 363763	ł		0. 000000	0. 000000	21. 00 22. 00

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO	HHA COST CENTERS STATISTICAL Provider CCN: 14-0015	Period: Worksheet H-2

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL
BASIS

HHA CCN: 14-0015
HHA CCN: 14-7031

Peri od: From 10/01/2022 Part II
Date/Time Prepared: 12/29/2023 3:54 pm
Home Heal th
PPS

						nome near th	PP5	
						Agency I		
	Cost Center Description	PARAMED ED	PARAMED ED	PARAMED ED	PARAMED ED	PARAMED ED		
		PRGM	PRGM-RADI OLOGY	PRGM-LABORATOR	PRGM-PHARMACY	PRGM-RESPI RATO		
		(ASSI GNED		Υ	(ASSI GNED	RY		
		TIME)	(ASSI GNED	(ASSI GNED	TIME)	(ASSI GNED		
			TIME)	TIME)		TIME)		
		23. 00	23. 01	23. 02	23. 03	23. 04		
1.00	Administrative and General	0	0	0	C	0		1. 00
2.00	Skilled Nursing Care	0	0	0	C	0		2. 00
3.00	Physical Therapy	0	0	0	C	0		3. 00
4.00	Occupational Therapy	0	0	0	C	0		4. 00
5.00	Speech Pathology	0	0	0	C	0		5. 00
6.00	Medical Social Services	0	0	0	C	0		6. 00
7.00	Home Health Aide	0	0	0	C	0		7. 00
8.00	Supplies (see instructions)	0	0	0	C	0		8. 00
9.00	Drugs	0	0	0	C	0		9. 00
10.00	DME	0	0	0	C	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	C	0		11. 00
12.00	Respiratory Therapy	0	0	0	C	0		12. 00
13.00	Private Duty Nursing	0	0	0	C	0		13. 00
14.00	Clinic	0	0	0	C	0		14. 00
15.00	Health Promotion Activities	0	0	0	C	0		15. 00
16.00	Day Care Program	0	0	0	C	0		16. 00
17.00	Home Delivered Meals Program	0	0	0	C	0		17. 00
18. 00	Homemaker Service	0	0	0	l c	0		18. 00
19.00	All Others (specify)	0	0	0	l c	0		19. 00
19. 50	Tel emedi ci ne	0	0	0	C	0		19. 50
20.00	Total (sum of lines 1-19)	0	0	0	C	O		20. 00
21.00	Total cost to be allocated	0	0	0	l c	O		21. 00
22. 00	Unit cost multiplier	0. 000000	0. 000000	0.000000	0. 000000	0.000000		22. 00

Provider CCN: 14-0015	Heal th	Financial Systems		BLESSING F	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HAR COX			S		Provi der C		Peri od:	Worksheet H-3	
Cost Center Description   From West   Facility Costs   Facility Costs   Center Description   From West   Facility Costs   Cost Center Description   From West   Facility Costs   Center Description   From West   Facility Costs   Center Description   From West   Facility Costs   Center Description   From West   Facility Costs   Center Description   From West   Facility Costs   Center Description   From West   Facility Costs   Fa					HHA CCN:			Date/Time Pre	pared: 54 pm
Cost Center Description					Ti tl e	e XVIII		PPS	
Coll   28,   line   H-2,   Part   1     Costs (From   +2)     Cost   3 + coll		Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA		Average Cost	
Part						1	1		
PART   - COMPUTATION OF LESSER OF AGGREGATE PROCRAM COST, AGGREGATE OF THE PROCRAM LIMITATION COST, OR SENETICIARY COST LIMITATION			col. 28, line	H-2, Part I)		+ 2)		`	
RART   - COMPUTATION OF LESSER OF AGGREGATE PROGRAW COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR SENTER CHAPTOST LIMITATION COST. OR SENTER CHAPTOST LIMITATION COST. OR SENTER CHAPTOST LIMITATION COST. OR SENTER CHAPTOST LIMITATION COST. OR SENTER CHAPTOST LIMITATION COST. OR SENTER CHAPTOST LIMITATION COST. OR SENTER CHAPTOST LIMITATION COST. OR SENTER CHAPTOST LIMITATION COST. OR SENTER CHAPTOST LIMITATION COST. OR SENTER CHAPTOST LIMITATION COST. OR SENTER CHAPTOST LIMITATION COST. OR SENTER CHAPTOST LIMITATION COST. OR SENTER CHAPTOST LIMITATION COST. OR SENTER CHAPTOST LIMITATION COST. OR SENTER CHAPTOST LIMITATION COST. OR SENTER CHAPTOST LIMITATION. OR SENTER CHAPTOST LIMITATION COST. OR SENTER CHAPTOST LIMITATION. OR S			0	1.00		2.00	4.00		
BRREFICIARY COST LIMITATION		DART I COMPUTATION OF LESSER							
1.00   Skilled Nursing Care   2.00   2.574,792   0.2574,792   16,720   153.99   1.00		BENEFICIARY COST LIMITATION	OF AGGREGATE F	RUGRAW CUST, A	GUREGATE OF TR	IE PROGRAW LIW	TIATION COST, OF	7	
2.00   Physical Therapy   3.00   2.075,550   0   2.075,550   10,924   190.00   2.00	1 00		2.00	2 574 702		2 574 70	14 720	152.00	1 00
100   0ccupational Therapy			1		,				
1.00   Speech Pathology					_	1			
Medical Social Services   6.00   187, 348   187, 348   74   2, 531.73   5.00									
Mome Heal th Aide			1	· ·					
Total (sum of lines 1-6)		II	1	· ·					
Cost Center Description   Cost Limits   CBSA No. (1)   Part A   No. (200   Part B   Cost Consurance   Cost Cost Consurance   Cost Consurance   Cost Cost Cost Cost Cost Consurance   Cost Cost Cost Cost Cost Cost Cost Cost	7. 00	II	1		C	1			
Cost Center Description   Cost Limits   CBSA No. (1)   Part A   Not Subject to Deductibles & Coinsurance   Coins	7.00	110141 (0411 01 111100 1 0)		0,2:0,200					7.00
Cost Center Description									
Limitation Cost Computation		Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject t	o Subject to		
Limitation Cost Computation   Skilled Nursing Care   99914   0   1,168   8.00   8.01   99926   0   1,168   8.01   9.00						Deductibles 8	Deductibles		
Limitation Cost Computation									
8.00   Skilled Nursing Care   99914   0   4,872   8.00   8.01   Skilled Nursing Care   99926   0   1,168   8.01   8.01   Skilled Nursing Care   99926   0   1,168   8.01   8.00   9.00   9.01   Physical Therapy   99914   0   4,086   9.00   9.01   9.01   10.00   0   0   0   0   0   0   0   0   0		Tea	0	1.00	2. 00	3.00	4. 00	5. 00	
Skilled Nursing Care	0.00		I	00014		1 07	ما	I	0.00
Physical Therapy					_	1 .,			
9.01   Physical Therapy   99926   99914   0   1,315   10.00   1,000   1,463   10.00   10.00   1,000   1,463   10.00		9				1			
10.00									
10. 01						1			
11.00									
11. 01									
12.00   Medical Social Services   99914   0   35   12.00   Medical Social Services   99926   0   5   12.00   13.00   Medical Social Services   99926   0   5   12.00   13.00   14.00   14.53   13.00   14.00   14.53   13.00   14.00   15.193   14.00   14.00   15.193   14.00   15.193   14.00   15.193   14.00   15.193   14.00   15.193   14.00   15.193   15					Č	1			
12.01   Medical Social Services   99926   99914   0   1,453   12.01   13.00   14.00   15.01   14.00   15.01	12. 00				Ċ				
13. 01   Home Heal th Aide	12. 01	Medical Social Services		99926	C		5		12. 01
14. 00   Total (sum of lines 8-13)   Cost Center Description   From Wkst. H-2   Facility Costs   Cost Center Description   Part I, col. 28, line   Doctor of Medical Supplies   Supplies and Drugs Cost Computations   Doctor of Drugs   Doctor of Drugs   Doctor of Deductibles & Cost Center Description   Part A   Doctor of Deductibles & Coinsurance   Doctor of Deductibles &	13.00	Home Health Aide		99914	C	1, 45	3		13. 00
Cost Center Description   From Wkst. H-2   Facility Costs   (from Wkst. H-2, Part I)   28, I in e   H-2, Part I)   0   1.00   2.00   3.00   4.00   5.00	13.01	Home Health Aide		99926	C	27	6		13. 01
Part I, col   28, line   H-2, Part I)   Costs (from Wkst.   H-2, Part I)   Costs (from HHA   Records)   Records)	14.00				C	15, 19			14.00
28, line		Cost Center Description							
Supplies and Drugs Cost Computations								÷ col. 4)	
Supplies and Drugs Cost Computations			28, line	H-2, Part I)		+ 2)	Records)		
Supplies and Drugs Cost Computations				1.00		0.00	4.00	F 00	
15. 00   Cost of Medical Supplies   8. 00   9. 00   10, 120   10, 120   0   0   0   0   0   0   0   0   0		Supplies and Drugs Cost Comput		1.00	2.00	3.00	4.00	5.00	
16.00   Cost of Drugs   9.00   0   0   0   0   0   0   0   0   0	15 00			0	10 120	10 12	0 82 082	0 123291	15 00
Part B			1			1			
Part B		1			_	Cost of	-	0.00000	
Cost Center Description						Servi ces			
Deductibles & Coinsurance				Par	t B		Part B		
Coi nsurance   Coi nsurance   Coi nsurance   Coi nsurance		Cost Center Description	Part A			Part A			
Accordance   Computation   Cost Per Visit Cost Per Visit Cost Per Visit Cost Per Visit Cost Per Visit									
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
BENEFICIARY COST LIMITATION   Cost Per Visit Computation   1.00   Skilled Nursing Care   0   6,040   0   930,100   1.00   2.00   Physical Therapy   0   5,401   0   1,026,190   2.00   313,452   3.00   0ccupational Therapy   0   1,793   0   313,452   3.00   Speech Pathology   0   190   0   50,126   4.00   5.00   Medical Social Services   0   40   0   101,269   5.00   6.00   Home Health Aide   0   1,729   0   287,775   6.00		DART I COMPUTATION OF LECCED							
1. 00     Skilled Nursing Care     0     6,040     0     930,100     1.00       2. 00     Physical Therapy     0     5,401     0     1,026,190     2.00       3. 00     Occupational Therapy     0     1,793     0     313,452     3.00       4. 00     Speech Pathology     0     190     0     50,126     4.00       5. 00     Medical Social Services     0     40     0     101,269     5.00       6. 00     Home Health Aide     0     1,729     0     287,775     6.00		BENEFICIARY COST LIMITATION	OF AGGREGATE F	TRUGRAW CUST, A	GUKEGATE UF TE	IE PKUGKAW LIM	TATION COST, OF	τ	
2.00     Physical Therapy     0     5, 401     0     1,026,190     2.00       3.00     Occupational Therapy     0     1,793     0     313,452     3.00       4.00     Speech Pathology     0     190     0     50,126     4.00       5.00     Medical Social Services     0     40     0     101,269     5.00       6.00     Home Health Aide     0     1,729     0     287,775     6.00	1 00		_				0 000 400		1 00
3.00     Occupational Therapy     0     1,793     0     313,452     3.00       4.00     Speech Pathology     0     190     0     50,126     4.00       5.00     Medical Social Services     0     40     0     101,269     5.00       6.00     Home Health Aide     0     1,729     0     287,775     6.00		_							
4.00     Speech Pathology     0     190     0     50, 126     4.00       5.00     Medical Social Services     0     40     0     101, 269     5.00       6.00     Home Health Aide     0     1, 729     0     287, 775     6.00			_						
5.00     Medical Social Services     0     40     0     101, 269     5.00       6.00     Home Health Aide     0     1, 729     0     287, 775     6.00			•						
6.00   Home Health Aide   0   1,729   0   287,775   6.00			_						
7.00   10tai (3uii 01 111163 1-0)   0  13, 173    0  2, 700, 712    7.00									
	7.50	Total (Sam of Titles 1 0)	1	15, 175		1	2,700,712	ı	, , , , ,

n Financial Systems FIONMENT OF PATIENT SERVICE COST	S	BLESSI NG 1				u of Form CMS	
			Provi der Co	CN: 14-0015	Peri od:	Worksheet H-3	
			HHA CCN:	14-7031	From 10/01/2022 To 09/30/2023	Part I Date/Time Pre 12/29/2023 3:	
			Title	· XVIII	Home Health Agency I	PPS	<u>01 piii</u>
Cost Center Description	( 00	7.00	0.00	0.00		44.00	
Limitation Cost Computation	6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Home Health Aide Home Health Aide							8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 12. 01 13. 00 13. 01
Total (sum of lines 8-13)	5	0 1 0		0 1 6			14. 00
	Progi			Servi ces			
Cost Center Description		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
Supplies and Drugs Cost Computa		7.00	8.00	9.00	10.00	11.00	
Cost of Medical Supplies Cost of Drugs		0		1	0 0		15. 00 16. 00
Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	
	930 100						1.00
Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)	1, 026, 190 313, 452 50, 126 101, 269						2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
Cost Center Description	12.00						-
Limitation Cost Computation	12.00						
Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide Home Health Aide							8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 12. 01 13. 00 13. 01
	Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide Home Health Aide Total (sum of lines 8-13)  Cost Center Description  Supplies and Drugs Cost Computation Cost of Medical Supplies Cost of Drugs Cost Center Description  PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Medical Social Services Medical Social Services Medical Social Services Medical Social Services Medical Social Services Medical Social Services Home Health Aide	Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide Home Health Aide Total (sum of lines 8-13)  Cost Center Description  Cost of Medical Supplies Cost Center Description  Cost Center Description  Cost Center Description  Cost Center Description  Part A  Supplies and Drugs Cost Computations Cost of Drugs  Cost Center Description  Cost Center Description  PART I - COMPUTATION OF LESSER OF AGGREGATE F BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation  Skilled Nursing Care Physical Therapy Occupational Therapy Cost Center Description  Limitation Cost Computation  Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services	Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Medical Social Services Home Health Aide Home Health Aide Total (sum of lines 8-13)  Program Covered Cha  Cost Center Description  Cost of Medical Supplies Cost of Medical Supplies Cost of Medical Supplies Cost Center Description  Part A  Part A  Not Subject to Deductibles & Coinsurance 6.00 7.00  Supplies and Drugs Cost Computations Cost of Medical Supplies Cost Center Description  Cost (sum of cols. 9-10) Total Program C	Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Home Heal th Ai de Home Heal th Ai de Total (sum of lines 8-13)  Program Covered Charges  Cost Center Description  Part A  Part B Not Subject to Deductibles & Coinsurance Ocinsurance ysical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Medical Social Services Medical Social Services Medical Social Services  Cost Center Description  Part A  Part B  Not Subject to Deductibles & Coinsurance Coinsurance Coinsurance Coinsurance Coinsurance Coinsurance Cost of Medical Supplies Cost of Medical Supplies Cost of Drugs  Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description Skilled Nursing Care Physical Therapy 1,026,190 Occupational Therapy 313,452 Speech Pathology Solida Services 101,269 Home Health Aide Delication Skilled Nursing Care Physical Therapy Cocupational Therapy Cocupational Therapy Cocupational Therapy Cocupational Therapy Cocupational Therapy Physical Therapy Physi	Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathol ogy	Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Home Health Aide Total (sum of lines 8-13)  Program Covered Charges  Cost Center Description Cost Per Visit Computation Skilled Nursing Care 1, 2026, 1900 0ccupational Therapy 1, 2026, 1900 0ccupational Therapy 1, 2026, 1900 0ccupational Therapy Cost Center Description 12. 00 Limitation Cost Computation Skilled Nursing Care Physical Therapy Cocupational Ther	

Health Financial Systems	BLESSING HOSPITAL				In Lieu of Form CMS-2552-10		
APPORTIONMENT OF PATIENT SERVICE COST	ΓS		Provi der C	CN: 14-0015	Peri od:	Worksheet H-3	
			HHA CCN:	14-7031	From 10/01/2022 To 09/30/2023		narad:
			HHA CCN:	14-7031	10 09/30/2023	12/29/2023 3:	
					Home Health	PPS	<u> </u>
					Agency I		
Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
	Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1. 00	2. 00	3. 00	4. 00		
PART II - APPORTIONMENT OF COS				TAL DEPARTMEN	_		1
1.00 Physical Therapy	66. 00	0. 362319	0	1	0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy	67. 00	0. 262064	0	1	0 col. 2, line 3	. 00	2. 00
3.00 Speech Pathology	68. 00	0. 197688	0	1	0 col. 2, line 4	. 00	3. 00
4.00 Cost of Medical Supplies	71.00	0. 123287	82, 082	10, 1:	20 col. 2, line 1	5. 00	4. 00
5.00 Cost of Drugs	73. 00	0. 093760	0	)	0 col. 2, line 1	6. 00	5. 00

eal th	Financial Systems BLESSING HOS	SPI TAL			In Lie	u of Form CMS-2	2552-1
ALCUL	ATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der CO	CN: 14-0015		ri od:	Worksheet H-4	
		HHA CCN:	14-7031	Fr To	om 10/01/2022 09/30/2023	Part I-II Date/Time Pre 12/29/2023 3:	
		Title	XVIII		Home Health Agency I	PPS	<u> Э4 рііі</u>
					Par		
			Part A		lot Subject to Deductibles &	Subject to Deductibles &	
			1.00		Coi nsurance	Coi nsurance	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST	OMARY CHARGE	1. 00 S		2. 00	3. 00	
	Reasonable Cost of Part A & Part B Services						
. 00 . 00	Reasonable cost of services (see instructions) Total charges			0	0 2, 533, 318	0	1.00
. 00	Customary Charges			<u> </u>	2, 555, 510	0	2.0
. 00	Amount actually collected from patients liable for payment fo	r servi ces		0	0	0	3.0
. 00	on a charge basis (from your records) Amount that would have been realized from patients liable for	payment		0	0	0	4. 0
. 00	for services on a charge basis had such payment been made in with 42 CFR §413.13(b)					· ·	
. 00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	00	0. 000000	0. 000000	
. 00 . 00	Total customary charges (see instructions) Excess of total customary charges over total reasonable cost	(complete		0	2, 533, 318 2, 533, 318	0	6. 00 7. 00
. 00	only if line 6 exceeds line 1)			U	2, 555, 516	O	/.0
. 00	Excess of reasonable cost over customary charges (complete on 1 exceeds line 6)	lyifline		0	0	0	8. 0
. 00	Primary payer amounts			0	О	0	9. 0
					Part A	Part B	
				-	Servi ces 1.00	Servi ces 2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT						
0.00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers				0	0 2, 559, 896	
2. 00	Total PPS Reimbursement - Full Episodes without outriers				o	2, 559, 696 99, 207	
3. 00	Total PPS Reimbursement - LUPA Episodes				0	31, 353	
4. 00	Total PPS Reimbursement - PEP Episodes				0	42, 480	
5. 00 6. 00	Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes				0	28, 826 141	15. 0 16. 0
7. 00	Total Other Payments				Ö	0	1
8. 00	DME Payments				0	0	18.0
9. 00 0. 00	Oxygen Payments Prosthetic and Orthotic Payments				0	0	19. 0 20. 0
1. 00	Part B deductibles billed to Medicare patients (exclude coins	urance)			Ĭ	0	
2. 00	,				0	2, 761, 903	
3. 00 4. 00	Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)				0	0 2, 761, 903	
5. 00	Coinsurance billed to program patients (from your records)				Ĭ	0	
6. 00	Net cost (line 24 minus line 25)				0	2, 761, 903	
	Allowable bad debts (from your records) Adjusted reimbursable bad debts (see instructions)					0	
	Allowable bad debts for dual eligible (see instructions)					0	1
9. 00	Total costs - current cost reporting period (see instructions	)			О	2, 761, 903	
0.00	MSP AND PRIOR AUTHORIZATION AMOUNT	۵)			0	-1, 183	1
0. 50 0. 99	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	3)			0	0	30. 5 30. 9
1. 00	Subtotal (see instructions)				Ö	2, 760, 720	1
1. 01	Sequestration adjustment (see instructions)				0	55, 215	1
1. 02 1. 75	Demonstration payment adjustment amount after sequestration Sequestration adjustment for non-claims based amounts (see in	structions)			0 0	0	1
	Interim payments (see instructions)	5ti ucti (iis)			0	2, 705, 505	
3. 00	Tentative settlement (for contractor use only)				0	0	33.0
4. 00 5. 00	Balance due provider/program (line 31 minus lines 31.01, 31.0 Protested amounts (nonallowable cost report items) in accorda				0	0	
	ificiested amounts chonarrowable COST Lebolt Litems) ID accorda	TICE WILLI UMS	rup. 15-2.		()I	()	i 50. 0

BLESSING HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems BLESSING HANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED Peri od: From 10/01/2022 To 09/30/2023 Date/Ti me Prepared: 12/29/2023 3:54 pm Provider CCN: 14-0015 TO PROGRAM BENEFICIARIES HHA CCN: 14-7031

				Home Health Agency I	PPS	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2, 705, 505 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3.01				0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
3. 50	Provider to Program			ol	1 0	3. 50
3. 50				0		3. 50
3. 51				0		3. 52
3. 53				0		3. 53
3. 54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			Ö	l ol	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	2, 705, 505	4. 00
	TO BE COMPLETED BY CONTRACTOR			·		
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
г 01	Program to Provider			ما		F 01
5. 01 5. 02				0	0	5. 01 5. 02
5. 02				0		5. 02
3.03	Provider to Program			<u> </u>		5. 05
5.50	The state of the s			0	0	5. 50
5. 51				o	0	5. 51
5.52				o	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)			Cantrooter	2, 705, 505 NPR Date	7. 00
				Contractor Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	(	J	1. 00	2. 00	8. 00
6.00	Name of Contractor			1	ı l	0.00

Health Financial Systems
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS Provider CCN: 14-0015 Peri od: From 10/01/2022 To 09/30/2023 Worksheet 0 Date/Time Prepared: 12/29/2023 3:54 pm Hospi ce CCN: 14-1501

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI - CATIONS	SUBTOTAL	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3. 00
4.00	ADMINISTRATIVE & GENERAL*	402, 307	80, 419	482, 726	0	482, 726	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5. 00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6. 00
7.00	HOUSEKEEPI NG*	0	0	0	0	0	7. 00
8.00	DI ETARY*	0	0	0	0	0	8. 00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	o	0	0	0	0	10.00
11. 00	MEDI CAL RECORDS*	o	0	0	0	0	11. 00
12.00	STAFF TRANSPORTATION*	o	161, 287	161, 287	0	161, 287	12. 00
13.00	VOLUNTEER SERVICE COORDINATION*	o	0	0	0	0	13.00
14.00	PHARMACY*	o	0	0	o	0	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	o	0	0	0	0	15. 00
16. 00	OTHER GENERAL SERVICE*	o	0	0	0	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		_		-		17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS	LL		l.			
25. 00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES**	144, 366	2, 410	146, 776	0	146, 776	26. 00
27. 00	NURSE PRACTITIONER**	37, 683	2, 373	40, 056	0	40, 056	27. 00
28. 00	REGISTERED NURSE**	754, 752	-, -, -	754, 752	-8, 403	746, 349	28. 00
29. 00	LPN/LVN**	0	0	0	0, 100	0	29. 00
30. 00	PHYSI CAL THERAPY**		0	o o	0	0	30. 00
31. 00	OCCUPATIONAL THERAPY**		0	o o	0	0	31. 00
32. 00	SPEECH/LANGUAGE PATHOLOGY**		0	o o	0	0	32. 00
33. 00	MEDICAL SOCIAL SERVICES**	90, 230	0	90, 230	0	90, 230	33. 00
34. 00	SPIRITUAL COUNSELING**	89, 426	0	89, 426	0	89, 426	34. 00
35. 00	DI ETARY COUNSELI NG**	07, 120	0	07, 120	0	07, 120	35. 00
36. 00	COUNSELING - OTHER**		0	o o	0	0	36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	113, 749	0	113, 749	0	113, 749	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	110,717	219, 308	219, 308	0	219, 308	38. 00
39. 00	PATIENT TRANSPORTATION**		6, 550	6, 550	0	6, 550	39. 00
40. 00	IMAGING SERVICES**		0, 550	0, 330	0	0, 330	40. 00
41. 00	LABS & DI AGNOSTI CS**		1, 200	1, 200	0	1, 200	41. 00
42. 00	MEDICAL SUPPLIES-NON-ROUTINE**		58, 407	58, 407	-4, 484	53, 923	42. 00
42. 50	DRUGS CHARGED TO PATIENTS**		173, 189	173, 189	-4, 404	173, 189	42. 50
43. 00	OUTPATIENT SERVICES**		173, 107	173, 107	0	173, 107	43. 00
44. 00	PALLIATIVE RADIATION THERAPY**		0	0	0	0	44. 00
45. 00	PALLIATIVE CHEMOTHERAPY**		0		0	0	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	19, 095	0	19, 095	0	19, 095	46. 00
40.00	NONREI MBURSABLE COST CENTERS	17,075		17, 073	<u> </u>	17,075	40.00
60. 00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60. 00
61. 00	VOLUNTEER PROGRAM *		0	Ö	26, 957	26, 957	61. 00
62. 00	FUNDRAI SI NG*		0	o o	20, 707	20, 707	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*		0	o o	0	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM*	529, 940	10, 814	540, 754	0	540, 754	64. 00
65. 00	OTHER PHYSICIAN SERVICES*	027,710	10, 011	010, 701	0	0 10, 701	65. 00
66. 00	RESIDENTI AL CARE*		0	Ŏ	0	0	66. 00
67. 00	ADVERTI SI NG*		0		0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*		0		n	0	68. 00
69. 00	THRIFT STORE*		0		0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD*		0	٥	٥	0	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*		0		0	0	71.00
	TOTAL	2, 181, 548	715, 957	2, 897, 505	14, 070	2, 911, 575	
	efor the amounts in column 7 to Wket 0-5 co			2,071,000	17, 070	2, /11, 0/0	. 55. 55

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Hospi ce CCN: 14-1501

				Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
	I	6. 00	7. 00		
	GENERAL SERVICE COST CENTERS		_	T	
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	•	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	1	3. 00
4.00	ADMINISTRATIVE & GENERAL*	-1, 676	481, 050	•	4. 00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5. 00
6.00	LAUNDRY & LINEN SERVICE*	0	0	•	6. 00
7.00	HOUSEKEEPI NG*	0	0	1	7. 00
8.00	DI ETARY*	0	0	1	8. 00
9.00	NURSING ADMINISTRATION*	0	0	1	9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10. 00
11. 00	MEDI CAL RECORDS*	0	0		11. 00
12.00	STAFF TRANSPORTATION*	0	161, 287		12. 00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13. 00
14.00	PHARMACY*	0	0		14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15. 00
16.00	OTHER GENERAL SERVICE*	0	0		16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	175, 300	175, 300		25. 00
26.00	PHYSICIAN SERVICES**	o	146, 776		26. 00
27.00	NURSE PRACTITIONER**	o	40, 056		27. 00
28.00	REGI STERED NURSE**	o	746, 349		28. 00
29.00	LPN/LVN**	O	0	1	29. 00
30.00	PHYSI CAL THERAPY**	o	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32. 00
33.00	MEDICAL SOCIAL SERVICES**	o	90, 230		33. 00
34.00	SPIRITUAL COUNSELING**	o	89, 426		34.00
35. 00	DI ETARY COUNSELI NG**	0	0	•	35. 00
36. 00	COUNSELING - OTHER**	0	0		36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	113, 749	•	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	219, 308	•	38. 00
39. 00	PATIENT TRANSPORTATION**	0	6, 550		39. 00
40. 00	I MAGI NG SERVI CES**	0	0	1	40. 00
41. 00	LABS & DI AGNOSTI CS**	0	1, 200	1	41.00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	53, 923	•	42. 00
42. 50	DRUGS CHARGED TO PATIENTS**	0	173, 189	•	42. 50
43. 00	OUTPATIENT SERVICES**	0	0		43. 00
44. 00	PALLIATIVE RADIATION THERAPY**	0	0	•	44. 00
45. 00	PALLIATIVE CHEMOTHERAPY**	0	0	1	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	19, 095	1	46.00
10. 00	NONREI MBURSABLE COST CENTERS	١	17,070	I.	10.00
60.00	BEREAVEMENT PROGRAM *	0	0		60, 00
61. 00	VOLUNTEER PROGRAM *	0	26, 957	1	61, 00
62. 00	FUNDRAI SI NG*	0	0	•	62, 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*		0	1	63. 00
64. 00	PALLIATIVE CARE PROGRAM*	0	540, 754	l .	64.00
65. 00	OTHER PHYSICIAN SERVICES*		0 0	1	65. 00
66. 00	RESI DENTI AL CARE*		0	1	66.00
67. 00	ADVERTI SI NG*		0	1	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*		0	•	68. 00
69.00	THRIFT STORE*		0	1	69.00
70.00			0		70.00
70.00	NURSING FACILITY ROOM & BOARD* OTHER NONREIMBURSABLE (SPECIFY)*		0		70.00
100.00		172 424	3, 085, 199	l .	100.00
	TOTAL	173, 624	3,000,199		1100.00

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

14-1501 Hospi ce CCN:

Peri od: Worksheet 0-2 From 10/01/2022 09/30/2023 To Date/Time Prepared:

12/29/2023 3:54 pm Hospi ce I SALARI ES SUBTOTAL (col RECLASSI FI -SUBTOTAL OTHER 1 + col. CATI ONS 2) 2.00 5. 00 1 00 3 00 4 00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 25.00 PHYSICIAN SERVICES 26.00 144, 366 2, 410 146, 776 146, 776 26, 00 27.00 NURSE PRACTITIONER 40, 056 37.683 2, 373 40,056 0 27.00 28.00 REGISTERED NURSE 711, 183 711, 183 -8, 403 702, 780 28.00 29.00 LPN/LVN 29.00 30.00 PHYSI CAL THERAPY 0 0 0 0 30.00 0 OCCUPATIONAL THERAPY 0 0 31.00 0 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 32.00 33.00 MEDICAL SOCIAL SERVICES 87, 465 0 87, 465 0 87, 465 33.00 0 86, 770 34.00 SPIRITUAL COUNSELING 86,770 0 86, 770 34.00 0 35.00 DIETARY COUNSELING 0 35.00 36.00 COUNSELING - OTHER 0 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 113, 364 37.00 113, 364 113, 364 37.00 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 219, 308 0 219, 308 219, 308 38.00 39. 00 PATIENT TRANSPORTATION 0 6, 550 6,550 0 6, 550 39.00 40.00 I MAGING SERVICES 0 0 40.00 0 1, 200 41.00 LABS & DIAGNOSTICS 1, 200 1, 200 0 41.00 MEDICAL SUPPLIES-NON-ROUTINE 42.00 58, 363 58, 363 -4.484 53, 879 42.00 42.50 DRUGS CHARGED TO PATIENTS 0 0 173,060 173, 060 173,060 42.50 OUTPATIENT SERVICES 0 43.00 43.00 0 0 PALLIATIVE RADIATION THERAPY 44.00 C 0 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY 0 C 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 19,095 19,095 19,095 46.00

1, 199, 926

463, 264

1, 663, 190

-12, 887

1, 650, 303 100. 00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	I NPATIENT CARE-CONTRACTED			25. 00
26.00	PHYSI CI AN SERVI CES	0	146, 776	26. 00
27.00	NURSE PRACTITIONER	0	40, 056	27. 00
28.00	REGI STERED NURSE	0	702, 780	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	87, 465	33.00
34.00	SPIRITUAL COUNSELING	0	86, 770	34.00
35.00	DI ETARY COUNSELI NG	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	113, 364	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	219, 308	38. 00
39.00	PATI ENT TRANSPORTATION	0	6, 550	39. 00
40.00	I MAGI NG SERVI CES	0	o	40.00
41.00	LABS & DIAGNOSTICS	0	1, 200	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	53, 879	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	173, 060	42. 50
43.00	OUTPATIENT SERVICES	0	o	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	o	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	o	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	19, 095	46. 00
100.00	TOTAL *	0	1, 650, 303	100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

100.00 TOTAL \*

Hospi ce CCN: 14-1501

Peri od: Worksheet 0-3 From 10/01/2022 To 09/30/2023

Date/Time Prepared: 12/29/2023 3:54 pm

				Hospi ce I			
	SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL		
			1 + col. 2)	CATI ONS			
	1.00	2. 00	3. 00	4. 00	5. 00		
DIRECT PATIENT CARE SERVICE COST CENTERS							
25. 00   I NPATI ENT CARE-CONTRACTED		0	0	0	0	25. 00	
26. 00 PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00	
27. 00 NURSE PRACTITIONER	0	0	0	0	0	27. 00	
28. 00 REGI STERED NURSE	1, 215	0	1, 215	0	1, 215		
29. 00   LPN/LVN	0	0	0	0	0	29. 00	
30. 00 PHYSI CAL THERAPY	0	0	0	0	0	30. 00	
31. 00 OCCUPATI ONAL THERAPY	0	0	0	0	0	31. 00	
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00	
33.00 MEDICAL SOCIAL SERVICES	161	0	161	0	161	33. 00	
34.00 SPIRITUAL COUNSELING	72	0	72	0	72	34.00	
35. 00 DI ETARY COUNSELI NG	0	0	0	0	0	35. 00	
36. 00 COUNSELING - OTHER	0	0	0	0	0	36. 00	
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	385	0	385	0	385	37. 00	
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00	
39. 00 PATIENT TRANSPORTATION	0	0	0	0	0	39. 00	
40.00   I MAGI NG SERVI CES	0	0	0	0	0	40. 00	
41.00 LABS & DIAGNOSTICS	0	0	0	0	0	41.00	
42.00 MEDICAL SUPPLIES-NON-ROUTINE	0	44	44	0	44	42. 00	
42.50 DRUGS CHARGED TO PATIENTS	0	129	129	0	129	42. 50	
43. 00 OUTPATIENT SERVICES	0	0	0	0	0	43.00	
44.00 PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00	
45.00 PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45. 00	
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46. 00	
100.00 TOTAL *	1, 833	173	2, 006	0	2, 006	100.00	
* Transfer the amount in column 7 to Wkst 0-5 column 1 line 52							

Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col E	
		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6, 00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	
25. 00	I NPATI ENT CARE-CONTRACTED	2, 294	2, 294	25. 00
26.00	PHYSI CI AN SERVI CES	0	o	26. 00
27.00	NURSE PRACTITIONER	0	ol	27. 00
28. 00	REGI STERED NURSE	0	1, 215	28. 00
29. 00	LPN/LVN	0	o	29. 00
30.00	PHYSI CAL THERAPY	0	o	30.00
31.00	OCCUPATIONAL THERAPY	0	o	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	o	32.00
33.00	MEDICAL SOCIAL SERVICES	0	161	33.00
34.00	SPI RI TUAL COUNSELI NG	0	72	34.00
35.00	DI ETARY COUNSELI NG	0	o	35.00
36.00	COUNSELING - OTHER	0	o	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	385	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	O	38.00
39. 00	PATIENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	44	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	129	42. 50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44. 00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45. 00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	2, 294	4, 300	100. 00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

Peri od: From 10/01/2022 To 09/30/2023 Worksheet 0-4

INPATIENT CARE Date/Time Prepared: 12/29/2023 3:54 pm Hospi ce CCN: 14-1501 Hospi ce I

					Hospi ce i		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2.00	3.00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		C	0	0	0	25. 00
26.00	PHYSI CI AN SERVI CES	0	C	0	0	0	26. 00
27.00	NURSE PRACTITIONER	0	C	0	0	0	27. 00
28. 00	REGI STERED NURSE	42, 354	C	42, 354	0	42, 354	28. 00
29. 00	LPN/LVN	0	C	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	C	0	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	C	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	C	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	2, 604	C	2, 604	0	2, 604	33. 00
34.00	SPIRITUAL COUNSELING	2, 584	C	2, 584	0	2, 584	34.00
35.00	DI ETARY COUNSELING	0	C	0	0	0	35. 00
36.00	COUNSELING - OTHER	0	C	0	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	C	0	0	0	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	C	0	0	0	38. 00
39. 00	PATIENT TRANSPORTATION	0	C	0	0	0	39. 00
40.00	I MAGING SERVICES	0	C	0	0	0	40. 00
41.00	LABS & DIAGNOSTICS	0	C	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	C	0	0	0	42. 00
42. 50	DRUGS CHARGED TO PATIENTS	0	C	0	0	0	42. 50
43.00	OUTPATIENT SERVICES	0	C	0	0	0	43. 00
44.00	PALLIATIVE RADIATION THERAPY	0	C	0	0	0	44. 00
45.00	PALLIATIVE CHEMOTHERAPY	0	C	0	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	C	0	0	0	46. 00
100.00	TOTAL *	47, 542	C	47, 542	0	47, 542	100.00
* Tron	efor the amount in column 7 to Wket O.E. col	ump 1 line E2					

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

Transfer the amount in column 7 to wast. 0-3, column 1, fine 33.								
		ADJUSTMENTS	TOTAL (col. 5					
			± col. 6)					
		6. 00	7. 00					
	DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	I NPATIENT CARE-CONTRACTED	173, 006	173, 006					
26. 00	PHYSI CI AN SERVI CES	0	0	26. 00				
27.00	NURSE PRACTITIONER	0	0	27. 00				
28. 00	REGI STERED NURSE	0	42, 354	28. 00				
29. 00	LPN/LVN	0	0	29. 00				
30.00	PHYSI CAL THERAPY	0	0	30.00				
31.00	OCCUPATI ONAL THERAPY	0	0	31.00				
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32. 00				
33.00	MEDICAL SOCIAL SERVICES	0	2, 604	33.00				
34.00	SPIRITUAL COUNSELING	0	2, 584	34.00				
35.00	DI ETARY COUNSELI NG	0	0	35. 00				
36.00	COUNSELING - OTHER	0	0	36.00				
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37. 00				
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	o	38.00				
39.00	PATIENT TRANSPORTATION	0	o	39.00				
40.00	I MAGI NG SERVI CES	0	o	40.00				
41.00	LABS & DIAGNOSTICS	0	o	41.00				
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	o	42.00				
42.50	DRUGS CHARGED TO PATIENTS	0	o	42. 50				
43.00	OUTPATIENT SERVICES	0	o	43.00				
44.00	PALLIATIVE RADIATION THERAPY	0	o	44. 00				
45.00	PALLI ATI VE CHEMOTHERAPY	0	o	45. 00				
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	o	46. 00				
100.00	TOTAL *	173, 006	220, 548	100.00				
	6 11 1 7 1 7 1 7 1	4 1: 50						

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

lealth Financial Systems	BLESSING HOS	SPLTAL		In Lie	u of Form CMS-2	552-10
COST ALLOCATION - DETERMINATION OF HOSPITAL-BASEXPENSES FOR ALLOCATION		_		Period: From 10/01/2022	Worksheet 0-5	
EXCENSES FOR NELEGOTTON		Hospi ce CC	N: 14-1501	To 09/30/2023	Date/Time Prep 12/29/2023 3:5	
				Hospi ce I		
Descriptions			HOSPICE DIRECT		TOTAL EXPENSES (sum of cols.	
			instructions)	EXPENSES FROM WKST B PART I	1 + 2)	
				(see instructions)		
			1.00	2. 00	3. 00	

	Descriptions	HOSPICE DIRECT	GENERAL	TOTAL EXPENSES	
		EXPENSES (see	SERVI CE	(sum of cols.	
		instructions)	EXPENSES FROM	1 + 2)	
			WKST B PART I		
			(see		
		1.00	instructions)	0.00	
	ACTUACH ACTUAC AGAIN ACTUACHA	1.00	2. 00	3. 00	
	GENERAL SERVI CE COST CENTERS		_		4 00
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	7, 880		2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	126, 927	126, 927	3. 00
4.00	ADMINISTRATIVE & GENERAL	481, 050	904, 413		4. 00
5. 00	PLANT OPERATION & MAINTENANCE	0	0	0	5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6. 00
7.00	HOUSEKEEPING	0	0	0	7. 00
8.00	DI ETARY	0	0	0	8. 00
9.00	NURSI NG ADMI NI STRATI ON	0	521, 940	521, 940	9. 00
10.00	ROUTI NE MEDI CAL SUPPLI ES	0	0	0	10.00
11. 00	MEDI CAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	161, 287		161, 287	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	0	0	0	14.00
15.00	PHYSI CI AN ADMINI STRATI VE SERVI CES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	5, 764	5, 764	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPI CE CONTI NUOUS HOME CARE	0		0	50.00
51.00	HOSPI CE ROUTI NE HOME CARE	1, 650, 303		1, 650, 303	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	4, 300		4, 300	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	220, 548		220, 548	53.00
	NONREI MBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	26, 957		26, 957	61.00
62.00	FUNDRAI SI NG	0		0	62.00
63.00	HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	540, 754		540, 754	64.00
65.00	OTHER PHYSICIAN SERVICES	. 0		0	65. 00
66, 00	RESI DENTI AL CARE	0		o	66. 00
67. 00	ADVERTI SI NG	0		0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	1 0		0	68. 00
69. 00	THRI FT STORE	1 0		0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD	1 0		0	70.00
	OTHER NONREI MBURSABLE (SPECIFY)	1 0		0	71.00
99. 00	NEGATIVE COST CENTER	1 0		0	99.00
	TOTAL	3, 085, 199	1, 566, 924		
100.00	, · · · · · · ·	1 0,000,177	1,000,724	1, 002, 120	. 50. 55

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 14-0015 Peri od: Worksheet 0-6 From 10/01/2022 Part I Hospi ce CCN: 09/30/2023 Date/Time Prepared: 14-1501 To 12/29/2023 3:54 pm Hospi ce I TOTAL EXPENSES CAP REL BLDG & CAP REL MVBLE EMPLOYEE SUBTOTAL Descriptions EQUI P **BENEFITS** FIX DEPARTMENT 1.00 2.00 0 3.00 3A GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 1.00 7, 880 2.00 CAP REL COSTS-MVBLE EQUIP 7,880 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 126, 927 126, 927 3.00 ADMINISTRATIVE & GENERAL 1, 385, 463 7,880 23, 251 1, 416, 594 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 0 5.00 0 0 LAUNDRY & LINEN SERVICE 0 6.00 0 0 0 0 6.00 7.00 HOUSEKEEPI NG 0 0 0 7.00 8.00 DI ETARY 0 0 0 8.00 NURSING ADMINISTRATION 0 0 9.00 0 521, 940 521, 940 9.00 οĺ ROUTINE MEDICAL SUPPLIES 0 10.00 Λ 10.00 11.00 MEDICAL RECORDS 0 0 0 11.00 12.00 STAFF TRANSPORTATION 161, 287 0 161, 287 12.00 VOLUNTEER SERVICE COORDINATION 0 0 1, 334 13.00 13.00 0 1, 334 0 14.00 PHARMACY 0 C Ω 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 OTHER GENERAL SERVICE 0 16.00 5, 764 0 5, 764 16.00 PATIENT/RESIDENTIAL CARE SERVICES 0 17.00 0 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 50.00 HOSPICE ROUTINE HOME CARE 1, 650, 303 68, 861 1, 719, 164 51.00 51.00 HOSPICE INPATIENT RESPITE CARE 4, 300 52.00 C 0 106 4, 406 52.00 2, 748 53.00 HOSPICE GENERAL INPATIENT CARE 220, 548 0 0 223, 296 53.00 NONREI MBURSABLE COST CENTERS 60 00 BEREAVEMENT PROGRAM n 0 60 00 0 VOLUNTEER PROGRAM 0 26, 957 61.00 26, 957 0 0 61.00 0 62.00 FUNDRAI SI NG 0 0 0 62.00 0 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 PALLIATIVE CARE PROGRAM 0 0 30, 627 571, 381 64.00 540, 754 64.00 65.00 OTHER PHYSICIAN SERVICES 0 0 Ω 65.00 0 0 66.00 RESIDENTIAL CARE 0 0 66.00 0 0 0 67 00 ADVERTI SI NG 0 0 67 00 0 0 TELEHEALTH/TELEMONI TORI NG 68.00 0 0 0 68.00 69.00 THRIFT STORE 0 0 0 0 69.00 0 70.00 NURSING FACILITY ROOM & BOARD 0 70.00 0 OTHER NONREIMBURSABLE (SPECIFY) Ω O 71.00 71 00 0 99.00 NEGATIVE COST CENTER 0 0 0 99.00

4, 652, 123

7,880

126, 927

4, 652, 123 100. 00

100.00 TOTAL

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 14-0015 Peri od: Worksheet 0-6 From 10/01/2022 Part I Hospi ce CCN: 14-1501 09/30/2023 Date/Time Prepared: 12/29/2023 3:54 pm Hospi ce I ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY Descriptions & GENERAL OPERATION & LINEN SERVICE MAI NTENANCE 4.00 6.00 7. 00 8. 00 5.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 ADMINISTRATIVE & GENERAL 1, 416, 594 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 0 0 6.00 0 6.00 7.00 HOUSEKEEPI NG 0 7.00 8.00 DI ETARY 0 0 0 0 0 0 0 8.00 NURSING ADMINISTRATION 9.00 228, 518 9.00 ROUTINE MEDICAL SUPPLIES 10.00 10.00 11.00 MEDICAL RECORDS 0 11.00 12.00 STAFF TRANSPORTATION 70, 615 12.00 VOLUNTEER SERVICE COORDINATION 13.00 0 13.00 584 14.00 PHARMACY 0 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 OTHER GENERAL SERVICE 16.00 0 16.00 2.524 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 50.00 HOSPICE ROUTINE HOME CARE 752, 692 51.00 51.00 HOSPICE INPATIENT RESPITE CARE 1, 929 52.00 C 0 0 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 97, 765 0 0 0 0 53.00 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM n 60 00 0 0 0 0 0 0 0 0 VOLUNTEER PROGRAM 0 61.00 11,802 61.00 62.00 FUNDRAI SI NG 0 62.00 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 PALLIATIVE CARE PROGRAM 0 64.00 250, 165 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 0 66.00 0 67 00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 0 0 68.00 68.00 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 71 00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 71.00 0 0 Ω

1, 416, 594

0

0

0

99.00

0 100.00

0

99.00 NEGATIVE COST CENTER

100.00 TOTAL

Heal	th Financial Systems	BLESSI NG HO	ISPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS			Provi der Co	CN: 14-0015	Peri od:	Worksheet 0-6	
					From 10/01/2022	Part I	
			Hospi ce CCI	N: 14-1501	To 09/30/2023	Date/Time Pre	pared:
						12/29/2023 3:	54 pm
	D!!	NUDCING	DOUTLNE	MEDICAL	Hospi ce I	VOLUNTEED	
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
		ADMI NI STRATI ON	MEDI CAL	RECORDS	TRANSPORTATI ON		
		0.00	SUPPLI ES	44.00	10.00	COORDI NATI ON	
	CENEDAL CEDALOE COCT CENTEDO	9. 00	10. 00	11.00	12. 00	13. 00	
1 00	GENERAL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FLXT			1			1 00
1.00							1.00
2.00							2. 00
3.00							3. 00
4.00							4. 00
5.00							5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION	750, 458					9. 00
10. C	O ROUTINE MEDICAL SUPPLIES	o	0	)			10.00
11. C	MEDICAL RECORDS	o			0		11. 00
12. C	O STAFF TRANSPORTATION	l ol			231, 902		12. 00
13. C	O VOLUNTEER SERVICE COORDINATION	l ol			o	1, 918	13.00
14. C	1	ol			o	0	14. 00
15. C	•	ام			o	0	15. 00
16. C		أ			0	0	16. 00
17. C						Ü	17. 00
.,. 0	LEVEL OF CARE			1			17.00
50. C		0	0		0 0	0	50.00
51. C		750, 458	0	1	0 225, 033	1, 862	
52.0		730, 430	0		0 223, 033	1, 002	52.00
53. C		0	0	1	0 6, 701	55	
55. 0	NONREI MBURSABLE COST CENTERS	<u> </u>		'	0, 701	55	33.00
60. C		0				0	60.00
61. 0					0	0	61. 00
62.0					0	0	62. 00
63. C					0	0	1
		٥			U		63.00
64.0		O O			0	0	64.00
65. C		O O			0	0	65. 00
66. C		O			0	0	66. 00
67. C		O			0	0	67. 00
68. C					0	0	68. 00
69. C		0			0	0	69. 00
70. C							70. 00
71. C				[	0	0	71. 00
99. C		0	0	1	0 0	0	99. 00
100.	00 TOTAL	750, 458	0		0 231, 902	1, 918	100. 00

Heal th	Financial Systems	BLESSI NG	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provi der C	CN: 14-0015	Peri od:	Worksheet 0-6	
					From 10/01/2022	Part I	
			Hospi ce CC	N: 14-1501	To 09/30/2023		
						12/29/2023 3:	54 pm
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERA		TOTAL	
			ADMI NI STRATI VE	SERVI CE	RESI DENTI AL		
			SERVI CES		CARE SERVICES		
		14. 00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS						1
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9. 00	NURSING ADMINISTRATION						9. 00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11. 00	MEDI CAL RECORDS						11. 00
12. 00	STAFF TRANSPORTATION						12. 00
13. 00	VOLUNTEER SERVICE COORDINATION						13. 00
14. 00	PHARMACY	0					14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES		l .				15. 00
16. 00	OTHER GENERAL SERVICE		1	8, 28	00		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	<b>'</b>	0, 20	0		17. 00
17.00			1		0		17.00
50. 00	HOSPI CE CONTI NUOUS HOME CARE	0		\[ \	0	0	50. 00
				1	~		1
51.00	HOSPICE ROUTINE HOME CARE	· ·	1	8, 28		3, 457, 497	1
52.00	HOSPICE INPATIENT RESPITE CARE	0			0	6, 504	1
53. 00	HOSPICE GENERAL INPATIENT CARE	0	) <u> </u>	<u> </u>	0 0	327, 817	53. 00
	NONREI MBURSABLE COST CENTERS						
60.00		0	l .		0	0	
61. 00	VOLUNTEER PROGRAM	0	)		0	38, 759	1
62. 00	FUNDRAI SI NG	0	)		0	0	
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	)		0	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM	0	)		0	821, 546	64. 00
65. 00	OTHER PHYSICIAN SERVICES	0	)		0	0	65. 00
66.00	RESI DENTI AL CARE	0	)		0	0	66. 00
67.00	ADVERTI SI NG	0	)		0	0	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	0	)		0	0	68. 00
69.00	THRIFT STORE	0	)		0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	) (		0 0	0	71. 00
	NEGATIVE COST CENTER	0	) (		0 0	0	99. 00
	TOTAL	0	ol c	8, 28	38 0	4, 652, 123	100.00
	'	1	•		1		

Health Financial Systems	BLESSING HOS	PITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOS	PICE GENERAL SERVICE COSTS	Provider CCN: 14-0015	Peri od:	Worksheet 0-6
STATISTICAL BASIS			From 10/01/2022	Part II

Hospice CCN: 14-1501 | From 10/01/2022 | Falt II | To 09/30/2023 | Date/Time Prepared: | 12/29/2023 3:54 pm STATISTICAL BASIS

			· ·			12/29/2023 3:	54 pm_
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG &	CAP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
		FLX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET)	(DOLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
		,	,	(GROSS		COSTS)	
				SALARI ES)		ĺ	
		1.00	2.00	3.00	4A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT	0					1.00
2. 00	CAP REL COSTS-MVBLE EQUIP		7, 956				2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	,,,,,,	2, 196, 230			3. 00
4. 00	ADMINISTRATIVE & GENERAL	0	7, 956	402, 307		3, 235, 529	4.00
5. 00	PLANT OPERATION & MAINTENANCE		7,730	402, 307	-1, 410, 374	0, 233, 327	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0			0	
	·	0	0			_	6.00
7.00	HOUSEKEEPI NG	0	0			0	7. 00
8. 00	DI ETARY	0	0		0	0	8. 00
9. 00	NURSING ADMINISTRATION	0	0	C	0	521, 940	1
10. 00	ROUTINE MEDICAL SUPPLIES	0	0	C	0	0	10. 00
11. 00	MEDI CAL RECORDS	0	0	C	0	0	11. 00
12.00	STAFF TRANSPORTATION	0	0	C	0	161, 287	12. 00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	23, 085	0	1, 334	13. 00
14.00	PHARMACY	0	0	C	0	0	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	C	0	0	15. 00
16.00	OTHER GENERAL SERVICE	0	0	l	0	5, 764	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17. 00
	LEVEL OF CARE	•	<u>'</u>		"		
50.00	HOSPI CE CONTI NUOUS HOME CARE			0	0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE			1, 191, 523	0	_	
52. 00	HOSPICE INPATIENT RESPITE CARE	0	0	1, 833		4, 406	1
53. 00	HOSPICE GENERAL INPATIENT CARE	0		47, 542		223, 296	
33. 00	NONREI MBURSABLE COST CENTERS			77, 572	-  -	225, 270	33.00
60.00	BEREAVEMENT PROGRAM	0	1		0	0	60.00
61. 00	VOLUNTEER PROGRAM	0				26, 957	
62. 00	FUNDRAI SI NG	0				20, 437	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0			0	63.00
		0	0	529, 940		_	1
64.00	PALLIATIVE CARE PROGRAM	0	0	529, 940		571, 381	
65. 00	OTHER PHYSI CI AN SERVI CES	0	0		0	0	65. 00
66. 00	RESI DENTI AL CARE	0	0		0	0	
67. 00	ADVERTI SI NG	0	0	C	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0	C	0	0	68. 00
69. 00	THRI FT STORE	0	0	C	0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD				0		70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	[ C	0	0	71. 00
99. 00	NEGATI VE COST CENTER						99. 00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	7, 880			1, 416, 594	
101.00	UNIT COST MULTIPLIER	0. 000000	0. 990447	0. 057793	3	0. 437825	101.00

Health Financial Systems	BLESSING HOSE	PLTAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE	GENERAL SERVICE COSTS	Provider CCN: 14-0015	Peri od:	Worksheet 0-6

From 10/01/2022 | Part II To 09/30/2023 | Date/Time Prepared: STATISTICAL BASIS Hospi ce CCN: 14-1501 12/29/2023 3:54 pm Hospi ce I Cost Center Descriptions PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG OPERATION & LINEN SERVICE (IN-FACILITY (SQUARE FEET) ADMINISTRATION (IN-FACILITY MAI NTENANCE DAYS) (SQUARE FEET) (DIRECT NURS. DAYS) HRS.) 5.00 6.00 7.00 8.00 9.00 GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 ADMINISTRATIVE & GENERAL 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 000000000000 6.00 LAUNDRY & LINEN SERVICE 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 0 8.00 NURSING ADMINISTRATION 0 9.00 50, 362 9.00 10.00 ROUTINE MEDICAL SUPPLIES 0 10.00 MEDICAL RECORDS 0 11.00 0 11.00 STAFF TRANSPORTATION 0 12 00 12 00 0 13.00 VOLUNTEER SERVICE COORDINATION 0 0 13.00 PHARMACY 0 14.00 14.00 0 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 15 00 0 OTHER GENERAL SERVICE 0 16.00 0 16.00 17.00 PATIENT/RESIDENTIAL CARE SERVICES 0 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50 00 50 00 0 HOSPICE ROUTINE HOME CARE 51.00 50, 362 51.00 52.00 HOSPICE INPATIENT RESPITE CARE 0 0 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 0 0 0 53.00 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 0 0 60.00 VOLUNTEER PROGRAM 00000000 0 0 61.00 61.00 FUNDRAI SI NG 0 62.00 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 63.00 0 0 64.00 PALLIATIVE CARE PROGRAM 0 64.00 OTHER PHYSICIAN SERVICES 65.00 65.00 66.00 RESIDENTIAL CARE 0 0 66.00 0 0 ADVERTI SI NG 67.00 0 67.00 68.00 TELEHEALTH/TELEMONI TORI NG 68.00 THRIFT STORE 0 0 69.00 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71.00 0 71.00

0.000000

0.000000

0.000000

0.000000

99.00

750, 458 100. 00 14. 901275 101. 00

99.00

NEGATIVE COST CENTER

101.00 UNIT COST MULTIPLIER

100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I)

Health Financial Systems			BLESSING HOSPITAL				In l	_i eu o	of Form CMS-2552-10	
COST ALLOCATION	- HOSPITAL-BASED	HOSPI CE GENERAL	SERVI CE	COSTS	Provi der	CCN:	14-0015	Peri od:	Wc	orksheet 0-6

Hospice CCN: 14-0015 | From 10/01/2022 | Part II | Hospice CCN: 14-1501 | To 09/30/2023 | Date/Time Prepared: STATISTICAL BASIS

			Hospi ce CC	N: 14-1501   1	0 09/30/2023	12/29/2023 3:	
					Hospi ce I	,,	<u> </u>
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
	•	MEDI CAL	RECORDS	TRANSPORTATION	SERVI CE	(CHARGES)	
		SUPPLI ES	(PATIENT DAYS)		COORDI NATI ON	·	
		(PATIENT DAYS)	,	(MI LEAGE)	(HOURS OF		
					SERVICE)		
		10.00	11.00	12.00	13.00	14. 00	
-	GENERAL SERVICE COST CENTERS			'	<u>'</u>		
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8.00
9. 00	NURSING ADMINISTRATION						9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	0					10.00
11. 00	MEDI CAL RECORDS		0				11.00
12. 00	STAFF TRANSPORTATION		Ĭ	20, 661			12.00
13. 00	VOLUNTEER SERVICE COORDINATION			20,001	20, 661		13. 00
14. 00	PHARMACY				20,001	0	1
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES				0	0	
	OTHER GENERAL SERVICES				0	0	
16. 00 17. 00				0	U U	Ü	16. 00 17. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES LEVEL OF CARE						17.00
50. 00	HOSPICE CONTINUOUS HOME CARE	0	0	) 0		0	50.00
50.00	HOSPICE CONTINUOUS HOME CARE		1	1	20.040	0	
	HOSPICE ROUTINE HOWE CARE HOSPICE INPATIENT RESPITE CARE	0	<b>l</b>				
52. 00		0	l e		15 597	0	
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0	<u> 597</u>	597	0	53.00
(0.00	NONREI MBURSABLE COST CENTERS				ol		(0.00
60.00	BEREAVEMENT PROGRAM			0	-	0	
61.00	VOLUNTEER PROGRAM			0	-	0	1
62.00	FUNDRAL SI NG			0	0	0	
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	1
64. 00	PALLIATIVE CARE PROGRAM			0	0	0	
65. 00	OTHER PHYSI CI AN SERVI CES			0	0	0	1
66. 00	RESI DENTI AL CARE			0	0	0	
67. 00	ADVERTI SI NG			0	0	0	1
68. 00	TELEHEALTH/TELEMONI TORI NG			0	0	0	
69. 00	THRI FT STORE			0	0	0	
70. 00	NURSING FACILITY ROOM & BOARD						70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	
99. 00	NEGATI VE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	231, 902			100. 00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	11. 224142	0. 092832	0. 000000	101.00

Health Financial Systems	PI TAL		In Lieu of Form CMS-2552-10		
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS	GENERAL SERVICE COSTS	Provider CCN:		From 10/01/2022	
		Hospi ce CCN:	14-1501	To 09/30/2023	Date/Time Prepared:

			Hospi ce C	CN: 14-1501	10	09/30/2023	12/29/2023 3:	
						Hospi ce I	127 277 2020 0.	от рііі
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERA	L PATIENT/	1			
		ADMI NI STRATI VE		RESI DENTI A	L			
		SERVI CES	(SPECIFY	CARE SERVIC				
		(PATIENT DAYS)	BASIS)	(IN-FACILIT				
		(171112111 37110)	5,10.0)	DAYS)				
		15. 00	16. 00	17. 00				
	GENERAL SERVICE COST CENTERS	10.00	10.00	177.00				
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2. 00	CAP REL COSTS-MVBLE EQUIP							2. 00
3. 00	EMPLOYEE BENEFITS DEPARTMENT							3. 00
4. 00	ADMINISTRATIVE & GENERAL							4. 00
5. 00	PLANT OPERATION & MAINTENANCE							5. 00
6. 00	LAUNDRY & LINEN SERVICE							6. 00
7. 00	HOUSEKEEPI NG							7. 00
8. 00	DI ETARY							8. 00
9. 00								1
	NURSI NG ADMINI STRATI ON							9.00
10.00	ROUTINE MEDICAL SUPPLIES							10.00
11. 00	MEDI CAL RECORDS							11. 00
12. 00	STAFF TRANSPORTATION							12. 00
13. 00	VOLUNTEER SERVICE COORDINATION							13. 00
14. 00	PHARMACY							14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0						15. 00
	OTHER GENERAL SERVICE		2	25				16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0			17. 00
	LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0		0				50.00
51.00	HOSPICE ROUTINE HOME CARE	0	2	25				51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0		0	0			52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	0		o	0			53.00
	NONREI MBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0				60.00
61. 00	VOLUNTEER PROGRAM			o				61. 00
62.00	FUNDRAI SI NG			o				62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			o				63. 00
64.00	PALLIATIVE CARE PROGRAM			o				64.00
65. 00	OTHER PHYSICIAN SERVICES			o				65. 00
66. 00	RESI DENTI AL CARE	0		o	0			66. 00
67. 00	ADVERTI SI NG				Ĭ			67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG			ől				68. 00
69. 00	THRI FT STORE							69. 00
70. 00	NURSING FACILITY ROOM & BOARD			٦				70.00
	OTHER NONREIMBURSABLE (SPECIFY)				0			71.00
				٩	U			99.00
	NEGATIVE COST CENTER		0.00	0	0			1
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		8, 28		U			100.00
101.00	UNIT COST MULTIPLIER	0. 000000	331. 52000	0.0000				101. 00

APPORT	Financial Systems  TONMENT OF HOSPITAL-BASED HOSPICE SHARED SERV	BLESSING HOS	SPITAL Provider CO	CN: 14-0015	Peri od:	w of Form CMS-2 Worksheet 0-7	
LEVEL	OF CARE		Hospi ce CCI	N: 14-1501	From 10/01/2022 To 09/30/2023	Date/Time Pre 12/29/2023 3:	
					Hospi ce I	12,27,2020 01	<u>о г р</u>
			<u>'</u>	Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, Co	st to Charge	HCHC	HRHC	HI RC	
	·	Part I, Col. 9	Ratio				
		line					
		0	1. 00	2. 00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS		0.010010	T			
1.00	PHYSI CAL THERAPY	66.00	0. 362319		0 0		
2. 00 3. 00	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	67. 00 68. 00	0. 262064 0. 197688		0 0	0	
4.00	DRUGS CHARGED TO PATIENTS	73. 00	0. 197066		0 0	0	
5. 00	DURABLE MEDICAL EQUIP-RENTED	96. 00	0.073700				5.00
6. 00	LABORATORY	60.00	0. 084011		0 0	0	6.00
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0. 123287		0 0	Ö	7. 00
8. 99	PARTIAL HOSPITALIZATION PROGRAM	93. 99	0. 615592		0 0	Ō	
9.00	RADI OLOGY-THERAPEUTI C	55. 00	0. 146475		0 0	0	9. 00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76. 00					10.00
11. 00	Totals (sum of lines 1-11)						11. 00
		Charges by LOC		Shared Servi	ce Costs by LOC		
		(from Provider					
	Cost Center Descriptions	Records) HGIP HC	IIC (aal 1 v	UDUC (aal 1	xHIRC (col. 1 x	UCLD (and 1 v	
	cost center bescriptions	noi P	col. 2)	col. 3)	col. 4)	col. 5)	
		5. 00	6.00	7.00	8. 00	9. 00	
	ANCILLARY SERVICE COST CENTERS	•			<u> </u>		
1.00	PHYSI CAL THERAPY	0	0		0 0	0	
2.00	OCCUPATI ONAL THERAPY	0	0		0	0	
3.00	SPEECH PATHOLOGY	0	0		0 0	0	3. 00
4.00	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
5. 00 6. 00	DURABLE MEDICAL EQUIP-RENTED LABORATORY		0		0 0	0	5. 00 6. 00
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
8. 99	PARTIAL HOSPITALIZATION PROGRAM		0		0 0	0	
9. 00	RADI OLOGY-THERAPEUTI C		0		0 0	0	
10.00	OTHER ANCILLARY SERVICE COST CENTERS		Ü				10.00
	Totals (sum of lines 1-11)		0		0 0	0	
		·					

Health Financial Systems	BLESSING HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provider CCN: 14-001	Peri od:	Worksheet 0-8

Hospice CCN: 14-1501 From 10/01/2022 To 09/30/2023 Date/Time Prepared: 12/29/2023 3: 54 pm

					12/29/2023 3: !	54 pm_
				Hospi ce I		
	<u> </u>		TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE			'		
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7	'. col. 6.			0	1. 00
	line 11)	,				
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				ol	2.00
3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3. 00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	10)		0		4. 00
5. 00	Program cost (line 3 times line 4)	, .0)		0 0		5. 00
0.00	HOSPI CE ROUTI NE HOME CARE			<u> </u>		0.00
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7	col 7			3, 457, 497	6. 00
0.00	line 11)	, сог. 7,			3, 437, 477	0.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				20, 049	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)				172. 45	8. 00
9. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	ne 11)	18, 50	733	172. 10	9. 00
10. 00	Program cost (line 8 times line 9)	ic 11)	3, 190, 32			10. 00
10.00	HOSPICE INPATIENT RESPITE CARE		3, 170, 32	.5  120, 400		10.00
11. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7	z col 8			6 504	11. 00
11.00	line 11)	, сог. о,			0, 304	11.00
12. 00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				15	12. 00
13. 00	Total average cost per diem (line 11 divided by line 12)				433. 60	
14. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	no 12)		5 0	455.00	14. 00
15. 00	Program cost (line 13 times line 14)	12)	6. 50	-		15. 00
13.00	HOSPICE GENERAL INPATIENT CARE		0, 30	74		13.00
16. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7	z col 9			327, 817	16. 00
10.00	line 11)	, COI. 7,			327,017	10.00
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				597	17. 00
18. 00	Total average cost per diem (line 16 divided by line 17)				549. 11	18. 00
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	no 13)	52	20 40	347.11	19. 00
20. 00	Program cost (line 18 times line 19)	13)	285, 53			20. 00
20.00	TOTAL HOSPICE CARE		200, 00	21, 704		20.00
21. 00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				3, 791, 818	21. 00
	1 ,					
22. 00	Total unduplicated days (Wkst. S-9, col. 4, line 14)				20, 661	
23.00	Average cost per diem (line 21 divided by line 22)		l		183. 53	∠3.00

	Financial Systems BLESSIN ATION OF CAPITAL PAYMENT	Provider CCN: 14-0015	Peri od:	eu of Form CMS-2 Worksheet L	2002-10
ONLOGE	THE OF THE THINEN	Trovider con. Tr coro	From 10/01/2022	Parts I-III	
			To 09/30/2023	Date/Time Pre 12/29/2023 3:	
		Title XVIII	Hospi tal	PPS	. p
				1.00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				1
1.00	Capital DRG other than outlier			3, 603, 518	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1.0
2.00	Capital DRG outlier payments			223, 358	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 0
3.00	Total inpatient days divided by number of days in the cos	st reporting period (see inst	ructions)	180. 39	
4.00	Number of interns & residents (see instructions)			13. 16	
5.00	Indirect medical education percentage (see instructions)			2. 08	
6. 00	Indirect medical education adjustment (multiply line 5 by 1.01) (see instructions)	,		74, 953	
7. 00	Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)	t A patient days (Worksheet E	E, part A line	0.00	7.00
8. 00	Percentage of Medicaid patient days to total days (see in	nstructions)		0.00	8.00
9.00	Sum of lines 7 and 8			0.00	
10. 00	Allowable disproportionate share percentage (see instruc-	tions)		0.00	
11. 00	Disproportionate share adjustment (see instructions)			0	1
12. 00	Total prospective capital payments (see instructions)			3, 901, 829	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 instruction			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)	)		0	
4.00	Capital cost payment factor (see instructions)			0	1
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1.00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 0
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums	otopoo (ooo i potruoti opo)		0	
3. 00	Net program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2)	,			1
4. 00	Applicable exception percentage (see instructions)	)		0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)	)		0.00	
6. 00	Percentage adjustment for extraordinary circumstances (se	,		0.00	
7. 00	Adjustment to capital minimum payment level for extraordi	•	(line 6)	0.00	1
8. 00	Capital minimum payment level (line 5 plus line 7)	9 0 040 ( 2 /		Ö	1
9. 00	Current year capital payments (from Part I, line 12, as a	appl i cabl e)		0	9. 0
40 00	Current year comparison of capital minimum payment level		less line 9)	0	10.0
10.00	Carryover of accumulated capital minimum payment level on Worksheet L, Part III, line 14)	ver capital payment (from pri	or year	0	11.00
		al payments (line 10 plus lin	ne 11)	0	12.00
11. 00	Net comparison of capital minimum payment level to capital	a. paymente (e re prae		1	13.00
11. 00 12. 00	Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive,		9)	0	13.00
11. 00 12. 00 13. 00		enter the amount on this line	,	0	
11. 00 12. 00 13. 00 14. 00	Current year exception payment (if line 12 is positive, carryover of accumulated capital minimum payment level on	enter the amount on this line ver capital payment for the f	,		14. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Current year exception payment (if line 12 is positive, of Carryover of accumulated capital minimum payment level of (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see	enter the amount on this line ver capital payment for the f e instructions)	,	o o	14. 00

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 14-0015	Peri od: Worksheet M-1

Heal th	Financial Systems	BLESSING H	OSPI TAL		In Lie	eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	CN: 14-0015	Peri od:	Worksheet M-1	
			Component (	CCN: 14-3422	From 10/01/2022 To 09/30/2023		
					RHC I	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1		1			
1.00	Physi ci an	0	0	1	0 0	0	1.00
2.00	Physician Assistant	000 557	0	1	0 0	0	2.00
3.00	Nurse Practitioner	228, 557	0		0	228, 557	3.00
4.00	Visiting Nurse	0	0			0 0	4. 00 5. 00
5. 00 6. 00	Other Nurse		0		0		
7. 00	Clinical Psychologist Clinical Social Worker		0		0	0	6. 00 7. 00
8.00	Laboratory Techni ci an		0		0	0	8.00
9. 00	Other Facility Health Care Staff Costs	212, 144	31, 230	243, 3	74 0	243, 374	9.00
10.00	Subtotal (sum of lines 1 through 9)	440, 701	31, 230			471, 931	
11. 00	Physician Services Under Agreement	440,701	144, 305			144, 305	
12. 00	Physician Supervision Under Agreement		144, 303		0 0	0	12.00
13. 00	Other Costs Under Agreement		0		0 0	ĺ	13. 00
14. 00	Subtotal (sum of lines 11 through 13)		144, 305		-	144, 305	
15. 00	Medical Supplies	0	0 ,		0 0	0	15. 00
16. 00	Transportation (Health Care Staff)		0		0 0	0	16.00
17. 00	Depreciation-Medical Equipment	0	0		0 0	0	17. 00
18.00	Professional Liability Insurance	o	0		0 0	0	18. 00
19.00	Other Health Care Costs	0	0		0 0	0	19. 00
20.00	Allowable GME Costs						20. 00
21.00	Subtotal (sum of lines 15 through 20)	0	0		0 0	0	21. 00
22.00	Total Cost of Health Care Services (sum of	440, 701	175, 535	616, 23	36 0	616, 236	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES	1		ı			
23. 00	Pharmacy	0	0	1	0 0	0	23. 00
24. 00	Dental	0	0		0 0	0	24. 00
25. 00	Optometry	0	0		0	0	25. 00
25. 01	Tel eheal th	2, 313	1, 012	3, 32		3, 325	
25. 02	Chronic Care Management	0	0		0 0	0	25. 02
26. 00	All other nonreimbursable costs	١	0		0 0	0	26. 00 27. 00
27. 00 28. 00	Nonallowable GME costs Total Nonreimbursable Costs (sum of lines 23	2, 313	1, 012	3, 32	25 0	3, 325	
26.00	through 27)	2, 313	1,012	3, 3,	25	3, 323	20.00
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	98, 605	98, 60	05 49, 250	147, 855	29. 00
30. 00	Administrative Costs	118, 053	29, 133			147, 186	
31. 00	Total Facility Overhead (sum of lines 29 and	1 ' 1	127, 738			l	31.00
51.00	30)	1 10,000	127, 730	[ 213, 7		2,0,041	31.00
32. 00	Total facility costs (sum of lines 22, 28	561, 067	304, 285	865, 35	52 49, 250	914, 602	32. 00
	and 31)		,		1 , 222		
		•					

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Period: Worksheet M-1 From 10/01/2022
		To 09/30/2023 Date/Time Prepared:

			Component	CCN: 14-3422	То	09/30/2023	Date/Time Pro   12/29/2023 3:	
						RHC I	Cost	
		Adjustments	Net Expenses					
			for Allocation	ו				
			(col. 5 + col.					
			6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS	اه						
1.00	Physi ci an	0	(	1				1.00
2.00	Physician Assistant	0	(	- 1				2. 00
3.00	Nurse Practitioner	0	228, 557					3. 00
4.00	Visiting Nurse	U	(					4. 00
5.00	Other Nurse	U	(					5. 00
6. 00 7. 00	Clinical Psychologist Clinical Social Worker	0	(					6. 00 7. 00
7. 00 8. 00	Laboratory Techni ci an	0	(					8.00
9. 00	Other Facility Health Care Staff Costs	0	243, 374	- 1				9. 00
10. 00	Subtotal (sum of lines 1 through 9)	0	471, 931					10.00
11. 00	Physician Services Under Agreement	0	144, 305					11. 00
12. 00	Physician Supervision Under Agreement	0	144, 300	1				12. 00
13. 00	Other Costs Under Agreement	0	(					13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	144, 305	1				14.00
15. 00	Medical Supplies	0	144, 300	1				15. 00
16. 00	Transportation (Health Care Staff)	0	(	1				16.00
17. 00	Depreciation-Medical Equipment	0	(	o l				17. 00
18. 00	Professional Liability Insurance	0	(	o l				18. 00
19. 00	Other Health Care Costs	0	(					19. 00
20.00	Allowable GME Costs		•	1				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	(					21. 00
22. 00	Total Cost of Health Care Services (sum of	0	616, 236	5				22. 00
	lines 10, 14, and 21)		2.2, 20					
	COSTS OTHER THAN RHC/FQHC SERVICES	·						
23.00	Pharmacy	0	(					23. 00
24.00	Dental	0	(					24. 00
25.00	Optometry	0	(					25. 00
25. 01	Tel eheal th	0	3, 325	5				25. 01
25. 02	Chronic Care Management	0	(					25. 02
26. 00	All other nonreimbursable costs	0	(					26. 00
27. 00	Nonallowable GME costs							27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	3, 325	5				28. 00
	through 27)							
	FACILITY OVERHEAD			1				
29. 00	3	-86, 302	61, 553					29. 00
30. 00	Administrative Costs	4, 629	151, 815	1				30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	-81, 673	213, 368	3				31. 00
22.00	30)	01 (70	000 000					22.00
32. 00	Total facility costs (sum of lines 22, 28	-81, 673	832, 929	<b>7</b>				32. 00
	and 31)			I				I

ANAL YS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 14-0015	Peri od:	Worksheet M-1	
711071213	NO OF HOOF THE BROLD WHO F GHO COSTO		Trovider o	011. 11 0010	From 10/01/2022	WOT RESTRECT IN T	
			Component	CCN: 14-8629	To 09/30/2023		
			·			12/29/2023 3:	54 pm
					RHC II	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi ficati	Recl assi fi ed	
		·		+ col . 2)	ons	Trial Balance	
				· ·		(col. 3 + col.	
						4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS					5.55	
1.00	Physi ci an	973, 260	C	973, 20	50 0	973, 260	1.00
2.00	Physi ci an Assi stant	l ol	0		0 0	0	2.00
3.00	Nurse Practitioner	68, 788	0	68, 78	38 0	68, 788	3.00
4. 00	Visiting Nurse	0	0	]	0 0	0	4.00
5.00	Other Nurse		0			Ö	5.00
6. 00	Clinical Psychologist		0		0	0	6.00
		U O	0		0	1	
7.00	Clinical Social Worker	U	U	'	0	0	7. 00
8.00	Laboratory Techni ci an	0		'l	0	0	8. 00
9.00	Other Facility Health Care Staff Costs	459, 021	112, 683			571, 704	9. 00
10. 00	Subtotal (sum of lines 1 through 9)	1, 501, 069	112, 683	1, 613, 7	52 0	1, 613, 752	10.00
11. 00	Physician Services Under Agreement	0	0	1	0	0	11. 00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12. 00
13.00	Other Costs Under Agreement	0	0	)	0 0	0	13. 00
14.00	Subtotal (sum of lines 11 through 13)	l ol	0		0 0	0	14. 00
15.00	Medical Supplies	l ol	0	)	0 0	0	15. 00
16.00	Transportation (Health Care Staff)	ol	0	,	0	0	16, 00
17. 00	Depreciation-Medical Equipment		0		0 0	l ő	17. 00
18. 00	Professional Liability Insurance	ام	0		0	Ö	18.00
19. 00	Other Health Care Costs		0			0	19.00
		١	U		0	٥	20.00
20.00	Allowable GME Costs						ı
21. 00	Subtotal (sum of lines 15 through 20)				0	0	21.00
22. 00	Total Cost of Health Care Services (sum of	1, 501, 069	112, 683	1, 613, 75	52 0	1, 613, 752	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES			ı			
23. 00	Pharmacy	0	0	1	0		23. 00
24. 00	Dental	0	0	1	0	0	24. 00
25. 00	Optometry	0	0	)	0	0	25. 00
25. 01	Tel eheal th	66	9		75 0	75	25. 01
25. 02	Chronic Care Management	66	9	1	75 0	75	25. 02
26.00	All other nonreimbursable costs	0	0	)	0 0	0	26.00
27.00	Nonallowable GME costs						27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	132	18	15	50 0	150	28. 00
	through 27)						
	FACILITY OVERHEAD			,		·	ĺ
29. 00	Facility Costs	O	0		0 0	0	29. 00
30.00	Administrative Costs	332, 341	1, 152	333, 49	93 0		30.00
31. 00	Total Facility Overhead (sum of lines 29 and	332, 341	1, 152			333, 493	31.00
31.00	30)	332, 341	1, 102	]		555, 475	] 51. 50
32. 00	Total facility costs (sum of lines 22, 28	1, 833, 542	113, 853	1, 947, 39	0.5	1, 947, 395	32. 00
JZ. 00	and 31)	1,000,042	115,000	1, 747, 3	, 5	1, 747, 373	32.00
	14.14 0.7	ı I		1	T.	ı	1

Health Financial Systems	BLESSI NG HOSPI TAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-0015	Period: Worksheet M-1 From 10/01/2022
	Component CCN: 14-8629	To 09/30/2023 Date/Time Prepared:

			Component		 10	09/30/2023	12/29/2023 3	
						RHC II	Cost	. 54 piii
		Adjustments	Net Expenses			KIIC II	0031	
			for Allocation					
			(col . 5 + col .					
			6)					
		6. 00	7.00	-				
	FACILITY HEALTH CARE STAFF COSTS	5. 57		-				
1.00	Physi ci an	0	973, 260	0				1.00
2.00	Physician Assistant	o		ol				2. 00
3.00	Nurse Practitioner	o	68, 788	8				3. 00
4.00	Visiting Nurse	o		ol				4. 00
5. 00	Other Nurse	o		ol				5.00
6. 00	Clinical Psychologist	o	(	ol				6.00
7. 00	Clinical Social Worker	o	(	ol				7. 00
8. 00	Laboratory Techni ci an	o	(	ol				8.00
9. 00	Other Facility Health Care Staff Costs	o	571, 704	4				9.00
10.00	Subtotal (sum of lines 1 through 9)	o	1, 613, 752					10.00
11. 00	Physician Services Under Agreement	o		0				11.00
12. 00	Physician Supervision Under Agreement	o	(	ol				12. 00
13. 00	Other Costs Under Agreement	o	(	ol				13. 00
14. 00	Subtotal (sum of lines 11 through 13)	o	(	ol				14. 00
15. 00	Medical Supplies	o	(	ol				15. 00
16. 00	Transportation (Health Care Staff)	o		ol				16. 00
17. 00	Depreciation-Medical Equipment	o	(	ol				17. 00
18. 00	Professional Liability Insurance	o	(	ol				18. 00
19.00	Other Health Care Costs	o	(	ol				19. 00
20.00	Allowable GME Costs							20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	(	ol				21. 00
22. 00	Total Cost of Health Care Services (sum of	o	1, 613, 752	2				22. 00
	lines 10, 14, and 21)		,, -					
	COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	(	0				23. 00
24.00	Dental	o	(	0				24. 00
25.00	Optometry	o	(	0				25. 00
25. 01	Tel eheal th	o	75	5				25. 01
25.02	Chronic Care Management	o	75	5				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	150	0				28. 00
	through 27)							
	FACILITY OVERHEAD							
29. 00	Facility Costs	0		0				29. 00
30.00	Administrative Costs	10, 126	343, 619	9				30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	10, 126	343, 619	9				31. 00
	30)							
32.00	Total facility costs (sum of lines 22, 28	10, 126	1, 957, 52	1				32. 00
	and 31)							1

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 14-0015	Peri od: Worksheet M-1

Heal th	Financial Systems	BLESSING H	OSPI TAL		In Li∈	eu of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	CN: 14-0015	Peri od:	Worksheet M-1	
			Component	CCN: 14-8630	From 10/01/2022 To 09/30/2023	Date/Time Pre 12/29/2023 3:	
					RHC III	Cost	o i piii
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati		
				+ col . 2)	ons	Trial Balance	
				,		(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	0		0	0	1. 00
2.00	Physician Assistant	104, 768	0	104, 70	58 0	104, 768	2. 00
3.00	Nurse Practitioner	0	0		0	0	3. 00
4.00	Visiting Nurse	0	0		0	0	4. 00
5.00	Other Nurse	0	0		0	0	5. 00
6.00	Clinical Psychologist	0	0	l .	0	0	6. 00
7.00	Clinical Social Worker	0	0		0	0	7. 00
8. 00	Laboratory Techni ci an	0	0		0 0	0	8. 00
9.00	Other Facility Health Care Staff Costs	171, 612	25, 808			126, 479	9. 00
10.00	Subtotal (sum of lines 1 through 9)	276, 380	25, 808		-70, 941	231, 247	10.00
11.00	Physician Services Under Agreement	0	0		0	0	11. 00
12.00	Physician Supervision Under Agreement	0	0	1	0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14. 00
15.00	Medical Supplies	0	0		0	0	15. 00
16.00	Transportation (Health Care Staff)	0	0		0	0	16.00
17. 00	Depreciation-Medical Equipment	0	0		0	0	17. 00
18.00	Professional Liability Insurance	0	0		0	0	18. 00 19. 00
19. 00 20. 00	Other Health Care Costs Allowable GME Costs	٥	Ü		0	0	20.00
			0			0	
21. 00 22. 00	Subtotal (sum of lines 15 through 20)	274 200	25, 808	202 1	38 -70, 941		21. 00 22. 00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	276, 380	25, 808	302, 18	-70, 941	231, 247	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			l		l .	
23. 00	Pharmacy	0	0		0 0	0	23. 00
24. 00	Dental	0	0	1	0 0	0	24. 00
25. 00	Optometry	0	0		0 0	0	25. 00
25. 01	Tel eheal th	730	316	1, 0	46 0	1, 046	
25. 02	Chronic Care Management	0	0		0 0	0	25. 02
26. 00	All other nonreimbursable costs	o	0		0 0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	730	316	1, 0	46 0	1, 046	28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	99, 526	99, 52	26 69, 681	169, 207	29. 00
30.00	Administrative Costs	151, 440	28, 627	180, 0	67 0	180, 067	30. 00
31.00	Total Facility Overhead (sum of lines 29 and	151, 440	128, 153	279, 59	93 69, 681	349, 274	31. 00
	30)						
32. 00	Total facility costs (sum of lines 22, 28	428, 550	154, 277	582, 83	-1, 260	581, 567	32. 00
	and 31)						

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-0015	Period: Worksheet M-1 From 10/01/2022
	Component CCN: 14-8630	To 09/30/2023 Date/Time Prepared:

			component	CCN: 14-8630	10	09/30/2023	12/29/2023 3	
						RHC III	Cost	. 54 piii
	·	Adjustments	Net Expenses		-	MIO III	0031	
		Auj us tilicites	for Allocation					
			(col. 5 + col.					
			6)					
		6. 00	7.00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	C					1.00
2.00	Physician Assistant	0	104, 768	3				2. 00
3.00	Nurse Practitioner	0	l	1				3. 00
4.00	Visiting Nurse	0	l d					4. 00
5. 00	Other Nurse	0	l d					5. 00
6.00	Clinical Psychologist	0	l c					6.00
7. 00	Clinical Social Worker	0	l c					7. 00
8.00	Laboratory Techni ci an	0	l c					8. 00
9. 00	Other Facility Health Care Staff Costs	0	126, 479					9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	231, 247	1				10.00
11. 00	Physician Services Under Agreement	0		1				11. 00
12. 00	Physician Supervision Under Agreement	0	l c					12. 00
	Other Costs Under Agreement	0	l c					13. 00
	Subtotal (sum of lines 11 through 13)	0						14. 00
	Medi cal Supplies	0	ĺ					15. 00
	Transportation (Health Care Staff)	0		•				16. 00
	Depreciation-Medical Equipment	0	ĺ					17. 00
	Professional Liability Insurance	0	l c					18. 00
	Other Health Care Costs	0	l c					19. 00
	Allowable GME Costs							20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	l					21. 00
	Total Cost of Health Care Services (sum of	0	231, 247	,				22. 00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	C					23. 00
24.00	Dental	0	C					24. 00
25.00	Optometry	0	C					25. 00
25. 01	Tel eheal th	0	1, 046					25. 01
25. 02	Chronic Care Management	0	C					25. 02
26.00	All other nonreimbursable costs	0	C					26. 00
27.00	Nonallowable GME costs							27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	1, 046					28. 00
	through 27)							
	FACILITY OVERHEAD							
29. 00	Facility Costs	-65, 127		)				29. 00
30.00	Administrative Costs	1, 663	181, 730	)				30. 00
31.00	Total Facility Overhead (sum of lines 29 and	-63, 464	285, 810	)				31. 00
	30)							
32. 00	Total facility costs (sum of lines 22, 28	-63, 464	518, 103	3				32. 00
	and 31)							1

			Component		o 09/30/2023	Date/Time Prep 12/29/2023 3:	pared: 54 pm_
					RHC IV	Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Recl assi fi cati ons	Reclassified Trial Balance (col. 3 + col.	
		1. 00	2. 00	3.00	4. 00	4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
1.00	Physi ci an	8, 221, 330	367, 940	8, 589, 270	0	8, 589, 270	1. 00
2. 00	Physician Assistant	0, 221, 330	0 0		0	0, 307, 270	2. 00
3.00	Nurse Practitioner	1, 438, 850	0	·	1	1, 438, 850	3. 00
4. 00	Visiting Nurse	1, 430, 030	0	1, 430, 030		0	4. 00
5. 00	Other Nurse	0	0		o o	0	5. 00
6. 00	Clinical Psychologist	0	0		o o	0	6. 00
7. 00	Clinical Social Worker	0	0	ĺ	o o	0	7. 00
8.00	Laboratory Techni ci an	0	0	ĺ	o o	0	8. 00
9. 00	Other Facility Health Care Staff Costs	3, 977, 928	1, 116, 804	5, 094, 732	-191, 875	4, 902, 857	9. 00
10.00	Subtotal (sum of lines 1 through 9)	13, 638, 108	1, 484, 744			14, 930, 977	10. 00
11. 00	Physician Services Under Agreement	0	0	(	0	0	11. 00
12. 00	Physician Supervision Under Agreement	0	0	l d	0	0	12. 00
13. 00	Other Costs Under Agreement	0	0		0	0	13. 00
14.00	Subtotal (sum of lines 11 through 13)	o	0		0	0	14. 00
15. 00	Medical Supplies	o	0		0	0	15. 00
16.00	Transportation (Health Care Staff)	0	0	l c	0	0	16. 00
17. 00	Depreciation-Medical Equipment	0	0	l c	0	0	17. 00
18.00	Professional Liability Insurance	0	0		0	0	18. 00
19.00	Other Health Care Costs	0	0	C	0	0	19. 00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	l	0	0	21. 00
22.00	Total Cost of Health Care Services (sum of	13, 638, 108	1, 484, 744	15, 122, 852	-191, 875	14, 930, 977	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	[ C	0	0	23. 00
24.00	Dental	0	0	C	0	0	24. 00
25. 00	Optometry	0	0	C	0	0	25. 00
25. 01	Tel eheal th	973, 384	162, 669	1, 136, 053	-70, 420	1, 065, 633	
25. 02	Chronic Care Management	0	0	C	0	0	25. 02
26. 00	All other nonreimbursable costs	0	0	C	0	0	26. 00
27. 00	Nonallowable GME costs	070 004	4.0	4 404 050	70.400	4 0/5 /00	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	973, 384	162, 669	1, 136, 053	-70, 420	1, 065, 633	28. 00
	through 27)						
20.00	FACILITY OVERHEAD	٥	077 740	077 740	077 740	0	20.00
29. 00 30. 00	Facility Costs Administrative Costs	0 1, 131, 560	877, 748 33, 026	·		0 1, 164, 586	29. 00 30. 00
	Total Facility Overhead (sum of lines 29 and		•				
31. 00	30)	1, 131, 560	910, 774	2, 042, 334	-877, 748	1, 164, 586	31. 00
32. 00	Total facility costs (sum of lines 22, 28	15, 743, 052	2, 558, 187	18, 301, 239	-1, 140, 043	17, 161, 196	32. 00
52.00	and 31)	13, 743, 032	2, 330, 107	10, 301, 237	1, 140, 043	17, 101, 170	52.00
	1	ı		1	1	·	

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Period: Worksheet M-1 From 10/01/2022
	Component CCN: 14-8631	

			Component CC	N: 14-8031	10 09/30/20	12/29/2023 3	
					RHC I V	Cost	5. 54 piii
		Adjustments	Net Expenses		I KIIO I V	0031	
			for Allocation				
			col . 5 + col .				
			6)				
		6. 00	7.00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	-3, 251, 014	5, 338, 256				1.00
2.00	Physici an Assistant	O	0				2. 00
3.00	Nurse Practitioner	-260, 704	1, 178, 146				3.00
4.00	Visiting Nurse	0	0				4. 00
5.00	Other Nurse	o	o				5. 00
6.00	Clinical Psychologist	o	o				6. 00
7.00	Clinical Social Worker	o	o				7. 00
8. 00	Laboratory Techni ci an	o	o				8. 00
9.00	Other Facility Health Care Staff Costs	-398, 086	4, 504, 771				9. 00
10.00	Subtotal (sum of lines 1 through 9)	-3, 909, 804	11, 021, 173				10.00
11. 00	Physician Services Under Agreement	0	0				11. 00
12. 00	Physician Supervision Under Agreement	o	o				12. 00
13. 00	Other Costs Under Agreement	o	o				13. 00
14.00	Subtotal (sum of lines 11 through 13)	o	o				14. 00
15.00	Medical Supplies	O	o				15. 00
16.00	Transportation (Health Care Staff)	O	o				16. 00
17.00	Depreciation-Medical Equipment	O	o				17. 00
18.00	Professional Liability Insurance	O	o				18. 00
19.00	Other Health Care Costs	O	o				19. 00
20.00	Allowable GME Costs						20. 00
21.00	Subtotal (sum of lines 15 through 20)	O	o				21. 00
22. 00	Total Cost of Health Care Services (sum of	-3, 909, 804	11, 021, 173				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	1, 065, 633				25. 01
25. 02	Chronic Care Management	0	0				25. 02
26. 00	All other nonreimbursable costs	0	0				26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	1, 065, 633				28. 00
	through 27)						
	FACILITY OVERHEAD						
	Facility Costs	0	0				29. 00
30.00	Administrative Costs	83, 278	1, 247, 864				30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	83, 278	1, 247, 864				31. 00
	30)						
32. 00	Total facility costs (sum of lines 22, 28	-3, 826, 526	13, 334, 670				32. 00
	and 31)						I

					RHC V	Cost	
		Compensation	Other Costs	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	0	) (	0	0	1. 00
2.00	Physician Assistant	521, 180	0	521, 180	0	521, 180	2. 00
3.00	Nurse Practitioner	O	0	) (	0	0	3. 00
4.00	Visiting Nurse	o	0	) (	0	0	4. 00
5.00	Other Nurse	o	0	ol c	0	0	5. 00
6.00	Clinical Psychologist	0	0		0	0	6. 00
7. 00	Clinical Social Worker	0	0		0	0	7. 00
8. 00	Laboratory Techni ci an	0	0		0	0	8. 00
9. 00	Other Facility Health Care Staff Costs	484.749	24, 762	509, 511	il o	509, 511	9. 00
10. 00	Subtotal (sum of lines 1 through 9)	1, 005, 929	24, 762			1, 030, 691	10.00
11. 00	Physician Services Under Agreement	1,003,727	24, 702	1,030,071		1,030,071	11.00
12. 00	Physician Supervision Under Agreement	0	0			ĺ	12.00
13. 00	Other Costs Under Agreement	0	0			0	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0			0	14. 00
15. 00	Medical Supplies	0	0				15. 00
16. 00	Transportation (Health Care Staff)	0	0			0	16.00
		0	0			0	17. 00
17. 00	Depreciation-Medical Equipment	U	0				
18.00	Professional Liability Insurance	0	0			0	18. 00
19.00	Other Health Care Costs	O <sub>1</sub>	0		) 0	0	19.00
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	1 225 222	0		0	0	21.00
22. 00	Total Cost of Health Care Services (sum of	1, 005, 929	24, 762	1, 030, 691	0	1, 030, 691	22. 00
	lines 10, 14, and 21)						
23. 00	COSTS OTHER THAN RHC/FQHC SERVICES	0			0	0	23. 00
	Pharmacy	0	0		,	·	
24. 00	Dental	U	0				24. 00
25. 00	Optometry	U	0			0	25. 00
25. 01 25. 02	Tel eheal th	U	0			1	25. 01 25. 02
	Chronic Care Management	0	0			0	
26. 00	All other nonreimbursable costs	O <sub>1</sub>	0		0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	)	0	0	28. 00
	through 27)						
00.00	FACILITY OVERHEAD	ما			05.040	05.040	00.00
29. 00	Facility Costs	0	47/ /40	0 0 0	,0,00,		29. 00
30.00	Administrative Costs	187, 874	176, 640				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	187, 874	176, 640	364, 514	119, 269	483, 783	31. 00
00.00	30)	4 400 000	004 100	4 005 005	440.010	4 544 .5.	00.00
32. 00	Total facility costs (sum of lines 22, 28	1, 193, 803	201, 402	1, 395, 205	119, 269	1, 514, 474	32. 00
	and 31)	l		I	1	I	l

Health Financial Systems	BLESSING HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-0015	Peri od: From 10/01/2022	Worksheet M-1
	Component CCN: 14-8634	To 09/30/2023	Date/Time Prepared: 12/29/2023 3:54 pm

			Component C	CN: 14-8634	10	09/30/2023	Date/IIME Pre   12/29/2023 3:	
						RHC V	Cost	эч рііі
		Adjustments	Net Expenses			KIIO V	0031	
			or Allocation					
			col. 5 + col.					
		(	6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	0					1.00
2. 00	Physician Assistant	o	521, 180					2. 00
3. 00	Nurse Practitioner	o	0					3. 00
4. 00	Visiting Nurse	0	0					4. 00
5. 00	Other Nurse	o	0					5. 00
6. 00	Clinical Psychologist	o	0					6. 00
7. 00	Clinical Social Worker	o	0					7. 00
8. 00	Laboratory Techni ci an	o	0					8. 00
9. 00	Other Facility Health Care Staff Costs	Ö	509, 511					9. 00
10. 00	Subtotal (sum of lines 1 through 9)	Ö	1, 030, 691					10.00
11. 00	Physician Services Under Agreement		0					11.00
12. 00	Physician Supervision Under Agreement		0					12.00
13. 00	Other Costs Under Agreement		0					13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0					14.00
15. 00	Medical Supplies	0	0					15. 00
16. 00	Transportation (Health Care Staff)	0	0					16.00
17. 00	Depreciation-Medical Equipment	0	0					17. 00
18. 00	·	0	0					18.00
19. 00		0	0					19. 00
20. 00	Allowable GME Costs	٥	O <sub>1</sub>					20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	0					21.00
21.00	Total Cost of Health Care Services (sum of	0	1, 030, 691					22. 00
22.00	lines 10, 14, and 21)	۷	1, 030, 691					22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
23. 00		0	0					23. 00
24. 00	Dental		0					24. 00
25. 00	Optometry		0					25. 00
25. 01	Tel eheal th	0	0					25. 00
25. 01	Chronic Care Management		0					25. 02
26. 00	All other nonreimbursable costs	0	0					26. 00
27. 00	Nonallowable GME costs	ď						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0					28. 00
20.00	through 27)	٥	o <sub>l</sub>					20.00
	FACILITY OVERHEAD							
29 00	Facility Costs	0	95, 069					29. 00
30. 00	Administrative Costs	12, 699	401, 413					30.00
31. 00	Total Facility Overhead (sum of lines 29 and	12, 699	496, 482					31.00
51.00	30)	12, 077	770, 402					31.00
32. 00	Total facility costs (sum of lines 22, 28	12, 699	1, 527, 173					32.00
32. 00	and 31)	12, 377	1, 527, 175					02.00
		ı	'					•

					RHC VI	Cost	
		Compensation	Other Costs	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS		_		_		
1.00	Physi ci an	1, 108, 937	0	1, 108, 937			1. 00
2.00	Physician Assistant	0	0	0		0	2. 00
3.00	Nurse Practitioner	802, 778	0	802, 778	0	802, 778	
4.00	Visiting Nurse	0	0	0	0	0	4. 00
5.00	Other Nurse	0	0	0	0	0	5. 00
6. 00	Clinical Psychologist	0	0	0	0	0	6. 00
7.00	Clinical Social Worker	0	0	0	0	0	7. 00
8.00	Laboratory Techni ci an	0	0	0	0	0	8. 00
9. 00	Other Facility Health Care Staff Costs	775, 356	131, 809				9. 00
10.00	Subtotal (sum of lines 1 through 9)	2, 687, 071	131, 809	2, 818, 880	-1, 917	2, 816, 963	10.00
11. 00	Physician Services Under Agreement	0	0	0	0	0	11. 00
12. 00	Physician Supervision Under Agreement	0	0	0	0	0	12. 00
13.00	Other Costs Under Agreement	0	0	0	0	0	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14. 00
15. 00	Medical Supplies	0	0	0	0	0	15. 00
16. 00	Transportation (Health Care Staff)	0	0	0	0	0	16. 00
17. 00	Depreciation-Medical Equipment	0	0	0	0	0	17. 00
18. 00	Professional Liability Insurance	0	0	0	0	0	18. 00
19. 00	Other Health Care Costs	0	0	0	0	0	19. 00
20.00	Allowable GME Costs						20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21. 00
22.00	Total Cost of Health Care Services (sum of	2, 687, 071	131, 809	2, 818, 880	-1, 917	2, 816, 963	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	0	0	0	24. 00
25.00	Optometry	0	0	0	0	0	25. 00
25. 01	Tel eheal th	0	0	0	0	0	25. 01
25. 02	Chronic Care Management	0	0	0	0	0	25. 02
26. 00	All other nonreimbursable costs	0	0	0	0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	0	0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	0	_			29. 00
30. 00	Administrative Costs	54, 743	60, 326			115, 069	30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	54, 743	60, 326	115, 069	0	115, 069	31. 00
	30)						
32. 00	Total facility costs (sum of lines 22, 28	2, 741, 814	192, 135	2, 933, 949	-1, 917	2, 932, 032	32. 00
	and 31)						

Health Financial Systems	BLESSING HOSPITAL	In Lieu c	of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS	Provi der CCN: 14-0015	Peri od: Wo From 10/01/2022	orksheet M-1
	Component CCN: 14-8635		ate/Time Prepared:

			Component	CCN. 14-0033	077 307 20	12/29/2023 3: 5	
					RHC VI	Cost	
	·	Adjustments	Net Expenses		<u> </u>		
			for Allocation				
			(col. 5 + col.				
			6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	1, 108, 937				1.00
2.00	Physician Assistant	0	0				2.00
3.00	Nurse Practitioner	o	802, 778				3.00
4.00	Visiting Nurse	o	0				4.00
5.00	Other Nurse	o	Ō				5. 00
6.00	Clinical Psychologist	o	0				6.00
7.00	Clinical Social Worker	o	0				7.00
8.00	Laboratory Techni ci an	o	0				8. 00
9.00	Other Facility Health Care Staff Costs	o	905, 248				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	2, 816, 963				10.00
11. 00	Physician Services Under Agreement	o	2, 2 . 2 , . 2 2	1			11. 00
12. 00	Physician Supervision Under Agreement	o	0				12. 00
13. 00	Other Costs Under Agreement	o	0				13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0				14. 00
15. 00	Medical Supplies	0	0				15. 00
16. 00	Transportation (Health Care Staff)	0	Ö	ł			16. 00
17. 00	Depreciation-Medical Equipment	0	0				17. 00
18. 00	Professional Liability Insurance	0	0				18. 00
19. 00	Other Health Care Costs	0	0				19. 00
20. 00	Allowable GME Costs	ŏ	0				20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	Ō				21. 00
22. 00	Total Cost of Health Care Services (sum of	0	2, 816, 963				22. 00
22.00	lines 10, 14, and 21)	U	2, 010, 903				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00		0	C				23. 00
24. 00	Dental	0	0	1			24. 00
25. 00	Optometry	0	0				25. 00
25. 00	Tel eheal th	0	0				25. 00
25. 01	Chronic Care Management	0	0				25. 02
26. 00	All other nonreimbursable costs	0	0				26. 00
27. 00	Nonallowable GME costs	U	U				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0				28. 00
28.00	· ·	U	U				28.00
	through 27)						
20.00	FACILITY OVERHEAD	0	C				29. 00
29. 00	Facility Costs	ŭ,	-	1			
30.00	Administrative Costs	20, 194	135, 263	1			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	20, 194	135, 263				31. 00
22.00	30)	20 104	2 052 224				22.00
32. 00	Total facility costs (sum of lines 22, 28	20, 194	2, 952, 226				32. 00
	and 31)			I			

			Component	CCN: 26-8800	10 09/30/2023	12/29/2023 3:	
					RHC VII	Cost	
	·	Compensation	Other Costs	Total (col. 1	Recl assi fi cati	Reclassi fied	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	2, 170, 683	0	2, 170, 68	-255, 114	1, 915, 569	1.00
2.00	Physician Assistant	0	0	)	0	0	2. 00
3.00	Nurse Practitioner	414, 105	0	414, 10	-93, 618	320, 487	3. 00
4.00	Visiting Nurse	0	0		0	0	4.00
5.00	Other Nurse	o	0	)	0	0	5. 00
6.00	Clinical Psychologist	o	0	)	0	0	6. 00
7.00	Clinical Social Worker	o	0	)	0	0	7. 00
8.00	Laboratory Techni ci an	o	0	)	0	0	8. 00
9.00	Other Facility Health Care Staff Costs	698, 032	313, 960	1, 011, 99:	-163, 265	848, 727	9. 00
10.00	Subtotal (sum of lines 1 through 9)	3, 282, 820	313, 960	3, 596, 780	-511, 997	3, 084, 783	10.00
11.00	Physician Services Under Agreement	o	0	1	0	0	11. 00
12.00	Physician Supervision Under Agreement	o	0	)	0	0	12.00
13.00	Other Costs Under Agreement	o	0		0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	l ol	0	)	0	0	14.00
15. 00	Medical Supplies	o	0		0	0	15. 00
16. 00	Transportation (Health Care Staff)	o	0		0	0	16.00
17. 00	Depreciation-Medical Equipment	o	0		0	0	17. 00
18. 00	Professional Liability Insurance	o	0		0	0	18. 00
19.00	Other Health Care Costs	o	0		0	0	19. 00
20. 00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	0		0	0	21. 00
22. 00	Total Cost of Health Care Services (sum of	3, 282, 820	313, 960	3, 596, 780	-511, 997		
22.00	lines 10, 14, and 21)	0,202,020	0.07,700	0,0,0,,0	0.1,777	0,001,700	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			'	<b>'</b>	!	
23.00	Pharmacy	0	0	)	0	0	23. 00
24.00	Dental	o	0	)	0	0	24. 00
25.00	Optometry	o	0	)	0	0	25. 00
25. 01	Tel eheal th	5, 497	498	5, 99	5 0	5, 995	25. 01
25. 02	Chronic Care Management	o	0		0	0	25. 02
26.00	All other nonreimbursable costs	o	0	)	0	0	26. 00
27.00	Nonallowable GME costs						27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	5, 497	498	5, 99	5 0	5, 995	
	through 27)						
	FACILITY OVERHEAD				-		
29.00	Facility Costs	0	24, 516	24, 51	5 0	24, 516	29. 00
30.00	Administrative Costs	96, 824	8, 980	105, 80	18, 366	124, 170	30. 00
31.00	Total Facility Overhead (sum of lines 29 and	96, 824	33, 496	130, 320	18, 366	148, 686	31. 00
	30)						
32.00	Total facility costs (sum of lines 22, 28	3, 385, 141	347, 954	3, 733, 09	-493, 631	3, 239, 464	32. 00
	and 31)						

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 14-0015	Period: Worksheet M-1 From 10/01/2022
	Component CCN: 26-8800	To 09/30/2023 Date/Time Prepared: 12/29/2023 3:54 pm

			Componen	CCN. 20-0000	10 097 307 2023	12/29/2023 3:54 pm
					RHC VII	Cost
		Adjustments	Net Expense	s		
		-	for Allocati	on		
			(col. 5 + co	I .		
			6)			
		6.00	7. 00			
	FACILITY HEALTH CARE STAFF COSTS					
1.00	Physi ci an	0	1, 915, 5	69		1.00
2.00	Physician Assistant	0		0		2. 00
3.00	Nurse Practitioner	o	320, 4	87		3.00
4.00	Visiting Nurse	o		o		4. 00
5.00	Other Nurse	o		o		5.00
6.00	Clinical Psychologist	ol		o		6. 00
7.00	Clinical Social Worker	ol		О		7.00
8.00	Laboratory Techni ci an	ol		О		8.00
9.00	Other Facility Health Care Staff Costs	ol	848, 7	27		9.00
10.00	Subtotal (sum of lines 1 through 9)	o	3, 084, 7			10.00
11. 00	Physician Services Under Agreement	ol	-,, -	0		11.00
12. 00	Physician Supervision Under Agreement	ol		0		12.00
13. 00	Other Costs Under Agreement	ol		0		13.00
14. 00	Subtotal (sum of lines 11 through 13)	o		0		14. 00
15. 00	Medical Supplies	ol		0		15.00
16. 00	Transportation (Health Care Staff)	Ö		o		16. 00
17. 00	Depreciation-Medical Equipment	Ö		0		17. 00
18. 00	Professional Liability Insurance	0		0		18. 00
19. 00	Other Health Care Costs	0		0		19. 00
20. 00	Allowable GME Costs	ď				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0		0		21. 00
22. 00	Total Cost of Health Care Services (sum of	o	3, 084, 7	02		22. 00
22.00	lines 10, 14, and 21)	٩	3,004,7	03		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES					
23. 00		O		0		23. 00
24. 00	Dental	Ö		o		24. 00
25. 00	Optometry	Ö		o		25. 00
25. 01	Tel eheal th	Ö	5, 9	-1		25. 0
25. 02	Chronic Care Management	Ö	0, 7	0		25. 02
26. 00	All other nonreimbursable costs	Ö		0		26. 00
27. 00	Nonallowable GME costs	Ĭ				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23)	0	5, 9	95		28. 00
20.00	through 27)	ď	5, 7	/3		20.00
	FACILITY OVERHEAD					
29. 00	Facility Costs	n	24, 5	16		29. 00
30. 00	Administrative Costs	0	124, 1			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	148, 6			31. 00
31.00	30)	٩	140, 0			31.00
32. 00	Total facility costs (sum of lines 22, 28	٥	3, 239, 4	64		32.00
32.00	and 31)	Ĭ	0,207,4	~ ·		32.00
	1	1		1		1

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-0015	Peri od: Worksheet M-1
		From 10/01/2022
		T- 00 (20 (2022   D-+- /T: D

ANALISIS OF HOSELTAL-DASED MICHAIL COSTS			Trovider co	From 10/01/2022			
			Component (	Component CCN: 26-8801		Date/Time Prepared:	
			· ·		To 09/30/2023	12/29/2023 3:54 pm	
					RHC VIII	Cost	
		Compensation	Other Costs	Total (col. 1	Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	141, 337	0	141, 33	7 0	141, 337	1. 00
2.00	Physician Assistant	0	0		0 0	0	2. 00
3.00	Nurse Practitioner	38, 188	0	38, 18	8 0	38, 188	3. 00
4.00	Visiting Nurse	0	0		0 0	0	4. 00
5.00	Other Nurse	0	0		0 0	0	5. 00
6.00	Clinical Psychologist	0	0		0 0	0	6. 00
7.00	Clinical Social Worker	0	0		0 0	0	7. 00
8.00	Laboratory Techni ci an	0	0		0	0	8. 00
9.00	Other Facility Health Care Staff Costs	77, 637	37, 566	115, 20	3 -21, 475	93, 728	9. 00
10.00	Subtotal (sum of lines 1 through 9)	257, 162	37, 566	294, 72	8 -21, 475	273, 253	10.00
11.00	Physician Services Under Agreement	0	0		o o	0	11. 00
12.00	Physician Supervision Under Agreement	0	0		o o	0	12.00
13.00	Other Costs Under Agreement	0	0		o o	0	13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0		o o	0	14. 00
15.00	Medical Supplies	0	0		o o	0	15. 00
16.00	Transportation (Health Care Staff)	0	0		o o	0	16. 00
17.00	Depreciation-Medical Equipment	0	0		o o	0	17. 00
18. 00	Professional Liability Insurance	0	0		o o	0	18. 00
19. 00	Other Health Care Costs	0	0		o o	0	19.00
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	0		o o	0	21. 00
22. 00	Total Cost of Health Care Services (sum of	257, 162	37, 566	294, 72	8 -21, 475	273, 253	
	lines 10, 14, and 21)	, ,			,		
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0	0	23. 00
24.00	Dental	0	0		o o	0	24. 00
25.00	Optometry	0	0		o o	0	25. 00
25. 01	Tel eheal th	0	0		o o	0	25. 01
25. 02	Chronic Care Management	0	0		o o	0	25. 02
26. 00	All other nonreimbursable costs	0	0		o o	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		o o	0	l
	through 27)						
	FACILITY OVERHEAD				·		
29. 00	Facility Costs	0	15, 420	15, 42	0 48, 477	63, 897	29. 00
30. 00	Administrative Costs	27, 220	8, 963			36, 183	
31. 00	Total Facility Overhead (sum of lines 29 and	27, 220	24, 383			100, 080	ł
	30)	. ==	.,				
32.00	Total facility costs (sum of lines 22, 28	284, 382	61, 949	346, 33	1 27, 002	373, 333	32.00
	and 31)						

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-				
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-0015	Peri od: Worksheet M-1 From 10/01/2022				
	Component CCN: 26-8801					

			component	JCN: 26-8801	10 09/30/2023	12/29/2023 3:	
					RHC VIII	Cost	. эч рііі
		Adjustments	Net Expenses		I KIIO VIII	0031	
			for Allocation				
			(col. 5 + col.				
			6)				
		6.00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS					-	
1.00	Physi ci an	0	141, 337				1.00
2.00	Physician Assistant	0	0				2. 00
3. 00	Nurse Practitioner	0	38, 188				3. 00
4. 00	Visiting Nurse	0	0	ı			4. 00
5. 00	Other Nurse	0	0				5. 00
6. 00	Clinical Psychologist	0	0	1			6. 00
7. 00	Clinical Social Worker	0	0				7. 00
8. 00	Laboratory Techni ci an	0	0	1			8.00
9. 00	Other Facility Health Care Staff Costs	0	93, 728				9. 00
10. 00	Subtotal (sum of lines 1 through 9)	0	273, 253				10.00
11. 00	Physician Services Under Agreement	0	273, 233				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	0				15. 00
16. 00	Transportation (Health Care Staff)	0	0				16.00
17. 00	Depreciation-Medical Equipment	0	0				17. 00
18. 00	· ·	0	0				18.00
19. 00	Other Health Care Costs	0	0				19.00
20. 00	Allowable GME Costs	٥	O				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	0				21.00
21.00	Total Cost of Health Care Services (sum of	0	273, 253				22.00
22.00	lines 10, 14, and 21)	٩	273, 233				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			l			
23. 00	Pharmacy	0	0				23. 00
24. 00	Dental	0	0				24. 00
25. 00	Optometry	0	0				25. 00
25. 00	Tel eheal th	0	0				25. 00
25. 01	Chronic Care Management	0	0				25. 02
26. 00	All other nonreimbursable costs	0	0				26.00
27. 00	Nonallowable GME costs	٥	O				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0				28. 00
26.00	through 27)	٩	U				20.00
	FACILITY OVERHEAD						
20 00	Facility Costs	-5, 966	57, 931				29. 00
30.00	Administrative Costs	518	36, 701	•			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-5, 448	94, 632	1			31.00
51.00	30)	-5, 440	74, 032				31.00
32. 00	Total facility costs (sum of lines 22, 28	-5, 448	367, 885				32.00
32.00	and 31)	-5, 440	307,000				32.00
	Janua 01)	1		ı			1

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-10		
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-0015	Peri od: From 10/01/2022	Worksheet M-1	

Heal th	Financiai Systems	BLESSING F	HUSPI TAL		In Lieu of Form CMS-25			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS			Provi der C		Peri od:	Worksheet M-1		
			Component CCN: 26-8802		From 10/01/2022 To 09/30/2023		narod:	
			Component	JCIN: 20-8802	10 09/30/2023	12/29/2023 3:		
					RHC I X	Cost	от рііі	
		Compensation	Other Costs	Total (col	Recl assi fi cati			
		oumportou troir	011101 00010	+ col . 2)	ons	Trial Balance		
				, , , , ,		(col. 3 + col.		
						4)		
		1.00	2.00	3.00	4. 00	5. 00		
	FACILITY HEALTH CARE STAFF COSTS			•				
1.00	Physi ci an	62, 884	0	62, 88	4 0	62, 884	1.00	
2.00	Physician Assistant	o	0		o o	0	2. 00	
3.00	Nurse Practitioner	20, 000	0	20, 00	o o	20, 000	3. 00	
4.00	Visiting Nurse	o	0		o o	0	4. 00	
5.00	Other Nurse	o	0		o o	0	5. 00	
6.00	Clinical Psychologist	o	0		o o	0	6. 00	
7.00	Clinical Social Worker	o	0		o o	0	7. 00	
8.00	Laboratory Techni ci an	l ol	0		o o	0	8. 00	
9.00	Other Facility Health Care Staff Costs	23, 081	6, 997	30, 07	8 -10, 132	19, 946	9. 00	
10.00	Subtotal (sum of lines 1 through 9)	105, 965	6, 997		2 -10, 132	102, 830	10.00	
11.00	Physician Services Under Agreement	l ol	. 0		ol o	0	11. 00	
12. 00	Physician Supervision Under Agreement	l ol	0		o o	0	12.00	
13. 00	Other Costs Under Agreement	l ol	0		o o	0	13. 00	
14. 00	Subtotal (sum of lines 11 through 13)	l ol	0		o o	0	14. 00	
15. 00	Medical Supplies	l ol	0		o o	0	1	
16. 00	Transportation (Health Care Staff)	l ol	0		o o	0	1	
17. 00	Depreciation-Medical Equipment	o	0		0 0	0	17. 00	
18.00	Professional Liability Insurance	o	0		o o	0	18. 00	
19.00	Other Health Care Costs	o	0		o o	0	19. 00	
20.00	Allowable GME Costs						20.00	
21. 00	Subtotal (sum of lines 15 through 20)	l ol	0		ol o	0	21. 00	
22. 00	Total Cost of Health Care Services (sum of	105, 965	6, 997	112, 96	2 -10, 132	102, 830		
	lines 10, 14, and 21)		-,	, , ,	,	,		
	COSTS OTHER THAN RHC/FQHC SERVICES						1	
23.00	Pharmacy	0	0		0 0	0	23. 00	
24.00	Dental	O	0		0 0	0	24. 00	
25.00	Optometry	O	0		0 0	0	25. 00	
25. 01	Tel eheal th	O	0		0 0	0	25. 01	
25. 02	Chronic Care Management	o	0		0 0	0	25. 02	
26.00	All other nonreimbursable costs	o	0		0 0	0	26. 00	
27.00	Nonallowable GME costs						27. 00	
28. 00	Total Nonreimbursable Costs (sum of lines 23	o	0		0 0	0	28. 00	
	through 27)							
	FACILITY OVERHEAD							
29. 00	Facility Costs	0	15, 895					
30.00	Administrative Costs	10, 582	7, 461			18, 043	30. 00	
31.00	Total Facility Overhead (sum of lines 29 and	10, 582	23, 356	33, 93	8 1, 255	35, 193	31. 00	
	30)							
32.00	Total facility costs (sum of lines 22, 28	116, 547	30, 353	146, 90	0 -8, 877	138, 023	32. 00	
	and 31)							

Health Financial Systems	BLESSING HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Period: Worksheet M-1 From 10/01/2022
		To 09/30/2023 Date/Time Prepared:

			Compone	nt CCN	N: 26-8802	То	09/30/2023	Date/Time Pro 12/29/2023 3:	
							RHC IX	Cost	
		Adjustments	Net Expens	es					
			for Allocat						
		(	(col. 5 + c	ol.					
			6)						
		6. 00	7. 00						
	FACILITY HEALTH CARE STAFF COSTS	_1							4
1.00	Physi ci an	0	62,	884					1. 00
2.00	Physician Assistant	0		0					2. 00
3.00	Nurse Practitioner	0	20,	000					3. 00
4.00	Visiting Nurse	0		0					4. 00
5.00	Other Nurse	0		0					5. 00
6.00	Clinical Psychologist	U O		0					6. 00
7.00	Clinical Social Worker	U O		0					7. 00
8.00	Laboratory Technician	0	10	0					8. 00
9. 00 10. 00	Other Facility Health Care Staff Costs Subtotal (sum of lines 1 through 9)	0	19,	946					9. 00 10. 00
11. 00	Physician Services Under Agreement	0	102,	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		0					15. 00
16. 00	Transportation (Health Care Staff)	0		0					16.00
17. 00	Depreciation-Medical Equipment	0		0					17. 00
18. 00	Professional Liability Insurance	0		0					18. 00
19. 00	Other Health Care Costs	o o		0					19.00
20. 00	Allowable GME Costs	J		Ĭ					20.00
21. 00	Subtotal (sum of lines 15 through 20)	0		0					21. 00
22. 00	Total Cost of Health Care Services (sum of	o l	102,	-1					22. 00
22.00	lines 10, 14, and 21)	Ĭ	.027						22.00
	COSTS OTHER THAN RHC/FQHC SERVICES	,							1
23.00	Pharmacy	0		0					23. 00
24.00	Dental	O		o					24. 00
25.00	Optometry	0		o					25. 00
25. 01	Tel eheal th	0		0					25. 01
25. 02	Chronic Care Management	0		0					25. 02
26. 00	All other nonreimbursable costs	0		0					26. 00
27. 00	Nonallowable GME costs								27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0		0					28. 00
	through 27)								_
	FACILITY OVERHEAD	<u> </u>							4
29. 00	3	0		150					29. 00
30.00	Administrative Costs	-316		727					30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	-316	34,	877					31. 00
22.00	30)	04.	107	707					22.00
32. 00	Total facility costs (sum of lines 22, 28	-316	137,	/0/					32. 00
	and 31)	1		- 1					I

	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	BLESSING I SERVICES	Provider CO	CN: 14-0015	Peri od:	u of Form CMS-2 Worksheet M-2		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	THE STATE OF STEINERS TO HOST TIME BRIDES THIS, I QUIE	22 02.0			From 10/01/2022			
			Component (	CCN: 14-3422	To 09/30/2023	Date/Time Prep 12/29/2023 3:		
					RHC I	Cost		
		Number of FTE	Total Visits		Minimum Visits			
		Personnel		Standard (1)	(col. 1 x col.			
					3)	4		
		1. 00	2. 00	3. 00	4. 00	5. 00		
	VISITS AND PRODUCTIVITY							
	Posi ti ons							
1.00	Physi ci an	0. 34					1. 00	
2.00	Physi ci an Assi stant	0. 00		,			2. 00	
3.00	Nurse Practitioner	1. 63	· ·				3. 00	
4.00	Subtotal (sum of lines 1 through 3)	1. 97	· ·		4, 851	5, 360		
5.00	Visiting Nurse	0.00				0	5. 00	
6.00	Clinical Psychologist	0.00				0	6. 00	
7.00	Clinical Social Worker	0. 11				153	7. 00	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01	
7. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7. 02	
8. 00	Total FTEs and Visits (sum of lines 4 through 7)	2. 08	5, 513			5, 513	8. 00	
9. 00	Physician Services Under Agreements		0			0	9. 00	
7.00	Trifysi ci air Sei vi ces under Agreements		0			0	7.00	
						1. 00		
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPITAL-BASE	D RHC/FOHC SER	VLCES		1.00		
10. 00	Total costs of health care services (from Wk					616, 236	10.00	
	Total nonreimbursable costs (from Wkst. M-1,					3, 325		
12. 00	Cost of all services (excluding overhead) (s					619, 561		
13. 00	Ratio of hospital-based RHC/FQHC services (I					0. 994633		
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		213, 368		
15. 00	Parent provider overhead allocated to facili			,		275, 658		
16. 00								
17. 00								
18.00	Enter the amount from line 16					489, 026	17. 00 18. 00	
	Overhead applicable to hospital-based RHC/FQ	HC services (li	ne 13 x line 1	8)		486, 401	19.00	
	Total allowable cost of hospital-based RHC/F						20.00	

	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	BLESSI NG I ERVI CES	Provider Co		Peri od:	u of Form CMS-2 Worksheet M-2	
			Component (		From 10/01/2022 To 09/30/2023	Date/Time Pre 12/29/2023 3:	
					RHC II	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	,					
1.00	Physi ci an	3. 33					1. 00
2.00	Physician Assistant	0.00		' '			2.00
3.00	Nurse Practitioner	0. 59					3.00
4.00	Subtotal (sum of lines 1 through 3)	3. 92	11, 930		15, 225	15, 225	4.00
5.00	Visiting Nurse	0.00	0			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	0			0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0. 00	0			0	7. 02
8. 00	Total FTEs and Visits (sum of lines 4	3. 92	11, 930			15, 225	8. 00
9. 00	through 7) Physician Services Under Agreements		0			0	9. 00
9.00	Priysi ci ari ser vi ces under Agreements		U			U	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			VI CES			
	Total costs of health care services (from Wk					1, 613, 752	
11. 00	Total nonreimbursable costs (from Wkst. M-1,					150	11. 00
12.00	Cost of all services (excluding overhead) (s					1, 613, 902	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 999907	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		343, 619	14.00
15. 00	Parent provider overhead allocated to facili	ty (see instruc	tions)			1, 019, 060	15.00
16. 00	Total overhead (sum of lines 14 and 15)					1, 362, 679	
17. 00	Allowable GME overhead (see instructions)					0	17. 00
	Enter the amount from line 16					1, 362, 679	
	Overhead applicable to hospital-based RHC/FQ					1, 362, 552	
20 00	Total allowable cost of hospital-based RHC/F	OHC services (s	um of lines 10	and 19)		2, 976, 304	20.00

	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC S	BLESSING I	Provider C	CN: 14-0015	Period:	u of Form CMS-2 Worksheet M-2		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	THE STATE OF THE STATE BRIDES WINDS AND STATE OF	,2			From 10/01/2022			
			Component	CCN: 14-8630	To 09/30/2023	Date/Time Prep 12/29/2023 3:		
					RHC III	Cost		
		Number of FTE	Total Visits		Minimum Visits			
		Personnel		Standard (1)	(col. 1 x col.			
					3)	4		
		1.00	2. 00	3. 00	4. 00	5. 00		
	VISITS AND PRODUCTIVITY							
	Posi ti ons							
1.00	Physi ci an	0.00		., =-			1. 00	
2.00	Physician Assistant	0. 00					2. 00	
3.00	Nurse Practitioner	0. 95					3. 00	
4.00	Subtotal (sum of lines 1 through 3)	0. 95			1, 995	1, 995	4. 00	
5.00	Visiting Nurse	0.00				0	5. 00	
6.00	Clinical Psychologist	0.00	l e			0	6. 00	
7.00	Clinical Social Worker	0.00	l e			0	7. 00	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l e			0	7. 01	
7. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7. 02	
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0. 95	1, 954			1, 995	8. 00	
9. 00	Physician Services Under Agreements		0			0	9.00	
7.00	Triysi ci air Sei vi ces onder Agreements					0	7.00	
						1. 00		
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O HOSPITAL-BASE	D RHC/FOHC SER	VICES		11 00		
	Total costs of health care services (from Wk					231, 247	10.00	
	Total nonreimbursable costs (from Wkst. M-1,					1, 046		
12.00	Cost of all services (excluding overhead) (s	·	,			232, 293		
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 995497		
14.00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		285, 810		
15.00	Parent provider overhead allocated to facili			•		203, 714	15. 00	
16. 00	Total overhead (sum of lines 14 and 15)	,	,			489, 524	16.00	
17.00								
18.00	Enter the amount from line 16					489, 524	17. 00 18. 00	
19.00	Overhead applicable to hospital-based RHC/FQ	HC services (li	ne 13 x line 1	8)		487, 320	19. 00	
	Total allowable cost of hospital-based RHC/F					718, 567		

	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC S	BLESSING F	Provi der C	CN: 14-0015	Peri od:	u of Form CMS-2 Worksheet M-2	2002 10
					From 10/01/2022		
			Component	CCN: 14-8631	To 09/30/2023	12/29/2023 3:	
					RHC I V	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
					3)	4	
	h	1.00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	17.00			al 70.70/		
1.00	Physi ci an	17. 33					1.00
2.00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	9. 23			·		3. 00
4.00	Subtotal (sum of lines 1 through 3)	26. 56		1	92, 169		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	11. 05				10, 905	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0. 00	0			0	7. 02
8.00	Total FTEs and Visits (sum of lines 4	37. 61	74, 475			103, 074	8. 00
	through 7)		·			·	
9.00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	HOSPITAL-BASE	D RHC/FQHC SER	VI CES			
	Total costs of health care services (from Wk					11, 021, 173	
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			1, 065, 633	11. 00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			12, 086, 806	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			0. 911835	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet. N	M-1, col. 7, li	ne 31)		1, 247, 864	14. 00
15.00	0 Parent provider overhead allocated to facility (see instructions)						
16.00	Total overhead (sum of lines 14 and 15)					9, 086, 018	16. 00
17.00	Allowable GME overhead (see instructions)					0	17. 00
	Enter the amount from line 16					9, 086, 018	18. 00
	Overhead applicable to hospital-based RHC/FQ					8, 284, 949	19. 00
20.00	Total allowable cost of hospital-based RHC/F	QHC services (s	sum of lines 10	and 19)		19, 306, 122	20.00

	Financial Systems	BLESSI NG					u of Form CMS-	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi de	er CC		Peri od:	Worksheet M-2	
			Compone	nt C		From 10/01/2022 To 09/30/2023	Date/Time Pre	nared:
			Comporte		JON: 11 0001	10 077 007 2020	12/29/2023 3:	
						RHC V	Cost	
		Number of FTE	Total Visi	ts		Minimum Visits		
		Personnel			Standard (1)	(col. 1 x col.		
						3)	4	
	hu ou to take propulativi ti	1.00	2.00		3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY							1
4 00	Posi ti ons	0.00			4 00			1
1.00	Physician	0.00		0	4, 20		l	1.00
2. 00 3. 00	Physician Assistant Nurse Practitioner	0. 00 4. 15		001	2, 10		l	2.00
3.00 4.00				991 991	2, 10	8, 715 8, 715	l .	4.00
4. 00 5. 00	Subtotal (sum of lines 1 through 3) Visiting Nurse	4. 15 0. 00		991		8, /15	14, 991 0	
6. 00	Clinical Psychologist	0.00		0			0	
7. 00	Clinical Social Worker	0.00		0			0	
7. 00 7. 01	Medical Nutrition Therapist (FQHC only)	0.00		0			0	
7. 02	Diabetes Self Management Training (FQHC	0.00		0			0	
7.02	only)	0.00		۷				/. 02
8. 00	Total FTEs and Visits (sum of lines 4	4. 15	14.	991			14, 991	8.00
	through 7)							
9. 00	Physician Services Under Agreements			0			0	9.00
				•				
							1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			SER	VI CES			
	Total costs of health care services (from Wk						1, 030, 691	10.00
	Total nonreimbursable costs (from Wkst. M-1,						0	
12. 00	Cost of all services (excluding overhead) (s						1, 030, 691	
13. 00	Ratio of hospital-based RHC/FQHC services (I						1. 000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr			, lii	ne 31)		496, 482 558, 969	
15. 00								
16. 00	Total overhead (sum of lines 14 and 15)						1, 055, 451	
17.00	Allowable GME overhead (see instructions)						0	
	Enter the amount from line 16		40		0)		1, 055, 451	
	Overhead applicable to hospital-based RHC/FQ						1, 055, 451	
20. 00	Total allowable cost of hospital-based RHC/F	UHC services (s	sum of line	s 10	and 19)		2, 086, 142	20.00

ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der Co		Period: From 10/01/2022	Worksheet M-2	
			Component		To 09/30/2023	Date/Time Prep 12/29/2023 3:	
					RHC VI	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	2. 67		4, 20	0 11, 214		1. 00
2.00	Physi ci an Assi stant	0.00	0	2, 10	0		2. 00
3.00	Nurse Practitioner	3. 84	14, 605	2, 10	0 8, 064		3.00
4.00	Subtotal (sum of lines 1 through 3)	6. 51	25, 408		19, 278	25, 408	4.00
5.00	Visiting Nurse	0.00	0			0	5. 00
6.00	Clinical Psychologist	0.00	0			0	6. 00
7.00	Clinical Social Worker	0.00	0			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0. 00	0			0	7. 02
8. 00	Total FTEs and Visits (sum of lines 4	6. 51	25, 408			25, 408	8. 00
0.00	through 7)	0. 31	23, 400			23, 400	0.00
9. 00	Physician Services Under Agreements		0			0	9. 00
7. 00	Triysi ci air sei vi ces under Agreements					0	7. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPITAL-BASE	D RHC/FOHC SER	VLCES		11 00	
10. 00	Total costs of health care services (from Wk			020		2, 816, 963	10. 00
	Total nonreimbursable costs (from Wkst. M-1,					0	11. 00
12. 00	Cost of all services (excluding overhead) (s					2, 816, 963	
13. 00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		135, 263	
15. 00	Parent provider overhead allocated to facili			,		1, 373, 285	
16. 00	Total overhead (sum of lines 14 and 15)	,	,			1, 508, 548	
17. 00	Allowable GME overhead (see instructions)					0	17. 00
18. 00	Enter the amount from line 16					1, 508, 548	
	Overhead applicable to hospital-based RHC/FC	HC services (li	ne 13 x line 1	8)		1, 508, 548	
	Total allowable cost of hospital-based RHC/F					4, 325, 511	

ALLOC <i>A</i>	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provider CO		Peri od:	Worksheet M-2	
			Component (		From 10/01/2022 To 09/30/2023	Date/Time Prep 12/29/2023 3:	
					RHC VII	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1. 00	Physi ci an	5. 86					1. 00
2.00	Physici an Assistant	0.00		, , ,			2.00
3.00	Nurse Practitioner	2. 32					3.00
4.00	Subtotal (sum of lines 1 through 3)	8. 18			29, 484	29, 484	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	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0. 00	l e			0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7. 02
8. 00	Total FTEs and Visits (sum of lines 4 through 7)	8. 18	21, 610			29, 484	8. 00
9. 00	Physician Services Under Agreements		0			0	9. 00
7.00	Frigst Chair Services under Agreements		0			U	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPITAL-BASE	D RHC/FOHC SER	VLCES		1.00	
10 00	Total costs of health care services (from Wk			020		3, 084, 783	10. 00
	Total nonreimbursable costs (from Wkst. M-1,					5, 995	
12. 00	Cost of all services (excluding overhead) (s					3, 090, 778	
13. 00	Ratio of hospital-based RHC/FQHC services (I					0. 998060	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		148, 686	
15. 00	Parent provider overhead allocated to facili			,		1, 552, 097	
16. 00	Total overhead (sum of lines 14 and 15)	,	,			1, 700, 783	
17. 00	Allowable GME overhead (see instructions)					0	17. 00
18. 00	Enter the amount from line 16					1, 700, 783	
19. 00	Overhead applicable to hospital-based RHC/FC	MC services (li	ne 13 x line 1	8)		1, 697, 483	
	Total allowable cost of hospital-based RHC/F					4, 782, 266	20.00

	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC S	BLESSING I ERVICES	Provider C		Peri od:	w of Form CMS-2 Worksheet M-2	
			Component		From 10/01/2022 To 09/30/2023	Date/Time Pre	nared:
			Component	CCIV. 20-0001	10 07/30/2023	12/29/2023 3:	
					RHC VIII	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
					3)	4	
	hu ou to take propulativii ti	1.00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						ļ
1 00	Posi ti ons	0.24	2 111	1 20	0 1 120		1 00
1.00	Physician	0. 34					1.00
2.00	Physician Assistant	0.00					2.00
3. 00 4. 00	Nurse Practitioner	0. 18 0. 52			1, 806		3. 00 4. 00
5. 00	Subtotal (sum of lines 1 through 3) Visiting Nurse	0. 52			1, 806	3,712	5.00
6. 00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00				0	7.00
7. 00	Medical Nutrition Therapist (FQHC only)	0.00				0	7.00
7. 02	Diabetes Self Management Training (FQHC	0.00				0	7. 02
7.02	only)	0.00					7.02
8. 00	Total FTEs and Visits (sum of lines 4	0. 52	3, 712			3, 712	8.00
	through 7)					•	
9.00	Physician Services Under Agreements		0			0	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			VI CES			
	Total costs of health care services (from Wk					273, 253	
	Total nonreimbursable costs (from Wkst. M-1,	·	,			0	11. 00
12.00	Cost of all services (excluding overhead) (s					273, 253	
13.00	Ratio of hospital -based RHC/FQHC services (I			>		1. 000000 94, 632	
14.00							
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			125, 169	
16.00	Total overhead (sum of lines 14 and 15)					219, 801	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
	Enter the amount from line 16	UC corvinos (1:	no 12 v lino 1	0)		219, 801	18. 00 19. 00
	Overhead applicable to hospital-based RHC/FQ Total allowable cost of hospital-based RHC/FQ					219, 801 493, 054	
20.00	Total allowable cost of hospital-based RHC/F	unc services (s	suii oi itnes to	aliu 19)		493, 054	<sub>1</sub> 20.

Heal th	Financial Systems	BLESSI NG 1	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 10/01/2022 To 09/30/2023		
					RHC IX	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
					3)	4	
	LUCITO AND DECRUCTANTA	1. 00	2.00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
4 00	Posi ti ons	0.44	07/	4.00	0 500	I	4 00
1.00	Physi ci an	0. 14					1.00
2.00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	0. 17			0 357 945		3.00
4.00	Subtotal (sum of lines 1 through 3)	0. 31			945		4.00
5.00	Visiting Nurse Clinical Psychologist	0.00				0	
6. 00 7. 00	Clinical Social Worker	0. 00 0. 00				0	6. 00 7. 00
7. 00 7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.00
7. 01	Diabetes Self Management Training (FQHC	0.00				0	7.01
7.02	only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4	0. 31	620			945	8. 00
0.00	through 7)	0.01	020			710	0.00
9.00	Physician Services Under Agreements		0			0	9. 00
	,	L		I.		_	
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	HOSPI TAL-BASE	D RHC/FQHC SER	VI CES			
10.00	Total costs of health care services (from Wks	st. M-1, col. 7	7, line 22)			102, 830	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			0	11. 00
12.00	Cost of all services (excluding overhead) (so	um of lines 10	and 11)			102, 830	12.00
13.00	Ratio of hospital-based RHC/FQHC services (Li	ne 10 di vi ded	by line 12)			1.000000	13. 00
14.00	Total hospital-based RHC/FQHC overhead - (fro	om Worksheet. M	M-1, col. 7, li	ne 31)		34, 877	14. 00
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			47, 289	15. 00
16.00	Total overhead (sum of lines 14 and 15)					82, 166	
17. 00	Allowable GME overhead (see instructions)					0	17. 00
	Enter the amount from line 16					82, 166	1
	Overhead applicable to hospital-based RHC/FQ					82, 166	1
20. 00	Total allowable cost of hospital-based RHC/F	DHC services (s	sum of lines 10	and 19)		184, 996	20.00

	Financial Systems  BLESSING HOS  ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC	Provider CCN: 14-0015	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI (		Component CCN: 14-3422	From 10/01/2022 To 09/30/2023	Date/Time Pre 12/29/2023 3:	pared:
		Title XVIII	RHC I	Cost	<u> </u>
				1 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1. 00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		1, 102, 637	1.00
2. 00	Cost of injections/infusions and their administration (from Wh			62, 345	
3.00	Total allowable cost excluding injections/infusions (line 1 mi	nus line 2)		1, 040, 292	
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5, l	ino (l)		5, 513 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	The 9)		5, 513	
7. 00	Adjusted cost per visit (line 3 divided by line 6)			188. 70	
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Pate Period 2	
			(10/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	09/30/2023)	
0.00	Don visit normant limit (from CNC Dub. 100 04 shorter 0, 520	( or your contractor)	1. 00	2.00	0.00
8. 00 9. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20. Rate for Program covered visits (see instructions)	6 or your contractor)	113.00	126. 00 126. 00	
7. 00	CALCULATION OF SETTLEMENT		113.00	120.00	7.00
10. 00	Program covered visits excluding mental health services (from	contractor records)	330	872	10.00
11. 00	Program cost excluding costs for mental health services (line		37, 290	109, 872	
12.00	Program covered visits for mental health services (from contra	,	0	2	12. 00 13. 00
13. 00 14. 00	Program covered cost from mental health services (line 9 x lin Limit adjustment for mental health services (see instructions)		0	252 252	
15. 00	Graduate Medical Education Pass Through Cost (see instructions		Ĭ	252	15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		o	147, 414	
16. 01	Total program charges (see instructions)(from contractor's red	•		223, 190	
16. 02	Total program preventive charges (see instructions)(from provi	•		33, 255	
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.03			21, 965 83, 307	
10. 04	(Titles V and XIX see instructions.)	and roy trines . ooy		03, 307	10.04
16. 05	Total program cost (see instructions)		o	105, 272	16. 05
17. 00	Pri mary payer amounts			267	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		21, 315	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		0	19. 00
	records)				
20. 00	Net Medicare cost excluding vaccines (see instructions)			105, 005	
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		22, 287	
22. 00 23. 00	Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions)			127, 292 0	
23. 01	Adjusted reimbursable bad debts (see instructions)			0	
24. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	24. 00
25. 00		_		0	1
25. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	
25. 99 26. 00	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			127, 292	
26. 01	Sequestration adjustment (see instructions)			2, 546	
26. 02	Demonstration payment adjustment amount after sequestration			0	1
27. 00	Interim payments			100, 787	
28. 00	Tentative settlement (for contractor use only)	22 and 20)		0	
29. 00 30. 00	Balance due component/program (line 26 minus lines 26.01, 26.0 Protested amounts (nonallowable cost report items) in accordan	· · · · · · · · · · · · · · · · · · ·		23, 959 0	
50.00	chapter I, §115.2	iso with ows rub. 13-11,		U	30.00

	Financial Systems  BLESSING HOST ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC	Provider CCN: 14-0015	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI (		Component CCN: 14-8629	From 10/01/2022 To 09/30/2023	Date/Time Pre 12/29/2023 3:	pared:
		Title XVIII	RHC II	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1.00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		2, 976, 304	1.00
2.00	Cost of injections/infusions and their administration (from We			145, 441	2. 00
3.00	Total allowable cost excluding injections/infusions (line 1 mi	nus line 2)		2, 830, 863	
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		15, 225 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	THE 7)		15, 225	
7. 00	Adjusted cost per visit (line 3 divided by line 6)			185. 94	7. 00
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(10/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	09/30/2023) 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
9. 00	Rate for Program covered visits (see instructions)	·	113. 00	126. 00	9. 00
10. 00	CALCULATION OF SETTLEMENT  Program covered visits excluding mental health services (from	contractor records)	729	2, 091	10.00
11. 00	Program cost excluding costs for mental health services (line	· · · · · · · · · · · · · · · · · · ·	82, 377	263, 466	
12. 00	Program covered visits for mental health services (from contra	actor records)	0	0	12. 00
13.00	Program covered cost from mental health services (line 9 x line)		0	0	
14. 00 15. 00	Limit adjustment for mental health services (see instructions) Graduate Medical Education Pass Through Cost (see instructions		0	0	14. 00 15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	345, 843	
16. 01	Total program charges (see instructions) (from contractor's rec			548, 722	
16. 02	Total program preventive charges (see instructions)(from provi	•		167, 976	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			105, 870	1
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03 (Titles V and XIX see instructions.)	and 18) times .80)		158, 201	16. 04
16. 05	Total program cost (see instructions)		0	264, 071	16. 05
17. 00	Primary payer amounts			82	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		42, 222	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		0	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			263. 989	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		48, 426	
22. 00	Total reimbursable Program cost (line 20 plus line 21)			312, 415	
23. 00	Allowable bad debts (see instructions)			0	
23. 01	Adjusted reimbursable bad debts (see instructions)			0	
24. 00 25. 00	Allowable bad debts for dual eligible beneficiaries (see instr OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	
25. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	
25. 99	Demonstration payment adjustment amount before sequestration			0	
26. 00	Net reimbursable amount (see instructions)			312, 415	
26. 01	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			6, 248 0	1
26. 02 27. 00	Interim payments			254, 198	
28. 00	Tentative settlement (for contractor use only)			0	
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.0	02, 27, and 28)		51, 969	
30. 00	Protested amounts (nonallowable cost report items) in accordar chapter I, §115.2	nce with CMS Pub. 15-II,		0	30. 00

	Financial Systems  ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC	Provider CCN: 14-0015	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI (	CES	Component CCN: 14-8630	From 10/01/2022 To 09/30/2023	Date/Time Prep 12/29/2023 3:	
		Title XVIII	RHC III	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1. 00 2. 00 3. 00 4. 00 5. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Cost of injections/infusions and their administration (from WI Total allowable cost excluding injections/infusions (line 1 mi Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5, lotal adjusted visits (line 4 plus line 5)	kst. M-4, line 15) inus line 2)		718, 567 10, 664 707, 903 1, 995 0 1, 995	2. 00 3. 00 4. 00 5. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			354. 84	7.00
			Cal cul ati on	of Limit (1)	
			Rate Peri od 1 (10/01/2022 through 12/31/2022) 1.00	Rate Peri od 2 (01/01/2023 through 09/30/2023) 2.00	
3. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	.6 or your contractor)	113. 00	126. 00	•
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		113. 00	126. 00	9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 01 16. 02 16. 03 16. 04	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contra Program covered cost from mental health services (line 9 x III Limit adjustment for mental health services (see instructions) Graduate Medical Education Pass Through Cost (see instructions Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions) (from contractor's reconstructions program preventive charges (see instructions) (from province program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.03) (Titles V and XIX see instructions.)	9 x line 10) actor records) ne 12) ) s) and 3) * cords) ider's records) line 16)	51 5, 763 0 0 0	24, 192 0 0 0 29, 955 43, 865 4, 722 3, 225 18, 539	12. 00 13. 00 14. 00 15. 00 16. 01 16. 02 16. 03 16. 04
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		0	21, 764	16. 05
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		3, 556	18.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		0	19. 00
20. 00 21. 00 22. 00 23. 00 23. 01 24. 00 25. 00 25. 50 25. 59 26. 00 26. 01 26. 02 27. 00 28. 00 29. 00	Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst. Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractor use only) Balance due component/program (line 26 minus lines 26.01, 26.0) Protested amounts (nonallowable cost report items) in accordance.	ructions) s) 02, 27, and 28)		25, 270 0 0 0 0 0 25, 270 505 0 21, 020 0 3, 745	21. 00 22. 00 23. 00 23. 01 24. 00 25. 00 25. 50 25. 99 26. 00 26. 01 26. 02 27. 00

Heal th	Financial Systems BLESSING HOSF	ΡΙΤΔΙ	In lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der CCN: 14-0015	Peri od:	Worksheet M-3	
SERVI (	ES	Component CCN: 14-8631	From 10/01/2022 To 09/30/2023	Date/Time Pre 12/29/2023 3:	
		Title XVIII	RHC I V	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	Wkst. M-2, line 20)		19, 306, 122	1. 00
2.00	Cost of injections/infusions and their administration (from Wk	st. M-4, line 15)		883, 187	2. 00
3.00	Total allowable cost excluding injections/infusions (line 1 mi	nus line 2)		18, 422, 935	3. 00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			103, 074	4.00
5. 00 6. 00	Physicians visits under agreement (from Wkst. M-2, column 5, I Total adjusted visits (line 4 plus line 5)	The 9)		0 103, 074	5. 00 6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			178. 74	7. 00
7.00	Trail de tou oost per trei t (triile e ur trueu e)		Cal cul ati on		7.00
				Rate Period 2	
			(10/01/2022 through	(01/01/2023 through	
			12/31/2022)	09/30/2023)	
			1.00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	113. 00	126. 00	
9. 00	Rate for Program covered visits (see instructions)		113. 00	126. 00	9. 00
10. 00	CALCULATION OF SETTLEMENT  Program covered visits excluding mental health services (from	contractor records)	1, 696	4, 785	10.00
11. 00	Program cost excluding costs for mental health services (line		191, 648	602, 910	
12. 00	Program covered visits for mental health services (from contra		208	668	12. 00
13.00	Program covered cost from mental health services (line 9 x lin	e 12)	23, 504	84, 168	13. 00
14. 00	Limit adjustment for mental health services (see instructions)		23, 504	84, 168	
15. 00	Graduate Medical Education Pass Through Cost (see instructions	•		000 000	15.00
16. 00 16. 01	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's rec		0	902, 230 1, 522, 313	
16. 01	Total program preventive charges (see instructions)(from provi	•		143, 789	16. 01
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			85, 219	16. 03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03			548, 072	16. 04
	(Titles V and XIX see instructions.)		_		
16. 05	Total program cost (see instructions)		0	633, 291	16. 05
17. 00 18. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		271 131, 921	17. 00 18. 00
10.00	records)	(11 cm contractor		101, 721	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	s) (from contractor		0	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			633, 020	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4. line 16)		44, 632	
22. 00	Total reimbursable Program cost (line 20 plus line 21)	,		677, 652	
23. 00	Allowable bad debts (see instructions)			0	23. 00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	24. 00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	.)		0	
25. 50 25. 99	Demonstration payment adjustment amount before sequestration	")		0	
26. 00	Net reimbursable amount (see instructions)			677, 652	
26. 01	Sequestration adjustment (see instructions)			13, 553	
26. 02	Demonstration payment adjustment amount after sequestration			0	26. 02
27. 00	Interim payments			617, 499	
28. 00 29. 00	Tentative settlement (for contractor use only) Balance due component/program (line 26 minus lines 26.01, 26.0	12 27 and 201		0 46, 600	28. 00 29. 00
30.00	Protested amounts (nonallowable cost report items) in accordan			46, 600	30.00
55. 55	chapter I, §115.2				55. 55
				'	-

Heal th	Financial Systems BLESSING HOS	PI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-0015	Peri od:	Worksheet M-3	
SERVI (	ES	Component CCN: 14-8634	From 10/01/2022 To 09/30/2023	Date/Time Prep 12/29/2023 3:	
		Title XVIII	RHC V	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	n Wkst. M-2, line 20)		2, 086, 142	1.00
2.00	Cost of injections/infusions and their administration (from W			145, 256	•
3.00	Total allowable cost excluding injections/infusions (line 1 mi	nus line 2)		1, 940, 886	•
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5, l	ino (l)		14, 991 0	4. 00 5. 00
6.00	Total adjusted visits (line 4 plus line 5)	The 9)		14, 991	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			129. 47	7. 00
			Cal cul ati on	of Limit (1)	
			2 . 2	D . D	
			(10/01/2022	Rate Period 2 (01/01/2023	
			through	through	
			12/31/2022)	09/30/2023)	
			1. 00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	113.00	126.00	
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		113. 00	126. 00	9. 00
10. 00	Program covered visits excluding mental health services (from	contractor records)	228	428	10.00
11. 00	Program cost excluding costs for mental health services (line		25, 764	53, 928	
12.00	Program covered visits for mental health services (from contra	actor records)	0	0	12.00
13. 00	Program covered cost from mental health services (line 9 x line 9	•	0	0	13. 00
14. 00 15. 00	Limit adjustment for mental health services (see instructions)		0	0	14. 00 15. 00
16. 00	Graduate Medical Education Pass Through Cost (see instructions Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	79, 692	1
16. 01	Total program charges (see instructions) (from contractor's red			84, 215	ł
16. 02	Total program preventive charges (see instructions)(from provi			28, 630	16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			27, 092	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03	3 and 18) times .80)		33, 378	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	60, 470	16. 05
17. 00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		10, 877	18. 00
40.00	records)			0	40.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		0	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			60, 470	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		48, 848	21. 00
22. 00	Total reimbursable Program cost (line 20 plus line 21)			109, 318	1
23. 00	Allowable bad debts (see instructions)			0	23. 00
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	23. 01 24. 00
25. 00	· ·	uetrons)		0	
25. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	1 .
25. 99	Demonstration payment adjustment amount before sequestration			0	
26. 00	Net reimbursable amount (see instructions)			109, 318	1
26. 01 26. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			2, 186 0	1
27. 00	Interim payments			58, 750	ł
28. 00	' '			0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.0			48, 382	
30. 00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-II,		0	30. 00
	chapter I, §115.2		ı		I

Heal th	Financial Systems BLESSING HOSF	νιται	Inlie	u of Form CMS-2	2552_10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-0015	Peri od:	Worksheet M-3	
SERVI (	ES	Component CCN: 14-8635	From 10/01/2022 To 09/30/2023	Date/Time Prep 12/29/2023 3:	
		Title XVIII	RHC VI	Cost	
				1 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1. 00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	Wkst. M-2, line 20)		4, 325, 511	1. 00
2.00	Cost of injections/infusions and their administration (from Wk			0	2. 00
3.00	Total allowable cost excluding injections/infusions (line 1 mi	nus line 2)		4, 325, 511	3. 00
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8)	ino O)		25, 408 0	4. 00 5. 00
6. 00	Physicians visits under agreement (from Wkst. M-2, column 5, I Total adjusted visits (line 4 plus line 5)	THE 9)		25, 408	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			170. 24	7. 00
			Cal cul ati on		
				Rate Period 2	
			(10/01/2022 through	(01/01/2023 through	
			12/31/2022)	09/30/2023)	
			1. 00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	113. 00	126. 00	8. 00
9. 00	Rate for Program covered visits (see instructions)		113. 00	126. 00	9. 00
10. 00	CALCULATION OF SETTLEMENT  Program covered visits excluding mental health services (from	contractor records)	259	825	10. 00
11. 00	Program cost excluding costs for mental health services (line		29, 267	103, 950	
12.00	Program covered visits for mental health services (from contra		0	0	12. 00
13.00	Program covered cost from mental health services (line 9 x lin	•	0	0	13. 00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instructions	•	0	122 217	15. 00 16. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's rec		U	133, 217 195, 751	16. 00
16. 02	Total program preventive charges (see instructions)(from provi	•		7, 745	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			5, 271	16. 03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03	and 18) times .80)		87, 382	16. 04
1/ 05	(Titles V and XIX see instructions.)			02 (52	1/ 05
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		0	92, 653 66	16. 05 17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		18, 718	
	records)	(1.1 3 33.11.1 43.13.		13, 713	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	s) (from contractor		0	19. 00
20.00	records)			02 507	20. 00
20. 00 21. 00	Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		92, 587 0	20.00
22. 00	Total reimbursable Program cost (line 20 plus line 21)	W 4, 1111C 10)		92, 587	22. 00
23. 00	Allowable bad debts (see instructions)			0	23. 00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		0	24. 00
25. 00		`		0	
25. 50 25. 99	Prioneer ACO demonstration payment adjustment (see instructions	)		0	25. 50 25. 99
26. 00	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			92, 587	25. 99 26. 00
26. 01	Sequestration adjustment (see instructions)			1, 852	
26. 02	Demonstration payment adjustment amount after sequestration			0	26. 02
27. 00	Interim payments			90, 351	27. 00
28. 00	,	0 07 100		0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.0	•		384	29.00
30. 00	Protested amounts (nonallowable cost report items) in accordan chapter I, §115.2	CE WILII CWO PUD. 15-II,		0	30. 00
	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		·	ı	

	Financial Systems BLESSING HOS			u of Form CMS-2	
SERVI C	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-0015	Peri od: From 10/01/2022	Worksheet M-3	
SERVIC		Component CCN: 26-8800	To 09/30/2023	Date/Time Prep 12/29/2023 3:	
		Title XVIII	RHC VII	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		4, 782, 266	1.00
2.00	Cost of injections/infusions and their administration (from W			204, 801	2.00
3. 00 4. 00	Total allowable cost excluding injections/infusions (line 1 mi Total Visits (from Wkst. M-2, column 5, line 8)	nus line 2)		4, 577, 465 29, 484	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		29, 404	5.00
6.00	Total adjusted visits (line 4 plus line 5)			29, 484	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			155. 25	7. 00
			Cal cul ati on	of Limit (1)	
				Rate Period 2	
			(10/01/2022	(01/01/2023	
			through 12/31/2022)	through 09/30/2023)	
			1.00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	113. 00	126. 00	
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		113. 00	126. 00	9. 00
10. 00	Program covered visits excluding mental health services (from	contractor records)	O	7	10.00
11.00	Program cost excluding costs for mental health services (line		0	882	11. 00
12.00	Program covered visits for mental health services (from contra		0	0	
13. 00 14. 00	Program covered cost from mental health services (line 9 x lin Limit adjustment for mental health services (see instructions)		0	0	1
15. 00	Graduate Medical Education Pass Through Cost (see instructions			U	15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	882	
16. 01	Total program charges (see instructions)(from contractor's red	•		1, 256	1
16. 02 16. 03	Total program preventive charges (see instructions) (from provi			0	16. 02 16. 03
16. 03	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.03			-299	
	(Titles V and XIX see instructions.)	3 and 10, 11 mes 100,		2,,	
16. 05	Total program cost (see instructions)		0	-299	•
17. 00	Primary payer amounts	(from contractor		1 254	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(Troil contractor		1, 256	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		0	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			-299	20.00
21. 00		M-4, line 16)		52, 333	21. 00
22. 00	Total reimbursable Program cost (line 20 plus line 21)			52, 034	1
23. 00 23. 01	Allowable bad debts (see instructions)			0	
24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	ı
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	detrons)		0	
25. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	
25. 99	Demonstration payment adjustment amount before sequestration			0 F2 024	
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			52, 034 1, 041	
26. 02	Demonstration payment adjustment amount after sequestration			1, 041	1
27. 00	Interim payments			0	
28. 00	Tentative settlement (for contractor use only)			0	
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.0			50, 993	
30.00	Protested amounts (nonallowable cost report items) in accordar chapter I, §115.2	ice with CMS Pub. 15-11,		0	30. 00

Heal th	Financial Systems BLESSING HOSE	PI TAI	In lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-0015	Peri od:	Worksheet M-3	
SERVI (	ES	Component CCN: 26-8801	From 10/01/2022 To 09/30/2023	Date/Time Prep 12/29/2023 3:	
		Title XVIII	RHC VIII	Cost	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1. 00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	n Wkst. M-2. line 20)		493, 054	1. 00
2.00	Cost of injections/infusions and their administration (from Wk			15, 589	2. 00
3.00	Total allowable cost excluding injections/infusions (line 1 mi			477, 465	3. 00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3, 712	4. 00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		0	5. 00
6.00	Total adjusted visits (line 4 plus line 5)			3, 712	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	128.63	7. 00
			Carcuration	OI LIIII L (I)	
			Rate Period 1	Rate Period 2	
			(10/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	09/30/2023)	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	1. 00	2. 00 126. 00	8. 00
9. 00	Rate for Program covered visits (see instructions)	o or your contractor)	113.00	126.00	
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from		0	0	10. 00
11. 00	Program cost excluding costs for mental health services (line		0	0	11. 00
12.00	Program covered visits for mental health services (from contra		0	0	12.00
13. 00 14. 00	Program covered cost from mental health services (line 9 x lin	*	0	0	13. 00 14. 00
15. 00	Limit adjustment for mental health services (see instructions) Graduate Medical Education Pass Through Cost (see instructions		U	U	15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	· ·	0	0	16. 00
16. 01	Total program charges (see instructions)(from contractor's rec			Ö	16. 01
16. 02	Total program preventive charges (see instructions)(from provi			0	16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			0	16. 03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03	3 and 18) times .80)		0	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	0	16. 05
17. 00	Pri mary payer amounts		Ĭ	Ö	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0	18. 00
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		0	19. 00
20. 00	records) 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)		9, 327	
22. 00	Total reimbursable Program cost (line 20 plus line 21)	,		9, 327	22. 00
23. 00	Allowable bad debts (see instructions)			0	23. 00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	24. 00
25. 00				0	
25. 50 25. 99	Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration	o)		0	25. 50 25. 99
26. 00	Net reimbursable amount (see instructions)			9, 327	26. 00
26. 01	Sequestration adjustment (see instructions)			187	26. 01
26. 02	Demonstration payment adjustment amount after sequestration			0	26. 02
27. 00	Interim payments			0	27. 00
	Tentative settlement (for contractor use only)	20 07 1 003		0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.0	· ·		9, 140	
30. 00	Protested amounts (nonallowable cost report items) in accordar chapter I, §115.2	ICE WITH CMS PUD. 15-11,		0	30. 00
	1		ı	·	'

	Financial Systems BLESSING ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provi der Co	CN: 14-0015	Peri od:	worksheet M-4	
		Component (	CCN: 14-3422	From 10/01/2022 To 09/30/2023	Date/Time Pre 12/29/2023 3:	
		Title	XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	471, 931				1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000499				2.00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	235	1, 8	13 848	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	9, 497	·			4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	9, 732				5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	616, 236	616, 23	616, 236	616, 236	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	486, 401				7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 015793	0. 02274	0. 018004	0.000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	7, 682			0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	17, 414	·		0	10.00
11. 00	Total number of injections/infusions (from your records)	50				11.00
12.00	Cost per injection/infusion (line 10/line 11)	348. 28				
13. 00	Number of injection/infusion administered to Program beneficiaries	18	12	24 36	0	13.00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 0
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	6, 269	8, 0	7, 941	0	14. 00
					COST OF INJECTIONS / INFUSIONS AND	
					ADMI NI STRATI ON	
				1. 00	2.00	

62, 345 15. 00

15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)

16.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

Heal th	Financial Systems BLESSING	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	FATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CO	CN: 14-0015	Peri od:	Worksheet M-4	
		Component (	CCN: 14-8629	From 10/01/2022 To 09/30/2023	Date/Time Pre 12/29/2023 3:	
			XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	1, 613, 752 0. 000733			1, 613, 752 0. 000000	
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	1, 183	5, 8	53 0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	40, 885	·		0	4. 00
5. 00 6. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	42, 068 1, 613, 752			0 1, 613, 752	0.00
7. 00 8. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	1, 362, 552 0. 026068				
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	35, 519 77, 587			0	
11. 00 12. 00 13. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program beneficiaries	183 423. 97 67		0.00	0 0.00 0	12. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	28, 406	20, 0:	20 0		14. 00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1. 00	2. 00	
	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			145, 441	15. 00
16. 00	Total Program cost of injections/infusions and their admin columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount				48, 426	16. 00

	Financial Systems BLESSING ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provider CC	:N: 14-0015	Peri od:	u of Form CMS-2 Worksheet M-4	
JOINI O	ATTON OF HOSPITAL BASED KNOTT GITC VACCINE COST			From 10/01/2022		
		Component C	CN: 14-8630	To 09/30/2023	Date/Time Prep 12/29/2023 3:	
		Title		RHC III	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	231, 247 0. 000125	231, 2 <sup>4</sup> 0. 00095		231, 247 0. 000000	1. 00 2. 00
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	29	22	22 0	0	3. 0
1. 00	Injections/infusions and related medical supplies costs (from your records)	1, 398	1, 78		0	4. 0
5. 00 5. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 427 231, 247	2, 00 231, 24		0 231, 247	5. 0 6. 0
7. 00 3. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	487, 320 0. 006171	487, 32 0. 00867		487, 320 0. 000000	7. 0 8. 0
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	3, 007 4, 434	4, 22 6, 23		0	9. 0 10. 0
11. 00 12. 00 13. 00	Total number of injections/infusions (from your records)  Cost per injection/infusion (line 10/line 11)  Number of injection/infusion administered to Program beneficiaries	9 492. 67 4	90. 2	59 0 29 0.00 17 0	0 0. 00 0	12. 0
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 0
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1, 971	1, 53	35 0	0	14. 0
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		columns 1,		10, 664	15. C
16. 00	Total Program cost of injections/infusions and their admin		/oum of		3, 506	1,,,

	Financial Systems BLESSING ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provider CO	N. 14 001E	Peri od:	eu of Form CMS-2 Worksheet M-4	
COMPUT	ATTON OF HOSPITAL-BASED RHC/FORC VACCINE COST	Provider Co	JN: 14-0015	From 10/01/2022		
		· ·	CCN: 14-8631	To 09/30/2023		
			XVIII	RHC I V	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	11, 021, 173 0. 001172	0. 0022	0.000010		2.00
3.00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	12, 917	24, 3	57 110	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	386, 187			0	4.00
5. 00 6. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	399, 104 11, 021, 173				5. 00 6. 00
7. 00 8. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	8, 284, 949 0. 036212				7. 00 8. 00
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	300, 015 699, 119				
11. 00 12. 00 13. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	1, 856 376. 68 64	52.		0 0.00 0	12. 00
13. 01	beneficiaries Number of COVID-19 vaccine injections/infusions administered to MA enrollees			С	0	13. 0°
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	24, 108	20, 5	24 C	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1. 00	2. 00	
	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			883, 187	
16. 00	Total Program cost of injections/infusions and their adminicolumns 1, 2, 2.01, and 2.02, line 14) (transfer this amount		•		44, 632	16.0

	Financial Systems BLESSING TATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	HOSPITAL Provider CO	N. 14 001E	Period:	eu of Form CMS-2 Worksheet M-4	
JUMPU	ATTON OF HOSPITAL-BASED RHC/FORC VACCINE COST	Provider CC	JN: 14-0015	From 10/01/2022		
		'	CCN: 14-8634	To 09/30/2023		
			XVIII	RHC V	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1. 00	2. 00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	1, 030, 691 0. 000000	,			1. 00 2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	0	5, 8	90 3, 244	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	0	29, 5			4. 00
5. 00 6. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	0 1, 030, 691	35, 3 1, 030, 6			5. 00 6. 00
7. 00 3. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	1, 055, 451 0. 000000				7. 00 8. 00
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	36, 2 71, 6			9. 00 10. 00
11. 00 12. 00 13. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	0 0.00 0			0.00	12.00
3. 01	beneficiaries Number of COVID-19 vaccine injections/infusions administered to MA enrollees			C	0	13. 0°
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	O	19, 2	47 29, 601	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1. 00	2. 00	
	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			145, 256	
16. 00	Total Program cost of injections/infusions and their adminicolumns 1, 2, 2.01, and 2.02, line 14) (transfer this amount				48, 848	16.00

	Financial Systems BLESSING ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC	CN: 14-0015	Peri od:	Worksheet M-4	
		Component C	CCN: 26-8800	From 10/01/2022 To 09/30/2023		
		Title	XVIII	RHC VII	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	3, 084, 783 0. 001668	3, 084, 7 0. 0012			1. ( 2. (
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	5, 145	4, 0	04 355	0	3. (
1.00	Injections/infusions and related medical supplies costs (from your records)	105, 918	14, 7	1, 935	0	4. (
5. 00 5. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	111, 063 3, 084, 783	18, 79 3, 084, 79			5. 6.
. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	1, 697, 483 0. 036004	1, 697, 4 0. 0060			7. 8.
. 00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	61, 116 172, 179	10, 3 29, 0			9. 10.
1. 00 2. 00 3. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	495 347. 84 112	75.	85 17 51 208. 82 55 8		12.
3. 01	beneficiaries Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	38, 958	11, 7	04 1, 671	0	14.
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		columns 1,		204, 801	15.
6. 00	Total Program cost of injections/infusions and their admin	istration costs	(sum of		52, 333	16.

	Financial Systems BLESSING ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provi der Co	CN: 14-0015	Peri od:	u of Form CMS-2 Worksheet M-4	
		Component (	CCN: 26-8801	From 10/01/2022 To 09/30/2023	Date/Time Pre 12/29/2023 3:	
		Title	XVIII	RHC VIII	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	273, 253				1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000552				2.00
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	151	33	32 0	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	5, 740	2, 41	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	5, 891			0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	273, 253	273, 25	273, 253	273, 253	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	219, 801	219, 80		219, 801	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 021559	0. 01005	0. 000000	0.000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	4, 739	2, 2	11 0	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	10, 630			0	10.00
11.00	Total number of injections/infusions (from your records)	25		55 0	0	
12.00	Cost per injection/infusion (line 10/line 11)	425. 20			0.00	
13. 00	Number of injection/infusion administered to Program beneficiaries	16	2	0	0	13.00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 0°
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	6, 803	2, 52	24 0	0	14. 00
					COST OF INJECTIONS / INFUSIONS AND	
					ADMI NI STRATI ON	
				1. 00	2. 00	

15, 589 15. 00

15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)

16.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

	Financial Systems BLESSING ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provi der Co	CN: 14-0015	Peri od:	worksheet M-4	
		Component	CCN: 26-8802	From 10/01/2022 To 09/30/2023		
			XVIII	RHC IX	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1. 00	2. 00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	102, 830	102, 83	102, 830	102, 830	1. 00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 002141	0. 0048	0. 000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	220	49	95 0	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	1, 601	1, 0	52 0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1, 821			0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	102, 830	102, 83	102, 830	102, 830	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	82, 166	82, 10	82, 166	82, 166	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 017709	0. 01504	0. 000000	0.000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1, 455	1, 23	36 0	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	3, 276			0	10.00
11. 00	Total number of injections/infusions (from your records)	12	1	27 0	0	
12. 00	Cost per injection/infusion (line 10/line 11)	273. 00	103. (	0.00		
13. 00	Number of injection/infusion administered to Program beneficiaries	2		6 0	0	13.00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	546	6	0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND	
					ADMI NI STRATI ON	
				1. 00	2.00	

6, 059 15. 00

15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)

16.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

Health Financial Systems	BLESSING HOSPITAL	In Lieu o	of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R SERVICES RENDERED TO PROGRAM BENEFICIARI	FS	10/01/2022 09/30/2023 Da	orksheet M-5 ate/Time Prepared: 2/29/2023 3:54 pm

		Component CCN: 14-3422	10 09/30/2023	12/29/2023 3: 5	
			RHC I	Cost	, p
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			100, 787	1.0
2. 00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero	period. If none, write		0	2. 0
. 00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)  Program to Provider				3. 0
. 01	1 Togram to 11 ovi dei			0	3. C
. 02					3. 0
. 03					3. 0
. 03					3. 0
. 05					3. (
. 03	Provider to Program			0	J. (
. 50	11 ovi dei 10 11 ogi din			0	3. !
51					3.
52					3.
53					3.
54					3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)			3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)			100, 787	4. (
	TO BE COMPLETED BY CONTRACTOR				
. 00	List separately each tentative settlement payment after deseach payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date o	f		5. (
	Program to Provider				
. 01				0	5. (
. 02				0	5. (
. 03				0	5. (
	Provider to Program				
50				0	5.
51				0	5.
52				0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5.
00	Determined net settlement amount (balance due) based on the	cost report. (1)			6.
01	SETTLEMENT TO PROVI DER			23, 959	6.
. 02	SETTLEMENT TO PROGRAM			0	6.
. 00	Total Medicare program liability (see instructions)			124, 746	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	8. C
8. 00	Name of Contractor				

Health Financial Systems	BLESSI NG HOS	PITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVI DER FOR	Provider CCN: 14-0015 Component CCN: 14-8629	From 10/01/2022	Worksheet M-5  Date/Time Prepared: 12/29/2023 3:54 pm

		Component CCN: 14-8629	10 09/30/2023	12/29/2023 3: 5	
			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			252, 530	1.00
2.00	Interim payments payable on individual bills, either submit			0	2. 00
	the contractor for services rendered in the cost reporting	period. If none, write			
0.00	"NONE" or enter a zero				0.00
3. 00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period.				3. 00
	payment. If none, write "NONE" or enter a zero. (1)	ALSO SHOW date of each			
	Program to Provider				
3. 01	11 ogram to 11 ovrder		05/31/2023	1, 668	3. 01
3. 02				0	3. 02
3. 03				0	3. 03
3.04				О	3. 04
3.05				0	3. 05
	Provider to Program				
3.50				0	3. 50
3. 51				0	3. 51
3.52				0	3. 52
3. 53				0	3. 53
3.54		99)		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.1			1, 668	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans: 27)	rer to worksheet M-3, line		254, 198	4. 00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	k review. Also show date o	f		5. 00
0.00	each payment. If none, write "NONE" or enter a zero. (1)	in review 711 de chem date e	•		0.00
	Program to Provider		<u>'</u>		
5.01				0	5. 01
5.02				0	5. 02
5.03				0	5. 03
	Provider to Program				
5. 50				0	5. 50
5. 51				0	5. 51
5. 52		99)		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5. 99
6.00	Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER	cost report. (1)		F1 0/0	6. 00
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			51, 969 0	6. 01 6. 02
7. 00	Total Medicare program liability (see instructions)			306, 167	7. 00
7.00	Total medicale program trabitity (see thistractions)		Contractor	NPR Date	7.00
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
8. 00	Name of Contractor				8. 00
	·		'	'	

ANALYCIC OF DAVIENTS TO LICEDITAL PACED BUG/FOLIO PROVIDED FOR	ealth Financial Systems	BLESSI NG HOSP	TAL I'	In Lie	u of Form CMS-2552-10
SERVICES RENDERED TO PROGRAM BENEFICIARIES    SERVICES RENDERED TO PROGRAM BENEFICIARIES   From 10/01/2022   To 09/30/2023   Date/Time Preparation	NALYSIS OF PAYMENTS TO HOSPITAL-BASED ERVICES RENDERED TO PROGRAM BENEFICIA 	RIES	Provider CCN: 14-0015 Component CCN: 14-8630	From 10/01/2022	

		Component CCN: 14-8630	10 09/30/2023	12/29/2023 3: 5	
			RHC III	Cost	<u>, р</u>
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			21, 020	1. 00
2. 00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero	period. If none, write		0	2. 00
3. 00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1) Program to Provider				3. 00
3. 01	Frogram to Frovider			0	3. 01
3. 02				0	3. 02
3. 03				0	3. 03
3. 04				0	3. 04
3. 05				0	3. 05
	Provider to Program				
3.50				0	3. 50
3. 51				0	3.5
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.			0	3. 9
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)	fer to Worksheet M-3, line		21, 020	4. 00
	TO BE COMPLETED BY CONTRACTOR		_		
5. 00	List separately each tentative settlement payment after des each payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date o	f		5. 00
	Program to Provider			_	
5. 01				0	5. 0
5. 02				0	5. 02
5. 03	Provider to Program			0	5. 03
5. 50	Provider to Program			0	5. 50
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)		Ö	5. 9
6. 00	Determined net settlement amount (balance due) based on the			Ĭ	6. 0
6. 01	SETTLEMENT TO PROVIDER	· opo. c. (.)		3, 745	6. 0
6. 02	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)			24, 765	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
8. 00	Name of Contractor			1	8.00

Health Financial Systems	BLESSI NG HOS	PITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 14-0015 Component CCN: 14-8631	From 10/01/2022	Worksheet M-5 Date/Time Prepared: 12/29/2023 3:54 pm

		Component CCN: 14-8631	10 09/30/2023	12/29/2023 3: 5	
			RHC IV	Cost	
		·	Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			612, 248	1. 0
2. 00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero	period. If none, write		0	2. 0
3. 00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)				3. 0
0.1	Program to Provider		05 (21 (2022	F 251	2.0
3. 01			05/31/2023	5, 251	3. 0
3. 02				0	3. 0
3. 03				0	3.0
3. 04				0	3.0
3. 05				0	3. C
. 50	Provider to Program			0	3. 5
. 50 . 51					3. 5
. 51 . 52					3. !
. 53					3. ! 3. !
. 54	Cultural (	00)			3. 9
. 99 . 00	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3. Total interim payments (sum of lines 1, 2, and 3.99) (trans			5, 251 617, 499	4. 0
. 00	27)	ster to worksheet M-3, line		617, 499	4. (
	TO BE COMPLETED BY CONTRACTOR				
. 00	List separately each tentative settlement payment after des	k review Also show date o	f		5. (
. 00	each payment. If none, write "NONE" or enter a zero. (1)	ak review. Also show date o	'		5. (
	Program to Provider				
. 01	1 rogram to 11 ovi dei			0	5. 0
. 02				0	5. (
. 03				0	5. 0
. 00	Provider to Program			U	J. V
. 50	11 ovi del 10 11 egi din			0	5. 5
. 51				0	5. 5
. 52				0	5. 5
. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5.
. 00	Determined net settlement amount (balance due) based on the				6. (
. 01	SETTLEMENT TO PROVIDER	. 3031 Topol I. (1)		46, 600	6. (
. 02	SETTLEMENT TO PROGRAM			70,000	6. (
. 02 '. 00	Total Medicare program liability (see instructions)			664, 099	7. (
. 00	Total medicale program trabitity (see instructions)		Contractor	NPR Date	7. (
		0	Number 1.00	(Mo/Day/Yr) 2.00	

Health Financial Systems	BLESSI NG HOS	PITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED F SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 14-0015 Component CCN: 14-8634	From 10/01/2022	Worksheet M-5 Date/Time Prepared: 12/29/2023 3:54 pm

02	NEW MEMBERS OF THOSAN IN CENTER TO THAT ES	Component CCN: 14-8634	То	09/30/2023	Date/Time Prep 12/29/2023 3:5	
			L,	RHC V	Cost	
			L	Par		
			L	mm/dd/yyyy	Amount	
				1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC				58, 750	1. 00
2.00	Interim payments payable on individual bills, either submit				0	2. 00
	the contractor for services rendered in the cost reporting	period. It none, write				
0.00	"NONE" or enter a zero					0.00
3.00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period.					3. 00
	payment. If none, write "NONE" or enter a zero. (1)	ALSO Show date of each				
	Program to Provider					
3. 01	1 Togram to 11 ovider		$\top$		0	3. 0°
3. 02					ő	3. 02
3. 03					ő	3. 0
3. 04					Ö	3. 0
3. 05					ő	3. 0
0.00	Provider to Program				0	0.0
3. 50	Trovidor to trogram				0	3. 5
3. 51					o	3. 5
3. 52					o	3. 5
3. 53					o	3. 5
3.54					0	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)			0	3. 9
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line			58, 750	4. 0
	27)				•	
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after des	sk review. Also show date o	f			5. 0
	each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01					0	5. 0
5. 02					0	5. 0
5. 03					0	5.0
	Provider to Program				0	
5. 50 5. 51					0	5. 5 5. 5
5. 51 5. 52					0	5. 5
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	00)			0	5. 5
5. 99 5. 00	Determined net settlement amount (balance due) based on the				۷	6. 0
5. 00 5. 01	SETTLEMENT TO PROVIDER	E cost report. (1)			48, 382	6. 0
5. 01 6. 02	SETTLEMENT TO PROVIDER				40, 302	6. 0
7. 00	Total Medicare program liability (see instructions)				107, 132	7. 0
,. 00	Trotal moderate program trabitity (see this tractions)			Contractor	NPR Date	7.0
				Number	(Mo/Day/Yr)	
		0		1. 00	2.00	
8. 00	Name of Contractor	-	_			8. 00

Health Financial Systems	BLESSING HOS	SPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0015	Peri od: From 10/01/2022	Worksheet M-5
		Component CCN: 14-8635	To 09/30/2023	Date/Time Prepared: 12/29/2023 3:54 pm

		Component CCN: 14-8635	To 09/30/2023	Date/Time Prep 12/29/2023 3:5	
			RHC VI	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			90, 351	1.00
2. 00	Interim payments payable on individual bills, either submit			0	2.00
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3. 00	List separately each retroactive lump sum adjustment amount				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)				
0.01	Program to Provider			0	2 01
3. 01 3. 02					3. 01 3. 02
3. 02 3. 03					3. 02
					3. 04
3. 04 3. 05					3.02
3. 03	Provider to Program			U	3.00
3. 50	Frovider to Frogram			0	3. 50
3. 51				ا	3.5
3. 52				٥	3. 52
3. 53				0	3. 53
3. 54				ام	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		ام	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			90, 351	4. 00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5. 00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5. 01				0	5. 01
5. 02				0	5. 02
5. 03	Provider to Program			U	5. 03
5. 50	Frovider to Frogram			0	5. 50
5. 51				0	5.5
5. 52				٥	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		Ö	5. 99
5. 00	Determined net settlement amount (balance due) based on the				6.00
5. 01	SETTLEMENT TO PROVIDER			384	6. 01
5. 02	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)			90, 735	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
3. 00	Name of Contractor				8. 00