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: 14-1324 Worksheet S Peri od: From 04/01/2022 Parts I-III AND SETTLEMENT SUMMARY 03/31/2023 Date/Time Prepared: 8/31/2023 4: 04 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 8/31/2023 4: 04 pm] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FERRELL HOSPITAL (14-1324) for the cost reporting period beginning 04/01/2022 and ending 03/31/2023 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	SIGNATURE STATEMENT	
1	Anth	nony Keene	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	Anthony Keene			2
3	Signatory Title	CHIEF EXECUTIVE OFFICER			3
4	Date	(Dated when report is electronica			4

		Title	XVIII			
	Title V	Part A	Part B	HI T	Title XIX	
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1. 00 HOSPI TAL	0	-74, 568	-887, 537	0	0	1.00
2. 00 SUBPROVI DER - I PF	0	0	0		0	2.00
3. 00 SUBPROVI DER - I RF	0	0	0		0	3.00
5. 00 SWING BED - SNF	0	635, 240	0		0	5. 00
6.00 SWING BED - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		322, 886		0	10.00
10.01 RURAL HEALTH CLINIC II	0		179, 545		0	10. 01
10.02 RURAL HEALTH CLINIC III	0		31, 551		0	10. 02
10.03 RURAL HEALTH CLINIC IV	0		44, 911		0	10.03
200. 00 TOTAL	0	560, 672				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.

Heal th	Financial Systems	FERRELL HO	SPI TAL				Ir	Lieu	of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provid	der CC	CN: 14		Period: From 04/01/		Workshe Part I	et S-2	
							To 03/31/	2023	Date/Ti 8/31/20		
	1. 00	2. 00		3. 00			4	1. 00	0/ 31/ 20	723 4.0	4 DIII
1. 00	Hospital and Hospital Health Care Co Street: 1201 PINE STREET	omplex Address: PO Box:									1. 00
	City: EL DORADO	State: IL	Zip Cod	le: 629			y: SALINE				2. 00
		Component Name	CCN Number	CBS Numb		Provi der Type	Date Certified		nt Syst 0, or		
			Number	IVAIIIK	bei	Турс	oci ti i cu	V ,	XVIII		
	Hospital and Hospital-Based Componer	1.00	2.00	3.0	00	4. 00	5. 00	6. 00	7. 00	8. 00	
3. 00	Hospi tal	FERRELL HOSPITAL	141324	999	14	1	02/01/2003	N	0	0	3. 00
4.00	Subprovi der - IPF				ĺ						4.00
5. 00 6. 00	Subprovi der – IRF Subprovi der – (Other)										5. 00 6. 00
7. 00	Swing Beds - SNF	FERRELL SWINGBED SNF	14Z324	999	14		02/01/2003	N	0	0	7. 00
8. 00 9. 00	Swing Beds - NF Hospital-Based SNF										8. 00 9. 00
	Hospi tal -Based NF										10.00
	Hospi tal -Based OLTC										11.00
	Hospital-Based HHA Separately Certified ASC										12. 00 13. 00
	Hospital -Based Hospice										14.00
	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - RHC	FERRELL HOSPITAL CLINIC CARMI CLINIC	148506 148588	999			04/01/2009 05/23/2018	N N	0	0	15. 00 15. 01
	11										
15. 02	Hospital-Based Health Clinic - RHC	MCLEANSBORO FAMILY MEDICINE	148616	999	014		03/26/2020	N	0	0	15. 02
15. 03	Hospital-Based Health Clinic - RHC	HARRISBURG FAMILY	148627	999	14		12/07/2021	N	0	0	15. 03
16. 00	V Hospital-Based Health Clinic - FQHC	MEDI CI NE									16. 00
	Hospital-Based (CMHC) I Renal Dialysis										17. 00 18. 00
19. 00	1										19.00
							From: 1.00		To 2. 0		
20. 00	Cost Reporting Period (mm/dd/yyyy)						04/01/20		03/31/		20. 00
21. 00	Type of Control (see instructions)						2				21. 00
						1. 00	2. 00		3. 0	00	
22 00	Inpatient PPS Information Does this facility qualify and is it	currently receiving nav	ments fo	ır		N					22. 00
22.00	disproportionate share hospital adju	ıstment, in accordance wi	th 42 CF								22.00
	§412.106? In column 1, enter "Y" for facility subject to 42 CFR Section §										
	hospital?) In column 2, enter "Y" fo	or yes or "N" for no.									
22. 01	Did this hospital receive interim UC this cost reporting period? Enter in					N	N				22. 01
	for the portion of the cost reportir	g period occurring prior	to Octo	ber							
	 Enter in column 2, "Y" for yes or cost reporting period occurring on c 		tion of t	he							
	instructions)	arter october 1. (see									
22. 02	Is this a newly merged hospital that determined at cost report settlement	•		d umn		N	N				22. 02
	1, "Y" for yes or "N" for no, for th	e portion of the cost re	eporti ng								
	period prior to October 1. Enter in for the portion of the cost reportir			no,							
22. 03	Did this hospital receive a geograph			О		N	N		N		22. 03
	rural as a result of the OMB standar										
	adopted by CMS in FY2015? Enter in c for the portion of the cost reporting	g period prior to Octobe	er 1. Ent								
	in column 2, "Y" for yes or "N" for										
	reporting period occurring on or aft Does this hospital contain at least	•									
	counted in accordance with 42 CFR 41	2.105)? Enter in column	3, "Y" f	or							
22. 04	yes or "N" for no. Did this hospital receive a geograph	ic reclassification from	n urban t	0							22. 04
	rural as a result of the revised OME	delineations for statis	stical ar	eas							
	adopted by CMS in FY 2021? Enter in for the portion of the cost reportir										
	in column 2, "Y" for yes or "N" for	no for the portion of th	ne cost								
	reporting period occurring on or aft Does this hospital contain at least										
	counted in accordance with 42 CFR 41										
23. 00	yes or "N" for no. Which method is used to determine Me	edicaid days on lines 24	and/or 2	5			1 N				23. 00
	below? In column 1, enter 1 if date	of admission, 2 if censu	ıs days,	or 3							
	if date of discharge. Is the method reporting period different from the	3 0		cost							
	reporting period? In column 2, ente										

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

Health Financial Systems	FER	RELL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: rom 04/01/2022	Worksheet S-2 Part I	
			Unwei ghted	Unwei ghted	8/31/2023 4:0 Ratio (col.	
			FTEs Nonprovi der Si te	FTEs in Hospital	1/ (col . 1 + col . 2))	
			1.00	2. 00	3. 00	
Section 5504 of the ACA Base Yea			This base year	is your cost	reporti ng	
period that begins on or after of 64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to resident FTEs that trained in your of (column 1 divided by (column).	s yes, or your facilit aber of unweighted nor otations occurring in a number of unweighted our hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovider Site	FTEs in Hospital	3/ (col. 3 + col. 4))	
(5.00 5.1	1. 00	2. 00	3.00	4. 00	5. 00	45.00
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 Ratio (col.	65. 00
			FTEs	FTEsin	1/ (col. 1 +	
			Nonprovider Site	Hospi tal	col. 2))	
			1. 00	2. 00	3. 00	
Section 5504 of the ACA Current		n Nonprovider Setting				
beginning on or after July 1, 20 66.00 Enter in column 1 the number of		ry care resident	0.00	0. 00	0. 000000	66 00
FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	occurring in all nonpount unweighted non-priman cal. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0.00000	00.00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2. 00	3.00	4. 00	5.00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00	0.000000	67.00

	Financial Systems FERRELL HOSPITAL AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC		Period: From 04/01/2 To 03/31/2	022	of Form CMS Worksheet S- Part I Date/Time Pr 8/31/2023 4:	2 epared:
				-	1. 00	-
58. 00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49 For a cost reporting period beginning prior to October 1, 2022, did you of MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final (August 10, 2022)?	otain permiss	ion from you		N	68. 00
				1. 00	2.00 3.00)
70. 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it conta	ain an IPF su	bprovi der?	N		70.00
71. 00	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching recent cost report filed on or before November 15, 2004? Enter "Y" for year 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for year Column 3: If column 2 is Y, indicate which program year began during this (see instructions) Inpatient Rehabilitation Facility PPS	es or "N" for in a new tea es or "N" for	no. (see chi ng no.		0	71.00
75. 00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it co	ontain an IRF		N		75.00
	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching recent cost reporting period ending on or before November 15, 2004? Enter no. Column 2: Did this facility train residents in a new teaching program CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If indicate which program year began during this cost reporting period. (see	"Y" for yes in accordanc column 2 is	or "N" for e with 42 Y,		0	76. 00
				ŀ	1. 00	_
	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for Is this a LTCH co-located within another hospital for part or all of the "Y" for yes and "N" for no.		g period? En	iter	N N	80. 00 81. 00
	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter Did this facility establish a new Other subprovider (excluded unit) under			no.	N	85. 00 86. 00
37. 00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified to 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	under section			N	87. 00
	TOOG(G) (T) (D) (VT): Enter T TOT yes of W TOT HO.		Approved f Permanen Adjustmer (Y/N) 1.00	t	Number of Approved Permanent Adjustments 2.00	
38. 00	Column 1: Is this hospital approved for a permanent adjustment to the TEFF amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete		е			0 88.00
	Column 2: Enter the number of approved permanent adjustments.	Wkst. A Line	e Effecti v	'Δ	Approved	
		No.	Date		Permanent Adjustment Amount Per Discharge	
39. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1.00	2.00		3. 00	0 89.00
37.00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.	0. 0				0 07.00
	Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.					
			V 1.00		XI X 2. 00	
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? En	nter "Y" for	N		Υ	90.00
91. 00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost reportfull or in part? Enter "Y" for yes or "N" for no in the applicable column.		N		Υ	91.00
92. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual certificati				N	92.00
93. 00	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column.	d XIX? Enter	N		N	93. 00
94. 00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no applicable column.	o in the	N		N	94.00
	If line 94 is "Y", enter the reduction percentage in the applicable column	า.	0.00		0.00	95.00
	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no applicable column.	o in the	N		N	96.00

118.00

118.00|s the malpractice insurance a claims-made or occurrence policy? Enter 1

if the policy is claim-made. Enter 2 if the policy is occurrence.

Health Financial Systems	FERRE	LL HOSPIT	ΓAL				In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DATA	P	rovider CC	CN: 14-1324		eriod: com 04/0 0 03/3	1/2022 1/2023		epared:
								1.00	+
147.00Was there a change in the statist	ical basis? Enter "Y"	for yes	or "N" for	no.				N 1.00	147. 00
148.00 Was there a change in the order o								N	148.00
149.00 Was there a change to the simplif	ied cost finding metho	od? Enter	"Y" for y	es or "N"	for r	10.		N	149.00
			Part A	Part		Titl		Title XIX	
			1. 00	2. 00		3. 0		4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or									
155. 00 Hospi tal			N	N		N		N	155.00
156. 00 Subprovi der - IPF			N	l N		N		N	156.00
157.00 Subprovi der - IRF			N	N		N		N	157.00
158. 00 SUBPROVI DER									158. 00
159. 00 SNF			N	N N		N		N	159.00
160.00 HOME HEALTH AGENCY			N	N		N		N	160.00
161. 00 CMHC				N N		N		N	161.00
								1.00	_
Mul ti campus									
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one or	more camp	uses in di	ffere	ent CBSA	s?	N	165. 00
Litter 1 for yes of 14 for 110.	Name	Сс	unty	State	Zip (Code	CBSA	FTE/Campus	
	0		. 00	2.00	3. (4. 00	5. 00	
166.00 f 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	0 166. 00
								1. 00	-
Health Information Technology (HI	T) incentive in the Am	merican R	ecovery an	nd Rei nves	tment	Act		1.00	
167.00 s this provider a meaningful use 168.00 f this provider is a CAH (line 1						enter t	he	Y	167. 00 168. 00
reasonable cost incurred for the 168.01 If this provider is a CAH and is	not a meaningful user,	does th				a hardsh	iр		168. 01
exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful transition factor. (see instructi	user (line 167 is "Y")					N"), ent	er the	O. C	0169.00
To ans. C. S Sector . (See Trist) dett	/					Begi nı	ni ng	Endi ng	
						1. C	00	2.00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and end	ding date	for the r	eporti ng					170.00
						1. 0	10	2.00	
171.00 If line 167 is "Y", does this pro	vider have any days fo	or indivi	duals enro	lledin		1. C			0171.00
section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, umn 1. If column 1 is	Pt. I,	line 2, co	I. 6? Ente		IV.			3,77.00

	Financial Systems FERRELL H				u of Form CMS-			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CCN: 14-1324	Peri od: From 04/01/2022 To 03/31/2023		epared:		
			i pti on	Y/N	Y/N			
	10.11		0	1.00	3. 00	00.00		
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	EPT CHILDRENS	HOSPI TALS)					
	Capital Related Cost	. notruet enc			N	1 22 00		
	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense	ring the cost	N N	22.00				
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered	ed into during	this cost r	eporting period?	N	24. 00		
25. 00								
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	he cost report	ing period?	If yes, see	N	26.00		
27. 00	instructions. Has the provider's capitalization policy changed during the	e cost reporti	ng period? I	f yes, submit	N	27. 00		
ĺ	Copy. Interest Expense							
28. 00	Were new Loans, mortgage agreements or Letters of credit en period? If yes, see instructions.	ntered into du	ring the cos	t reporting	N	28.00		
29. 00	00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions							
30. 00	Has existing debt been replaced prior to its scheduled maturinstructions.		debt? If yes	s, see	N	30.00		
	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If ye	s, see	N	31.00		
	<u>Purchased Services</u> Have changes or new agreements occurred in patient care se		ed through c	ontractual	N	32.00		
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to compet	itive bidding? I1	N	33.00		
	Provi der-Based Physi ci ans							
34.00	Were services furnished at the provider facility under an a lf yes, see instructions.	arrangement wi	th provider-	based physicians?	Y	34.00		
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		ents with the	provi der-based	N	35.00		
	physicians during the cost reporting period: if yes, see if	nstructions.		Y/N	Date			
				1.00	2. 00			
	Home Office Costs			V		1 2/ 2/		
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu	repared by the	home office	? Y 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			f Y	09/30/2022	38.00		
39. 00	the provider? If yes, enter in column 2 the fiscal year end of line 36 is yes, did the provider render services to other			s, N		39.00		
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40.00		
	instructions.							
	Cook Donard Dayson Control Cook	1.	00	2.	00			
	held by the cost report preparer in columns 1, 2, and 3,	BLUE AND CO		BLUE AND CO		41.00		
	respectively.	I				II		
42. 00	Enter the employer/company name of the cost report preparer.	BLUE AND CO				42.00		

Health Financial Systems	FERRELL HC	SPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	STI ONNAI RE	Provi der CCN:		Period: From 04/01/2022 Fo 03/31/2023	Worksheet S-2 Part II Date/Time Pre 8/31/2023 4:0	pared:
			L		7 07 0 17 2020 1. 0	, piii
		3.00				
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the title.		BLUE AND CO				41.00
held by the cost report preparer in columns 1	, 2, and 3,					
respecti vel y.						
42.00 Enter the employer/company name of the cost re	eport					42.00
preparer.						
43.00 Enter the telephone number and email address						43.00
report preparer in columns 1 and 2, respective	el y.					

Health Financial Systems FERRELL HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1324
Period:
From 04/01/2022
To 03/31/2023 Part I
Date/Time Prepared:
8/31/2023 4: 04 pm

I /P Days /
O/P Visits /
Tripe

					'	0 03/31/2023	8/31/2023 4:0	
							I/P Days /	
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA				1			
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	9, 125	39, 216. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3. 00	HMO IPF Subprovider							3.00
4. 00	HMO IRF Subprovider							4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			25	9, 125	39, 216. 00	0	7.00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT							8. 00
9.00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY							13.00
14. 00	Total (see instructions)			25	9, 125	39, 216. 00	0	14.00
15.00	CAH visits						0	15.00
15. 10	REH hours and visits							15. 10
16.00	SUBPROVIDER - I PF							16.00
17. 00 18. 00	SUBPROVI DER - I RF SUBPROVI DER							17. 00 18. 00
19.00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30.00						24. 10
25.00	CMHC - CMHC							25.00
26.00	RHC (CONSOLI DATED)	88. 00					0	26.00
26. 01	RURAL HEALTH CLINIC II	88. 01					0	26. 01
26. 02	RURAL HEALTH CLINIC III	88. 02					0	26. 02
26. 03	RURAL HEALTH CLINIC IV	88. 03					0	26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			25			_	27. 00
28. 00	Observation Bed Days						0	28. 00
29.00	Ambul ance Trips							29.00
30.00	Employee discount days (see instruction)							30. 00 31. 00
31. 00 32. 00	Employee discount days - IRF Labor & delivery days (see instructions)			0				32.00
32. 00	Total ancillary labor & delivery room			U				32. 00 32. 01
JZ. UI	outpatient days (see instructions)							JZ. U1
33. 00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01
	Temporary Expansion COVID-19 PHE Acute Care	30.00		0	C		0	
						'		

Provider CCN: 14-1324

						8/31/2023 4:0	4 pm
		I/P Days	s / O/P Visits	/ Tri ps	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7.00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 107	11	1, 600			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	0	168	•			2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	970	0	1, 285			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	119	1		6.00
7.00	Total Adults and Peds. (exclude observation	2, 077	11	3, 004			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	2, 077	11	3, 004	0.00	233. 85	14.00
15.00	CAH visits	0	0	C)		15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			[c)		24. 10
25.00	CMHC - CMHC						25.00
26. 00	RHC (CONSOLI DATED)	10, 286	0	24, 788	0.00	52. 70	26.00
26. 01	RURAL HEALTH CLINIC II	3, 859	0	12, 026	0.00	14. 86	26. 01
26. 02	RURAL HEALTH CLINIC III	835	0	6, 038	0.00	9. 91	26. 02
26. 03	RURAL HEALTH CLINIC IV	1, 305	0	4, 792	0.00	8. 95	26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	· c	0.00	0.00	26. 25
27. 00					0.00	320. 27	
28. 00			12	984			28. 00
29. 00		0					29.00
30. 00	•			l c	ı		30.00
31. 00							31.00
32. 00	1 ' 3	0	0	1			32.00
32. 01				ĺ			32. 01
	outpatient days (see instructions)]			
33. 00		O					33.00
33. 01		o					33. 01
	Temporary Expansion COVID-19 PHE Acute Care	0	0	C			34.00

Provider CCN: 14-1324

				To	03/31/2023	Date/Time Pre 8/31/2023 4:0	
		Full Time		Di sch	arges	0/31/2023 4.0	4 piii
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	40.00	44.00	Pati ents	
	DART I CTATICTICAL DATA	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and		0	310	3	519	1. 00
1.00	8 exclude Swing Bed, Observation Bed and		0	310	3	517	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			0	53		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	310	3	519	14.00
15.00	CAH visits						15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVIDER - IPF						16.00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE						20. 00 21. 00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLI DATED)	0.00					26.00
26. 01	RURAL HEALTH CLINIC II	0.00					26. 01
26. 02	RURAL HEALTH CLINIC III	0.00					26. 02
26. 03	RURAL HEALTH CLINIC IV	0.00					26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00 29. 00	Observation Bed Days Ambulance Trips						28. 00 29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days (see firsti detroit)						31.00
32. 00	Labor & delivery days (see instructions)						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

HOSPITAL-BASED RIKC/FORC STATISTICAL DATA	Health Financial Systems		FERRELL H	OSPI TAL		In Lie	u of Form CMS-:	2552-10
Component CON: 14-8506 To 03/31/2023 Date/files Prepared 8/31/2023 2-6 de files 8/31/		TATISTICAL DATA			CN: 14-1324	Peri od:		
City State State				Component	CCN: 14-8506			
1.00 Street 1.00 Street 1.00 Street 1.00 Street 1.00 Street 1.00 1.00 2.00 3.00 2.00 1.00 2.00 3.00 2.00 1.00 2.00 3.00 2.00 1.00 2.00 3.00 2.00 1.00 2.00 3.00 2.00 1.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 3.00 2.00 3.00						RHC I		04 pm
Clinic Address and Identification 1201 PINE STREET 1.00 1.00 2.00 3.00 1.00 2.00 3.00 1.00 2.00 3.00 1.00 2.00 3.00 1.00 2.00 3.00 1.00 2.00 3.00 1.00 2.00 3.00 1.00 3						THIS I	0031	
1.00 Street						1.	00	
City State ZIP Code Z.00 City State ZIP Code Z.00 Z.00		I denti fi cati on				1201 DINE STDE	СТ	1 00
1.00	1.00 311 ee t			Ci	tv			1.00
1.00						2.00	3. 00	
MOSPITAL-BASED FORCS ONLY: Designation - Enter "R" for rural or "U" for urban	2.00 City, State, ZIP Co	ode, County		EL DORADO		IL	62930	2.00
NoSPITAL-BASED FORCS ONLY: Designation - Enter "R" for rural or "U" for urban Date							1 00	
Source of Federal Funds	3. 00 HOSPI TAL-BASED FOHO	Cs ONLY: Designation - Ente	er "R" for rura	al or "U" for	urban			3.00
Source of Federal Funds	or do priodit trib briological	oo oner boorgnation ent		<u> </u>		nt Award		0.00
A .00 Community Health Center (Section 330(d), PHS Act) S .00 Migrant Health Center (Section 329(d), PHS Act) S .00 Community Health Center (Section 329(d), PHS Act) S .00 Community Health Services for the Honeless (Section 340(d), PHS Act) S .00 Community Health Services for the Honeless (Section 340(d), PHS Act) S .00 Community Health Services for the Honeless (Section 340(d), PHS Act) S .00 Community Health Services for the Honeless (Section 340(d), PHS Act) S .00 Community Health Services S						1. 00	2. 00	
Some content Section			A a + \					4 00
Heal th Services for the Homeless (Section 340(d), PHS Act)								5.00
8.0	9							6.00
0.00 OTHER (SPECIFY) 9.00 OTHER (SPECIFY) 1.00 2.00		al Commission						7. 00
1.00 Does this facility operate as other than a hospital -based RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday								8.00
10.00 Does this facility operate as other than a hospital-based RHC or FOVE? Enter "" for yes or "N" for no in column 1. If yes, enter in column 2. (Enter in subscripts of line 11 the type of other operations) and the operating hours. Sunday	9.00 OTHER (SPECIFY)							9.00
yes or "N" for no in column 1. If yes, indicate number of other operating						1.00	2. 00	
2 (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday							0	10.00
Sunday Monday Tuesday	2. (Enter in subscri							
1.00 2.00 3.00 4.00 5.00			Sun	day	N	londay		
Facility hours of operations (1) 13:00 17:00 07:00 19:00 07:00 11.00 11.00 12.00 12.00 13:00 17:00 1					-			
11.00 CLINIC 13:00 17:00 07:00 19:00 07:00 11.00	Facility hours of o	porations (1)	1.00	2.00	3.00	4.00	5.00	
12.00 Have you received an approval for an exception to the productivity standard? N 13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section Y 2 13.00 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below. Provider name CCN 1.00 2.00			13: 00	17: 00	07: 00	19: 00	07: 00	11.00
12.00 Have you received an approval for an exception to the productivity standard? N 13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section Y 2 13.00 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below. Provider name CCN 1.00 2.00					'			
13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below. Provider name CCN 1.00 2.00							2. 00	
number of providers included in this report. List the names of all providers and numbers below. Provider name CCN 1.00 2.00 14.00 RHC/FOHC name, CCN FERRELL HOSPITAL CLINIC 148506 14.0 ELDORADO FAMILY CLINIC 148507 14.0 Y/N V XVIII XIX Total Visits 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) County 1.00 2.00 3.00 4.00 5.00 County 4.00 2.00 City, State, ZIP Code, County Facility hours of operations (1)	13.00 Is this a consolida	ated cost report as defined	d in CMS Pub. 1	100-04, chapte	r 9, section		2	12. 00 13. 00
Numbers below. Provider name CCN 1.00 2.00								
Provider name CCN 1.00 2.00		s included in this report.	List the names	s or all provi	ders and			
14.00 RHC/FOHC name, CCN FERRELL HOSPITAL CLINIC 148506 14.00	Traineer's berow.				Prov	ider name	CCN	
14.01								
Y/N V XVIII XIX Total Visits					•			14.00
1.00 2.00 3.00 4.00 5.00 15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) County	14. 01		Y/N	V				14.01
GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) County 4.00 2.00 City, State, ZIP Code, County SALINE Tuesday Wednesday Thursday to from to from to 6.00 7.00 8.00 9.00 10.00 Facility hours of operations (1)				-				
column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) County 4.00 2.00 City, State, ZIP Code, County Tuesday Tuesday Wednesday Thursday To from to from to 6.00 7.00 8.00 9.00 10.00 Facility hours of operations (1)								15.00
4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) County 4.00 2.00 City, State, ZIP Code, County Tuesday Vednesday Thursday to from to from to 6.00 7.00 8.00 9.00 10.00 Facility hours of operations (1)								
Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) County 4.00 City, State, ZIP Code, County Tuesday Wednesday To from to from to 6.00 7.00 8.00 9.00 10.00 Facility hours of operations (1)								
number of total visits for this provider. (see instructions)								
(see instructions)								
County 4.00 2.00 City, State, ZIP Code, County SALINE 2.00 City, State, ZIP Code, County SALINE 2.00 City, State, ZIP Code, County SALINE 2.00 City, State, ZIP Code, County SALINE 2.00 City, State, ZIP Code, County SALINE 2.00 City, State, ZIP Code, County SALINE City Code, County City Code, Cod		sits for this provider.						
A. 00 City, State, ZIP Code, County SALINE 2. 00 Tuesday Wednesday Thursday Thursday To from to from to 6. 00 7. 00 8. 00 9. 00 10. 00	(See Thathuctions)			Cou	ınty			
Tuesday Wednesday Thursday to from to from to 6.00 7.00 8.00 9.00 10.00 Facility hours of operations (1)								
to from to from to 6.00 7.00 8.00 9.00 10.00	2.00 City, State, ZIP Co	ode, County				_		2.00
6.00 7.00 8.00 9.00 10.00 Facility hours of operations (1)								
Facility hours of operations (1)								
11 00 CLINIC 19.00 19.00 19.00 10.00 10.00 10.00 11.00		perations (1)	2.00					
17.00 17.00 17.00 17.00 17.00	11.00 CLINIC		19: 00	07: 00	19: 00	07: 00	19: 00	11.00

Health Financial Systems	FERRELL H	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Peri od:	Worksheet S-8	}
		Component		From 04/01/2022 To 03/31/2023		pared: 04 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	07: 00	19: 00	09: 00	17: 00		11. 00

Heal th	n Financial Systems	FERRELL F	HOSPI TAL		In Li€	eu of Form CMS-	2552-10
HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der 0	CN: 14-1324	Peri od:	Worksheet S-8	8
			Component	CCN: 14-8588	From 04/01/2022 To 03/31/2023		
					RHC II	Cost	. p
	Clinic Address and Identification					00	
1. 00	Street				1340 HI GHWAY 1	, SULTE A	1.00
	1		Ci	ty	State	ZIP Code	
	Tax t			00	2. 00	3. 00	
2. 00	City, State, ZIP Code, County		CARMI		IL	62821	2.00
						1. 00	
3. 00	HOSPITAL-BASED FOHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for	urban		C C	3.00
					nt Award	Date	
	Causas of Fadaval Funda				1. 00	2. 00	
4. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	S Act)		T			4.00
5. 00	Migrant Health Center (Section 329(d), PHS A						5.00
6.00	Health Services for the Homeless (Section 34						6.00
7. 00	Appal achi an Regi onal Commi ssi on						7.00
8. 00 9. 00	Look-Alikes OTHER (SPECIFY)						8. 00 9. 00
9.00	OTHER (SPECIFY)						9.00
					1. 00	2. 00	
10.00	j 1					C	10.00
	yes or "N" for no in column 1. If yes, indic						
	2. (Enter in subscripts of line 11 the type of hours.)	or other operat	ion(s) and the	operating			
	Thou 3.)	Sur	nday	l N	Monday	Tuesday	
		from	to	from	to	from	
		1. 00	2. 00	3.00	4. 00	5. 00	
11 00	Facility hours of operations (1)	13: 00	17: 00	07: 00	19: 00	07: 00	11.00
11.00	OEI NI O	13.00	117.00	107.00	17.00	07.00	11.00
	,				1. 00	2. 00	
12.00					N		12.00
13. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col				N		13. 00
	number of providers included in this report.						
	numbers below.						
				Prov	ider name	CCN	
14 00	RHC/FOHC name, CCN				1. 00	2. 00	14.00
14.00	MICH GIC Halle, CON	Y/N	V	XVIII	XI X	Total Visits	14.00
		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 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)						
	Trace Triati deti olia)	1	Cou	L unty		1	
			4.	00			
2. 00	City, State, ZIP Code, County		WHI TE				2. 00
		Tuesday		esday T +o		rsday L +o	
		6. 00	7.00	8. 00	9.00	to 10.00	
	Facility hours of operations (1)	0.00	7.00	3.00		10.00	
11. 00	CLINIC	19: 00	07: 00	19: 00	07: 00	19: 00	11. 00

Health Financial Systems	FERRELL H	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Peri od:	Worksheet S-8	}
		Component		From 04/01/2022 To 03/31/2023	Date/Time Pre 8/31/2023 4:0	pared: 04 pm
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)	_					
11. 00 CLINIC	07: 00	19: 00	09: 00	17: 00		11. 00

Provider CN: 14-1324 Period Period Provider CN: 14-1324 Period Period Provider P	Health Financial Systems	FERRELL H	IOSPI TAL		In Lie	u of Form CMS-	2552-10
Component CCN: 14-8616 To 03/31/20/3 Detart Time Prepared (%3/31/20/3 Detart T				CN: 14-1324	Peri od:		
Birth Birth Birth Cost Cost			Component	CCN: 11_8616		Date/Time Dre	nared:
1.00			Component	CCN. 14-0010	03/31/2023		
Clinic Address and Identification 1.00					RHC III	Cost	
Clinic Address and Identification 1.00							_
1.00 Street	Clinic Address and Identification				1.	00	
City State ZIP Code 1.00 2.00 3.00					1340 II - 1		1 00
1.00 2.00 3.00 1.6821 2.00 3.00 1.6821 2.00 3.00 1.6821 2.00 3.00 1.6821 2.00 3.00 1.6821 2.00 3.00 1.6821 2.00 3.00 1.6821 3.00 3.00 1.6821 3.00	1.00 311 cc t		Ci	tv		ZIP Code	1.00
1.00							
3.00 HoSPITAL-BASED FOHCS ONLY: Designation - Enter "R" for rural or "U" for urban 0 3.00	2.00 City, State, ZIP Code, County		CARMI		IL	62821	2.00
3.00 HoSPITAL-BASED FOHCS ONLY: Designation - Enter "R" for rural or "U" for urban 0 3.00						1.00	
Source of Federal Funds	2 00 HOSPITAL PASED FOHCE ONLY. Decimpation Ent	or "D" for rur	al or "II" for	urhan			2 00
Source of Federal Funds	3.00 HOSPITAL-BASED FUNCS UNLY: Designation - Ent	er k for rur	al of U for		nt Award		3.00
Source of Federal Funds							
5.00 Migrant Health Center (Section 329(d), PHS Act) 6.00 Content (Section 340(d)), PHS Act) 6.00 7	Source of Federal Funds			1			
Heal th Services for the Homeless (Section 340(d), PHS Act)							
Appal achian Regional Commission 7.00 8.00 00.							1
1.00		O(d), PHS Act)					
9.00 OTHER (SPECIFY) 9.00	1 1 1						
10.00 Does this facility operate as other than a hospital-based RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operations) and the operating hours. Sunday Monday Tuesday From to from from to from from to from							
10.00 Does this facility operate as other than a hospital-based RHC or FCHC? Enter "Y" for year. If year, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday	7. 00 OTTER (OF EOTT I)						7.00
yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operations)					1. 00	2. 00	
2 (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday						0	10.00
Nours. Sunday Monday Tuesday							
Sunday Monday Tuesday Tuesday From to From From to From From to From to From to From to From to From From to From From to From From to From From To From T	, ,	t other operat	ion(s) and the	operating			
From to from to from	[Hours.]	Sun	ndav	londay	Tuesday		
Facility hours of operations (1) 11.00 13:00 17:00 08:00 18:00 07:00 11.00 11.00 12.00 12.00 13:00 13:00 17:00 08:00 18:00 07:00 11.00 12.00 13:00 1							
11.00 CLINIC		1. 00	2.00	3.00	4. 00	5. 00	
1.00			1				
12.00 Have you received an approval for an exception to the productivity standard? 13.00 15 this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N	11. 00 CLINI C	13: 00	17: 00	08: 00	18: 00	07: 00	11.00
12.00 Have you received an approval for an exception to the productivity standard? 13.00 15 this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N					1.00	2.00	
13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below. Provider name CCN	12 00 Have you received an approval for an exception	on to the prod	uctivity stand	ard?		2.00	12 00
number of providers included in this report. List the names of all providers and numbers below. Provider name CCN 1.00 2.00						0	
Numbers below. Provider name CCN 1.00 2.00							
Provider name CCN 14.00 RHC/FQHC name, CCN 1.00 2.00 14.00 RHC/FQHC name, CCN 14.00		List the name	s of all provi	ders and			
1.00 2.00 14.00	numbers below.			Drovi	don nome	CCN	
14.00 RHC/FOHC name, CCN							
Y/N V XVIII XIX Total Visits	14.00 RHC/FOHC name. CCN				1. 00	2.00	14.00
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) County 4.00		Y/N	V	XVIII	XIX	Total Visits	
GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) County		1. 00	2. 00	3. 00	4. 00	5. 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) County 4.00 2.00 City, State, ZIP Code, County WHITE 2.00 Tuesday Wednesday Thursday to from to from to 6.00 7.00 8.00 9.00 10.00 Facility hours of operations (1)							15.00
4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) County 4.00 2.00 City, State, ZIP Code, County WHITE 2.00 Tuesday Wednesday to from from from from from from from fro							
Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) County 4.00 City, State, ZIP Code, County Tuesday WHITE 2.00 Tuesday To from from to from to from to from from from from from from from fro							
XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) County 4.00 City, State, ZIP Code, County Tuesday Wednesday To from to from to 6.00 7.00 8.00 9.00 10.00 Facility hours of operations (1)							
(see instructions)							
County 4.00 2.00 City, State, ZIP Code, County WHITE 2.00							
A. 00	(see instructions)			L			
Z. 00 Ci ty, State, ZIP Code, County WHITE Z. 00 Facility hours of operations (1) Tuesday Wednesday Thursday Thursday to from to from to 9.00 10.00							
Tuesday Wednesday Thursday to from to from to 6.00 7.00 8.00 9.00 10.00 Facility hours of operations (1)	2 00 City State 7LP Code County			00			2 00
to from to from to 6.00 7.00 8.00 9.00 10.00 Facility hours of operations (1)	2. 35 State, 211 South, Southly	Tuesdav		esday	Thur	sday	2.00
6.00 7.00 8.00 9.00 10.00 Facility hours of operations (1)							
11. 00 CLINIC 17: 00 08: 00 18: 00 08: 00 17: 00 11. 00			1				
	TT. 00 CLINIC	17:00	lns: 00	[18: 00	08: 00	17:00	11.00

Health Financial Systems	FERRELL H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CCN: 14-1324	Peri od:	Worksheet S-8	
				From 04/01/2022		
		Component	CCN: 14-8616	To 03/31/2023		
					8/31/2023 4:0	4 pm
				RHC III	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 00	17: 00	09: 00	17: 00		11.00

Health Financial Systems	FERRELL H	OSPI TAL		In Lie	u of Form CMS-	2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1324	Peri od:	Worksheet S-8	3		
		Component	CCN: 14-8627	From 04/01/2022 To 03/31/2023	Date/Time Pre 8/31/2023 4:0			
				RHC I V	Cost	уч рііі		
				1.	00			
Clinic Address and Identification 1.00 Street				250 SMALL STRE	СТ	1.00		
1.00 311 ee t		Ci	ty	State	ZIP Code	1.00		
			00	2.00	3. 00			
2.00 City, State, ZIP Code, County		HARRI SBURG		IL	62946	2.00		
					1 00			
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ento	or "D" for rur	al or "II" for	urhan		1.00	3.00		
3.00 HOSFITAL-BASED TUNES ONET. Designation - Ente	er K TOLTULA	ai 0i 0 10i		nt Award	Date	3.00		
			5. 4	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 Ac 6.00 Health Services for the Homeless (Section 340						5. 00 6. 00		
7.00 Appalachian Regional Commission	J(u), PH3 ACI)					7.00		
8. 00 Look-Alikes						8.00		
9.00 OTHER (SPECIFY)						9.00		
10 00 Doos this facility energies as other than a h	anital based [DUC on FOUCA F	nton "V" for	1. 00 N	2. 00	10.00		
yes or "N" for no in column 1. If yes, indica	yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating							
11041 5.1)	Sun	day	N	londay	Tuesday			
	from	to	from	to	from			
	1. 00	2. 00	3. 00	4. 00	5. 00			
Facility hours of operations (1) 11.00 CLINIC			08: 00	17: 00	00.00	11 00		
TI. 00 CLINIC			08: 00	17:00	08: 00	11.00		
				1. 00	2. 00			
12.00 Have you received an approval for an exception	on to the produ	uctivity stand	ard?	N		12.00		
13.00 Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columnumber of providers included in this report.	umn 1. If yes,	enter in colu	mn 2 the	N	C	13.00		
numbers below.			Prov	ider name	CCN			
				1. 00	2. 00			
14.00 RHC/FQHC name, CCN						14.00		
	Y/N	V	XVIII	XIX	Total Visits			
15 00 Have you provided all or substantially all	1. 00	2.00	3. 00	4.00	5. 00	15.00		
15.00 Have you provided all or substantially all 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)								
(See That detrois)		Cou	ınty					
			00					
2.00 City, State, ZIP Code, County		SALINE				2.00		
	Tuesday		esday T		sday			
	to	from	to	from	to			
Facility hours of operations (1)	6. 00	7. 00	8. 00	9. 00	10.00			
	17: 00	08: 00	17: 00	08: 00	17: 00	11.00		
1	'	•	•	· ·	•			

Health Financial Systems	FERRELL H	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1324	Peri od:	Worksheet S-8	}
		Component	CCN: 14-8627	From 04/01/2022 To 03/31/2023		
				RHC IV	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	12: 00				11. 00

OSPI 7	n Financial Systems FERRELL HOSPITA TAL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovi der CCN: 14-1324	Peri od:	u of Form CMS-2 Worksheet S-1					
0011	THE GROOM ENGRIED AND THE GERT GARLE BATTA	0V1 dc1 00N. 11 1021	From 04/01/2022						
			To 03/31/2023	Date/Time Pre 8/31/2023 4:0					
	Uncompensated and indigent care cost computation			1.00					
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by line 202 colu	umn 8)	0. 533113	1.				
00	Medicaid (see instructions for each line)	100 25 11110 202 001	<u></u>	0.000110	i				
00	Net revenue from Medicaid			2, 618, 308	2.				
00	Did you receive DSH or supplemental payments from Medicaid?								
00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?								
00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid 2,784,6								
00	Medicaid charges Medicaid cost (line 1 times line 6)			16, 919, 222 9, 019, 857					
00	Difference between net revenue and costs for Medicaid program (I	ine 7 minus sum of	ines 2 and 5 if	3, 617, 462	1				
00	< zero then enter zero)	THE TIME TO SAME OF	TITICS 2 drid 5, TT	3,017,402	0.				
00	Children's Health Insurance Program (CHIP) (see instructions for	each line)							
00	Net revenue from stand-alone CHIP Stand-alone CHIP charges			0	1				
1. 00				0					
2. 00	1	ine 11 minus line 9	if < zero then	Ö					
	enter zero)								
	Other state or local government indigent care program (see instr								
	Net revenue from state or local indigent care program (Not inclu			0					
. 00	Charges for patients covered under state or local indigent care 10)	program (Not include	ed in lines 6 or	0	14.				
5. 00)		0	15.				
	Difference between net revenue and costs for state or local indi		ine 15 minus line						
	13; if < zero then enter zero)]				
	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)	and state/local inc	digent care progra	ams (see					
7. 00	,	nding charity care		0	17.				
	Government grants, appropriations or transfers for support of ho			0					
9. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	indigent care progra	ams (sum of lines	3, 617, 462	19.				
	10 12 and 10)	Uni nsure		Total (col. 1					
		patients		+ col . 2)					
	Uncompensated Care (see instructions for each line)	1.00	2. 00	3. 00					
0. 00	Charity care charges and uninsured discounts for the entire faci	lity 1, 366,	069 0	1, 366, 069	20.				
	(see instructions)		0.0	700 0/0					
1. 00	Cost of patients approved for charity care and uninsured discour instructions)	nts (see 728,	269 0	728, 269	21.				
2. 00		off as	0 0	0	22.				
00	charity care	45							
3. 00	Cost of charity care (line 21 minus line 22)	728,	269 0	728, 269	23.				
				1. 00					
1. 00			th of stay limit	N	24.				
5. 00			ram's length of	0	25.				
. 00	stay limit Total bad debt expense for the entire hospital complex (see inst	tructions)		1, 307, 260	26.				
	·	*		340, 911					
	Medicare allowable bad debts for the entire hospital complex (se			524, 478					
				782, 782	1				
7. 01	Non-Medicare bad debt expense (see instructions)			102, 102	1 20.				
7. 00 7. 01 8. 00 9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	ense (see instruction	ns)	600, 878	29.				
7. 01 8. 00 9. 00 0. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	•	ns)	l	29. 30.				

Heal th	Financial Systems	FERRELL HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
					From 04/01/2022		
					To 03/31/2023	Date/Time Pre	
			2.1			8/31/2023 4:0	4 pm
	Cost Center Description	Sal ari es	Other	Total (col.		Recl assi fi ed	
				+ col . 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +-	
						col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FIXT		2, 480, 434	2, 480, 43		1, 123, 578	1. 00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - EFM BLD		0		0 82, 130	82, 130	1. 01
1.02	00102 CAP REL COSTS-BLDG & FIXT - NEW WIN		0		0 1, 920, 320	1, 920, 320	1. 02
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0		0 452, 861	452, 861	2.00
3.00	00300 OTHER CAP REL COSTS		0		0 0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	161, 642	4, 298, 498	4, 460, 14	0 -4, 454	4, 455, 686	4.00
5. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	521, 171	920, 376	1, 441, 54	7 27, 312	1, 468, 859	5. 01
5.02	00591 OTHER ADMIN AND GENERAL	660, 198	4, 250, 004	4, 910, 20	2 -266, 848	4, 643, 354	5. 02
6.00	00600 MAINTENANCE & REPAIRS	319, 198	904, 845			552, 528	6.00
7.00	00700 OPERATION OF PLANT	O	0		0 659, 043	659, 043	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	140	14		111, 143	8.00
9. 00	00900 HOUSEKEEPI NG	443, 467	225, 033	•	·	546, 344	9.00
10.00	01000 DI ETARY	303, 372	295, 411	598, 78		303, 469	10.00
11. 00	01100 CAFETERI A	0	2,0, 111		0 276, 556	276, 556	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	361, 676	61, 529	1		419, 945	13.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	166, 649	36, 647	203, 29		203, 256	16.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	548, 849			536, 905	19.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	340, 047	340, 04	7 11, 744	330, 703	17.00
30.00	03000 ADULTS & PEDI ATRI CS	2, 208, 710	1, 292, 269	3, 500, 97	9 -13, 663	3, 487, 316	30.00
00.00	ANCILLARY SERVICE COST CENTERS	2,200,710	1,2,2,20,	0,000,77	7 10,000	0, 107, 010	00.00
50.00	05000 OPERATING ROOM	655, 788	991, 822	1, 647, 61	0 -568, 744	1, 078, 866	50.00
53.00	05300 ANESTHESI OLOGY	0	771, 022		0 000,711	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	808, 034	961, 118			1, 721, 189	54.00
60.00	06000 LABORATORY	1, 059, 875	1, 894, 059		·	2, 088, 927	60.00
65. 00	06500 RESPI RATORY THERAPY	478, 796	105, 733			550, 044	65.00
66. 00	06600 PHYSI CAL THERAPY	470,770	1, 356, 844	1, 356, 84	·	1, 353, 971	66.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	4, 792			1, 808, 264	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	4, 7,72		0 155, 569	155, 569	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	220, 891	4, 085, 515			4, 230, 145	73.00
73.00	OUTPATIENT SERVICE COST CENTERS	220, 071	4,000,010	4, 300, 40	0 -70, 201	4, 230, 143	73.00
88. 00	08800 RURAL HEALTH CLINIC	5, 538, 146	1, 652, 353	7, 190, 49	9 -117, 169	7, 073, 330	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	1, 430, 959	142, 396		·	1, 563, 877	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	724, 593	107, 836			998, 499	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	498, 449	101, 803		·	600, 252	88. 03
90.00	09000 CLINIC	82, 758	174, 138			256, 210	90.00
90.00	09001 CLINIC - MCLEANSBORO	166, 047				250, 210	90.00
90.01	09001 CLINIC - WCLEANSBORD	100, 047	23 179			0	90.01
90. 02	09002 CLINIC - CHF	111, 147	290, 125	•			90.02
90.03	09100 EMERGENCY	970, 456		•	·	398, 986	90.03
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	970, 456	1, 223, 450	2, 193, 90	6 -166, 802	2, 027, 104	91.00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
112 00		T	1 EOE 412	1 505 41	2 050 202	4EE 120	112 00
113.00	11300 INTEREST EXPENSE	17 000 000	1, 505, 413 29, 911, 634			655, 130	
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	17, 892, 022	29, 911, 634	47, 803, 65	0 0	47, 803, 656	1118.00
100.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ما	^		ol ol		190. 00
	19000 BIFI, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0	1	0 0		190.00
200.00	1 1	17, 892, 022	29, 911, 634			47, 803, 656	
200.00	TOTAL (SOM OF LINES TO UITOUGH 199)	11,072,022	27, 711, 034	1 47,003,03	ν _l ν	47,003,030	200.00

 Health Financial
 Systems
 FERREL

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN: 14-1324

			8/31/2023 4: 04 p	m
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
		Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 OO100 CAP REL COSTS-BLDG & FLXT	0	1, 123, 578	1	1.00
1.01 00101 CAP REL COSTS-BLDG & FLXT - EFM BLD	0	82, 130	1	1. 01
1.02 O0102 CAP REL COSTS-BLDG & FIXT - NEW WIN	ol	1, 920, 320	1	1. 02
2.00 00200 CAP REL COSTS-MVBLE EQUIP	o	452, 861	2	2. 00
3.00 00300 OTHER CAP REL COSTS	l ol	0		3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 273, 959	5, 729, 645	4	4. 00
5. 01 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	915	1, 469, 774		5. 01
5. 02 00591 OTHER ADMIN AND GENERAL	1, 236, 422	5, 879, 776		5. 02
6. 00 00600 MAINTENANCE & REPAIRS	0	552, 528		5. 00
7. 00 00700 OPERATION OF PLANT	412, 482	1, 071, 525		7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	111, 143		3. 00
9. 00 00900 HOUSEKEEPI NG	180, 403	726, 747		9. 00
10. 00 01000 DI ETARY	92, 718	396, 187	l e). 00). 00
11. 00 01100 CAFETERI A				1. 00
	-87, 368	189, 188		
13. 00 01300 NURSI NG ADMI NI STRATI ON	48, 968	468, 913		3.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-13, 944	189, 312		5.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	536, 905		9. 00
INPATIENT ROUTINE SERVICE COST CENTERS	000 075	0.745.504		
30. 00 03000 ADULTS & PEDIATRICS	228, 275	3, 715, 591		0. 00
ANCILLARY SERVICE COST CENTERS		4 070 044		
50. 00 05000 OPERATING ROOM	0	1, 078, 866	<u> </u>	0.00
53. 00 05300 ANESTHESI OLOGY	0	0	<u> </u>	3.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-1, 791	1, 719, 398		4. 00
60. 00 06000 LABORATORY	0	2, 088, 927	<u> </u>	0.00
65. 00 06500 RESPI RATORY THERAPY	0	550, 044	I	5. 00
66. 00 06600 PHYSI CAL THERAPY	0	1, 353, 971		5. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 808, 264	I	1.00
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS	0	155, 569		2. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	5, 589	4, 235, 734	73	3. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	800, 722	7, 874, 052		3. 00
88.01 08801 RURAL HEALTH CLINIC II	173, 283	1, 737, 160		3. 01
88.02 08802 RURAL HEALTH CLINIC III	88, 038	1, 086, 537	88	3. 02
88.03 08803 RURAL HEALTH CLINIC IV	0	600, 252	88	3. 03
90. 00 09000 CLI NI C	0	256, 210	90	0. 00
90. 01 09001 CLINIC - MCLEANSBORO	0	0	90	0. 01
90. 02 09002 CLI NI C - CHF	o	0	90	0. 02
90. 03 09003 CLINIC - ORTHO	ol	398, 986	90	0. 03
91. 00 09100 EMERGENCY	l ol	2, 027, 104	91	1.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		, , , , ,		2. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 NTEREST EXPENSE	-655, 130	0	113	3. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 783, 541	51, 587, 197		3. 00
NONREI MBURSABLE COST CENTERS		,,,		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	190	0. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	l ol	0	<u> </u>	2. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	3, 783, 541	51, 587, 197	<u> </u>	0.00
200.00 TOTAL (Som of Lines for this digit 177)	0, 700, 041	31, 337, 177	1200	00

| Peri od: | Worksheet A-6 | From 04/01/2022 | To 03/31/2023 | Date/Time Prepared:

					10 03/3	1/2023 Date/lime Prepared: 8/31/2023 4:04 pm
		Increases			, , , , , , , , , , , , , , , , , , ,	1 0, 0 1, 2020 11 0 1 511
	Cost Center	Li ne #	Sal ary	Other		
	2. 00 A - DEPRECIATION	3. 00	4. 00	5. 00		
1. 00	CAP REL COSTS-BLDG & FIXT -	1. 02	0	1, 920, 320		1.00
1.00	NEW WIN	1.02		1, 720, 320		1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0	35 <u>7, 7</u> 98		2.00
	TOTALS		0	2, 278, 118		
1 00	C - IMPLANT EXPENSE IMPL. DEV. CHARGED TO	72. 00	o	155 540		1.00
1. 00	PATIENTS	72.00	U	155, 569		1.00
	TOTALS	+		155, 569		
	D - MEDICAL SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00		1, 905, 848		1.00
2. 00	PATI ENT	0. 00		0		2.00
3. 00		0.00	0	0		2.00
4. 00		0. 00	ő	Ö		4.00
5.00		0.00	O	0		5. 00
6.00		0. 00	0	0		6.00
7.00		0.00	0	0		7.00
8. 00 9. 00	1	0. 00 0. 00	0	0		8. 00 9. 00
10. 00		0.00	0	0		10.00
11. 00		0.00	O	0		11.00
12.00		0.00	0	0		12.00
13.00		0. 00	0	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0.00	0	0		16.00
17. 00		0.00	o	0		17. 00
18.00		0.00	0	0		18. 00
19.00		0.00	0	0		19.00
20. 00	TOTAL C — — — —	0.00		0		20.00
	TOTALS E - OXYGEN EXPENSE		U _I	1, 905, 848		
1. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	53, 193		1.00
	PATI ENT			22, 113		
2. 00		0. 00	0	0		2.00
3.00		0.00	0	0		3.00
4. 00	TOTALS — — — —			53, 193		4.00
	F - PLANT OPERATIONS		<u> </u>	33, 173		
1.00	OPERATION OF PLANT		0	659, 043		1.00
	TOTALS		0	659, 043		
1 00	G - PROPERTY TAXES	1 00	ما	7, 711		1.00
1. 00	CAP REL COSTS-BLDG & FLXT TOTALS		0	$- \frac{7,711}{7,711}$		1.00
	H - CAFETERIA		<u> </u>	7, 711		
1.00	CAFETERI A	11. 00	144, 648	131, 908		1.00
	TOTALS		144, 648	131, 908		
1 00	I - HOSPITALIST	22.00	ما	00.057		1.00
1. 00	ADULTS & PEDIATRICS TOTALS	3000		9 <u>0, 3</u> 57 90, 357		1.00
	J - PROPERTY INSURANCE		<u> </u>	70, 337		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	57, 226		1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0	<u>95, 0</u> 63		2.00
	TOTALS		0	152, 289		
1. 00	K - RHC BUSINESS OFFICE CASHI ERING/ACCOUNTS	5. 01	11, 198	23, 841		1.00
1.00	RECEI VABLE	5.01	11, 170	23, 641		1.00
	TOTALS		11, 198	23, 841		
	L - EFM BUILDING RENT					
1.00	CAP REL COSTS-BLDG & FLXT	1.00	0	13, 753		1.00
2. 00	CAP REL COSTS-BLDG & FIXT - EFM BLD	1. 01	0	82, 130		2.00
3. 00	LI WI DED	0. 00	o	О		3.00
50	TOTALS — — — —		0	95, 883		3.00
	M - CLINIC - MCLEANSBORO					
1.00	RURAL HEALTH CLINIC III		166, 047			1.00
	TOTALS N - INTEREST EXPENSE		166, 047	23		
1. 00	CAP REL COSTS-BLDG & FIXT	1. 00	0	842, 572		1.00
55	TOTALS	— — ° 5		842, 572		
		'				'

Heal th	Financial Systems		FERRELL	HOSPI TAL		In Lie	u of Form CMS	2552-10
RECLASS	SI FI CATI ONS			Provi der (CCN: 14-1324	Peri od:	Worksheet A-	6
						From 04/01/2022 To 03/31/2023	Date/Time Pr 8/31/2023 4:	epared: 04 pm
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3.00	4. 00	5. 00				
	O - CLINIC CHF							
1.00	OTHER ADMIN AND GENERAL	5. 02	0	179				1.00
	TOTALS		0	179				
	P - HOUESEKEEPI NG							1
1.00	LAUNDRY & LINEN SERVICE	8. 00	0	111, 003				1.00
	TOTALS — — — — —	- $ T$	₀	111, 003				
500.00	Grand Total: Increases		321, 893	6, 507, 537				500.00

Provider CCN: 14-1324

Peri od: Worksheet A-6 From 04/01/2022 To 03/31/2023 Date/Time Prepared: 8/31/2023 4:04 pm

						8/31/2023 4: 04	4 pm
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	A - DEPRECIATION	7. 00	8. 00	9. 00	10. 00		
1. 00	CAP REL COSTS-BLDG & FLXT	1. 00	0	2, 278, 118	9		1. 00
2. 00	CAI REE COSTS-BEDG & TTAT	0. 00	0	2, 270, 110	9		2. 00
2.00	TOTALS — — — —			0 2, 278, 118			2.00
	C - IMPLANT EXPENSE		<u> </u>	2,270,110			
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	155, 569	0		1. 00
	PATI ENT	, 55		100,007	٩		00
	TOTALS			155, 569			
	D - MEDICAL SUPPLY	<u>'</u>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	4, 454	0		1.00
2.00	CASHI ERI NG/ACCOUNTS	5. 01	o	7, 727	0		2.00
	RECEI VABLE						
3.00	OTHER ADMIN AND GENERAL	5. 02	0	110, 463	0		3.00
4.00	MAINTENANCE & REPAIRS	6. 00	0	12, 472	0		4.00
	HOUSEKEEPI NG	9. 00	0	11, 153	0		5.00
	DI ETARY	10. 00	0	18, 758	0		6. 00
	NURSING ADMINISTRATION	13. 00	0	3, 260	0		7. 00
8. 00	MEDICAL RECORDS & LIBRARY	16. 00	0	40	0		8. 00
	NONPHYSICIAN ANESTHETISTS	19. 00	0	11, 944	0		9. 00
	ADULTS & PEDI ATRI CS	30. 00	0	78, 829	0		10.00
	OPERATI NG ROOM	50.00	0	564, 938	0		11.00
	RADI OLOGY-DI AGNOSTI C	54.00	0	47, 963	0		12.00
13.00	LABORATORY THERAPY	60.00	0	863, 785	0		13.00
	RESPI RATORY THERAPY	65. 00	-	11, 511	-		14.00
	PHYSI CAL THERAPY	66.00	0	2, 873	0		15.00
	DRUGS CHARGED TO PATIENTS	73. 00 90. 00	0	76, 261 686	0		16. 00 17. 00
	CLINIC - ORTHO	90.00	0		0		18.00
			0	2, 286	0		
	EMERGENCY	91. 00	٩	76, 445	0		19.00
20. 00	TOTALS	+		1 005 040	— — — 4		20. 00
	E - OXYGEN EXPENSE		U_	1, 905, 848			
1. 00	ADULTS & PEDIATRICS	30.00	0	25, 191	0		1. 00
2. 00	OPERATING ROOM	50.00	0	3, 806			2. 00
3. 00	LABORATORY	60.00	0	1, 222	0		3.00
4. 00	RESPI RATORY THERAPY	65. 00	0	22, 974	0		4. 00
4.00	TOTALS			53, 193	— — — 4		4.00
	F - PLANT OPERATIONS		<u> </u>	33, 173			
1. 00	MAINTENANCE & REPAIRS	6. 00	0	659, 043	0		1. 00
1.00	TOTALS		— — ў	659, 043	— — —		1.00
	G - PROPERTY TAXES		<u> </u>	3077 313			
1.00	INTEREST EXPENSE	113. 00	0	7, 711	13		1.00
	TOTALS			7, 711			
	H - CAFETERIA		-,	,			
1.00	DI ETARY	10.00	144, 648	131, 908	0		1.00
	TOTALS		144, 648	131, 908			
	I - HOSPI TALI ST			·			
1.00	EMERGENCY	91.00	0	90, 357	0		1.00
	TOTALS			90, 357			
	J - PROPERTY INSURANCE						
1.00	OTHER ADMIN AND GENERAL	5. 02	0	152, 289	12		1.00
2.00		0. 00	0	0	12		2.00
	TOTALS		0	152, 289			
	K - RHC BUSINESS OFFICE						
1. 00	RURAL HEALTH CLINIC	8800	11, 198	<u>23, 8</u> 41			1. 00
	TOTALS		11, 198	23, 841			
	L - EFM BUILDING RENT						
1.00	OTHER ADMIN AND GENERAL	5. 02	0	4, 275			1.00
	RURAL HEALTH CLINIC	88. 00	0	82, 130			2.00
3. 00	RURAL HEALTH CLINIC II	<u> </u>	•	<u>9, 4</u> 78	0		3. 00
	TOTALS		0	95, 883			
	M - CLINIC - MCLEANSBORO						
1. 00	CLINIC - MCLEANSBORO	<u>90.</u> 01	166, 047	23			1. 00
	TOTALS		166, 047	23			
	N - INTEREST EXPENSE	440.00	al	0.40 570			
1. 00	INTEREST EXPENSE	113.00	•	<u>842, 5</u> 72	11		1. 00
	TOTALS		0	842, 572			
1 00	O - CLINIC CHF	00.00	01	470	<u></u>		4 00
1. 00	CLINIC - CHF	90.02					1. 00
	TOTALS		0	179			
	P - HOUESEKEEPI NG HOUSEKEEPI NG	9. 00	ما	111 000			1 00
1 00	IBI II I NEK E E PI INI.	9 (10)	Ol	111, 003	0		1.00
1. 00		— — /. °° +	+				
	TOTALS Grand Total: Decreases		321, 893	111, 003 6, 507, 537			500. 00

Period: Worksheet A-7
From 04/01/2022 Part I Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS FERRELL HOSPITAL Provider CCN: 14-1324

					Го 03/31/2023	Date/Time Pre 8/31/2023 4:0	pared: 4 pm
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	188, 327	10, 000	(10, 000	0	1.00
2.00	Land Improvements	0	0	(0	0	2.00
3.00	Buildings and Fixtures	16, 588, 695	1, 923, 882	(1, 923, 882	0	3.00
4.00	Building Improvements	0	0	(0	0	4.00
5.00	Fixed Equipment	0	0	(0	0	5.00
6.00	Movable Equipment	28, 979, 662	521, 086		521, 086	0	6.00
7.00	HIT designated Assets	1, 581, 457	0		0	0	7.00
8.00	Subtotal (sum of lines 1-7)	47, 338, 141	2, 454, 968		2, 454, 968	0	8.00
9.00	Reconciling Items	0	0	(0	0	9.00
10.00	Total (line 8 minus line 9)	47, 338, 141	2, 454, 968	(2, 454, 968	0	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	198, 327	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	18, 512, 577	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	29, 500, 748	0				6.00
7.00	HIT designated Assets	1, 581, 457	0				7.00
8.00	Subtotal (sum of lines 1-7)	49, 793, 109	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	49, 793, 109	0				10. 00

Heal th	n Financial Systems	FERRELL H	OSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 14-1324	Peri od: From 04/01/2022 To 03/31/2023		
					10 00/01/2020	8/31/2023 4:0	
			Sl	JMMARY OF CAF	PLTAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
		0.00	10.00	11 00	instructions)	12.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	9.00	10.00	11.00 and 2	12. 00	13.00	
1. 00	CAP REL COSTS-BLDG & FLXT	2, 480, 434	· ·	110 2	0 0	0	1.00
1. 01	CAP REL COSTS-BLDG & FIXT - EFM BLD	2, 100, 101	0		0 0	0	1.01
1. 02	CAP REL COSTS-BLDG & FIXT - NEW WIN	0	0		0 0	Ō	1. 02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	2, 480, 434	0		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1)				
		Capital-Related Costs (see					
		instructions)	9 till ough 14)				
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	2, 480, 434				1.00
1.01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0				1. 01
1. 02	CAP REL COSTS-BLDG & FIXT - NEW WIN	0	0				1. 02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3. 00	Total (sum of lines 1-2)	0	2, 480, 434	l			3. 00

Heal th	Financial Systems	FERRELL H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	F	Period: From 04/01/2022 To 03/31/2023	Worksheet A-7 Part III Date/Time Pre 8/31/2023 4:04	pared:
		COMF	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1. 00 1. 01	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT - EFM BLD	18, 710, 904 0	0	C	0. 000000	0	1. 00 1. 01
1. 02	CAP REL COSTS-BLDG & FIXT - NEW WIN	31, 082, 205	0	31, 082, 205		0	1. 02
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	49, 793, 109	0	49, 793, 109	0. 000000 1. 000000	0	2. 00 3. 00
3.00	Total (Suil Of Titles 1-2)		TION OF OTHER (F CAPI TAL	3.00
	Cost Center Description	Taxes	Other Capi tal -Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0		202, 316	13, 753	1.00
1. 01 1. 02	CAP REL COSTS-BLDG & FIXT - EFM BLD CAP REL COSTS-BLDG & FIXT - NEW WIN	0	0		1, 920, 320	82, 130 0	1. 01 1. 02
2. 00	CAP REL COSTS-BLDG & FIXT - NEW WIN	0	0		357, 798		2. 00
3. 00	Total (sum of lines 1-2)	0	0		2, 480, 434	95, 883	3. 00
			Sl	IMMARY OF CAPI		.,	
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see instructions)	instructions)	Capital-Related Costs (see instructions)		
		11. 00	12. 00	13.00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C				"		
1.00	CAP REL COSTS-BLDG & FLXT	842, 572	57, 226			1, 123, 578	1.00
1. 01	CAP REL COSTS-BLDG & FIXT - EFM BLD	0	0	C	-	82, 130	1. 01
1. 02	CAP REL COSTS BLDG & FIXT - NEW WIN	0	0 05 040		0	1, 920, 320	1. 02
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	842, 572	95, 063 152, 289		0	452, 861 3, 578, 889	2. 00 3. 00
3.00	10tal (3uiii 01 111165 1-2)	042, 372	152, 209	1,711	0	3, 370, 009	3.00

					From 04/01/2022 To 03/31/2023		
				Expense Classification or	Worksheet A	8/31/2023 4:0	4 pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
1. 00	Investment income - CAP REL	1. 00	2. 00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00	5. 00 0	1.00
4 04	COSTS-BLDG & FLXT (chapter 2)			CAR DEL COCTO DI DO A FLYT	1 01	0	4 04
1. 01	Investment income - CAP REL COSTS-BLDG & FIXT - EFM BLD		0	CAP REL COSTS-BLDG & FIXT - EFM BLD	1.01	0	1. 01
1 00	(chapter 2)			CAR DEL COCTO DI DO A FLYT	1 00	0	1 00
1. 02	Investment income - CAP REL COSTS-BLDG & FIXT - NEW WIN			CAP REL COSTS-BLDG & FIXT - NEW WIN	1. 02	0	1. 02
2. 00	(chapter 2)			CAD DEL COSTS MUDIE EQUID	2.00	0	2. 00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2.00	Ü	2.00
3.00	Investment income - other (chapter 2)	В	-92, 905	INTEREST EXPENSE	113. 00	0	3. 00
4.00	Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of	В	_84_835	DRUGS CHARGED TO PATIENTS	73. 00	0	5. 00
	expenses (chapter 8)	В	-04, 033	DIGGS CHARGED TO FATTENTS			
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Tel ephone servi ces (pay	Α	-1, 137	OTHER ADMIN AND GENERAL	5. 02	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service	Α	-18, 346	OTHER ADMIN AND GENERAL	5. 02	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provi der-based physician	A-8-2	-1, 791			0	10.00
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11. 00
	(chapter 23)		4 050 450				
12. 00	Related organization transactions (chapter 10)	A-8-1	4, 853, 153			0	12.00
13.00	1 3	D	07.200	CAFETERIA	0.00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee			CAFETERIA RURAL HEALTH CLINIC	11. 00 88. 00	0	
17 00	and others				0.00	0	14 00
16. 00	Sale of medical and surgical supplies to other than				0.00	Ü	16. 00
17 00	patients Sale of drugs to other than		0		0.00	0	17. 00
	pati ents						
18. 00	Sale of medical records and abstracts	В	-13, 944	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
20.00	Vending machines		0		0.00	0	
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00
22.00	charges (chapter 21)				0.00	0	22.00
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
22.00	repay Medicare overpayments	A-8-3		RESPI RATORY THERAPY	65. 00		23. 00
23.00	Adjustment for respiratory therapy costs in excess of	A-0-3		RESPIRATORY THERAPY	65.00		23.00
24 00	limitation (chapter 14) Adjustment for physical	A-8-3		PHYSI CAL THERAPY	66. 00		24. 00
∠4. UU	therapy costs in excess of	M-0-3		THISTORE HIERAFT	66.00		∠4.00
25 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
25.00	physicians' compensation			Jost Jenter Dereteu	114.00		25.00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
	COSTS-BLDG & FLXT						
26. 01	Depreciation - CAP REL COSTS-BLDG & FIXT - EFM BLD		0	CAP REL COSTS-BLDG & FIXT - EFM BLD	1. 01	0	26. 01
26. 02	Depreciation - CAP REL			CAP REL COSTS-BLDG & FIXT -	1. 02	0	26. 02
	COSTS-BLDG & FIXT - NEW WIN		I	NEW WIN			

	Financial Systems		FERRELL F			u of Form CMS-	
ADJUST	MENTS TO EXPENSES				Peri od: From 04/01/2022	Worksheet A-8	3
					To 03/31/2023		pared:
						8/31/2023 4:0	
				Expense Classification o			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2.00	3, 00	4.00	Ref. 5.00	
27. 00	Depreciation - CAP REL	1.00	2. 00	CAP REL COSTS-MVBLE EQUIP	4.00	5.00	27.00
27.00	COSTS-MVBLE EQUIP			CAP REL COSTS-WVBLE EQUIP	2.00	0	27.00
28. 00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28.00
29. 00	Physicians' assistant		0		0.00	l .	
30.00	Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***			30.00
	therapy costs in excess of						
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)		_	l			
31. 00		A-8-3	0	*** Cost Center Deleted ***	68. 00		31.00
	pathology costs in excess of limitation (chapter 14)						
32 00	CAH HIT Adjustment for		0		0.00	0	32.00
32.00	Depreciation and Interest				0.00	Ĭ	32.00
33.00	LOBBYING DUES	Α	-12, 082	OTHER ADMIN AND GENERAL	5. 02	0	33.00
33. 01	PROVIDER TAX OFFSET	Α	-562, 225	INTEREST EXPENSE	113. 00	0	33. 01
33. 02	CARMI CLINIC MISC REVENUE	В	1	RURAL HEALTH CLINIC II	88. 01	0	33. 02
33. 04		В		OTHER ADMIN AND GENERAL	5. 02		33.04
33. 05	340B OFFSET	Α		DRUGS CHARGED TO PATIENTS	73. 00		33.05
33. 06	NON ALLOWABLE ADVERTISING -	Α	-44, 639	OTHER ADMIN AND GENERAL	5. 02	0	33.06
33. 07	A&G	В	015	CASHLEDI NC /ACCOUNTS	F 01	0	22 07
33.07	DONATIONS	B		CASHI ERI NG/ACCOUNTS RECEI VABLE	5. 01		33. 07
33. 08	A&G MISC INCOME	В	1	OTHER ADMIN AND GENERAL	5. 02	1	33.08
50.00	TOTAL (sum of lines 1 thru 49)		3, 783, 541	l .	3.02	١	50.00
50. 00	(Transfer to Worksheet A,		0, 700, 041				55.50
	column 6 line 200)						

column 6, line 200.)

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

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 14-1324 Peri od: From 04/01/2022 OFFICE COSTS

03/31/2023 Date/Time Prepared: 8/31/2023 4:04 pm

					0/31/2023 4.0	4 pili
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANI ZATI ONS OF	R CLAIMED HOME	
	OFFICE COSTS:					
1.00		EMPLOYEE BENEFITS DEPARTMENT	DHS - HR/EMPLOYEE BENEFITS	1, 273, 959	0	1.00
2.00	5. 02	OTHER ADMIN AND GENERAL	DHS - A&G	2, 116, 371	814, 818	2.00
3.00	7.00	OPERATION OF PLANT	DHS - OPERATION PLANT	412, 482	0	3.00
3. 01	9.00	HOUSEKEEPI NG	DHS - HOUSEKEEPING	180, 403	0	3. 01
4.00	10.00	DI ETARY	DHS - DIETARY	92, 718	0	4.00
4. 01	13. 00	NURSING ADMINISTRATION	DHS - NURSING ADMIN	48, 968	0	4.01
4.02	73. 00	DRUGS CHARGED TO PATIENTS	DHS - PHARMACY	271, 516	0	4.02
4.03	30.00	ADULTS & PEDIATRICS	DHS - CASE MANAGEMENT	228, 275	0	4.03
4.04	88. 00	RURAL HEALTH CLINIC	DHS - EL DORADO	46, 512	0	4.04
4. 05	88. 01	RURAL HEALTH CLINIC II	DHS - CARMI	172, 571	0	4.05
4.06	88. 00	RURAL HEALTH CLINIC	DHS - FERRELL FAMILY	715, 190	0	4.06
4.07	88. 02	RURAL HEALTH CLINIC III	DHS - MCLEANSBORO	88, 038	0	4.07
4. 08	5. 02	OTHER ADMIN AND GENERAL	DHS - RHC BUSINESS OFFICE	20, 968	0	4.08
5.00	TOTALS (sum of lines 1-4).			5, 667, 971	814, 818	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

 p			iodi a be i nai catca i ii coi aiiii	i oi tiii o pai ti	
			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELATE	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	0.00 DEACONESS HLTH 0.00	6.00
7.00	В	0.00 DEACONESS HOSP 0.00	7.00
8.00	В	0.00 DRHS 1L 0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (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.
- F. 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 appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

4.07

4.08

5.00

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

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

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

6. 00	6.00
7.00	7.00
8. 00	8.00
9. 00	9.00
10.00	10.00
7. 00 8. 00 9. 00 10. 00 100. 00	100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

0

0

4.07

4.08

5.00

88,038

20, 968

4, 853, 153

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

Provider CCN: 14-1324

Peri od: Worksheet A-8-2 From 04/01/2022 To 03/31/2023 Date/Time Prepared:

						10 03/31/202	8/31/2023 4:0	
	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	30.00	ADULTS & PEDIATRICS	70, 861	0	70, 861	C	0	1.00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	1, 791	1, 791	0	C	0	2. 00
3.00	91. 00	EMERGENCY	1, 072, 386	0	1, 072, 386	C	0	3. 00
4.00	0.00		0	0	0	l c	o	4.00
5.00	0.00		0	0	0	l c	o	5. 00
6.00	0.00		0	0	0	l c	0	6. 00
7. 00	0.00		0	0	0	l c	o	7. 00
8. 00	0.00		0	0	0	l c	o	8. 00
9. 00	0.00		0	0	0	l c	o	9. 00
10.00	0.00		0	0	0	l c	o	10.00
200.00			1, 145, 038	1, 791	1, 143, 247		0	1
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Continuing	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14.00	
1. 00	30.00	ADULTS & PEDIATRICS	0	0	0	C	0	1. 00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	C	0	2. 00
3.00	91. 00	EMERGENCY	0	0	0	l c	0	3.00
4.00	0.00		0	0	0	l c	0	4.00
5.00	0.00		0	0	0	l c	0	5. 00
6.00	0.00		0	0	0	l c	o	6. 00
7. 00	0.00		0	0	0	l c	o	7. 00
8. 00	0. 00		0	0	0		o	8. 00
9. 00	0. 00		0	0	0		o	9. 00
10.00	0.00	MI.	0	0	0		o	10.00
200.00			0	0	0	l c	o	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance	.,		
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00	30.00	ADULTS & PEDIATRICS	0	0	0	C		1. 00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	1, 791		2. 00
3.00	91.00	EMERGENCY	0	0	0	C		3.00
4.00	0.00		0	0	0	l c		4.00
5.00	0.00		0	0	0	l c		5. 00
6.00	0.00		0	0	0	l c		6. 00
7. 00	0.00		0	0	0	l c		7. 00
8. 00	0.00		1 0	0		l d		8.00
9. 00	0.00		0	Ō	0	ĺ		9. 00
10.00	0.00		0	Ō	0	l c		10.00
200.00			0			1, 791		200.00
	ı	I .	1	1	'	.,,,,	1	

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der Co	CN: 14-1324	Period: From 04/01/2022	Worksheet A-8 Parts I-VI	-3
OUISIL	E SUPPLIERS				To 03/31/2023		
					Physi cal Therapy		'
	PART I - GENERAL INFORMATION					1. 00	
1. 00	Total number of weeks worked (excluding aide	s) (see instruct	i ons)			52	1.00
2. 00 3. 00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervi	ear ar tharaniet	was on provi	dar sita (sa	a instructions)	780 0	2. 00 3. 00
4. 00	Number of unduplicated days in which therapy	assistant was c				Ö	4.00
5. 00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - supe		unists (see iu	nstructions)		o	5.0
5. 00	Number of unduplicated offsite visits - ther	apy assistants (include only	visits made		Ö	6.0
	assistant and on which supervisor and/or the instructions)	rapist was not p	resent durinç	g the visit(s)) (see		
7. 00	Standard travel expense rate					0.00	7. C
3. 00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	0.00 Trai nees	8.0
	I=	1. 00	2. 00	3. 00	4. 00	5. 00	
9. 00 10. 00	Total hours worked AHSEA (see instructions)	143. 00 120. 25	3, 223. 00 89. 07	5, 289. 66.		0. 00 0. 00	9. 0 10. 0
11.00	Standard travel allowance (columns 1 and 2,	44. 54	44. 54	33.			11.0
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	0	0		0		12.0
12. 01 13. 00	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12. C
13. 01	Number of miles driven (offsite)	0	0		0		13.0
						1. 00	
4 00	Part II - SALARY EQUIVALENCY COMPUTATION	Line 10)				17, 196	14 (
4. 00 5. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2,					287, 073	
6.00	Assistants (column 3, line 9 times column 3,		ataru tharan	on lines 1	1 1/ for all	353, 305	
7. 00	Subtotal allowance amount (sum of lines 14 a others)	na is for respir	atory therapy	y or rines r	+-10 101 all	657, 574	17. (
8. 00 9. 00	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l					0	18. 0 19. 0
20.00	Total allowance amount (sum of lines 17-19 f		herapy or lin	nes 17 and 18	3 for all others)	657, 574	20.0
	If the sum of columns 1 and 2 for respirator occupational therapy, line 9, is greater that						
	amount from line 20. Otherwise complete line	es 21-23.					
21. 00	Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3,			um of columns	s 1 and 2, line 9	0.00	21.0
2. 00	Weighted allowance excluding aides and train					0	22.0
23. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO	WANCE AND TRAVEL	EXPENSE COMP	PUTATION - PI	ROVIDER SITE	657, 574	23.0
	Standard Travel Allowance						
4. 00 5. 00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					0	24. (25. (
6.00	Subtotal (line 24 for respiratory therapy or				2 4	0	26.0
27. 00	Standard travel expense (line 7 times line 3 others)	for respiratory	therapy or s	sum or irnes	3 and 4 for all	0	27. (
8. 00	Total standard travel allowance and standard	travel expense	at the provi	der site (sur	n of lines 26 and	0	28.0
	27) Optional Travel Allowance and Optional Trave	I Expense					
9.00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3		12, line 12))		0	29. (30. (
1. 00	Subtotal (line 29 for respiratory therapy or		and 30 for a	all others)		ő	31. (
2. 00	Optional travel expense (line 8 times column columns 1-3, line 13 for all others)	s 1 and 2, line	13 for respin	ratory thera	by or sum of	0	32.0
3. 00	Standard travel allowance and standard trave					0	33.0
4. 00 5. 00	Optional travel allowance and standard trave Optional travel allowance and optional trave					0	34. 0 35. 0
2. 00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW				RVICES OUTSIDE PR		33.0
6. 00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36.0
37. 00	Assistants (line 6 times column 3, line 11)					0	37.0
88.00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su	m of lines 5 and	1.6)			0	38. 0 39. 0
, ,	Optional Travel Allowance and Optional Trave		. 0)				
0.00	Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times column		2, line 10)	·		0	40. 0 41. 0
1. 00 2. 00	Subtotal (sum of lines 40 and 41)	3, TITIE 10 <i>)</i>				0	41.0
3. 00	Optional travel expense (line 8 times the su Total Travel Allowance and Travel Expense - (Lowing throatin	0 es 11 15 or	43. (
	rotal fraver Arrowance and fraver Expense - 1	or ionice out vices	, complete of	I OI LINE I OI	. Jwing tiller III	UU TT, 4U, UI	

44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)
45.00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)

0 44.00 0 45.00

	BLE COST DETERMINATION FOR THERAPY SERVICES SUPPLIERS	FURNI SHED BY	Provi der CO		Peri od: From 04/01/2022 To 03/31/2023	8/31/2023 4:0	pared:
					Physical Therapy	Cost	
						1. 00	
5.00 0	ptional travel allowance and optional travel						46.00
			Assistants	Ai des	Trai nees	Total	
D	ART V - OVERTIME COMPUTATION	1. 00	2. 00	3. 00	4. 00	5. 00	
	vertime hours worked during reporting	0.00	0.00	0. (0.00	0.00	47.00
	eriod (if column 5, line 47, is zero or	0.00	0.00	0.	0.00	0.00	47.00
e	qual to or greater than 2,080, do not						
	omplete lines 48-55 and enter zero in each						
	olumn of line 56)	0.00	0.00	0	0.00		40.0
	vertime rate (see instructions) otal overtime (including base and overtime	0. 00 0. 00	0. 00 0. 00				48.00
	llowance) (multiply line 47 times line 48)	0.00	0.00	0. 1	0.00		49.0
	ALCULATION OF LIMIT						1
	ercentage of overtime hours by category	0.00	0.00	0.	0.00	0.00	50.00
(divide the hours in each column on line 47						
	y the total overtime worked - column 5,						
	ine 47)	0.00					
	Illocation of provider's standard work year	0. 00	0. 00	0. (0.00	0.00	51.0
	or one full-time employee times the ercentages on line 50) (see instructions)						
	ETERMINATION OF OVERTIME ALLOWANCE						1
	djusted hourly salary equivalency amount	89. 07	66. 80	0.	0.00		52.0
(see instructions)						
. 00 0	vertime cost limitation (line 51 times line	0	0		0		53.0
1	2)						
	aximum overtime cost (enter the lesser of	0	0		0		54.0
	ine 49 or line 53) ortion of overtime already included in		0		0 0		55.0
	ourly computation at the AHSEA (multiply	٩	U		0		35.0
	ine 47 times line 52)						
	vertime allowance (line 54 minus line 55 -	o	0		0 0	0	56.0
	f negative enter zero) (Enter in column 5						
	he sum of columns 1, 3, and 4 for						
	espiratory therapy and columns 1 through 3						
T	or all others.)						
						1. 00	
Pa	art VI - COMPUTATION OF THERAPY LIMITATION A	AND EXCESS COST	ADJUSTMENT			11.00	
	alary equivalency amount (from line 23)					657, 574	57.0
	ravel allowance and expense - provider site					0	58.0
	ravel allowance and expense - Offsite service	ces (from lines	44, 45, or 46	5)		0	59.0
	vertime allowance (from column 5, line 56)					0	60.0
	quipment cost (see instructions)					4, 290	
	upplies (see instructions)					8, 700	
	otal allowance (sum of lines 57-62) otal cost of outside supplier services (from	n vour records)				670, 564 562, 536	
	xcess over limitation (line 64 minus line 6		enter zero)			0 0	1
	INE 33 CALCULATION	o ii negative,	011101 2010)			<u> </u>	00.0
	ine 26 = line 24 for respiratory therapy or	sum of lines 24	and 25 for a	all others		0	100.0
0. 01 L	ine 27 = line 7 times line 3 for respiratory	, therapy or sum	of lines 3 a	and 4 for all	others	0	100. C
	ine 33 = line 28 = sum of lines 26 and 27					0	100. C
	INE 34 CALCULATION						
- 1	ine 27 = line 7 times line 3 for respiratory				others		101.0
	ine 31 = line 29 for respiratory therapy or	sum of lines 29	and 30 for a	all others			101.0
	ine 34 = sum of lines 27 and 31					0	101. 0
	INE 35 CALCULATION ine 31 = line 29 for respiratory therapy or	sum of Lines 20	and 30 for a	all others		0	 102. 0
	ine 31 = 11ne 29 for respiratory therapy or ine 32 = 1ine 8 times columns 1 and 2, line				umns 1-3 line		102.0
	ino de - indo o tidos columbs I aliu e, IIIIC	io ioi respirat	огу инстару (or sam of COI	anno 1-0, TITIE	ı	1,02.6
	3 for all others						

	NABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provi der CC	N: 14-1324	Peri od: From 04/01/2022 To 03/31/2023 Occupati onal Therapy		pared:
						1.00	
	PART I - GENERAL INFORMATION	\					4 00
1. 00 2. 00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	s) (see instruct	ions)			52 780	1.00 2.00
3. 00	Number of unduplicated days in which supervis					0	
1. 00	Number of unduplicated days in which therapy nor therapist was on provider site (see instr		n provider si	te but neiti	ner supervisor	0	4.00
5. 00	Number of unduplicated offsite visits - super			,	b 16	0	5.00
5. 00	Number of unduplicated offsite visits - thera assistant and on which supervisor and/or ther					0	6.00
7. 00	instructions) Standard travel expense rate					0.00	7.00
3. 00	Optional travel expense rate per mile					0.00	
		Supervi sors 1.00	Therapi sts 2.00	Assi stants 3.00	Ai des 4.00	Trai nees 5. 00	
9. 00	Total hours worked	75. 00	1, 949. 00	2, 495.			9. 00
10.00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	113. 96 42. 21	84. 41 42. 21	63. 31.		0. 00	10.00 11.00
11.00	one-half of column 2, line 10; column 3,	42. 21	42. 21	31.	00		11.00
12. 00	one-half of column 3, line 10) Number of travel hours (provider site)	0	0		0		12.00
12. 00	Number of travel hours (offsite)	o	0		0		12.00
13. 00 13. 01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0		0		13. 00 13. 01
13.01	number of mires driver (orrsite)	<u> </u>	<u>0</u>		O _I		13.01
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14.00	Supervisors (column 1, line 9 times column 1,					8, 547	14.00
15. 00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					164, 515 157, 958	
17. 00	Subtotal allowance amount (sum of lines 14 ar	,	atory therapy	or lines 1	4-16 for all	331, 020	
18. 00	others) Aides (column 4, line 9 times column 4, line	10)				0	18.00
19. 00	Trainees (column 5, line 9 times column 5, li	ne 10)				0	19.00
20. 00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory						20.00
	occupational therapy, line 9, is greater than	ıline 2, make n					
21 00	amount from line 20. Otherwise complete line Weighted average rate excluding aides and tra		divided by su	ım of column	s 1 and 2 line 9	0.00	21.00
	for respiratory therapy or columns 1 thru 3,	line 9 for all	others)	01 001 4	3 . a.i.a 2,i.e ,		
22. 00 23. 00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions)	ees (line 2 time	es line 21)			0 331, 020	22. 00 23. 00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	EXPENSE COMP	UTATION - PI	ROVI DER SITE	·	
24. 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					_	
25. 00	Assistants (line 4 times column 3, line 11)					1 01	24.00
	Subtotal (line 24 for respiratory therapy or			11		0	25.00
26. 00 27. 00	Standard travel expense (line 7 times line 3				3 and 4 for all		25. 00 26. 00
27. 00	others)	for respiratory	therapy or s	um of lines		0 0	25. 00 26. 00 27. 00
		for respiratory	therapy or s	um of lines		0 0	25. 00 26. 00 27. 00
27. 00 28. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel	for respiratory travel expense Expense	therapy or s	um of lines Her site (su		0 0	25. 00 26. 00 27. 00 28. 00
27. 00	others) Total standard travel allowance and standard 27)	for respiratory travel expense Expense of columns 1 and	therapy or s	um of lines Her site (su		0 0	25. 00 26. 00 27. 00 28. 00
27. 00 28. 00 29. 00 30. 00 31. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	travel expense Expense of columns 1 and line 12) sum of lines 29	at the providual the providual 12, line 12)	dum of lines der site (sum	m of lines 26 and	0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00
27. 00 28. 00 29. 00 30. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,	travel expense Expense of columns 1 and line 12) sum of lines 29	at the providual the providual 12, line 12)	dum of lines der site (sum	m of lines 26 and	0 0	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel	travel expense Expense Off columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line	at the provide 12, line 12) and 30 for a 13 for respir	dum of lines der site (su de	m of lines 26 and	0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and optional travel Optional travel allowance and optional travel	travel expense Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum of	at the providual the providual 12, line 12) and 30 for a 13 for respir 28) of lines 27 and 13 for lines 31 and 13 for lines 31 and 15 for lines 31	dum of lines ler site (sur	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWARD	travel expense Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum of	at the providual the providual 12, line 12) and 30 for a 13 for respir 28) of lines 27 and 13 for lines 31 and 13 for lines 31 and 15 for lines 31	dum of lines ler site (sur	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11)	travel expense Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum of	at the providual the providual 12, line 12) and 30 for a 13 for respir 28) of lines 27 and 13 for lines 31 and 13 for lines 31 and 15 for lines 31	dum of lines ler site (sur	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	travel expense Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum of	at the providual the providual 12, line 12) and 30 for a 13 for respir 28) of lines 27 and 13 for lines 31 and 13 for lines 31 and 15 for lines 31	dum of lines ler site (sur	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00 37. 00
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	travel expense Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum of	at the providual the providual the providual to the provi	dum of lines ler site (sur	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00 37. 00 38. 00
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sun Optional Travel Allowance and Optional Travel	travel expense Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum of expense (sum of expense (sum of expense (sum of expense)	at the provided the provided at the provided a	dum of lines ler site (sur	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00
27. 00 28. 00 30. 00 31. 00 32. 00 333. 00 344. 00 355. 00 366. 00 37. 00 38. 00 39. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Optional travel allowance and optional travel Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.04	travel expense Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum of expense (sum o	at the provided the provided at the provided a	dum of lines ler site (sur	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 37. 00 38. 00 37. 00 39. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	travel expense Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (sum of expense of lines 5 and Expense	at the providual the providual the providual the providual to the providual the providual the providual to t	der site (sur ler site (sur ll others) ratory thera dd 31) dd 32) TATION - SEI	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00
27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	travel expense Expense Of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum of expense (sum of expense (sum of expense (sum of expense olumn and of lines 5 and Expense Of times column and and line 10) and of columns 1-3	therapy or sat the provided at	dum of lines ler site (sur	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der Co		Period: From 04/01/2022 To 03/31/2023	Worksheet A-8 Parts I-VI Date/Time Pre 8/31/2023 4:0	pared:
					Occupati onal Therapy	Cost	
						1. 00	
	Optional travel allowance and standard travel					0	
46. 00	Optional travel allowance and optional travel	expense (sum Therapists	of lines 42 ar Assistants	nd 43 - see i Aides	nstructi ons) Trai nees	Total	46.00
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART V - OVERTIME COMPUTATION Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not	0.00	0.00	0.0	0.00	0.00	47. 00
	complete lines 48-55 and enter zero in each column of line 56)						
	Overtime rate (see instructions) Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0. 00 0. 00	0. 00 0. 00				48. 00 49. 00
50. 00	CALCULATION OF LIMIT Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,	0.00	0.00	0.0	0.00	0.00	50.00
51. 00	line 47) Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
	Adjusted hourly salary equivalency amount (see instructions)	84. 41	63. 31				52.00
53. 00	Overtime cost limitation (line 51 times line 52)	0	0		0 0		53.00
54. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
55. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0		55.00
56. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	0		0 0	0	56. 00
	respiratory therapy and columns 1 through 3 for all others.)						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65)	ces (from lines	s 44, 45, or 46	6)		331, 020 0 0 0 0 0 331, 020 293, 692 0	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
	Line 26 = line 24 for respiratory therapy or	sum of lines 2	24 and 25 for a	all others		0	100. 00
	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	/ therapy or su	um of lines 3 a	and 4 for all	others		100. 01 100. 02
101. 01	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				others	0	101. 00 101. 01 101. 02
102 00	Line 31 = line 29 for respiratory therapy or	sum of lines 2	29 and 30 for a	all others		0	102. 00

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der CCI		Period: From 04/01/2022 To 03/31/2023	Date/Time Pre 8/31/2023 4:0	pared:
					Speech Pathology		
	PART I - GENERAL INFORMATION					1. 00	
1. 00 2. 00 3. 00 4. 00	Total number of weeks worked (excluding aide Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervi Number of unduplicated days in which therapy	sor or therapist	was on provi			52 780 0 0	1.00 2.00 3.00 4.00
5. 00 6. 00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the	rvisors or thera apy assistants (include only	visits made		0	5. 00 6. 00
7. 00 3. 00	instructions) Standard travel expense rate Optional travel expense rate per mile					0. 00 0. 00	
		Supervi sors 1,00	Therapists 2.00	Assi stants 3.00	Ai des 4.00	Trai nees 5. 00	
	Total hours worked AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	20. 00 109. 51 40. 56	1, 202. 00 81. 12 40. 56	0. C 0. C	0. 00 00 0. 00	0.00	9. 00 10. 00 11. 00
12. 01 13. 00	one-half of column 3, line 10) Number of travel hours (provider site) Number of travel hours (offsite) Number of miles driven (provider site) Number of miles driven (offsite)	0 0	0 0 0		0 0 0 0		12. 00 12. 01 13. 00 13. 01
						1 00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1. 00	
15. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a	line 10) line10)	catory therany	or lines 14	-16 for all	2, 190 97, 506 0 99, 696	16.00
19. 00 20. 00	others) Aides (column 4, line 9 times column 4, line	10) ine 10) or respiratory 1 y therapy or col	therapy or lingumns 1-3 for p	es 17 and 18 physical the	for all others) rapy, speech pat	hology or	18. 00 19. 00 20. 00
	amount from line 20. Otherwise complete line Weighted average rate excluding aides and tr	es 21-23. ainees (line 17	divided by su				21.00
23. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions)	ees (line 2 time	es line 21)			0 99, 696	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	WANCE AND TRAVEL	EXPENSE COMPI	JTATION - PR	OVIDER SITE		
25. 00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 24	and 25 for a	I others)		0 0 0	24. 00 25. 00 26. 00
27. 00 28. 00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard					0	27. 00 28. 00
	27) Optional Travel Allowance and Optional Trave	<u> </u>	at the provide	31 21 to (3 u iii	or rines 20 une		20.00
9. 00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3		d 2, line 12)			0	29. 00 30. 00
1. 00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others)	sum of lines 29			y or sum of	0	31. 00 32. 00
34. 00	Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave	I expense (sum o	of lines 27 and			0 0	33.00 34.00 35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW				VICES OUTSIDE PR		33.00
36. 00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36.00
	Assistants (line 6 times column 3, line 11)					o	37.00
	Subtotal (sum of lines 36 and 37)					0	38.00

Heal th Finan	cial Systems	FERRELL HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
REASONABLE COUTSLIDE SUPP	OST DETERMINATION FOR THERAPY SERVICES LIERS	FURNI SHED BY	Provider CO	CN: 14-1324	Peri od: From 04/01/2022 To 03/31/2023		pared:
					Speech Pathology	Cost	
						1. 00	
46. 00 Opti or	nal travel allowance and optional trave						46. 00
		Therapi sts 1.00	Assi stants 2.00	Ai des 3. 00	Trai nees 4.00	Total 5. 00	
	/ - OVERTIME COMPUTATION						
peri o equal compl	ime hours worked during reporting d (if column 5, line 47, is zero or to or greater than 2,080, do not ete lines 48-55 and enter zero in each n of line 56)	0.00	0.00	0. (0.00	0.00	47.00
48.00 Overt	ime rate (see instructions)	0.00	0. 00	0. (0.00		48. 00
allow	overtime (including base and overtime ance) (multiply line 47 times line 48) _ATION OF LIMIT	0.00	0. 00	0. (0.00		49. 00
50.00 Percei (di vi d	ntage of overtime hours by category de the hours in each column on line 47 e total overtime worked - column 5,	0.00	0.00	0. (0. 00	0.00	50.00
51.00 Allocator of percent	ation of provider's standard work year ne full-time employee times the ntages on line 50) (see instructions)	0.00	0. 00	0. (0.00	0.00	51.00
	MINATION OF OVERTIME ALLOWANCE	81. 12	0.00	0. (0.00		52.00
(see	ted hourly salary equivalency amount instructions) ime cost limitation (line 51 times line		0.00	0.1	0 0		53.00
	um overtime cost (enter the lesser of 49 or line 53)	0	0		0 0		54.00
55.00 Portion	on of overtime already included in y computation at the AHSEA (multiply 47 times line 52)	0	0		0 0		55.00
56.00 Overti if ne the si respi	ime allowance (line 54 minus line 55 - gative enter zero) (Enter in column 5 um of columns 1, 3, and 4 for ratory therapy and columns 1 through 3 ll others.)	0	0		0 0	0	56.00
						1. 00	
	/I - COMPUTATION OF THERAPY LIMITATION A	AND EXCESS COST	ADJUSTMENT				
58. 00 Travel 59. 00 Travel 60. 00 Overti 61. 00 Equi pr 62. 00 Suppl 63. 00 Total 64. 00 Total 65. 00 Excess	y equivalency amount (from line 23) I allowance and expense - provider site I allowance and expense - Offsite servi ime allowance (from column 5, line 56) ment cost (see instructions) ies (see instructions) allowance (sum of lines 57-62) cost of outside supplier services (fro s over limitation (line 64 minus line 6 33 CALCULATION	ces (from lines m your records)	44, 45, or 46	5)		79, 437	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
100. 00 Li ne : 100. 01 Li ne : 100. 02 Li ne :	26 = line 24 for respiratory therapy or 27 = line 7 times line 3 for respirator 33 = line 28 = sum of lines 26 and 27 34 CALCULATION				others	0	100. 00 100. 01 100. 02
101. 00 Li ne : 101. 01 Li ne : 101. 02 Li ne :	27 = line 7 times line 3 for respirator 31 = line 29 for respiratory therapy or 34 = sum of lines 27 and 31 35 CALCULATION				others	0	101. 00 101. 01 101. 02
102. 00 Li ne 3	31 = line 29 for respiratory therapy or 32 = line 8 times columns 1 and 2, line				umns 1-3, line		102. 00 102. 01
1	r all others 35 = sum of lines 31 and 32					0	102. 02

| Peri od: | Worksheet B | From 04/01/2022 | Part | | To 03/31/2023 | Date/Time Prepared:

				T	o 03/31/2023	Date/Time Pre 8/31/2023 4:0	
				CAPI TAL REI	LATED COSTS	8/31/2023 4.0	4 piii
				I			
	Cost Center Description	Net Expenses	BLDG & FIXT	BLDG & FIXT -		MVBLE EQUIP	
		for Cost Allocation		EFM BLD	NEW WIN		
		(from Wkst A					
		col. 7)					
		0	1. 00	1. 01	1. 02	2. 00	
	GENERAL SERVICE COST CENTERS		11.00	1.0.		2.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 123, 578	1, 123, 578				1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - EFM BLD	82, 130	0	i .			1. 01
1.02	00102 CAP REL COSTS-BLDG & FIXT - NEW WIN	1, 920, 320	0	0	1, 920, 320		1. 02
2.00	00200 CAP REL COSTS-MVBLE EQUIP	452, 861				452, 861	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 729, 645	6, 375	0	0	3, 015	4. 00
5. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 469, 774	571		5, 891	270	5. 01
5. 02	00591 OTHER ADMIN AND GENERAL	5, 879, 776	151, 257	1	379, 011	71, 528	5. 02
6. 00	00600 MAI NTENANCE & REPAI RS	552, 528	217, 392	1	0	59, 971	6.00
7. 00	00700 OPERATION OF PLANT	1, 071, 525	0	1 / ' '	0	1, 070	
8. 00	00800 LAUNDRY & LINEN SERVICE	111, 143	20, 877		0	5, 760	
9.00	00900 HOUSEKEEPI NG	726, 747	6, 985		0	2, 168	
10.00	01000 DI ETARY	396, 187	38, 429	1	81, 229	10, 599	
11.00	01100 CAFETERI A	189, 188	0		54, 832	0	1
13.00	01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY	468, 913	2, 125 34, 573		0	586 16, 349	
16. 00 19. 00	01900 NONPHYSICIAN ANESTHETISTS	189, 312 536, 905	34, 5/3	l .		16, 349	
19.00	INPATIENT ROUTINE SERVICE COST CENTERS	330, 903	0	<u> </u>	l d	0	19.00
30. 00	03000 ADULTS & PEDIATRICS	3, 715, 591	153, 481	0	360, 885	48, 275	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	3, 713, 371	133, 401	0	300, 003	40, 273	30.00
50.00	05000 OPERATING ROOM	1, 078, 866	66, 253	0	416, 171	18, 899	50.00
53. 00	05300 ANESTHESI OLOGY	0	0	1	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 719, 398	32, 074	0	143, 538	15, 167	54.00
60.00	06000 LABORATORY	2, 088, 927	66, 253	0	89, 952	6, 876	60.00
65.00	06500 RESPI RATORY THERAPY	550, 044	26, 190	0	20, 166	7, 221	65.00
66.00	06600 PHYSI CAL THERAPY	1, 353, 971	24, 124	0	35, 233	6, 653	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 808, 264	0		0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	155, 569	0		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 235, 734	13, 518	0	68, 427	3, 731	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS	7 074 050	447 570	04.040	00.400	100.004	00.00
88.00	08800 RURAL HEALTH CLINIC	7, 874, 052	147, 578	1	22, 488	139, 094	88.00
88. 01 88. 02	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III	1, 737, 160	96, 417	1	0	26, 594	88. 01 88. 02
88. 02	08803 RURAL HEALTH CLINIC IV	1, 086, 537 600, 252	0		0	0	88.02
90.00	09000 CLINIC	256, 210	0		39, 142	0	90.00
90.00	09001 CLINIC - MCLEANSBORO	250, 210	0	_	37, 142	0	90.00
90. 01	09002 CLINIC - CHF		0	_	0	0	90.01
90. 03	09003 CLINIC - ORTHO	398, 986	0	0		0	90. 03
91. 00	09100 EMERGENCY	2, 027, 104	19, 106	_	188, 174	9, 035	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,027,101	. , ,		100, 17 1	7, 000	92.00
	SPECIAL PURPOSE COST CENTERS			1			
113.00	11300 NTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	51, 587, 197	1, 123, 578	82, 130	1, 905, 139	452, 861	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		15, 181		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
200.00	1 1						200. 00
201.00			0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	51, 587, 197	1, 123, 578	82, 130	1, 920, 320	452, 861	202.00

Provider CCN: 14-1324

Peri od: Worksheet B From 04/01/2022 Part I To 03/31/2023 Date/Ti me Prepared: 8/31/2023 4:04 pm

				''	0 00/01/2020	8/31/2023 4: 0	4 pm
	Cost Center Description	EMPLOYEE	CASHI ERI NG/AC	Subtotal	OTHER ADMIN	MAINTENANCE &	
	·	BENEFITS	COUNTS		AND GENERAL	REPAI RS	
		DEPARTMENT	RECEI VABLE				
		4. 00	5. 01	5A. 01	5. 02	6. 00	
GE	ENERAL SERVICE COST CENTERS						
1.00 00	0100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 00	0101 CAP REL COSTS-BLDG & FIXT - EFM BLD						1.01
1.02 00	0102 CAP REL COSTS-BLDG & FIXT - NEW WIN						1.02
	0200 CAP REL COSTS-MVBLE EQUIP						2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT	5, 739, 035					4.00
	0580 CASHI ERI NG/ACCOUNTS RECEI VABLE	336, 050	1				5. 01
	D591 OTHER ADMIN AND GENERAL	257, 500			6, 739, 072		5. 02
	0600 MAINTENANCE & REPAIRS	167, 032					6.00
	0700 OPERATION OF PLANT	0	o o	1, 073, 506	· ·		1
	0800 LAUNDRY & LINEN SERVICE	0	0				8.00
	0900 HOUSEKEEPI NG	361, 511	0	1, 097, 617	· ·		1
	1000 DI ETARY	102, 205	0				1
	1100 CAFETERI A	·	0	· ·	l :		1
		93, 177	0	337, 197	l :		1
	1300 NURSING ADMINISTRATION	67, 174		538, 798	l :	,	
	1600 MEDICAL RECORDS & LIBRARY	79, 995	1	020,22,	l :		
	1900 NONPHYSI CI AN ANESTHETI STS	0	0	536, 905	80, 677	0	19.00
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	959, 035	91, 839	5, 329, 106	800, 773	228, 941	30.00
	NCILLARY SERVICE COST CENTERS						
	OPERATING ROOM	239, 262					
	5300 ANESTHESI OLOGY	0	10,000				53.00
	5400 RADI OLOGY-DI AGNOSTI C	301, 921	442, 166				
	6000 LABORATORY	484, 302					60.00
	5500 RESPI RATORY THERAPY	172, 630		· ·			
	6600 PHYSI CAL THERAPY	0	102, 791				
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	54, 093	1, 862, 357	279, 845	0	71.00
72.00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	0	7, 477	163, 046	24, 500	0	72.00
	7300 DRUGS CHARGED TO PATIENTS	43, 699	240, 260	4, 605, 369	692, 021	30, 615	73.00
OL	JTPATIENT SERVICE COST CENTERS						
88. 00 08	B800 RURAL HEALTH CLINIC	951, 630	157, 663	9, 373, 518	1, 408, 518	292, 770	88. 00
88. 01 08	3801 RURAL HEALTH CLINIC II	268, 334	36, 604	2, 165, 109	325, 338	0	88. 01
88. 02 08	3802 RURAL HEALTH CLINIC III	178, 950	22, 084	1, 287, 571	193, 476	0	88. 02
88. 03 08	3803 RURAL HEALTH CLINIC IV	153, 489	16, 545	770, 286	115, 746	0	88. 03
90.00 09	9000 CLI NI C	33, 406	12, 477	341, 235	51, 275	11, 164	90.00
90. 01 09	9001 CLINIC - MCLEANSBORO	. 0	0				90. 01
90. 02 09	9002 CLINIC - CHF	0	0	0	0	0	90. 02
	9003 CLINIC - ORTHO	52, 367	14, 404	465, 757	69, 987	0	90. 03
	9100 EMERGENCY	435, 366					91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	,	100,	0	l		92.00
	PECIAL PURPOSE COST CENTERS					1	72.00
	1300 I NTEREST EXPENSE						113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	5, 739, 035	1, 812, 556	51, 572, 016	6, 736, 791	1, 142, 395	
	ONREIMBURSABLE COST CENTERS	5, 737, 033	1,612,550	31, 372, 010	0, 730, 771	1, 142, 373	1118.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	15, 181	2, 281	1 220	190. 00
	9200 PHYSICIANS' PRIVATE OFFICES	0	0				190.00
200. 00	Cross Foot Adjustments	U		0		1	200.00
200.00		^					200.00
	Negative Cost Centers	U E 720 025	1 010 557	U E1 E07 107	4 720 073		
202. 00	TOTAL (sum lines 118 through 201)	5, 739, 035	1, 812, 556	51, 587, 197	6, 739, 072	1, 146, 725	1202.00

Provider CCN: 14-1324

| Peri od: | Worksheet B | From 04/01/2022 | Part | To 03/31/2023 | Date/Time Prepared:

				10	03/31/2023	8/31/2023 4: 0	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	
	, , , , , , , , , , , , , , , , , , ,	PLANT	LINEN SERVICE				
		7. 00	8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - EFM BLD						1. 01
1. 02	00102 CAP REL COSTS-BLDG & FIXT - NEW WIN						1. 02
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 01
5. 02	00591 OTHER ADMIN AND GENERAL						5. 02
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT	1, 236, 673	l e				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	18, 516		•			8. 00
9.00	00900 HOUSEKEEPI NG	6, 649					9. 00
10.00	01000 DI ETARY	59, 107	538		901, 137		10.00
11. 00	01100 CAFETERI A	16, 893	ł		0	438, 592	•
13.00	01300 NURSING ADMINISTRATION	1, 885		-,	0	7, 702	13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	30, 662	0		0	9, 181	16.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	247, 300	116, 960	266, 353	901, 137	110, 097	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	193, 864	1	208, 800	0	27, 473	50.00
53. 00	05300 ANESTHESI OLOGY			١	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	72, 666			0	34, 649	1
60.00	06000 LABORATORY	86, 470			0	55, 588	60.00
65.00	06500 RESPI RATORY THERAPY	29, 440	l .	,	0	19, 810	65.00
66. 00	06600 PHYSI CAL THERAPY	32, 250	· ·		0	0	66.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1	-	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		- 1	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	33, 070	0	35, 618	0	5, 026	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS	24 / 247	4 540	240 (44		400.050	00.00
88. 00	08800 RURAL HEALTH CLINIC	316, 247	4, 519		0	109, 253	88.00
88. 01	08801 RURAL HEALTH CLINIC II	0	1	- 1	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	0	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	12.050	0	12.000	0	0	88. 03
90.00	09000 CLINIC	12, 059	0	12, 988	0	3, 826	90.00
90. 01	09001 CLINIC - MCLEANSBORO	0	0	0	0	0	90. 01
90. 02	09002 CLINIC - CHF	0	0	0	0	0	90.02
90. 03	09003 CLINIC - ORTHO	74 010	1 410	1 0	0	6, 017	90.03
91. 00 92. 00		74, 918	1, 410	80, 690	U	49, 970	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
112 00	11300 INTEREST EXPENSE			I	T		112 00
113.00	1 1	1, 231, 996	194, 140	1, 299, 811	901, 137	438, 592	113.00
110.00	NONREI MBURSABLE COST CENTERS	1, 231, 990	194, 140	1, 299, 011	901, 137	430, 392	1110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 677	0	5, 037	0	0	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 677	0	0,037	0		190.00
200.00			١		٩	U	200.00
200.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	_	_	0		0	200.00
201.00		1, 236, 673	194, 140	1, 304, 848	901, 137	438, 592	
202.00	1 TOTAL (Suil TITIES TTO ETITOUGH 201)	1, 230, 073	1 174, 140	1, 304, 640	701, 137	430, 372	1202.00

Health Financial Systems FERRELL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1324 Peri od: Worksheet B From 04/01/2022 Part I Date/Time Prepared: 03/31/2023 8/31/2023 4:04 pm Cost Center Description NURSI NG MEDI CAL NONPHYSI CI AN Subtotal Intern & RECORDS & ADMI NI STRATI O ANESTHETI STS Resi dents Ν LI BRARY Cost & Post Stepdown Adjustments 13.00 16.00 19.00 24.00 25.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT - EFM BLD 1.01 1.01 1.02 00102 CAP REL COSTS-BLDG & FIXT - NEW WIN 1.02 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.01 5.01 5.02 00591 OTHER ADMIN AND GENERAL 5.02 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7 00 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 633, 122 13.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 469, 600 16.00 01900 NONPHYSICIAN ANESTHETISTS 617, 582 19.00 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 30.00 336, 168 224, 879 0 8, 561, 714 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 83,886 2, 893, 359 0 50.00 53.00 05300 ANESTHESI OLOGY C 617, 582 664, 035 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 6,614 0 3, 326, 147 0 54.00 60 00 06000 LABORATORY 6 614 0 3, 867, 660 Ω 60.00 0 06500 RESPIRATORY THERAPY 0 65.00 60, 489 6,614 1, 122, 022 0 65.00 66.00 06600 PHYSI CAL THERAPY 6, 614 0 1, 861, 342 0 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 0 2, 142, 202 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 187, 546 72 00 0 0 72 00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 5, 401, 719 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 11, 845, 439 0 88.00 08801 RURAL HEALTH CLINIC II 0 0 2, 490, 447 0 88 01 88.01 0 0 0 88.02 08802 RURAL HEALTH CLINIC III C 1, 481, 047 0 88.02 08803 RURAL HEALTH CLINIC IV 886, 032 88.03 88.03 0 0 90.00 09000 CLI NI C 99, 211 0 531, 758 0 90.00 90. 01 09001 CLINIC - MCLEANSBORO 90.01 0 0 0 09002 CLINIC - CHF 09003 CLINIC - ORTHO 90.02 0 0 0 90.02

0

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119,054

469,600

469, 600

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152, 579

633, 122

633, 122

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617, 582

617, 582

541, 761

3, 751, 461

51, 555, 691

51, 587, 197

31, 506

0

0

0 90.03

0

0

91.00

92.00

113.00

0 118.00

0 190.00

0 192.00

0 200.00

0 201.00

0 202.00

90.03

91.00

92.00

118.00

200.00

201.00

202.00

09100 EMERGENCY

113. 00 11300 I NTEREST EXPENSE

09200 OBSERVATION BEDS (NON-DISTINCT PART

SUBTOTALS (SUM OF LINES 1 through 117)

TOTAL (sum lines 118 through 201)

SPECIAL PURPOSE COST CENTERS

NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

192. 00 19200 PHYSICIANS' PRIVATE OFFICES

Cross Foot Adjustments

Negative Cost Centers

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS FERRELL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 14-1324

| Peri od: | Worksheet B | From 04/01/2022 | Part I | To 03/31/2023 | Date/Ti me Prepared: | 8/31/2023 | 4:04 pm |

			8/31	/2023 4: 04 pm
	Cost Center Description	Total		
		26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FLXT			1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - EFM BLD			1. 01
1. 02	00102 CAP REL COSTS-BLDG & FIXT - NEW WIN			1. 02
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 01
5. 02	00591 OTHER ADMIN AND GENERAL			5. 02
6. 00	00600 MAI NTENANCE & REPAI RS			6.00
7. 00	00700 OPERATION OF PLANT			7.00
8. 00	00800 LAUNDRY & LINEN SERVICE			8.00
9. 00	00900 HOUSEKEEPI NG			9.00
10.00	01000 DI ETARY			10.00
11.00	01100 CAFETERI A			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON			13.00
16.00	01600 MEDI CAL RECORDS & LI BRARY			16.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS			19. 00
00.00	INPATIENT ROUTINE SERVICE COST CENTERS	0.5/4.744		20.00
30.00	03000 ADULTS & PEDI ATRI CS	8, 561, 714		30.00
FO 00	ANCILLARY SERVICE COST CENTERS	2 002 250		F0.00
50.00	05000 OPERATING ROOM	2, 893, 359		50.00
53.00	05300 ANESTHESI OLOGY	664, 035		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 326, 147		54.00
60.00	06000 LABORATORY	3, 867, 660		60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 122, 022		65. 00 66. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 861, 342		71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 142, 202 187, 546		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	5, 401, 719		73.00
73.00	OUTPATIENT SERVICE COST CENTERS	3, 401, 717		73.00
88. 00		11, 845, 439		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	2, 490, 447		88. 01
88. 02	08802 RURAL HEALTH CLINIC III	1, 481, 047		88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	886, 032		88. 03
90. 00	09000 CLI NI C	531, 758		90.00
90. 01	09001 CLINIC - MCLEANSBORO	0		90. 01
90. 02	09002 CLINIC - CHF	o		90. 02
90. 03	09003 CLINIC - ORTHO	541, 761		90. 03
91.00	09100 EMERGENCY	3, 751, 461		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 I NTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	51, 555, 691		118.00
	NONREI MBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	31, 506		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0		192.00
200.00	Cross Foot Adjustments	0		200. 00
201.00	Negative Cost Centers	0		201.00
202.00	TOTAL (sum lines 118 through 201)	51, 587, 197		202. 00

| Peri od: | Worksheet B | From 04/01/2022 | Part II | To 03/31/2023 | Date/Time Prepared: Provider CCN: 14-1324

Cost Center Description					10	03/31/2023	Date/lime Pre 8/31/2023 4:0	
COST CENTER DESCRIPTION Assist greet New Capit Lal Rel sted Costs BLDG & FIXT BLDG & FIXT NEW WIN New WI					CAPLTAL REL	ATED COSTS	0/31/2023 4.0	J pili
Assigned Rev Capital Related Costs Capital Relat					ON TIME REL	21120 00010		
Capit tal Rel ated Costs 1.00 1.01 1.02 2.00 1.00 1.01 1.02 2.00 1.00 1.01 1.02 2.00 1.00 1.01 1.02 2.00 1.00 1.01 1.02 2.00 1.00 1.01 1.02 2.00 1.00 1.01 1.02 2.00 1.00 1.01 1.02 2.00 1.00 1.01 1.02 2.00 1.00 1.01 1.02 2.00 1.00 1.01 1.02 2.00 1.00 1.01 1.02 2.00 1.00 1.01 1.02 2.00 1.00 1.01 1.02 2.00 1.00 1.01 1.02 2.00 1.00 1.01 1.02 2.00 1.00 1.01 1.02 2.00 1.00 1.01 1.02 2.00 1.00 1.01 1.00		Cost Center Description	Directly	BLDG & FIXT	BLDG & FIXT -	BLDG & FIXT -	MVBLE EQUIP	
Related Costs		'	Assigned New		EFM BLD	NEW WIN		
CEMERAL SERVICE COST CENTERS			Capi tal					
CEMBERAL SERVICE COST CENTRES			Related Costs					
1.00			0	1.00	1. 01	1. 02	2. 00	
1.01 00101 QAP REL COSTS-BLDG & FIXT - FEM BLD 1.02 00102 QAP REL COSTS-BLDG & FIXT - NEW WIN 1.02 00102 QAP REL COSTS-BLDG & FIXT - NEW WIN 1.02 000000								
1. 02 00102 CAP REL COSTS-BLD6 & FIXT - NEW WIN 0.00 0.		l l						
2.00								1
4. 00 00400 DMPLOYEE BENEFITS DEPARTMENT 0 6.375 0 0 3.015 4. 00								1
5.00								
5.00 00590 OTHER ADMIN AND GENERAL 0 151, 257 0 379, 011 71, 528 5.02 7.00 00700 00700 00700 00700 00 011 0 1,070 7.00 7.00 00700 00700 00700 00 00			0			0		
0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000			0					1
7.00		1 1	0		1			1
8. 00 00800 LAUNDRY & LINEN SERVICE 0 20,877 0 0 5,760 8. 00		1 1	0	·		_	·	1
9.00 0.0000 HOUSEKEEPING			0	-		-		
10.00 01000 DIETARY 0 38, 429 0 81, 229 10, 599 10. 00 10. 01 10. 00			0			-		1
11.00 0110		1 1	0		1	-		
13.00 01300 NURSI NG ADMINI STRATI ON 0 2, 125 0 0 586 13.00 10.00 10500 MEDICAL RECORDS & LI BRARY 0 34,573 0 0 0 16,349 10.00 10900 NOMPHYSI CLAN AMESTHETISTS 0 0 153,481 0 360,885 10.00 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 100000 10000 10000 10000 10000 1000			0	·			•	1
16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 19.0			0	-	1			
19.00			0	·				1
NPATI ENT ROUTINE SERVICE COST CENTERS 0 153, 481 0 360, 885 48, 275 30. 00 3000 ADULTS & PEDI ATRIC CS 0 153, 481 0 360, 885 48, 275 30. 00 3000 ADULTS & PEDI ATRIC CS 0 0 0 0 0 0 0 53. 00 30.			0		1		•	1
30.00 03000 ADULTS & PEDI ATRIC CS 0 153, 481 0 360, 885 48, 275 30.00 ANCI LLARY SERVICE COST CENTERS	19.00		0	0	0	U	0	19.00
ANCILLARY SERVICE COST CENTERS SOLUTION Color	20.00			150 401		2/0 005	40.075	20.00
50.00	30.00		l U	153, 481] 0	360, 885	48, 275	30.00
53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 53.00	EO 00			44 252	1 0	114 171	10 000	E0 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 0 32. 074 0 143, 538 15, 167 54. 00 66. 00 05000 LABORATORY 0 0 66. 253 0 89, 952 6. 876 60. 00 65. 00 05000 RESPI RATORY THERAPY 0 26, 190 0 20, 166 7, 221 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 24, 124 0 35, 233 6, 653 66. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 72. 00 73.		1 1	0				•	1
60.00 06000 LABORATORY 0 66, 253 0 89,952 6,876 60.00 65.00 06500 RESPIRATORY THERAPY 0 26,190 0 20,166 7,221 65.00 66.00 06600 PHYSI CAL THERAPY 0 24,124 0 35,233 6,653 66.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 7300 DRUGS CHARGED TO PATIENTS 0 13,518 0 68,427 3,731 73.00 07300 DRUGS CHARGED TO PATIENTS 0 147,578 81,013 22,488 139,094 88.00 88.01 08800 RURAL HEALTH CLINIC 1 0 96,417 0 0 26,594 88.01 88.02 08802 RURAL HEALTH CLINIC 1 0 96,417 0 0 26,594 88.01 88.02 08802 RURAL HEALTH CLINIC 1 0 0 0 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC V 0 0 0 0 0 88.02 89.02 08900 CLINIC - CHF 0 0 0 0 0 0 0 90.01 09001 CLINIC - MCLEANSBORO 0 0 0 0 0 0 90.03 09003 CLINIC - CHF 0 0 0 0 0 0 0 90.03 09003 CLINIC - CHF 0 0 0 0 0 0 90.04 09100 EMERGENCY 0 19,106 0 188,174 9,035 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 113.00 118.00 19200 DRYSCI CANSES SUBTOTALS (SUM OF LINES 1 through 117) 0 1,123,578 82,130 1,905,139 452,861 118.00 190.00 19000 PHYSICAL SUBTOTALS (SUM OF LINES 1 through 117) 0 1,123,578 82,130 1,905,139 452,861 118.00 190.00 19000 PHYSICAL SUBTOTALS (SUM OF LINES 1 through 117) 0 1,123,578 82,130 1,905,139 452,861 118.00 190.00 19000 PHYSICAL SUBTOTALS (SUM OF LINES 1 through 117) 0 1,123,578 82,130 1,905,139 452,861 118.00 190.00 19000 PHYSICAL SUBTOTALS (SUM OF LINES 1 through 117) 0 1,123,578 82,130 1,905,139 452,861 118.00 190.00 19000				-	_	- 1	-	
65. 00								1
66.00 06600 PHYSI CAL THERAPY 0 24, 124 0 35, 233 6, 653 66.00 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 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 13, 518 0 68, 427 3, 731 88.00 08800 RURAL HEALTH CLINIC 0 147, 578 81, 013 22, 488 139, 094 88.00 88.01 08801 RURAL HEALTH CLINIC 11 0 96, 417 0 0 26, 594 88.01 88.02 08802 RURAL HEALTH CLINIC 11 0 96, 417 0 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC 11 0 0 0 0 0 0 88.03 89.00 09000 CLINIC 0 0 0 0 0 0 0 90.01 09001 CLINIC MCLEANSBORO 0 0 0 0 0 0 90.02 09002 CLINIC CHF 0 0 0 0 0 0 90.03 09003 CLINIC CHF 0 0 0 0 0 90.04 09003 CLINIC CHF 0 0 0 0 0 91.00 09003 CLINIC CHF 0 0 0 0 0 92.00 08SERVATION BEDS (NON-DISTINCT PART 90.00 139, 100 139, 100 150, 139 452, 861 118.00 118.00 NOREH MBURSABLE COST CENTERS 113.00 1190.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00 Negative Cost Centers 0 0 0 0 201.00 0000 0000 0000 0000 0000 0000 0000 201.00 0000 0000 0000 0000 0000 0000 201.00 0000 0000 0000 0000 0000 0000 201.00 0000 0000 0000 0000 0000 0000 201.00 0000 0000 0000 0000 0000 0000 201.00 0000 0000 0000 0000 0000 0000 201.00 0000 0000 0000 0000 0000 0000 0000 201.00 0000 0000 0000 0000 0000 00000 201.00 00000 00000 00000 00000 00000 000000		1				·	•	1
71. 00				·	1		•	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 13,518 0 68,427 3,731 73.00 07300 DRUGS CHARGED TO PATIENTS 0 13,518 0 68,427 3,731 73.00 073000 073000 073000 073000 073000 073000 073000 073000								1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 13,518 0 68,427 3,731 73.00					1	-		
SECOLA PURPOSE COST CENTERS SECOND CENTERS SUBTOTALS (SUM OF LINES 1 through 117) SECOND CENTERS SUBTOTALS (SUM OF LINES 1 through 117) SECOND CENTERS SUBTOTALS (SUM OF LINES 1 through 117) SECOND CENTERS SUBTOTALS (SUM OF LINES 1 through 117) SECOND CENTERS SUBTOTALS (SUM OF LINES 1 through 117) SECOND CENTERS SUBTOTALS (SUM OF LINES 1 through 117) SECOND CENTERS SUBTOTALS (SUM OF LINES 1 through 117) SUBTOTALS (SUM OF LINES 1 through				-	1	-		1
88. 00	70.00		٩	10,010		00, 127	0, 701	70.00
88. 01 08801 RURAL HEALTH CLINIC III 0 96, 417 0 0 26, 594 88. 01 88. 02 08802 RURAL HEALTH CLINIC III 0 0 0 0 0 0 0 88. 02 88. 03 08803 RURAL HEALTH CLINIC IV 0 0 0 0 0 0 0 88. 03 90. 00 09000 CLINIC 0 0 0 0 39, 142 0 90. 00 90. 01 09001 CLINIC - MCLEANSBORO 0 0 0 0 0 0 0 0 0 0 90. 01 90. 02 09002 CLINIC - CHF 0 0 0 0 0 0 0 0 0 0 0 90. 01 90. 03 09003 CLINIC - ORTHO 0 0 0 0 0 0 0 0 0 90. 02 90. 03 09003 CLINIC - ORTHO 0 0 0 0 0 0 0 0 0 0 90. 03 91. 00 09100 EMERGENCY 0 19, 106 0 188, 174 9, 035 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 1, 123, 578 82, 130 1, 905, 139 452, 861 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 15, 181 0 190. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 15, 181 0 190. 00 201. 00 Negative Cost Centers	88 00		0	147 578	81 013	22 488	139 094	88 00
88. 02				·				
88. 03		1 1			1	-		
90. 00 09000 CLINIC 0 0 0 39, 142 0 90. 00 90. 01 09001 CLINIC - MCLEANSBORO 0 0 0 0 0 0 0 0 90. 01 90. 02 09002 CLINIC - CHF 0 0 0 0 0 0 0 0 0			0	0		ol		
90. 01 09001 CLINIC - MCLEANSBORO 0 0 0 0 0 90. 01 90. 02 09002 CLINIC - CHF 0 0 0 0 0 0 90. 02 90. 03 09003 CLINIC - ORTHO 0 0 0 0 0 0 90. 03 91. 00 09100 EMERGENCY 0 19, 106 0 188, 174 9, 035 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 00				0	_	39, 142		1
90. 02				0	_			
90. 03		1 1	0	0	Ō	ol		
91. 00 09100 EMERGENCY 0 19, 106 0 188, 174 9, 035 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 00 092. 00 OBSERVATION BEDS (NON-DISTINCT PART 92. 00 092. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 92. 00 092. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART 9, 035 91. 00 OBSERVATION BEDS (NON-DISTINCT PART			l ol	0	o	ol	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART	91.00		0	19. 106	0	188. 174	9. 035	1
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 11300 SUBTOTALS (SUM OF LINES 1 through 117) 0						,		1
113. 00 11300 INTEREST EXPENSE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 1, 123, 578 82, 130 1, 905, 139 452, 861 118. 00								
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 1,123,578 82,130 1,905,139 452,861 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 15,181 0 190.00 192.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192.00 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 0 0 0 0 0 201.00	113.00							113.00
NONRE MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 15, 181 0 190.00 192.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192.00 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 0 0 0 0 0 201.00	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	o	1, 123, 578	82, 130	1, 905, 139	452, 861	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 15, 181 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00 200. 00 Cross Foot Adj ustments 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0								1
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0<	190.00		0	0	0	15, 181	0	190. 00
201.00 Negative Cost Centers 0 0 0 201.00	192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	o	0	192.00
	200.00	Cross Foot Adjustments						200.00
202.00 TOTAL (sum lines 118 through 201) 0 1,123,578 82,130 1,920,320 452,861 202.00	201.00	Negative Cost Centers		0	0	o	0	201.00
	202.00	TOTAL (sum lines 118 through 201)	0	1, 123, 578	82, 130	1, 920, 320	452, 861	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1324

| Peri od: | Worksheet B | From 04/01/2022 | Part | I | To 03/31/2023 | Date/Time Prepared:

				To	03/31/2023	Date/Time Pre 8/31/2023 4:0	
	Cost Center Description	Subtotal	EMPLOYEE	CASHI ERI NG/AC	OTHER ADMIN	MAI NTENANCE &	PH PIII
			BENEFITS	COUNTS	AND GENERAL	REPAI RS	
			DEPARTMENT	RECEI VABLE			
		2A	4.00	5. 01	5. 02	6. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - EFM BLD						1. 01
1. 02	00102 CAP REL COSTS-BLDG & FIXT - NEW WIN						1.02
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0 000	0.000				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	9, 390	9, 390				4.00
5. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	6, 732	550		(02 217		5. 01
5. 02	00591 OTHER ADMIN AND GENERAL	601, 796	421	0	602, 217	201 022	5.02
6. 00	00600 MAI NTENANCE & REPAI RS	277, 363	273		13, 387	291, 023	1
7. 00 8. 00	00700 OPERATION OF PLANT	1, 981	0		14, 415	472	1
9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	26, 637	591	0	1, 850	4, 350	9.00
10.00	01000 DI ETARY	9, 359 130, 257	167	0	14, 739	1, 562	1
11. 00	01100 CAFETERI A	54, 832	152	-	8, 441 4, 528	13, 887 3, 969	
13. 00	01300 NURSI NG ADMI NI STRATI ON	2, 711	110		7, 235	443	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	50, 922	131		4, 300	7, 204	
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	50, 422	0		7, 210	7, 204	1
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	0	7,210	0	19.00
30. 00	03000 ADULTS & PEDIATRICS	562, 641	1, 572	367	71, 559	58, 102	30.00
30.00	ANCILLARY SERVICE COST CENTERS	302, 041	1, 372	307	71, 557	30, 102	30.00
50.00	05000 OPERATING ROOM	501, 323	391	298	25, 433	45, 548	50.00
53. 00	05300 ANESTHESI OLOGY	0	0		542	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	190, 779	494		35, 641	17, 073	54.00
60.00	06000 LABORATORY	163, 081	792		41, 392	20, 316	
65.00	06500 RESPIRATORY THERAPY	53, 577	282	187	11, 052	6, 917	65.00
66.00	06600 PHYSI CAL THERAPY	66, 010	0	411	20, 448	7, 577	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	216	25, 008	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	30	2, 189	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	85, 676	71	961	61, 841	7, 770	73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	390, 173	1, 557		125, 864	74, 299	
88. 01	08801 RURAL HEALTH CLINIC II	123, 011	439		29, 073	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	293		17, 290	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	251	66	10, 343	0	88. 03
90.00	09000 CLINIC	39, 142	55		4, 582	2, 833	
90. 01	09001 CLINIC - MCLEANSBORO	0	0		0	0	
90. 02	09002 CLINIC - CHF	0	0	_	0	0	
90.03	09003 CLINIC - ORTHO	21/ 215	86		6, 254	17 (02	90.03
91.00	09100 EMERGENCY	216, 315	712	425	37, 397	17, 602	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
118.00		3, 563, 708	9, 390	7, 282	602, 013	289, 924	1
110.00	NONREI MBURSABLE COST CENTERS	3, 303, 700	9, 390	1,202	002, 013	209, 924	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	15, 181	0	O	204	1 000	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	13, 101	0		204		192.00
200.00			0			0	200.00
201.00	J		0	0	n	n	201.00
202.00	9	3, 578, 889	9, 390	1 ~	602, 217	291, 023	
202.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	3, 3, 3, 30 7	7,070	., 202	002,217	27.,020	1-32.00

Provider CCN: 14-1324

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 04/01/2022 | Part II | Date/Time Prepared: 8/31/2023 4:04 pm |

					007 017 2020	8/31/2023 4: 0	04 pm
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	·	PLANT	LINEN SERVICE				
		7. 00	8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - EFM BLD						1. 01
1.02	00102 CAP REL COSTS-BLDG & FIXT - NEW WIN						1.02
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 01
5. 02	00591 OTHER ADMIN AND GENERAL						5. 02
6.00	00600 MAINTENANCE & REPAIRS						6.00
7. 00	00700 OPERATION OF PLANT	16, 868					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	253	33, 090				8.00
9. 00	00900 HOUSEKEEPI NG	91	5, 027				9.00
10.00	01000 DI ETARY	806	92		155, 180		10.00
11. 00	01100 CAFETERI A	230	0		0	64, 148	
13. 00	01300 NURSING ADMINISTRATION	26	0		0	1, 126	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	418	0	1	0	1, 343	1
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	1 0	0		0	1, 343	1
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	U		19.00
30. 00	03000 ADULTS & PEDIATRICS	3, 373	19, 937	6, 403	155, 180	16, 103	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	3,373	17, 737	0, 403	155, 160	10, 103	30.00
50.00	05000 OPERATING ROOM	2, 644	3, 617	5, 020	0	4, 018	50.00
53. 00	05300 ANESTHESI OLOGY	2,044	3,017		0	4,010	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	991	2, 314		0	5, 068	1
60.00	06000 LABORATORY	1, 179	2, 314		0	8, 130	1
65. 00	06500 RESPIRATORY THERAPY	402	0	· ·	0	2, 897	
			_		0		1
66. 00 71. 00	06600 PHYSI CAL THERAPY	440	1, 073		ĭ	0	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0	0	71.00
72. 00 73. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	_	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	451		856	U	735	73.00
88. 00	08800 RURAL HEALTH CLINIC	4, 314	770	8, 189	o	15, 979	88.00
88. 01	08801 RURAL HEALTH CLINIC II	4, 314	770		0	15, 979	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	0	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	0	0	0	0	1
90.00	09000 CLINIC	1/4	0	312	0	-	
90.00	09001 CLINIC - MCLEANSBORO	164	0	312	0	560 0	90.00
90.01	l	0	0	_	0	-	
	09002 CLINIC - CHF	0	0	0	U	0	
90.03	09003 CLINIC - 0RTH0	1 000	0	1 0 10	0	880	
91.00	09100 EMERGENCY	1, 022	240	1, 940	0	7, 309	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
112 00	SPECIAL PURPOSE COST CENTERS			I			112 00
	11300 INTEREST EXPENSE	17 004	22.000	21 240	155 100	(4.140	113.00
118. 00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	16, 804	33, 090	31, 248	155, 180	64, 148	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	64	0	121	ol	^	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	64	0		0		190.00
200.00					٥	0	200.00
	1 1	_	,			^	200.00
201.00	9	14 040	32 000	21 240	155 100		
202.00	TOTAL (sum lines 118 through 201)	16, 868	33, 090	31, 369	155, 180	64, 148	202.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1324 Peri od: Worksheet B From 04/01/2022 Part II Date/Time Prepared: 03/31/2023 8/31/2023 4:04 pm Cost Center Description NURSI NG MEDI CAL NONPHYSI CI AN Subtotal Intern & ADMI NI STRATI O RECORDS & ANESTHETI STS Resi dents Ν LI BRARY Cost & Post Stepdown Adjustments 13.00 16.00 19.00 24.00 25.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT - EFM BLD 1.01 1.01 1.02 00102 CAP REL COSTS-BLDG & FIXT - NEW WIN 1.02 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.01 5.01 5.02 00591 OTHER ADMIN AND GENERAL 5.02 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7 00 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 11,700 13.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 16.00 65, 112 01900 NONPHYSICIAN ANESTHETISTS 7, 210 19.00 19.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 31, 181 30.00 30.00 6, 212 932, 630 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 1,550 589, 842 0 50.00 53.00 05300 ANESTHESI OLOGY 0 C 704 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 917 256, 960 0 54.00 60 00 06000 LABORATORY 0 917 239, 451 Ω 60.00 06500 RESPIRATORY THERAPY 65.00 1, 118 917 78, 111 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 917 97, 711 0 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 0 25, 224 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 0 Ω 2, 219 0 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 158, 361 0 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 621, 776 0 88.00 88.01 08801 RURAL HEALTH CLINIC II 0 0 Ω 0 88 01 152, 669 88.02 08802 RURAL HEALTH CLINIC III C 17,671 0 88.02 08803 RURAL HEALTH CLINIC IV 0 88.03 10,660 0 90.00 09000 CLI NI C 13, 756 61, 454 0 90.00 90. 01 09001 CLINIC - MCLEANSBORO 90.01 C 0 0 09002 CLINIC - CHF 09003 CLINIC - ORTHO 90.02 0 0 90.02 90.03 0 7, 278 0 90.03 09100 EMERGENCY 91.00 91.00 16, 507 2,820 302, 289 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 3, 555, 010 0 118.00 11,700 65, 112 0 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 16, 669 0 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 C

11, 700

65, 112

7.210

7, 210

7, 210

3, 578, 889

0 200.00

0 201.00

0 202.00

200.00

201.00

202.00

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS FERRELL HOSPITAL Provider CCN: 14-1324

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 04/01/2022 | Part II | To 03/31/2023 | Date/Time Prepared:

			8/31/2023 4:	
	Cost Center Description	Total		
	'	26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT			1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - EFM BLD			1. 01
1.02	00102 CAP REL COSTS-BLDG & FIXT - NEW WIN			1. 02
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 01
5. 02	00591 OTHER ADMIN AND GENERAL			5. 02
6.00	00600 MAINTENANCE & REPAIRS			6. 00
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON			13.00
16.00	01600 MEDICAL RECORDS & LIBRARY			16. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS			19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	932, 630		30.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	589, 842		50.00
53.00	05300 ANESTHESI OLOGY	704		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	256, 960		54.00
60.00	06000 LABORATORY	239, 451		60.00
65.00	06500 RESPI RATORY THERAPY	78, 111		65.00
66.00	06600 PHYSI CAL THERAPY	97, 711		66. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	25, 224		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 219		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	158, 361		73. 00
	OUTPATIENT SERVICE COST CENTERS			
88. 00	08800 RURAL HEALTH CLINIC	621, 776		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	152, 669		88. 01
88. 02	08802 RURAL HEALTH CLINIC III	17, 671		88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	10, 660		88. 03
90.00	09000 CLI NI C	61, 454		90.00
90. 01	09001 CLINIC - MCLEANSBORO	0		90. 01
90. 02	09002 CLINIC - CHF	0		90.02
90. 03	09003 CLINIC - 0RTH0	7, 278		90. 03
91.00	09100 EMERGENCY	302, 289		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92.00
440.00	SPECIAL PURPOSE COST CENTERS			110 00
	11300 I NTEREST EXPENSE	0 555 040		113.00
118.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	3, 555, 010		118. 00
100.00	NONREI MBURSABLE COST CENTERS	1/ //0		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	16, 669		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	7 010		192.00
200.00	1 1 3	7, 210		200.00
201.00		0 570 000		201.00
202.00	TOTAL (sum lines 118 through 201)	3, 578, 889		202.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: Worksheet B-1 From 04/01/2022 To 03/31/2023 Date/Time Prepai Provider CCN: 14-1324

				T	03/31/2023	Date/Time Pre 8/31/2023 4:0	
			CAPITAL RE	LATED COSTS		0/31/2023 4.0	PH PIII
	Cost Center Description	BLDG & FIXT	BLDG & FIXT -	BLDG & FIXT -	MVBLE EQUIP	EMPLOYEE	
	·	(SQUARE FEET)	EFM BLD	NEW WIN	(SQUARE FEET)	BENEFITS	
			(SQUARE FEET)	(SQUARE FEET)		DEPARTMENT (FTE'S)	
		1. 00	1. 01	1. 02	2. 00	4. 00	
	RAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT	57, 101					1.00
	1 CAP REL COSTS-BLDG & FIXT - EFM BLD	0	10, 366	,			1. 01
	2 CAP REL COSTS-BLDG & FIXT - NEW WIN	0	0	33, 901	40.440		1.02
	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	324	0	0	48, 668 324	31, 782	2.00 4.00
1	CASHI ERI NG/ACCOUNTS RECEI VABLE	29	Ö	1	29	1, 861	5. 01
1	1 OTHER ADMIN AND GENERAL	7, 687	0	-,	7, 687	1, 426	1
	MAINTENANCE & REPAIRS OPERATION OF PLANT	11, 048	0 115		6, 445 115	925 0	6. 00 7. 00
8.00 0080	LAUNDRY & LINEN SERVICE	1, 061	0		619	0	8.00
	HOUSEKEEPI NG DI ETARY	355	26 0		233 1, 139	2, 002	9. 00 10. 00
1	CAFETERI A	1, 953 0			1, 139	566 516	1
13. 00 0130	NURSING ADMINISTRATION	108	l	· -	63	372	1
	MEDICAL RECORDS & LIBRARY NONPHYSICIAN ANESTHETISTS	1, 757 0	0		1, 757 0	443 0	1
	TIENT ROUTINE SERVICE COST CENTERS	0		,, 0	O _I	0	19.00
	ADULTS & PEDIATRICS	7, 800	0	6, 371	5, 188	5, 311	30.00
	LLARY SERVICE COST CENTERS OPERATING ROOM	3, 367	0	7, 347	2, 031	1, 325	50.00
	ANESTHESI OLOGY	0,007	Ö		0	0	53.00
	RADI OLOGY-DI AGNOSTI C	1, 630	0	_, -,	1, 630	1, 672	1
	LABORATORY RESPIRATORY THERAPY	3, 367 1, 331		1, 588 356	739 776	2, 682 956	1
	PHYSI CAL THERAPY	1, 226	Ö	622	715	0	1
	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	
	IMPL. DEV. CHARGED TO PATIENTS DDRUGS CHARGED TO PATIENTS	687		0 1, 208	0 401	0 242	72. 00 73. 00
OUTP	ATIENT SERVICE COST CENTERS		-	,			
1	RURAL HEALTH CLINIC	7, 500	1		14, 948	5, 270	1
	1 RURAL HEALTH CLINIC II 2 RURAL HEALTH CLINIC III	4, 900 0	0		2, 858 0	1, 486 991	88. 01 88. 02
88. 03 0880	RURAL HEALTH CLINIC IV	0	0	0	0	850	88. 03
	DCLINIC 1 CLINIC - MCLEANSBORO	0	0	691	0	185 0	90. 00 90. 01
	2 CLINIC - CHF	0		0	0	0	90.01
1	3 CLINIC - ORTHO	0	0	0	0	290	1
	DEMERGENCY DOBSERVATION BEDS (NON-DISTINCT PART	971	0	3, 322	971	2, 411	91. 00 92. 00
	AL PURPOSE COST CENTERS						72.00
1	INTEREST EXPENSE	57.404	40.0//	22 (22	40.770	24 700	113.00
118. 00 NONRI	SUBTOTALS (SUM OF LINES 1 through 117) EIMBURSABLE COST CENTERS	57, 101	10, 366	33, 633	48, 668	31, /82	118. 00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	268	0		190. 00
	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202. 00	Cost to be allocated (per Wkst. B,	1, 123, 578	82, 130	1, 920, 320	452, 861	5, 739, 035	1
203. 00	Part Unit cost multiplier (Wkst. B, Part)	19. 677028	7. 923018	56. 644937	9. 305108	180. 575011	203 00
204. 00	Cost to be allocated (per Wkst. B,	19.077028	7. 723010	30.044937	9. 303 100		203.00
005 00	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part					0. 295450	205.00
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
207.00	Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1324 Peri od: Worksheet B-1 From 04/01/2022 03/31/2023 Date/Time Prepared: 8/31/2023 4:04 pm Cost Center Description CASHI ERING/AC Reconciliatio OTHER ADMIN MAINTENANCE & OPERATION OF COUNTS AND GENERAL **REPAIRS** PLANT n RECEI VABLE (ACCUM. COST) (SQUARE FEET) (SQUARE FEET) (GROSS CHAR GES) 5. 01 5A. 02 5.02 6.00 7.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00101 CAP REL COSTS-BLDG & FIXT - EFM BLD 1.01 1 01 1.02 00102 CAP REL COSTS-BLDG & FIXT - NEW WIN 1.02 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.01 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 96, 706, 834 5.01 5.02 00591 OTHER ADMIN AND GENERAL -6, 739, 072 44, 848, 125 5.02 00600 MAINTENANCE & REPAIRS 996, 923 70, 980 6.00 6.00 0 00700 OPERATION OF PLANT 7 00 0 1,073,506 70.865 7 00 Ω 115 8.00 00800 LAUNDRY & LINEN SERVICE 0 C 137, 780 1,061 1,061 8.00 9.00 00900 HOUSEKEEPI NG 0 1, 097, 617 381 381 9.00 0 01000 DI ETARY 0 628, 649 3, 387 3, 387 10.00 10.00 01100 CAFETERI A 11.00 C 337, 197 968 968 11.00 13.00 01300 NURSING ADMINISTRATION 0 C 538, 798 108 108 13.00 1, 757 16.00 01600 MEDICAL RECORDS & LIBRARY 0 C 320, 229 1, 757 16.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 536, 905 0 0 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 0 14, 171 30.00 03000 ADULTS & PEDIATRICS 4, 899, 909 5, 329, 106 14, 171 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 3, 979, 236 Ω 1,894,034 11, 109 11, 109 50.00 53.00 05300 ANESTHESI OLOGY 2, 154, 645 0 40, 385 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 23, 592, 154 2, 654, 264 4, 164 4, 164 54.00 60 00 06000 LABORATORY 18, 470, 263 0 3.082.498 4.955 4.955 60 00 06500 RESPIRATORY THERAPY 65.00 2, 496, 040 0 823, 034 1,687 1,687 65.00 06600 PHYSI CAL THERAPY 5, 484, 221 0 1, 522, 772 1, 848 1,848 66.00 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 2, 886, 058 0 1, 862, 357 71.00 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 398 920 Ω 163 046 72 00 0 0 07300 DRUGS CHARGED TO PATIENTS 73.00 12, 818, 652 0 4, 605, 369 1,895 1, 895 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 8, 411, 815 9, 373, 518 18, 122 18, 122 88.00 08801 RURAL HEALTH CLINIC II 1, 952, 917 Ω 88 01 2, 165, 109 0 0 88 01 88.02 08802 RURAL HEALTH CLINIC III 1, 178, 260 0 1, 287, 571 0 0 88.02 08803 RURAL HEALTH CLINIC IV 88.03 882, 732 770, 286 0 88.03 90.00 09000 CLI NI C 665, 678 0 341, 235 691 691 90.00 09001 CLINIC - MCLEANSBORO 90.01 0 0 0 0 0 90.01 90.02 09002 CLINIC - CHF 0 0 90.02 09003 CLINIC - ORTHO 90 03 768, 498 0 465, 757 O 90.03 09100 EMERGENCY 4, 293 91.00 91.00 5, 666, 836 2, 784, 999 4, 293 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 96, 706, 834 70, 597 118. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) -6, 739, 072 44, 832, 944 70, 712 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 15, 181 268 268 190. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 0 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1, 812, 556 6, 739, 072 1, 146, 725 1, 236, 673 202. 00 Part I) 17. 451111 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.018743 0.150264 16. 155607 204.00 Cost to be allocated (per Wkst. B, 7, 282 602, 217 291, 023 16, 868 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000075 0.013428 4. 100070 0. 238030 205. 00 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207.00 Parts III and IV)

Health Financial Systems FERRELL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1324 Peri od: Worksheet B-1 From 04/01/2022 03/31/2023 Date/Time Prepared: 8/31/2023 4:04 pm Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG LINEN SERVICE ADMI NI STRATI O (SQUARE FEET) (TOTAL PATI (HOURS) (POUNDS OF ENT DAYS) Ν (DI RECT LAUNDRY) NRSING HRS) 8.00 9.00 10.00 11.00 13.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00101 CAP REL COSTS-BLDG & FIXT - EFM BLD 1.01 1 01 1.02 00102 CAP REL COSTS-BLDG & FIXT - NEW WIN 1.02 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.01 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.01 5.02 00591 OTHER ADMIN AND GENERAL 5.02 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7 00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 263, 884 8.00 9.00 00900 HOUSEKEEPI NG 40, 091 69, 423 9.00 01000 DI ETARY 3, 387 1,600 10.00 10.00 731 01100 CAFETERI A 440, 090 11.00 0 968 0 11.00 13.00 01300 NURSING ADMINISTRATION 0 108 0 7, 728 208, 059 13.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 1, 757 0 9, 212 16.00 0 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 1, 600 30.00 03000 ADULTS & PEDIATRICS 158, 978 14, 171 110, 473 110, 473 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 28,848 11, 109 0 27, 567 27, 567 50.00 53.00 05300 ANESTHESI OLOGY 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 18, 455 4, 164 0 34, 767 54.00 0 60 00 06000 LABORATORY 4 955 0 55. 778 60 00 162 0 06500 RESPIRATORY THERAPY 65.00 0 1, 687 0 19,878 19,878 65.00 66.00 06600 PHYSI CAL THERAPY 8,560 1,848 0 0 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 ol 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 0 72 00 0 0 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 1,895 5,043 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 6, 142 18, 122 0 109, 626 0 88.00 08801 RURAL HEALTH CLINIC II 0 88 01 88.01 0 0 0 0 88.02 08802 RURAL HEALTH CLINIC III 0 C 0 0 88.02 08803 RURAL HEALTH CLINIC IV 0 88.03 88.03 90.00 09000 CLI NI C 0 691 0 3.839 0 90.00 90.01 09001 CLINIC - MCLEANSBORO 0 90.01 0 C 0 0 90.02 09002 CLINIC - CHF 0 0 0 90.02 09003 CLINIC - ORTHO 90.03 0 6,038 O 90.03 09100 EMERGENCY 1,917 0 91.00 91.00 4, 293 50, 141 50, 141 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 1, 600 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 263, 884 69, 155 440,090 208, 059 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 268 О 0 190.00 0 192.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 194, 140 1, 304, 848 901, 137 438, 592 633, 122 202. 00 Part I) Unit cost multiplier (Wkst. B, Part I) 3. 042993 203. 00 203.00 0.735702 18. 795615 563. 210625 0.996596 Cost to be allocated (per Wkst. B, 204.00 33,090 31, 369 155, 180 64, 148 11, 700 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.125396 0.451853 96. 987500 0.145761 0.056234 205.00 II)206.00 NAHE adjustment amount to be allocated 206.00

207.00

207.00

(per Wkst. B-2)

Parts III and IV)

NAHE unit cost multiplier (Wkst. D,

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

| Peri od: | Worksheet B-1 | From 04/01/2022 | To 03/31/2023 | Date/Time Prepared: | Page 1/201/2018 | Provider CCN: 14-1324

				То	03/31/2023	Date/Ti me 8/31/2023	
	Cost Center Description	MEDI CAL	NONPHYSI CI AN			6/31/2023	4. 04 piii
	, , , , , , , , , , , , , , , , , , ,	RECORDS &	ANESTHETI STS				
		LI BRARY	(ASSI GNED				
		(TIME SPENT)	TIME)	-			
	GENERAL SERVICE COST CENTERS	16. 00	19. 00				
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - EFM BLD						1. 01
1.02	00102 CAP REL COSTS-BLDG & FIXT - NEW WIN						1. 02
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 01
5. 02 6. 00	OO591 OTHER ADMIN AND GENERAL OO600 MAINTENANCE & REPAIRS						5. 02 6. 00
7. 00	00700 OPERATION OF PLANT						7.00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	4 0/0					13.00
	01600 MEDICAL RECORDS & LIBRARY	4, 260					16.00
19. 00	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	0	100	/			19. 00
30.00	03000 ADULTS & PEDI ATRI CS	2,040	0				30.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0		•			50.00
53.00	05300 ANESTHESI OLOGY	0	100	1			53.00
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	60	0	1			54.00
60. 00 65. 00	06500 RESPI RATORY THERAPY	60		1			60. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	60		1			66.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	o o				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
00.00	OUTPATIENT SERVICE COST CENTERS						- 00.00
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	0	0	•			88. 00 88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	1			88. 02
	08803 RURAL HEALTH CLINIC IV	0	0	1			88. 03
90.00	09000 CLI NI C	900	0				90.00
90. 01	09001 CLINIC - MCLEANSBORO	0	0				90. 01
	09002 CLINIC - CHF	0	0	1			90. 02
90. 03	09003 CLI NI C - 0RTH0	1 000	0				90. 03
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 080	0) 			91. 00 92. 00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
113.00	11300 NTEREST EXPENSE						113. 00
118.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	4, 260	100				118. 00
400.5-	NONREI MBURSABLE COST CENTERS						100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0				190. 00 192. 00
200.00		0	0	,			200.00
201.00							201.00
202.00	3	469, 600	617, 582	2			202. 00
	Part I)						
203.00		110. 234742		1			203. 00
204. 00	,,	65, 112	7, 210)			204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part	15. 284507	72. 100000				205. 00
200.00		15. 204507	72. 100000				203.00
206.00							206. 00
	(per Wkst. B-2)						
207. 00							207. 00
	Parts III and IV)	I	I	I			I

Health Financial Systems	FERRELL H	IOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Peri od: From 04/01/2022 To 03/31/2023	Worksheet C Part I Date/Time Pre 8/31/2023 4:0	epared: 14 pm
		Title	: XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.		Di sal I owance	Total Costs	
LANDATA FAIT DOUTENE OFFICE OF COOT OFFITEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 5/4 74/			ار		
30. 00 03000 ADULTS & PEDIATRICS	8, 561, 714		8, 561, 71	4 0	0	30.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	2, 893, 359		2, 893, 35	59 0	0	50.00
50. 00 05000 0PERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	664, 035		2, 893, 35		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 326, 147		3, 326, 14		0	
60. 00 06000 LABORATORY	3, 867, 660		3, 867, 66		0	
65. 00 06500 RESPI RATORY THERAPY	1, 122, 022		1, 122, 02		0	1
66. 00 06600 PHYSI CAL THERAPY	1, 861, 342	l e	1, 861, 34		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 142, 202		2, 142, 20		0	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	187, 546	ł	187, 54		0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	5, 401, 719		5, 401, 71		0	
OUTPATIENT SERVICE COST CENTERS	57 10 17 7 17		0, 10.1, 7.	91		70.00
88. 00 08800 RURAL HEALTH CLINIC	11, 845, 439		11, 845, 43	39 0	0	88.00
88. 01 08801 RURAL HEALTH CLINIC II	2, 490, 447		2, 490, 44	17 ol	0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	1, 481, 047		1, 481, 04		0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV	886, 032		886, 03	32 0	0	88. 03
90. 00 09000 CLINIC	531, 758		531, 75	68 0	0	90.00
90. 01 09001 CLINIC - MCLEANSBORO	0			0 0	0	90. 01
90. 02 09002 CLINIC - CHF	0			0 0	0	90.02
90. 03 09003 CLI NI C - ORTHO	541, 761		541, 76	0	0	90.03
91. 00 09100 EMERGENCY	3, 751, 461		3, 751, 46	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 172, 652		2, 172, 65	52	0	92.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 INTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	53, 728, 343		001.2010			200.00
201.00 Less Observation Beds	2, 172, 652		2, 172, 65			201.00
202.00 Total (see instructions)	51, 555, 691	0	51, 555, 69	0	0	202.00

Health Financial Systems	FERRELL HOSPITAL			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1324			Period: From 04/01/2022 To 03/31/2023	Worksheet C Part I Date/Time Pre 8/31/2023 4:0	
		Title	: XVIII	Hospi tal	Cost	
		Charges		·		
Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent	

						8/31/2023 4:0	4 pm
			Title	Title XVIII		Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			·	+ col. 7)	Rati o	I npati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
I	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00	D3000 ADULTS & PEDIATRICS	3, 504, 320		3, 504, 320)		30.00
Δ	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	186, 339	3, 792, 897	3, 979, 23	0. 727114	0.000000	50.00
53.00	D5300 ANESTHESI OLOGY	86, 919	2, 067, 726	2, 154, 64	0. 308188	0.000000	53.00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	1, 273, 574	22, 318, 580	23, 592, 15	0. 140985	0.000000	54.00
60.00	06000 LABORATORY	1, 338, 116	17, 132, 147	18, 470, 26	0. 209399	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	731, 034	1, 765, 006	2, 496, 040	0. 449521	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	2, 647, 672	2, 836, 549	5, 484, 22	0. 339400	0.000000	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	880, 204	2, 005, 854	2, 886, 058	0. 742259	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	102, 472	296, 448	398, 920	0. 470134	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 249, 117	10, 569, 535	12, 818, 652	0. 421395	0.000000	73.00
C	DUTPATIENT SERVICE COST CENTERS						
88.00	D8800 RURAL HEALTH CLINIC	0	8, 411, 815	8, 411, 81	5		88. 00
88. 01	D8801 RURAL HEALTH CLINIC II	0	1, 952, 917	1, 952, 91	7		88. 01
88. 02	D8802 RURAL HEALTH CLINIC III	0	1, 178, 260	1, 178, 260	O		88. 02
88. 03	D8803 RURAL HEALTH CLINIC IV	0	882, 732	882, 73	2		88. 03
90.00	09000 CLI NI C	0	665, 678	665, 678	0. 798822	0.000000	90.00
90. 01	D9001 CLINIC - MCLEANSBORO	0	0	(0. 000000	0.000000	90. 01
90.02	09002 CLINIC - CHF	0	0	(0. 000000	0.000000	90.02
90. 03	D9003 CLINIC - ORTHO	0	768, 498	768, 498	0. 704961	0.000000	90. 03
91.00	09100 EMERGENCY	389, 752	5, 277, 084	5, 666, 83	0. 662003	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	202, 836	1, 192, 753	1, 395, 589	1. 556799	0.000000	92.00
S	SPECIAL PURPOSE COST CENTERS						
113.001	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	13, 592, 355	83, 114, 479	96, 706, 83	4		200. 00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	13, 592, 355	83, 114, 479	96, 706, 83	4		202. 00
,							

ealth Financial Systems	FERRELL HOS			of Form CMS-	2552-
OMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 14-1324	Peri od: From 04/01/2022	Worksheet C Part I	
			To 03/31/2023	Date/Time Pro	epare
				8/31/2023 4:0	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
O. OO O3000 ADULTS & PEDIATRICS					30.
ANCILLARY SERVICE COST CENTERS					
O. 00 05000 OPERATING ROOM	0. 000000				50.
3. 00 05300 ANESTHESI OLOGY	0. 000000				53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.
D. 00 06000 LABORATORY	0. 000000				60.
5. 00 06500 RESPI RATORY THERAPY	0. 000000				65.
5. 00 06600 PHYSI CAL THERAPY	0. 000000				66.
I.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.
OUTPATIENT SERVICE COST CENTERS					
3. 00 08800 RURAL HEALTH CLINIC					88.
B. 01 08801 RURAL HEALTH CLINIC II					88.
3.02 08802 RURAL HEALTH CLINIC III					88.
.03 08803 RURAL HEALTH CLINIC IV					88
0. 00 09000 CLI NI C	0. 000000				90
0. 01 09001 CLI NI C - MCLEANSBORO	0. 000000				90
0. 02 09002 CLINIC - CHF	0. 000000				90
0. 03 09003 CLI NI C - ORTHO	0. 000000				90
I. 00 09100 EMERGENCY	0. 000000				91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.
SPECIAL PURPOSE COST CENTERS					
13.00 11300 INTEREST EXPENSE					7 113.
00.00 Subtotal (see instructions)					200
01.00 Less Observation Beds					201.
O2.00 Total (see instructions)					202.

Health Financial Systems	FERRELL H	IOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co	CN: 14-1324	Peri od: From 04/01/2022 To 03/31/2023	Worksheet C Part I Date/Time Pre 8/31/2023 4:0	epared: 04 pm
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
	1. 00	2. 00	3. 00	4.00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						4
30. 00 03000 ADULTS & PEDIATRICS	8, 561, 714		8, 561, 7	14 0	8, 561, 714	30.00
ANCILLARY SERVICE COST CENTERS	0.000.050		0.000.0	-0 0	0.000.050	
50. 00 05000 OPERATING ROOM	2, 893, 359		2, 893, 3		2, 893, 359	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	664, 035	l e	664, 0		664, 035 3, 326, 147	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	3, 326, 147 3, 867, 660	l e	3, 326, 1 3, 867, 6		3, 326, 147	
65. 00 06500 RESPI RATORY THERAPY	1, 122, 022				1, 122, 022	
66. 00 06600 PHYSI CAL THERAPY	1, 861, 342	l e	1, 861, 3		1, 122, 022	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 142, 202	0	2, 142, 2		2, 142, 202	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	187, 546		187, 5		187, 546	
73. 00 07300 DRUGS CHARGED TO PATIENTS	5, 401, 719		5, 401, 7		5, 401, 719	
OUTPATIENT SERVICE COST CENTERS	0, 101, 717		0, 101, 7	17	0, 101, 717	70.00
88. 00 08800 RURAL HEALTH CLINIC	11, 845, 439		11, 845, 4	39 0	11, 845, 439	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	2, 490, 447	l e	2, 490, 4		2, 490, 447	
88. 02 08802 RURAL HEALTH CLINIC III	1, 481, 047		1, 481, 0		1, 481, 047	
88. 03 08803 RURAL HEALTH CLINIC IV	886, 032		886, 0	32 0	886, 032	88. 03
90. 00 09000 CLI NI C	531, 758		531, 7	58 0	531, 758	90.00
90. 01 09001 CLI NI C - MCLEANSBORO	0			0 0	0	90. 01
90. 02 09002 CLI NI C - CHF	0			0 0	0	90.02
90. 03 09003 CLI NI C - ORTHO	541, 761		541, 7	61 0	541, 761	90.03
91. 00 09100 EMERGENCY	3, 751, 461		3, 751, 4	61 0	3, 751, 461	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 172, 652		2, 172, 6	52	2, 172, 652	92.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	53, 728, 343		,, -		,,	
201.00 Less Observation Beds	2, 172, 652		2, 172, 6		2, 172, 652	
202.00 Total (see instructions)	51, 555, 691	0	51, 555, 6	91 0	51, 555, 691	202.00

Health Financial Systems	FERRELL H	FERRELL HOSPITAL			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1324		Peri od: From 04/01/2022	From 04/01/2022 Part I			
		Ti tl	e XIX	Hospi tal	Cost	<u> </u>	
		Charges					
Cost Center Description	Inpatient	Outpati ent	Total (col	. 6 Cost or Other	TEFRA		

						8/31/2023 4:0	04 pm
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PATIENT ROUTINE SERVICE COST CENTERS						
30.00 03	000 ADULTS & PEDIATRICS	3, 504, 320		3, 504, 32	0		30.00
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	186, 339	3, 792, 897	3, 979, 23	6 0. 727114	0. 000000	
53.00 05	300 ANESTHESI OLOGY	86, 919	2, 067, 726	2, 154, 64	5 0. 308188	0. 000000	53.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	1, 273, 574	22, 318, 580	23, 592, 15	0. 140985	0.000000	54.00
60.00 06	DOO LABORATORY	1, 338, 116	17, 132, 147	18, 470, 26	0. 209399	0. 000000	60.00
65. 00 06	500 RESPI RATORY THERAPY	731, 034	1, 765, 006	2, 496, 04	0. 449521	0. 000000	65.00
66. 00 06	600 PHYSI CAL THERAPY	2, 647, 672	2, 836, 549	5, 484, 22	0. 339400	0. 000000	66.00
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT	880, 204	2, 005, 854	2, 886, 05	8 0. 742259	0. 000000	71.00
72.00 07	200 IMPL. DEV. CHARGED TO PATIENTS	102, 472	296, 448	398, 92	0. 470134	0. 000000	72.00
73. 00 07	300 DRUGS CHARGED TO PATIENTS	2, 249, 117	10, 569, 535	12, 818, 65	0. 421395	0. 000000	73.00
	TPATIENT SERVICE COST CENTERS						
88. 00 08	800 RURAL HEALTH CLINIC	0	8, 411, 815	8, 411, 81	5 1. 408191	0. 000000	88. 00
88. 01 08	801 RURAL HEALTH CLINIC II	0	1, 952, 917	1, 952, 91	7 1. 275245	0. 000000	88. 01
88. 02 08	802 RURAL HEALTH CLINIC III	0	1, 178, 260	1, 178, 26	0 1. 256978	0. 000000	88. 02
	803 RURAL HEALTH CLINIC IV	0	882, 732	882, 73	1. 003738	0. 000000	88. 03
90.00 09	DOO CLI NI C	0	665, 678	665, 67	8 0. 798822	0. 000000	90.00
90. 01 09	001 CLINIC - MCLEANSBORO	0	0		0. 000000	0.000000	90. 01
90. 02 09	002 CLINIC - CHF	0	0		0. 000000	0. 000000	90. 02
90. 03 09	003 CLINIC - ORTHO	0	768, 498	768, 49	0. 704961	0.000000	90. 03
91.00 09	100 EMERGENCY	389, 752	5, 277, 084	5, 666, 83	6 0. 662003	0.000000	91.00
92.00 09	200 OBSERVATION BEDS (NON-DISTINCT PART	202, 836	1, 192, 753	1, 395, 58	1. 556799	0.000000	92.00
SPI	ECIAL PURPOSE COST CENTERS						
113. 00 11	300 INTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	13, 592, 355	83, 114, 479	96, 706, 83	4		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	13, 592, 355	83, 114, 479	96, 706, 83	4		202.00

	Financial Systems	FERRELL HOS		In Lieu	of Form CMS-25	552-10
COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1324	Peri od:	Worksheet C	
				From 04/01/2022 To 03/31/2023	Part I	orod.
				To 03/31/2023	Date/Time Preparents 8/31/2023 4:04	nm
			Title XIX	Hospi tal	Cost	Piii
	Cost Center Description	PPS Inpatient				
	•	Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	0. 000000			l l	50.00
	05300 ANESTHESI OLOGY	0. 000000				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60.00	06000 LABORATORY	0. 000000				60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000				65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000				66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				88.00
88. 01	08801 RURAL HEALTH CLINIC II	0. 000000				88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0. 000000				88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0. 000000				88. 03
90.00	09000 CLI NI C	0. 000000				90.00
	09001 CLINIC - MCLEANSBORO	0. 000000				90. 01
90. 02	09002 CLINIC - CHF	0. 000000				90.02
90. 03	09003 CLINIC - ORTHO	0. 000000				90.03
91.00	09100 EMERGENCY	0. 000000				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
	SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				1	13.00
200.00	Subtotal (see instructions)				2	200.00
201.00	Less Observation Beds				2	201.00
202.00	Total (see instructions)				2	202.00

Health Financial Systems	FERRELL H	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider CCN: 14-1324	Peri od: From 04/01/2022 To 03/31/2023	Worksheet D Part II Date/Time Prepared: 8/31/2023 4:04 pm
		Title XVIII	Hospi tal	Cost
Coot Contar Doporintian	Cani tal	Total Charges Datio of Co	at Innationt	Conital Coots

				To 03/31/2023		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	T		1	T		
50. 00 05000 OPERATING ROOM	589, 842					50.00
53. 00 05300 ANESTHESI OLOGY	704	,	•			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	256, 960		•			
60. 00 06000 LABORATORY	239, 451	18, 470, 263				60.00
65. 00 06500 RESPI RATORY THERAPY	78, 111					65.00
66. 00 06600 PHYSI CAL THERAPY	97, 711					66.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	25, 224					71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	2, 219					72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	158, 361	12, 818, 652	0. 012354	913, 934	11, 291	73. 00
OUTPATIENT SERVICE COST CENTERS				-1		
88. 00 08800 RURAL HEALTH CLINIC	621, 776	1			0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	152, 669				0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	17, 671	1, 178, 260			0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV	10, 660				0	88. 03
90. 00 09000 CLI NI C	61, 454	665, 678			0	90.00
90. 01 09001 CLI NI C - MCLEANSBORO	0	0	0.000000		0	90. 01
90. 02 09002 CLINIC - CHF	0	0	0. 000000		0	90. 02
90. 03 09003 CLI NI C - 0RTH0	7, 278	l	•		0	90. 03
91. 00 09100 EMERGENCY	302, 289					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	236, 667					92.00
200.00 Total (lines 50 through 199)	2, 859, 047	93, 202, 514		3, 074, 360	56, 039	200.00

Health Financial Systems	FERRELL HOSPIT	TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS F			Worksheet D
THROUGH COSTS			From 04/01/2022	Part IV

THROUG	H COSTS				From 04/01/2022 To 03/31/2023		
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health	
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
53.00	05300 ANESTHESI OLOGY	617, 582	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS		,			ı	
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	1 00.00
88. 01	08801 RURAL HEALTH CLINIC II	0	0		0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0		0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	0		0	0	88. 03
90.00	09000 CLINIC	0	0		0	0	90.00
90. 01	09001 CLINIC - MCLEANSBORO	0	0		0	0	90. 01
	09002	0	0		0	0	90. 02 90. 03
	109100 EMERGENCY	0	0		0	0	90.03
	09200 OBSERVATION BEDS (NON-DISTINCT PART				0	0	
200.00	,	617, 582	0		0 0	1	200. 00

Health Financial Systems	FERRELL HOS	PITAL		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AN THROUGH COSTS	NCILLARY SERVICE OTHER PASS	Provi der CC	CN: 14-1324	Peri od: From 04/01/2022 To 03/31/2023	Worksheet D Part IV Date/Time Prepared: 8/31/2023 4:04 pm
		Title	XVIII	Hospi tal	Cost
Cook Cooks Doorsisking	ALL 0+1	T-+-1 C+	T-+-1	Tatal Chaman	D-+!6 C+

				'	0 03/31/2023	8/31/2023 4:0	
			Title	: XVIII	Hospi tal	Cost	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	LARY SERVICE COST CENTERS			1	0.070.007	0.00000	
	OPERATING ROOM	0	0		3, 979, 236		
	ANESTHESI OLOGY	0	617, 582		2, 154, 645		
	RADI OLOGY-DI AGNOSTI C	0	0	C	23, 592, 154		
	LABORATORY	0	0	C	18, 470, 263		
	RESPI RATORY THERAPY	0	0	C	2, 496, 040		
	PHYSI CAL THERAPY	0	0	C	5, 484, 221	0. 000000	
	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	2, 886, 058		
	IMPL. DEV. CHARGED TO PATIENTS	0	0	C	398, 920		
	DRUGS CHARGED TO PATIENTS	0	0	C	12, 818, 652	0. 000000	73. 00
	TIENT SERVICE COST CENTERS	_			1		
4	RURAL HEALTH CLINIC	0	0	C	0,, 0.0		
	RURAL HEALTH CLINIC II	0	0		1, 952, 917		
	RURAL HEALTH CLINIC III	0	0		1, 178, 260		
	RURAL HEALTH CLINIC IV	0	0		882, 732		
	CLINIC	0	0		665, 678	0. 000000	
	CLINIC - MCLEANSBORO	0	0		0	0. 000000	
	CLINIC - CHF	0	0		0	0. 000000	
	CLINIC - ORTHO	0	0		768, 498	0. 000000	
	EMERGENCY	0	0		5, 666, 836		
	OBSERVATION BEDS (NON-DISTINCT PART	0	0		1, 395, 589		
200. 00	Total (lines 50 through 199)	0	617, 582	[C	93, 202, 514		200. 00

Health Financial Systems FERRELL HOSPITAL					In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY THROUGH COSTS	SERVICE OTHER PAS:	S Provider C	CN: 14-1324	Peri od: From 04/01/2022 To 03/31/2023	Worksheet D Part IV Date/Time Pre 8/31/2023 4:0		
		Title	xVIII	Hospi tal	Cost		
Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program		

					8/31/2023 4:0	4 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8		Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	51, 884		0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	26, 320		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	380, 801	0	0	0	54.00
60. 00 06000 LABORATORY	0. 000000	524, 906	0	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	279, 620	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	371, 957	0	0	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	376, 118	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	48, 360	0	0	0	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 000000	913, 934	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0	0	0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	0. 000000	0	0	0	0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV	0. 000000	0	0	0	0	88. 03
90. 00 09000 CLI NI C	0. 000000	0	0	0	0	90.00
90. 01 09001 CLI NI C - MCLEANSBORO	0. 000000	0	0	0	0	90. 01
90. 02 09002 CLI NI C - CHF	0. 000000	0	0	0	0	90. 02
90. 03 09003 CLI NI C - ORTHO	0. 000000	0	0	0	0	90. 03
91. 00 09100 EMERGENCY	0. 000000	84, 945	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	15, 515	0	0	0	92.00
200.00 Total (lines 50 through 199)		3, 074, 360	7, 544	0	0	200.00

Heal th Finar	ncial Systems	FERRELL H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		VACCINE COST	Provi der C		Peri od: From 04/01/2022		
					To 03/31/2023	Date/Time Pre 8/31/2023 4:0	pared: 4 pm
			Title	XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see		Services Not		
		Worksheet C,	inst.)	Subject To	Subj ect To		
		Part I, col.		Ded. & Coins			
		9		(see inst.)	(see inst.)		
		1. 00	2.00	3. 00	4. 00	5. 00	
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	0. 727114		1 ., 000, 00		0	
	ANESTHESI OLOGY	0. 308188		424, 10	0 8	0	53.00
	RADI OLOGY-DI AGNOSTI C	0. 140985		8, 047, 18	5 0	0	54.00
	LABORATORY	0. 209399	0	6, 672, 85	6 0	0	60.00
	RESPI RATORY THERAPY	0. 449521	0	837, 11	8 0	0	65.00
	PHYSI CAL THERAPY	0. 339400		1, 005, 69	0 8	0	
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 742259	0	554, 55	2 0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0. 470134	0	99, 98	7 0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0. 421395	0	4, 710, 23	5 0	0	73. 00
	TIENT SERVICE COST CENTERS						
	RURAL HEALTH CLINIC						88. 00
	RURAL HEALTH CLINIC II						88. 01
88. 02 08802	RURAL HEALTH CLINIC III						88. 02
	RURAL HEALTH CLINIC IV						88. 03
90.00 09000	CLINIC	0. 798822	0	663, 67	4 0	0	90.00
90. 01 09001	CLINIC - MCLEANSBORO	0. 000000	0		0	0	90. 01
90. 02 09002	CLINIC - CHF	0. 000000	0		0 0	0	90. 02
90. 03 09003	CLINIC - ORTHO	0. 704961	0	35, 61	9 0	0	90. 03
91.00 09100	EMERGENCY	0. 662003	0	1, 841, 07	6 0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	1. 556799	0	539, 18	0	0	92.00
200. 00	Subtotal (see instructions)		0	26, 437, 37	8 0	0	200.00
201. 00	Less PBP Clinic Lab. Services-Program				0		201.00
	Only Charges					l	
202. 00	Net Charges (line 200 - line 201)		0	26, 437, 37	8 0	0	202. 00

Health Financial Systems	FERRELL HOSP	PI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1324	Peri od:	Worksheet D

From 04/01/2022 Part V To 03/31/2023 Part V Date/Time Prepared: 8/31/2023 4:04 pm Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6. 00 7. 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 731, 539 50.00 05300 ANESTHESI OLOGY 130, 705 0 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1, 134, 532 54.00 60.00 06000 LABORATORY 1, 397, 289 0 60.00 65.00 06500 RESPIRATORY THERAPY 376, 302 0 65.00 οl 06600 PHYSI CAL THERAPY 341, 334 66.00 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 411, 621 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 47,007 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 984, 869 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 88. 01 08801 RURAL HEALTH CLINIC II 88.01 08802 RURAL HEALTH CLINIC III 88.02 88 02 08803 RURAL HEALTH CLINIC IV 88.03 88.03 90.00 09000 CLI NI C 530, 157 90.00 09001 CLINIC - MCLEANSBORO 0 90.01 90.01 09002 CLINIC - CHF 09003 CLINIC - ORTHO 0 90.02 90 02 0 0 90.03 25, 110 90.03 09100 EMERGENCY 91.00 1, 218, 798 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 839, 401 92.00 Subtotal (see instructions) 200.00 9, 168, 664 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 0 202.00 9, 168, 664

Health Financial Systems	FERRELL H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST		F	Period: From 04/01/2022 To 03/31/2023		epared: 04 pm
		Titl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 727114		84, 868		0	
53. 00 05300 ANESTHESI OLOGY	0. 308188		14, 382		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 140985	0	653, 625	5 0	0	54.00
60. 00 06000 LABORATORY	0. 209399	0	344, 114	1 0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 449521	0	51, 736	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 339400	0	30, 558	0	0	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 742259	0	45, 683	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 470134	0	(0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 421395	0	174, 402	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC						88. 00
88.01 08801 RURAL HEALTH CLINIC II						88. 01
88.02 08802 RURAL HEALTH CLINIC III						88. 02
88.03 08803 RURAL HEALTH CLINIC IV						88. 03
90. 00 09000 CLI NI C	0. 798822	0	1, 739	0	0	90.00
90. 01 09001 CLI NI C - MCLEANSBORO	0. 000000	0	(0	0	90. 01
90. 02 09002 CLINIC - CHF	0. 000000	0	(0	0	90. 02
90. 03 09003 CLI NI C - ORTHO	0. 704961	0	(0	0	90.03
91. 00 09100 EMERGENCY	0. 662003	0	170, 836	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 556799	0	17, 416	0	0	92.00
200.00 Subtotal (see instructions)		0	1, 589, 359	0	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, 589, 359	0	0	202. 00

Health Financial Systems	FERRELL HOSPI TAL			of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1324	Peri od: From 04/01/2022	Worksheet D Part V

03/31/2023 Date/Time Prepared: 8/31/2023 4:04 pm Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6. 00 7. 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 61, 709 50.00 05300 ANESTHESI OLOGY 4, 432 0 53.00 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 92, 151 54.00 60.00 06000 LABORATORY 72,057 0 60.00 65.00 06500 RESPIRATORY THERAPY 23, 256 0 65.00 οl 10, 371 66.00 06600 PHYSI CAL THERAPY 66.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 33, 909 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 73, 492 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 88. 01 08801 RURAL HEALTH CLINIC II 88.01 08802 RURAL HEALTH CLINIC III 88.02 88.02 08803 RURAL HEALTH CLINIC IV 88.03 88.03 90.00 09000 CLI NI C 1, 389 90.00 09001 CLINIC - MCLEANSBORO 0 90.01 90.01 09002 CLINIC - CHF 09003 CLINIC - ORTHO 90.02 0 0 90.02 0 90.03 0 90.03 09100 EMERGENCY 91.00 113, 094 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 27, 113 92.00 Subtotal (see instructions) 200.00 512, 973 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 0 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 512, 973 0 202.00

Health Financial Systems FERRELL HOSPITAL In Lieu of Form CMS-2552-10								
COMPUTATION OF INPATIENT OPERATING COST		rovi der CCN: 14-1324						
From 04/01/20 To 03/31/20		From 04/01/2022 To 03/31/2023	Date/Time Prep 8/31/2023 4:04					
	Title XVIII Hospital							
	Cost Center Description			1.00				
	PART I - ALL PROVIDER COMPONENTS			1. 00				
	INPATIENT DAYS				ı			
1. 00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		3, 988	1. 00			
2. 00	Inpatient days (including private room days, excluding swing-bed			2, 584	2.00			
3. 00	Private room days (excluding swing-bed and observation bed days)		ivate room days,	0	3.00			
	do not complete this line.	3 .			i			
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		1, 600	4.00			
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	r 31 of the cost	964	5.00			
	reporting period				Ì			
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	321	6. 00			
7.00	reporting period (if calendar year, enter 0 on this line)	I N I I December 1	04 . 6 . 11	00	7.00			
7. 00	Total swing-bed NF type inpatient days (including private room d	lays) through December	31 of the cost	89	7. 00			
8. 00	reporting period Total swing-bed NF type inpatient days (including private room d	lave) after December 2	1 of the cost	30	8. 00			
6.00	reporting period (if calendar year, enter 0 on this line)	lays) al tel Decembel s	I of the cost	30	0.00			
9. 00								
7. 00	newborn days) (see instructions)	The Trogram (exercating	Swifing bed did	1, 107	9. 00			
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only	728	10.00					
	through December 31 of the cost reporting period (see instructions)							
11. 00								
	December 31 of the cost reporting period (if calendar year, ente							
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX o	only (including privat	e room days)	0	12.00			
12 00	through December 31 of the cost reporting period			0	12.00			
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)				13. 00			
14. 00	Medically necessary private room days applicable to the Program			0	14. 00			
15. 00	Total nursery days (title V or XIX only)				15.00			
16. 00	Nursery days (title V or XIX only)				16.00			
	SWING BED ADJUSTMENT							
17.00	Medicare rate for swing-bed SNF services applicable to services	through December 31 c	f the cost		17.00			
	reporting period				ì			
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18.00			
	reporting period							
19. 00	Medicaid rate for swing-bed NF services applicable to services t	through December 31 of	the cost	159. 97	19. 00			
20. 00	reporting period	fter December 21 of t	ho ooot	159. 97	20. 00			
20.00	.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 159.							
21. 00	Total general inpatient routine service cost (see instructions)			8, 561, 714	21. 00			
22. 00								
50	5 x line 17)		3	0	22. 00			
23.00	Swing-bed cost applicable to SNF type services after December 31	of the cost reportin	g period (line 6	o	23.00			
	x line 18)				ì			
24. 00	Swing-bed cost applicable to NF type services through December 3 7×1 ine 19)	31 of the cost reporti	ng period (line	14, 237	24. 00			

3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
	do not complete this line.		
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	1, 600	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	964	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	321	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	02.	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	89	7.00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	30	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	1 107	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1, 107	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	728	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	242	11.00
40.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
10.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	o .	10.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only)	0	16.00
47.00	SWING BED ADJUSTMENT		47.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
10.00	reporting period		10.00
19.00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost	159. 97	19. 00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	159. 97	20. 00
21 00	reporting period	0 541 714	21 00
21. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	8, 561, 714 0	21. 00 22. 00
22.00	5 x line 17)	O	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line	0	23. 00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	14, 237	24.00
25 00	7 x line 19)	4 700	25 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	4, 799	25. 00
26 00	Total swing-bed cost (see instructions)	2, 856, 290	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5, 705, 424	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
	Private room charges (excluding swing-bed charges)	0	29.00
	Semi-private room charges (excluding swing-bed charges)	0 000000	30.00
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3)	0. 000000 0. 00	
	Average semi-private room per diem charge (line 30 ÷ line 4)		33.00
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		34.00
	Average per diem private room cost differential (line 34 x line 31)		35.00
	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	5, 705, 424	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	2, 207. 98	38. 00
	Program general inpatient routine service cost (line 9 x line 38)	2, 444, 234	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	2, 444, 234	41.00

	Financial Systems	FERRELL H		CON. 14 1004		u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der (CCN: 14-1324	Peri od: From 04/01/2022 To 03/31/2023	Worksheet D-1 Date/Time Pre 8/31/2023 4:0	epared:
	01.01	T		e XVIII	Hospi tal	Cost	
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col. 1		Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)						42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT			T			43.00
44. 00	CORONARY CARE UNIT						44.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col '	3 line 200)			1. 00 1, 228, 805	48. 00
48. 01	Program inpatient cellular therapy acquisiti			III. line 10	. column 1)	0	1
49.00	Total Program inpatient costs (sum of lines				,,	3, 673, 039	
	PASS THROUGH COST ADJUSTMENTS			·			
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, su	m of Parts I and	0	50.00
E1 00		ationt andillo	a. com/ coc (+	From What D	oum of Donto II	0	F1 00
51. 00	and IV)	atrent ancitra	y services (TOIII WKSt. D,	Sum of Parts II		51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				О	52.00
53.00	Total Program inpatient operating cost exclu		elated, non-pl	nysician anest	hetist, and	0	1
	medical education costs (line 49 minus line	52)					
F 4 00	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges Target amount per discharge					0.00	
55. 01	Permanent adjustment amount per discharge					0.00	
55. 02	Adjustment amount per discharge (contractor	use only)				0.00	1
56.00	Target amount (line 54 x sum of lines 55, 55)			0	56.00
57.00	Difference between adjusted inpatient operat	ing cost and ta	arget amount	(line 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)	I'				0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,		n the cost rep	porting period	ending 1996,	0.00	59.00
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						60.00
	market basket)		p				
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	the amount by	which operati	ng costs (line	0	61.00
62. 00	Relief payment (see instructions)					o	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			Ō	1
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	ne cost report	ing period (See	1, 607, 409	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ner 31 of the	cost reportin	a neriod (See	534, 331	65 00
03.00	instructions)(title XVIII only)	ts arter become	Jei 31 01 the	cost reportin	g perrou (see	334, 331	05.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	ll only); for	2, 141, 740	66.00
	CAH, see instructions			6			
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31	of the cost r	eporting period	0	67.00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	the cost rep	orting period	o	68.00
	(line 13 x line 20)				· · · · · · · · · · · · · · · · ·		
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N				`		70.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	,		•)		70.00
71.00	Program routine service cost (line 9 x line		1110 /O # 111R)			72.00
73.00	Medically necessary private room cost applic		m (line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine serv			*			74.00
75. 00	Capital-related cost allocated to inpatient	routine service	e costs (from	Worksheet B,	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	no 2)					76.00
77.00	Program capital-related costs (line 9 x line	. *					77.00
78. 00	Inpatient routine service cost (line 74 minu						78.00
79. 00	Aggregate charges to beneficiaries for exces						79.00
80.00	Total Program routine service costs for comp		cost limitatio	on (line 78 mi	nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi		1)				81. 00 82. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•				82.00
	Program inpatient ancillary services (see in		/				84.00
84. 00			202)				85.00
	Utilization review - physician compensation	(see mstructro	JIIS)			!	00.00
84.00	Total Program inpatient operating costs (sum	of lines 83 th					86.00
84. 00 85. 00		of lines 83 th S THROUGH COST				984	86.00

Health Financial Systems	FERRELL HOSPITAL In Lieu			u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 04/01/2022 To 03/31/2023		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			2, 172, 652	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	932, 630	8, 561, 714	0. 10893	0 2, 172, 652	236, 667	90.00
91.00 Nursing Program cost	0	8, 561, 714	0.00000	0 2, 172, 652	0	91.00
92.00 Allied health cost	0	8, 561, 714	0.00000	0 2, 172, 652	0	92.00
93.00 All other Medical Education	0	8, 561, 714	0.00000	0 2, 172, 652	0	93.00

Heal th	Financial Systems FERRELL HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 14-1324	Peri od:	Worksheet D-1	
			From 04/01/2022 To 03/31/2023	Date/Time Pre 8/31/2023 4:0	
		Title XIX	Hospi tal	Cost	
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days	excluding newborn)		3. 988	1. 00
2. 00	Inpatient days (including private room days, excluding swing-be			2, 584	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days		ivate room days.	0	3.00
	do not complete this line.	-, ,, p.		_	
4.00	Semi-private room days (excluding swing-bed and observation be	d days)		1, 600	4.00
5.00	Total swing-bed SNF type inpatient days (including private room		er 31 of the cost	964	5.00
	reporting period	3 /			
6.00	Total swing-bed SNF type inpatient days (including private room	m days) after December	31 of the cost	321	6.00
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	89	7.00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	11 of the cost	30	8. 00
	reporting period (if calendar year, enter 0 on this line)	5			
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	11	9. 00
10.00	newborn days) (see instructions)	lu (i naludi na naivata n	soom doves)	0	10. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruct)		oom days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		nom davel after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en		dom days) arter	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
.2.00	through December 31 of the cost reporting period	con y (mor daming private	dayo,	<u> </u>	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room davs)	0	13.00
	after December 31 of the cost reporting period (if calendar yes				
14.00	Medically necessary private room days applicable to the Program	m (excluding swing-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 c	of the cost		17.00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to services	s after December 31 of	the cost		18. 00
40.00	reporting period			450.07	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	159. 97	19. 00
20.00	reporting period	ofter December 21 of t	ho cost	159. 97	20. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	arter becember 31 or t	ne cost	159. 97	20.00
21. 00	Teporting period Total general inpatient routine service cost (see instructions	`		8, 561, 714	21. 00
21.00	Swing-bed cost applicable to SNF type services through December		ing period (line		22.00
22.00	5 x line 17)	. or or the cost report	ing period (illie		22.00
23. 00	Swing-bed cost applicable to SNF type services after December :	31 of the cost reportin	a period (line A	0	23. 00
	x line 18)		3 ,		
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	14, 237	24.00
	17 11 10)	•			

	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3, 988	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2, 584	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
	do not complete this line.		
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	1, 600	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	964	5. 00
	reporting period	221	/ 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	321	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	89	7. 00
7.00	reporting period	0,	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	30	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	11	9. 00
40.00	newborn days) (see instructions)		40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	٥	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13.00	Swing bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
17.00	reporting period		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
	reporting period		
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	159. 97	19.00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	159. 97	20.00
21 00	reporting period	0 5/1 714	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	8, 561, 714 0	21. 00 22. 00
22.00	5 x line 17)	٥	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	14, 237	24.00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	4, 799	25. 00
04.00	x line 20)	0.054.000	04 00
26. 00	Total swing-bed cost (see instructions)	2, 856, 290	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	5, 705, 424	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Pri vate room charges (excluding swing-bed charges)	ő	
30.00	Semi-private room charges (excluding swing-bed charges)	0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line 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 and private room cost differential (line	0 5 705 424	36.00
37.00	27 minus line 36)	5, 705, 424	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	2, 207. 98	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	24, 288	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	24, 288	41.00

OMPUTATION OF INPATIENT OPERATING COST		FERRELL H		CCN: 14-1324	Peri od: From 04/01/2022 To 03/31/2023	w of Form CMS-2 Worksheet D-1 Date/Time Pre 8/31/2023 4:0	epar
	Cost Center Description	Total Inpatient Cost	Tit Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
. 00	NURSERY (title V & XIX only)						42
	Intensive Care Type Inpatient Hospital Unit	S		1			١.,
. 00	INTENSIVE CARE UNIT						43
00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						45
00	SURGICAL INTENSIVE CARE UNIT						46
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description	·		'			
	<u> </u>					1. 00	
00	Program inpatient ancillary service cost (W					28, 709	
01	Program inpatient cellular therapy acquisit), column 1)	D 007	48
00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	or) (see rinstr	uctions)		52, 997	49
00	Pass through costs applicable to Program in	natient routine	services (fr	om Wkst D si	ım of Parts I and	0	50
00		patront routino	301 11 003 (11	om mot. b, se	am or rurts r und	· ·	"
00	Pass through costs applicable to Program in	patient ancilla	ry services (from Wkst. D,	sum of Parts II	0	51
_	and IV)						
. 00	Total Program excludable cost (sum of lines		-1-4-1	L		0	
. 00	Total Program inpatient operating cost excl		eιaτed, non-p	nysician anest	netist, and	0	53
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	UZ)					1
. 00	Program discharges					0	54
. 00	Target amount per discharge					0.00	
. 01	Permanent adjustment amount per discharge					0.00	55
. 02	Adjustment amount per discharge (contractor	use only)				0. 00	55
. 00	Target amount (line 54 x sum of lines 55, 5					0	
. 00	Difference between adjusted inpatient opera	ting cost and ta	arget amount	(line 56 minus	s line 53)	0	
. 00	Bonus payment (see instructions)	on line EE from	m +bo ooo+ no	non+i na noni o	landing 1004	0 0. 00	
. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket		ii the cost re	porting period	i endring 1996,	0.00) 5
. 00	Expected costs (lesser of line 53 ÷ line 54		om prior vear	cost report.	updated by the	0. 00	60
. 00	market basket) Continuous improvement bonus payment (ifli	ne 53 ÷ line 54	is less than	the lowest of	· Flines 55 plus	0	6
	55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54 enter zero. (see instructions)						
. 00	Relief payment (see instructions)					0	1 .
. 00	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instri	uctions)			0	63
. 00	Medicare swing-bed SNF inpatient routine co	sts through Dece	ember 31 of t	he cost report	ing period (See	0	64
. 00	instructions)(title XVIII only)	oro tili ougii book	cinder or or c	ne cost report	ing period (occ	Ü	ľ
. 00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	ber 31 of the	cost reportir	ng period (See	0	6
	instructions)(title XVIII only)			.=>		_	١.,
. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line	65)(title XVI	II only); for	0	66
. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routi	ne costs through	h December 31	of the cost r	reporting period	0	6
. 50	(line 12 x line 19)	00313 tili ougi	Secomber 31	37 1110 0031 1	opor tring period	O	
. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after l	December 31 o	f the cost rep	orting period	0	68
_	(line 13 x line 20)						
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER I					0	69
. 00	Skilled nursing facility/other nursing faci				')		70
. 00	Adjusted general inpatient routine service	-		•	<i>'</i>		7
. 00	Program routine service cost (line 9 x line			,			72
. 00	Medically necessary private room cost appli		•				73
. 00	Total Program general inpatient routine ser	•		•	Dont III		74
.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (Trom	worksneet B,	rait II, COLUMN		75
00	Per diem capital-related costs (line 75 ÷ 1	ine 2)					76
00	Program capital -related costs (line 9 x lin						7
00	Inpatient routine service cost (line 74 min	*					78
00	Aggregate charges to beneficiaries for exce						79
00	Total Program routine service costs for com	•	cost limitati	on (line 78 mi	nus line 79)		80
00	Inpatient routine service cost per diem lim		1)				8
00	Inpatient routine service cost limitation (* .				82
. 00	Reasonable inpatient routine service costs Program inpatient ancillary services (see i	•	113)				83
	Utilization review - physician compensation		ons)				85
. 00	Total Program inpatient operating costs (su	•	,				86
. 00	Total Frogram Impatrent operating costs (su						
00	PART IV - COMPUTATION OF OBSERVATION BED PART Total observation bed days (see instruction	SS THROUGH COST				984	

Health Financial Systems	FERRELL HOSPITAL In Lieu			u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 04/01/2022 To 03/31/2023		
		Ti tl e	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			2, 172, 652	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	932, 630	8, 561, 714	0. 10893	0 2, 172, 652	236, 667	90.00
91.00 Nursing Program cost	0	8, 561, 714	0.00000	0 2, 172, 652	0	91.00
92.00 Allied health cost	0	8, 561, 714	0.00000	0 2, 172, 652	0	92.00
93.00 All other Medical Education	o	8, 561, 714	0. 00000	0 2, 172, 652	0	93. 00

Health Financial Systems FERRELL HO	SPI TAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 14-1324	Peri od:	Worksheet D-3	
			From 04/01/2022 To 03/31/2023		
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	The state of the s	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1, 00	2.00	col . 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS			1, 682, 577		30.00
ANCI LLARY SERVI CE COST CENTERS			1,002,377		30.00
50. 00 05000 OPERATI NG ROOM		0. 7271	14 51, 884	37, 726	50.00
53. 00 05300 ANESTHESI OLOGY		0. 30818		· ·	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 14098		· ·	
60. 00 06000 LABORATORY		0. 2093		· ·	
65. 00 06500 RESPIRATORY THERAPY		0. 4495	21 279, 620	125, 695	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 33940	00 371, 957	126, 242	66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 7422			
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS		0. 4701:			
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 4213	95 913, 934	385, 127	73.00
OUTPATIENT SERVICE COST CENTERS		T		1	
88. 00 08800 RURAL HEALTH CLI NI C		0.0000		0	
88. 01 08801 RURAL HEALTH CLINIC II		0.0000		0	
88. 02 08802 RURAL HEALTH CLINIC III		0.00000		0	
88. 03 08803 RURAL HEALTH CLINIC IV 90. 00 09000 CLINIC		0. 00000 0. 7988		0	
90. 00 09000 CLINI C		0.7988		0	
90. 02 09002 CLINIC - CHF		0.0000		0	90.01
90. 03 09003 CLINIC - ORTHO		0. 7049		0	90.03
91. 00 09100 EMERGENCY		0. 66200		_	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 55679			
200.00 Total (sum of lines 50 through 94 and 96 through 98)			3, 074, 360	· ·	1
201.00 Less PBP Clinic Laboratory Services-Program only charge	ges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)	,		3, 074, 360		202.00

Health F	FERRELL HOSPI	ΤΔΙ		Inlie	u of Form CMS-2	2552_10
			CN: 14-1324	Peri od:	Worksheet D-3	
				From 04/01/2022		
		Component	CCN: 14-Z324	To 03/31/2023	Date/Time Pre 8/31/2023 4:0	
		Title	XVIII	Swing Beds - SNF		4 рііі
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
				ŭ .	col . 2)	
			1.00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS					
	3000 ADULTS & PEDIATRICS					30.00
	NCILLARY SERVICE COST CENTERS					
	5000 OPERATING ROOM		0. 72711		0	
	5300 ANESTHESI OLOGY		0. 30818		0	53.00
	5400 RADI OLOGY-DI AGNOSTI C		0. 14098			
1	6000 LABORATORY		0. 20939			
1	6500 RESPI RATORY THERAPY		0. 44952			
	6600 PHYSI CAL THERAPY		0. 33940			
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 74225			71.00 72.00
	7200 IMPL. DEV. CHARGED TO PATIENTS 7300 DRUGS CHARGED TO PATIENTS		0. 47013 0. 42139		ı	
	UTPATIENT SERVICE COST CENTERS		0.42139	310, /14	133, 462	73.00
	8800 RURAL HEALTH CLINIC		0.00000	10	0	88. 00
	8801 RURAL HEALTH CLINIC II		0. 00000		0	88. 01
	8802 RURAL HEALTH CLINIC III		0. 00000		Ö	88. 02
	8803 RURAL HEALTH CLINIC IV		0. 00000		Ö	88. 03
	9000 CLINIC		0. 79882		Ō	90.00
90. 01 0	9001 CLINIC - MCLEANSBORO		0. 00000		0	90. 01
90. 02 0	9002 CLINIC - CHF		0. 00000		0	90. 02
90. 03 0	9003 CLINIC - ORTHO		0. 70496	0	0	90. 03
91.00 0	9100 EMERGENCY		0. 66200	165	109	91.00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART		1. 55679	9 0	0	92.00
200. 00	Total (sum of lines 50 through 94 and 96 through 98)			2, 352, 034		
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0	l	201.00
202. 00	Net charges (line 200 minus line 201)			2, 352, 034		202.00

Health Financial Systems FERRELL HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 14-1324	Peri od:	Worksheet D-3	
			From 04/01/2022 To 03/31/2023	Date/Time Pre 8/31/2023 4:0	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1.00	0.00	col . 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS		1	16, 536		30.00
ANCI LLARY SERVI CE COST CENTERS			10, 530		30.00
50, 00 05000 OPERATING ROOM		0. 7271	4 0	0	50.00
53. 00 05300 ANESTHESI OLOGY		0. 30818		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 14098		2, 557	54.00
60. 00 06000 LABORATORY		0. 20939			
65. 00 06500 RESPIRATORY THERAPY		0. 44952	•	1, 062	ł
66. 00 06600 PHYSI CAL THERAPY		0. 33940	•		ł
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 74225	4, 791	3, 556	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 47013	0	0	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 42139	13, 219	5, 570	73.00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		1. 40819		0	88. 00
88.01 08801 RURAL HEALTH CLINIC II		1. 27524		0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III		1. 25697		0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV		1. 00373		0	88. 03
90. 00 09000 CLI NI C		0. 79882		0	90.00
90. 01 09001 CLI NI C - MCLEANSBORO		0.00000		0	90. 01
90. 02 09002 CLI NI C - CHF 90. 03 09003 CLI NI C - ORTHO		0.00000		0	90. 02 90. 03
91. 00 09100 EMERGENCY		0. 70496 0. 66200		_	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 55679		10, 323	
200.00 Total (sum of lines 50 through 94 and 96 through 98)		1. 5507	62, 987	28, 709	
201. 00 Less PBP Clinic Laboratory Services-Program only charg	es (line 61)		02, 707		201.00
202.00 Net charges (line 200 minus line 201)	CS (1111C 01)		62, 987		202.00
		•	*		•

Real th Financial Systems FERRELL HOSPITAL Provider CON: 14-1324 From 04/01/2022 Component CON: 14-2324 From 04/01/2022 Component CON: 14-2324 From 04/01/2023 Component CON: 14-2324	Health Financial Systems FERRELL HOS	DI TAI		In Lie	u of Form CMS	2552 10
NAME Component CCN: 14-Z324 From 071/2022 Date/Time Prepared: 8/31/2023 4: 04 pm			CN: 14_1324			
Title XIX Swing Beds - SNF Cost	THE ATTENT AND LEART SERVICE COST ATTORTTONINENT					
Name State Cost		Component			8/31/2023 4:0	
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00		Ti tl	e XIX	Swing Beds - SNF	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3	Cost Center Description					
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3			To Charges			
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 3.00				Charges		
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 3000 ADULTS & PEDIATRICS 30.00 30.00 30.00 ADULTS & PEDIATRICS 30.00 30.00 30.00 30.00 ADULTS & PEDIATRICS 30.00 ADULTS			1.00	0.00		
30. 00 3000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	INDATIENT POUTINE CEDVICE COCT CENTERS		1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS						00.00
50. 00 05000 OPERATING ROOM 0. 727114 0 0 0 50. 00						30.00
53. 00 05300 ANESTHESI OLOGY 0.308188 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.140985 0 0 54. 00 60. 00 06000 LABORATORY 0.209399 0 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.449521 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.339400 0 0 66. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.742259 0 0 71. 00 72. 00 07200 I IMPL. DEV. CHARGED TO PATI ENTS 0.470134 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.421395 0 0 73. 00 00TPATI ENT SERVI CE COST CENTERS 0 0.421395 0 0 73. 00 88. 01 08801 RURAL HEALTH CLINIC C 1.408191 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINIC IV 1.256978 0 0 88. 02 90. 00 09000 CLINIC MCLINIC - MCLEANSBORO 0 0			0.70711	4	1 0	F0 00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.140985 0 0.54.00 06000 LABORATORY 0.209399 0 0.60.00 06500 06500 RESPI RATORY THERAPY 0.339400 0 0.65.00 066.00 066.00 066.00 066.00 071.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.742259 0 0.71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.470134 0 0.72.00 07300 DRUGS CHARGED TO PATIENTS 0.421395 0 0.73.00 07300 DRUGS CHARGED TO PATIENTS 0.421395 0 0.73.00 07300 DRUGS CHARGED TO PATIENTS 0.421395 0 0.73.00 07300 08801 RURAL HEALTH CLINIC 1.275245 0 0.88.00 08801 RURAL HEALTH CLINIC 1 1.275245 0 0.88.00 08801 RURAL HEALTH CLINIC 1 1.275245 0 0.88.00 08803 RURAL HEALTH CLINIC 1 1.256978 0 0.88.00 08803 RURAL HEALTH CLINIC 1 1.003738 0 0.88.00 0.9000 0.9000 0.1000 0.9000					-	
60.00 06000 LABORATORY 0.209399 0 0 60.00 65.00 RESPIRATORY THERAPY 0.449521 0 0 65.00 65.00 RESPIRATORY THERAPY 0.339400 0 0 65.00 66.00 PHYSICAL THERAPY 0.339400 0 0 66.00 0 66.00 PHYSICAL SUPPLIES CHARGED TO PATIENT 0.742259 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.470134 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.421395 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.421395 0 0 73.00 00000000000000000000000000000						
65.00 06500 RESPIRATORY THERAPY 0. 449521 0 0 65.00					-	
66.00 06600 PHYSICAL THERAPY 0.339400 0 0 66.00 71.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.742259 0 0 71.00 71.00 72.00 171.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.470134 0 0 72.00 73.00 PMUSC CHARGED TO PATIENTS 0.421395 0 0 73.00 PMUSC CHARGED TO PATIENTS 0.421395 0 0 73.00 PMUSC CHARGED TO PATIENTS 0 0.421395 0 0 0 73.00 PMUSC CHARGED TO PATIENTS 0 0.421395 0 0 0 73.00 PMUSC CHARGED TO PATIENTS 0 0.421395 0 0 0 73.00 PMUSC CHARGED TO PATIENTS 0 0.421395 0 0 0 73.00 PMUSC CHARGED TO PATIENTS 0 0.421395 0 0 0 88.00 PMUSC CHARGED TO PATIENTS 0 0.421395 0 0 0 88.00 PMUSC CHARGED TO PATIENTS 0 0.421395 0 0 0 88.00 PMUSC CHARGED TO PATIENTS 0 0.421395 0 0 0 88.00 PMUSC CHARGED TO PATIENTS 0 0.421395 0 0 0 88.00 PMUSC CHARGED TO PATIENTS 0 0 0 0 88.00 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.01 PMUSC CHARGED TO PATIENTS 0 0 0 90.01 PMUSC CHARGED TO PATIENTS 0 0 0 90.02 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.03 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.03 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.03 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.00 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.00 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.00 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.00 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.00 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.00 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.00 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.00 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.00 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.00 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.00 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.00 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.00 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.00 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.00 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.00 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.00 PMUSC CHARGED TO PATIENTS 0 0 0 0 90.00 PMUSC CHARGED					-	
71. 00					1	
72.00			1		-	
73.00 07300 DRUGS CHARGED TO PATIENTS 0.421395 0 0.73.00					-	
SECTION SERVICE COST CENTERS SECTION S						
88.00 08800 RURAL HEALTH CLINIC 1 1 275245 0 0 88.01 88.01 88.02 08802 RURAL HEALTH CLINIC 1 1 275245 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC 1 1 1 256978 0 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC 1 1 1 003738 0 0 0 88.03 90.00 09000 CLINIC 0 0798822 0 0 90.00 09000 CLINIC 0 0798822 0 0 90.00 09000 CLINIC 0 000000 0 0 000000 0 0			0.4213	5 0		73.00
88. 01			1 40819	1 0	0	88 00
88.02 08802 RURAL HEALTH CLINIC III 1.256978 0 0 88.02 88.03 08803 RURAL HEALTH CLINIC IV 1.003738 0 0 0 88.03 90.00 09000 CLINIC 0.798822 0 0 090.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000					-	
88.03 08803 RURAL HEALTH CLINIC IV 1.003738 0 0 088.03 0.00 0.0					-	
90. 01					0	
90. 02 09002 CLINIC - CHF 0.000000 0 90. 02 90. 03 90. 03 90. 03 90. 03 90. 03 90. 03 90. 00 90. 03 90. 00 9	90. 00 09000 CLI NI C		0. 79882	2 0	0	90.00
90. 03	90. 01 09001 CLINIC - MCLEANSBORO		0.00000	0	0	90. 01
91.00 09100 EMERGENCY 0.662003 0 91.00 92.00 09200 08SERVATION BEDS (NON-DISTINCT PART 1.556799 0 92.00 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00	90. 02 09002 CLI NI C - CHF		0.00000	0 0	0	90. 02
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 1.556799 0 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 0 0 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	90. 03 09003 CLINIC - ORTHO		0. 70496	1 0	0	90.03
200.00 Total (sum of lines 50 through 94 and 96 through 98) 0 0 200.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	91. 00 09100 EMERGENCY		0. 66200	0	0	91.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART		1. 55679	9 0	0	92.00
				0		
202.00 Net charges (line 200 minus line 201) 0 202.00		es (line 61)		0		
	202.00 Net charges (line 200 minus line 201)			0		202.00

Health Financial Systems	FERRELL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1324	Peri od: From 04/01/2022 To 03/31/2023	Worksheet E Part B Date/Time Prepared: 8/31/2023 4:04 pm

	T. I. W. I.	8/31/2023 4:0	4 pm
	Title XVIII Hospital	Cost	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9, 168, 664	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3. 00 4. 00	OPPS or REH payments Outlier payment (see instructions)	0	
4. 01	Outlier reconciliation amount (see instructions)	0	4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	1
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	1
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	
10.00	Organ acquisitions	0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	9, 168, 664	
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
	Ancillary service charges	0	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13)	0	
14.00	Customary charges		14.00
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)		
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	18. 00 19. 00
17.00	instructions)	Ĭ	17.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
	instructions)		
	Lesser of cost or charges (see instructions)	9, 260, 351	ł
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructions)	0	
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		•
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	81, 873	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4, 002, 409	•
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	5, 176, 069	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 00
	REH facility payment amount		28. 50
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29. 00
	Subtotal (sum of lines 27, 28, 28.50 and 29)	5, 176, 069	•
	Primary payer payments	1, 673 5, 174, 396	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	5, 174, 390	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
	Allowable bad debts (see instructions)	483, 215	34.00
	Adjusted reimbursable bad debts (see instructions)	314, 090	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	483, 215	
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	5, 488, 486	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	1
	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)	0	39. 75
	Demonstration payment adjustment amount before sequestration	0	39. 97
	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)	5, 488, 486	39. 99 40. 00
40. 01	Sequestration adjustment (see instructions)	96, 048	
	Demonstration payment adjustment amount after sequestration	0	
	Sequestration adjustment-PARHM pass-throughs		40. 03
	Interim payments	6, 279, 975	
41.01	Interim payments-PARHM Tentative settlement (for contractors use only)	0	41. 01 42. 00
	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)	0	42.00
43. 00	Balance due provider/program (see instructions)	-887, 537	•
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		
90. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	0	90.00
	Outlier reconciliation adjustment amount (see instructions)	0	
	The rate used to calculate the Time Value of Money	0.00	•
93. 00		0	
94. 00	Total (sum of lines 91 and 93)	0	94.00

Health Financial Systems	FERRELL HOSP	I TAL	In Lieu	of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT				Worksheet E	
			From 04/01/2022		
			To 03/31/2023	Date/Time Pr	epared:
				8/31/2023 4:	04 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				(0 200. 00

Provider CCN: 14-1324

					8/31/2023 4: 04	4 pm
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1, 00	2, 00	3, 00	4, 00	
1. 00	Total interim payments paid to provider		3, 097, 36	3	6, 994, 763	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3,377,65	0	0	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 PROVI DER	10/19/2022	44, 62	4	0	3. 01
3. 02 3. 03 3. 04 3. 05	ADJUSTIMENTS TO FROVIDEN	12/14/2022 03/29/2023	18, 11 264, 17	3	0	3. 02 3. 03 3. 04 3. 05
0.00	Provider to Program			<u> </u>		0.00
3. 50 3. 51 3. 52	ADJUSTMENTS TO PROGRAM			0 10/19/2022 0 12/14/2022 0 03/29/2023	457, 894 224, 036 32, 858	3. 50 3. 51 3. 52
3. 53 3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0 0 8	0 0 -714, 788	3. 53 3. 54 3. 99
	3. 50-3. 98)		·		·	
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		3, 424, 27	1	6, 279, 975	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)					5. 00
	Program to Provider					
5. 01 5. 02	TENTATI VE TO PROVI DER			0	0	5. 01 5. 02
5. 03	Dravi dan ta Dragnam			0	0	5. 03
E E0	Provider to Program TENTATIVE TO PROGRAM					E E0
5. 50	IENIATIVE TO PROGRAM			0	0	5.50
5. 51				0	0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 52 5. 99
6. 00	5.50-5.98) 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 PROVIDER		74, 56	٧	887, 537	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 349, 70		5, 392, 438	7. 00
7.00	notal mean care program readility (see instructions)		1 3, 347, 70	Contractor Number	NPR Date (Mo/Day/Yr)	7.00
		,)	1. 00	2. 00	
8. 00	Name of Contractor		<i>J</i>	1.00	2.00	8. 00
0.00	Invalle of Collet actor			Ţ	ı l	0.00

Provider CCN: 14-1324 | Period: | Worksheet E-1 | Part | | Period: | Period: | From 04/01/2022 | Part | Par

					8/31/2023 4:0	4 pm
				ving Beds - SNF		
		Inpatien	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		2, 295, 173		0	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	10/19/2022	42, 573		0	
3. 02		12/14/2022	9, 735		0	
3. 03		03/29/2023	1, 078		0	
3. 04			0		0	
3.05			0		0	3.05
	Provider to Program					ļ
3. 50	ADJUSTMENTS TO PROGRAM		0		0	
3. 51			0		0	
3. 52			0		0	
3. 53			0		0	0.00
3. 54			0		0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		53, 386		0	3. 99
	3. 50-3. 98)		0 040 550			
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 348, 559		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					1
5. 00	List separately each tentative settlement payment after					5.00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					1
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			l o		0	
5. 03			0		0	5.03
	Provi der to Program			<u>'</u>	<u> </u>	1
5.50	TENTATI VE TO PROGRAM		0		0	5.50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		635, 240		0	
6. 02	SETTLEMENT TO PROGRAM		0		0	
7. 00	Total Medicare program liability (see instructions)		2, 983, 799		0	7. 00
				Contractor	NPR Date	
			2	Number	(Mo/Day/Yr)	
9 00	Nome of Contractor		0	1. 00	2.00	8.00
8. 00	Name of Contractor			l	l	J 8.00

Heal th	ealth Financial Systems FERRELL HOSPITAL In L			u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 14-1324 Period: From 04/01/2022 To 03/31/2023			Worksheet E-1 Part II Date/Time Pre 8/31/2023 4:0	pared:
		Title XVIII	Hospi tal	Cost	
				4 00	
	TO DE COMPLETED BY CONTRACTOR FOR MONETANDARD COST DEPORTS			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	N			-
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst		0.14		1.00
2. 00	Medicare days (see instructions)	. 3-3, 11. 1 601. 13 1111	C 14		2.00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4. 00	Total inpatient days (see instructions)				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	P.00 Sequestration adjustment amount (see instructions)			9. 00	
10. 00		(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)		,		31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00

Health Financial Systems FERRELL HOSPITAL		In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provi der CCN: 14-1324	Peri od: Worksheet E-2
		From 04/01/2022

		Component CCN: 14-Z324	From 04/01/2022 To 03/31/2023	8/31/2023 4:0	
		Title XVIII S	wing Beds - SNF Part A	Cost Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		2, 163, 157	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		884, 596	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swire that the color of t	ng-bed pass-through, see			
2 01	instructions) Nursing and allied health payment-PARHM (see instructions)				2 01
3. 01 4. 00	Per diem cost for interns and residents not in approved teachi	ng program (see		0. 00	3. 01 4. 00
4.00	instructions)	ng program (see		0.00	4.00
5. 00	Program days		970	0	5.00
6.00	Interns and residents not in approved teaching program (see in	nstructions)		0	•
7.00	Utilization review - physician compensation - SNF optional met	thod only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		3, 047, 753	0	8. 00
9.00	Primary payer payments (see instructions)		0	0	
10.00	Subtotal (line 8 minus line 9)		3, 047, 753	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	0	0	11. 00
12.00	professional services)		2 047 752	0	12.00
12. 00 13. 00	Subtotal (line 10 minus line 11) Coinsurance billed to program patients (from provider records)	(exclude coinsurance	3, 047, 753 10, 808	0	12. 00 13. 00
13.00	for physician professional services)	(exclude collisulance	10, 000	O	13.00
14. 00	80% of Part B costs (line 12 x 80%)			0	14.00
	Subtotal (see instructions)		3, 036, 945	0	•
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)			16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr	ration) payment	0		16. 55
	adjustment (see instructions)		_	_	
	Demonstration payment adjustment amount before sequestration		0	0	
	Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	suctions)	0	0	
	Total (see instructions)	uctions)	3, 036, 945	0	
	Sequestration adjustment (see instructions)		53, 146	0	•
	Demonstration payment adjustment amount after sequestration)		0	0	•
	Sequestration adjustment-PARHM pass-throughs				19. 03
19. 25	Sequestration for non-claims based amounts (see instructions)		0	0	19. 25
	Interim payments		2, 348, 559	0	20.00
	Interim payments-PARHM				20. 01
	Tentative settlement (for contractor use only)		0	0	
21. 01	Tentative settlement-PARHM (for contractor use only)	10 2E 20 and 21)	42E 240	0	21. 01 22. 00
22. 00 22. 01	Balance due provider/program (line 19 minus lines 19.01, 19.02 Balance due provider/program-PARHM (see instructions)	2, 19.25, 20, and 21)	635, 240	U	22.00
23. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2	0	0	1
20.00	chapter 1, §115.2	.55 66 . 45 2,		ŭ	20.00
	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) Adjustment	<u>'</u>		
200.00	Is this the first year of the current 5-year demonstration per	riod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
004 00	Cost Reimbursement	West D. A. Die H. Line	1		004 00
201.00	Medicare swing-bed SNF inpatient routine service costs (from V 66 (title XVIII hospital))	WKST. D-I, PT. II, IINE			201. 00
202 00	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst D_3 col 3 line			202. 00
202.00	200 (title XVIII swing-bed SNF))	WK31. D-3, COL. 3, TITLE			202.00
203.00	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curren	t 5-year demons	trati on	
	peri od)				
	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti				206. 00
207 00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs Program reimbursement under the §410A Demonstration (see inst				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	•			208.00
200.00	and 3)	_,			200.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209. 00
	Reserved for future use				210.00
	Comparision of PPS versus Cost Reimbursement				
215. 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see			215. 00
	i nstructi ons)		1		l

Provider CCN: 14-1324 | Peri od: From 04/01/2022 | To 03/31/2023 | Date/Time Prepared: 8/31/2023 4:04 pm

		00,01,2020	8/31/2023 4: 04	4 pm
	Title XIX S	wing Beds - SNF	Cost	
		Part A		
LITATION OF NET COCT OF COVERED CERVILORS		1.00	2. 00	
				1.00
				2.00
	t A and sum of Wkst D			3.00
	· · · · · · · · · · · · · · · · · · ·	o o		3.00
	ng bed pass thi dagii, see			
,				3. 01
	ing program (see	0.00		4.00
1.1	g pg (
ram days		0		5.00
rns and residents not in approved teaching program (see i	nstructions)	0		6.00
ization review - physician compensation - SNF optional me	thod only	0	l	7.00
otal (sum of lines 1 through 3 plus lines 6 and 7)		0	l	8.00
ary payer payments (see instructions)		0		9.00
otal (line 8 minus line 9)		0	l	10.00
ctibles billed to program patients (exclude amounts appli	cable to physician	0		11.00
essi onal servi ces)				
otal (line 10 minus line 11)		0		12.00
surance billed to program patients (from provider records) (exclude coinsurance	0		13.00
physician professional services)				
of Part B costs (line 12 x 80%)		0		14.00
otal (see instructions)		0		15.00
R ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16.00
eer ACO demonstration payment adjustment (see instruction	s)			16. 50
I community hospital demonstration project (§410A Demonst	ration) payment			16. 55
stment (see instructions)				
nstration payment adjustment amount before sequestration		0		16. 99
		0		17. 00
		0		17. 01
wable bad debts for dual eligible beneficiaries (see inst	ructi ons)	0		18. 00
· ·		0		19. 00
· · · · · · · · · · · · · · · · · · ·		0		19. 01
		0		19. 02
, ,				19. 03
· · · · · · · · · · · · · · · · · · ·				19. 25
. 3		0		20.00
. 3				20. 01
•		0		21.00
•	0 40 05 00 04)			21.01
	2, 19.25, 20, and 21)	U		22.00
	with CMC Dub. 1E 2			22. 01
	nce with CMS Pub. 15-2,	U		23. 00
	ration) Adivotment			
				200. 00
	Trod under the 21st			200.00
	Wkst D_1 Pt II line			201. 00
	wkst. b i, it. ii, iiie			201.00
	m Wkst D-3 col 3 line			202. 00
				202.00
				203. 00
				204.00
utation of Demonstration Target Amount Limitation (N/A in	first year of the current	t 5-year demons	trati on	
	•	,		
od)				
			l	205.00
od)	imes line 204)			205.00
od) care swing-bed SNF target amount				
od) care swing-bed SNF target amount care swing-bed SNF inpatient routine cost cap (line 205 t	sement			
od) care swing-bed SNF target amount care swing-bed SNF inpatient routine cost cap (line 205 t stment to Medicare Part A Swing-Bed SNF Inpatient Reimburs ram reimbursement under the §410A Demonstration (see inst	sement ructions)			206. 00
od) care swing-bed SNF target amount care swing-bed SNF inpatient routine cost cap (line 205 t stment to Medicare Part A Swing-Bed SNF Inpatient Reimburg	sement ructions)			206. 00 207. 00
od) care swing-bed SNF target amount care swing-bed SNF inpatient routine cost cap (line 205 t stment to Medicare Part A Swing-Bed SNF Inpatient Reimbur- ram reimbursement under the §410A Demonstration (see inst care swing-bed SNF inpatient service costs (from Wkst. E-	sement ructions) 2, col. 1, sum of lines 1			206. 00 207. 00
od) care swing-bed SNF target amount care swing-bed SNF inpatient routine cost cap (line 205 t stment to Medicare Part A Swing-Bed SNF Inpatient Reimbur- ram reimbursement under the §410A Demonstration (see inst care swing-bed SNF inpatient service costs (from Wkst. E- 3)	sement ructions) 2, col. 1, sum of lines 1			206. 00 207. 00 208. 00
care swing-bed SNF target amount care swing-bed SNF target amount care swing-bed SNF inpatient routine cost cap (line 205 t stment to Medicare Part A Swing-Bed SNF Inpatient Reimbur ram reimbursement under the §410A Demonstration (see instrucare swing-bed SNF inpatient service costs (from Wkst. E-3) stment to Medicare swing-bed SNF PPS payments (see instru	sement ructions) 2, col. 1, sum of lines 1			206. 00 207. 00 208. 00 209. 00
care swing-bed SNF target amount care swing-bed SNF inpatient routine cost cap (line 205 t stment to Medicare Part A Swing-Bed SNF Inpatient Reimburs ram reimbursement under the §410A Demonstration (see inst care swing-bed SNF inpatient service costs (from Wkst. E-3) stment to Medicare swing-bed SNF PPS payments (see instrurved for future use	sement ructions) 2, col. 1, sum of lines 1 ctions)			206. 00 207. 00 208. 00 209. 00
THE THEOREM SHOOT HOUSE IN VENEZULA THE STREET HOUSE OF HOUSE IN VENEZULA THE STREET HOUSE OF HOUSE	tient routine services - swing bed-NF (see instructions) Ilary services (from Wkst. D-3, col. 3, line 200, for Par V, cols. 6 and 7, line 202, for Part B) (For CAH and swi ructions) ing and allied health payment-PARHM (see instructions) ing and allied health payment-PARHM (see instructions) ing and allied health payment-PARHM (see instructions) ructions) ram days rus and residents not in approved teaching program (see i ization review - physician compensation - SNF optional me otal (sum of lines 1 through 3 plus lines 6 and 7) ary payer payments (see instructions) otal (line 8 minus line 9) ctibles billed to program patients (exclude amounts appli essional services) otal (line 10 minus line 11) surance billed to program patients (from provider records physician professional services) of Part B costs (line 12 x 80%) otal (see instructions) R ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) eer ACO demonstration payment adjustment (see instruction l community hospital demonstration project (§410A Demonst stment (see instructions) nstration payment adjustment amount before sequestration wable bad debts (see instructions) sted reimbursable bad debts (see instructions) sted reimbursable bad debts (see instructions) setration adjustment (see instructions) nstration payment adjustment amount after sequestration) estration adjustment (see instructions) nstration payment adjustment amount after sequestration) estration for non-claims based amounts (see instructions) rim payments rim payments -PARHM ative settlement (for contractor use only) ince due provider/program (line 19 minus lines 19.01, 19.0 nce due provider/program-PARHM (see instructions) ested amounts (nonallowable cost report items) in accorda ter 1, §115.2 Community Hosp	JIATION OF NET COST OF COVERED SERVICES tient routine services - swing bed-SNF (see instructions) tient routine services - swing bed-SNF (see instructions) tient routine services - swing bed-NF (see instructions) liary services (from Wkst. D. 3, col. 3, line 200, for Part A, and sum of Wkst. D., V. cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see ructions) ing and allied heal th payment-PARHM (see instructions) diem cost for interns and residents not in approved teaching program (see ructions) ram days ram days ram days ram and residents not in approved teaching program (see instructions) ization review - physician compensation - SNF optional method only otal (sum of lines 1 through 3 plus lines 6 and 7) ary payer payments (see instructions) otal (line 8 minus line 9) ctibles billed to program patients (exclude amounts applicable to physician essional services) otal (line 10 minus line 11) surance billed to program patients (from provider records) (exclude coinsurance physician profess) onal services) of Part B costs (line 12 x 80%) otal (see instructions) R ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) eer ACO demonstration payment adjustment (see instructions) I community hospital demonstration project (\$410A Demonstration) payment strent (see instructions) stration payment adjustment amount before sequestration wable bad debts (see instructions) sted eriembrusable bad debts (see instructions) sted riembrusable bad debts (see instructions) setration adjustment ARHMM pass-throughs estration of Justment-PARHM (for contractor use only) nice due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) nice due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) nice due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) nice due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) nice due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) nice due provider/program (TATION OF NET COST OF COVERED SERVICES tient routine services - swing bed-NF (see instructions) tient routine services - swing bed-NF (see instructions) lary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see ructions) ing and allied heal th payment-PARHM (see instructions) ing and allied heal the payment part (see instructions) ing and residents not in approved teaching program (see instructions) ram days ram days ram days ram days ram say and residents not in approved teaching program (see instructions) 1 2 3 4 10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	TITLE XIX SWING Beds - SWF Cost Part A Part B THE A PART

Health Financial Systems	FERRELL HOSPITAL	In Lieu of Form CMS-25		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1324	Peri od: From 04/01/2022 To 03/31/2023	Worksheet E-3 Part V Date/Time Prepared: 8/31/2023 4:04 pm	
	Title XVIII	Hospi tal	Cost	

		Title XVIII Hospi	tal	8/31/2023 4: 0- Cost	4 pm
PART V - CALCULATION OF REINBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REINBURSEMENT				1.00	
Inpatient services 3,673,039 1,00		DADT V CALCULATION OF DELMDIDSEMENT SETTLEMENT FOR MEDICADE DADT A SEDVICES COST DELMDIDS	EMENT	1.00	
Nursing and Allied Heal th Managed Care payment (see instructions)	1 00		LIVILINI	3 673 039	1 00
Organ acquisition 0 3.00					
1.00 Coltrol (sum of Irlns 1 through 3.01) 3.073,039 4.00 5.00 7.00					
Primary payer payments				0	
Total cost (line 4 less line 5). For CAH (see instructions) 8,709,769 6.00	4.00	Subtotal (sum of lines 1 through 3.01)	ļ	3, 673, 039	4.00
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Reasonable charges Routine service charges 0 7.00 8.00 Routine service charges 0 9.00 0.00 Routine service charges 0 9.00 0.00 Routine service charges 0 9.00 0.00 0.00 Routine service charges 0 9.00 0.00 Routine service charges 0 9.00 0.00 0.00 Routine service charges 0 9.00 0.00 Routine service charges 0 9.00 0	5.00			0	5.00
Reasonable charges 0	6.00			3, 709, 769	6.00
Routine service charges 0 7.00 0.00					
Ancillary service charges 0 8.00 0.000 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.000 0.00 0	7 00	J		0	7 00
0		9			
10.00 Total reasonable charges 0 10.00					
Customary charges					
11.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 11.00	10.00	J.		J	10.00
12.00 Amounts that would have been realized from patients liable for payment for services on a charge basis Nature	11. 00		basi s	0	11.00
13.00 Ratio of line 11 to line 12 (not to exceed 1.000000) 13.00 14.00	12.00			0	12.00
14. 00 Total customary charges (see instructions) 14. 00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see 15. 00 15. 00 15. 00 16					
15.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 18.00 19.0					
Instructions Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see 0 16.00 17.00					
16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see Instructions) 17.00 Cost of physicians' services in a teaching hospital (see instructions) 17.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT	15.00		е	0	15.00
Instructions Cost of physicians' services in a teaching hospital (see instructions) 0 17. 00	14 00		_	0	14 00
17.00	10.00		e	U	16.00
Sequential Computation C	17 00		-	0	17 00
18.00	17.00			Ü	17.00
20.00 Deductibles (exclude professional component) 326, 024 20.00	18.00			0	18. 00
21.00 Excess reasonable cost (from line 16) 0 21.00 22.00 3.383, 745 22.00 23.00 20.01 20.00 24.00 3.383, 745 22.00 23.00 25.00 All owable bad debts (exclude bad debts for professional services) (see instructions) 26, 821 25.00 27.00 All owable bad debts for dual eligible beneficiaries (see instructions) 26, 821 25.00 27.00 All owable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 29.00 29.00 29.50 29.90 29.50 29.90	19.00	Cost of covered services (sum of lines 6, 17 and 18)		3, 709, 769	19.00
22. 00 Subtotal (line 19 minus line 20 and 21) 3, 383, 745 22. 00 23. 00 Coinsurance 1, 200 23. 00 24. 00 Subtotal (line 22 minus line 23) 3, 382, 545 24. 00 25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 41, 263 25. 00 26. 00 Adjusted reimbursable bad debts (see instructions) 26, 821 26. 00 27. 00 Allowable bad debts for dual eligible benefic aries (see instructions) 41, 263 27. 00 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 3, 409, 366 28. 00 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29. 00 29. 98 Recovery of accelerated depreciation. 0 29. 90 29. 99 Demonstration payment adjustment amount before sequestration 0 29. 99 30. 01 Sequestration adjustment (see instructions) 3, 409, 366 30. 00 30. 02 Demonstration payment adjustment amount after sequestration 9 9, 603 30. 01 30. 02 Demonstration payments 3, 409, 366 30. 00 31. 01 Interim payments-PARHM 3, 409, 366 <td>20.00</td> <td>Deductibles (exclude professional component)</td> <td> </td> <td>326, 024</td> <td>20.00</td>	20.00	Deductibles (exclude professional component)		326, 024	20.00
23.00 Coinsurance 1, 200 23.00 24.00 Subtotal (line 22 minus line 23) 3, 382,545 24.00 0.00 26.00 Adjusted reimbursable bad debts (see instructions) 26.00 Adjusted reimbursable bad debts (see instructions) 26.821 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 26.821 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 3, 409, 366 28.00 29.00 0.01 0.					
24.00 Subtotal (line 22 minus line 23) 3,382,545 24.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 41,263 25.00 26.00 Adjusted reimbursable bad debts (see instructions) 26,821 25.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 41,263 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 3,409,366 28.00 29.50 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.00 29.90 Pioneer ACO demonstration payment adjustment (see instructions) 0 29.50 29.99 Recovery of accelerated depreciation. 0 29.99 29.99 Demonstration payment adjustment amount before sequestration 0 29.99 30.01 Sequestration adjustment (see instructions) 3,409,366 30.00 30.02 Demonstration payment adjustment amount after sequestration 0 29.99 30.03 Sequestration adjustment-PARHM 30.02 31.01 Interim payments 3,424,271 31.00 31.01 Interim payments-PARHM 31.01 31.01 32.01 <td></td> <td></td> <td></td> <td></td> <td></td>					
25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26.00 Adjusted reimbursable bad debts (see instructions) 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pi oneer ACO demonstration payment adjustment (see instructions) 29.98 Recovery of accelerated depreciation. 29.99 Demonstration payment adjustment amount before sequestration 30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment (see instructions) 30.01 Interim payments 30.02 Interim payments 30.03 Interim payments 30.04, 271 31.00 30.05 Sequestration adjustment (for contractor use only) 30.01 Tentative settlement (for contractor use only) 30.02 Bal ance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 30.01 Bal ance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32.01) 34.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,					
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34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00			1)	.,	
§115. 2	34.00			0	34.00
		§115. 2			

Health Financial Systems	FERRELL HOSPITAL	In Lieu of Form CMS-2552-1	-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1324	Peri od: Worksheet E-3 From 04/01/2022 Part VII To 03/31/2023 Part VII Date/Time Prepared:	

			To 03/31/2023	Date/Time Pre 8/31/2023 4:0	
		Title XIX	Hospi tal	Cost	ı pııı
		THE WAY	I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI		21.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	THE TOTAL THE PERSON AND AND AND AND AND AND AND AND AND AN	X 02.X 1 020		
1. 00	Inpatient hospital/SNF/NF services		52, 997		1.00
2. 00	Medical and other services		02,777	512, 973	2.00
3. 00	Organ acquisition (certified transplant programs only)		0	012, 770	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		53, 527	518, 103	•
5. 00	Inpatient primary payer payments		00,02,	0.07.00	5.00
6. 00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		53, 527	518, 103	7.00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		00,02,	0.07.00	7.00
	Reasonable Charges				
8. 00	Routine service charges		0		8.00
9. 00	Ancillary service charges		62, 987	1, 589, 359	9. 00
10.00	Organ acquisition charges, net of revenue		0	.,,	10.00
11. 00			0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		62, 987	1, 589, 359	•
	CUSTOMARY CHARGES		,	, , , , , ,	
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis	9			
14.00	Amounts that would have been realized from patients liable for	payment for services or	0	0	14.00
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		62, 987	1, 589, 359	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only	y if line 16 exceeds	9, 460	1, 071, 256	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
	16) (see instructions)		_	_	
19. 00	Interns and Residents (see instructions)		0	0	
20.00	Cost of physicians' services in a teaching hospital (see instr		0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		53, 527	518, 103	21.00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid		0	22 00
	Other than outlier payments		0	0	22. 00 23. 00
	Outlier payments Program capital payments		0	U	24.00
	Capital exception payments (see instructions)		0		25.00
26. 00	Routine and Ancillary service other pass through costs		0	0	•
27. 00	Subtotal (sum of lines 22 through 26)		0	0	•
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		53, 527	518, 103	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		33, 327	310, 103	27.00
30. 00	Excess of reasonable cost (from line 18)		0	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		53, 527	518, 103	
32. 00	Deductibles		0 0	0	32.00
33. 00	Coinsurance		0	0	
34. 00	Allowable bad debts (see instructions)		0	0	34.00
	Utilization review		0	U	35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	53, 527	518, 103	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		00,027	0	37.00
	Subtotal (line 36 ± line 37)		53, 527	518, 103	1
	Direct graduate medical education payments (from Wkst. E-4)		0	2.2, .22	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		53, 527	518, 103	40.00
41. 00	Interim payments		53, 527	518, 103	1
42.00	Balance due provider/program (line 40 minus line 41)		0	0	1
43.00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

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

Provider CCN: 14-1324

Course C	T DI	pm
CURRENT ASSETS	t Plant Fund	
1.00	4.00	
Temporary investments		
Notes receivable		1.00
Accounts receivable	I I	2.00
Other receivable 598,815 0 0 0 0 0 0 0 0 0	I I	4.00
All Owances for uncollectible notes and accounts receivable 0 0 0 0 0 0 0 0 0	I I	5. 00
Prepaid expenses	I I	6.00
9.00 Other current assets 0 0 0 11.00 Due from other funds 0 0 11.00 Total current assets (sum of lines 1-10) 8,248,878 0 12.00 Land Iand Inprovements 0 0 13.00 Buil dings 18,512,577 0 15.00 Buil dings 18,512,577 0 16.00 Accumulated depreciation -3,000,261 0 17.00 Leasehold improvements 0 0 0 17.00 Leasehold improvements 0 0 0 18.00 Accumulated depreciation 0 0 0 19.00 Fixed equipment 0 0 0 19.00 Fixed equipment 0 0 0 10.00 Automobiles and trucks 0 0 0 12.00 Automobiles and trucks 0 0 0 12.00 Accumulated depreciation 0 0 0 12.00 Accumulated depreciation 0 0 12.00 Deposition Capability Capabil	0 0	7.00
10.00 Due from other funds		8.00
11.00 Total current assets (sum of lines 1-10) 8, 248, 878 0		9. 00
FIXED ASSETS	· · · · · · · · · · · · · · · · · · ·	10. 00
12.00 Land Inprovements	0 0 1	11. 00
13. 00	0 0 1:	12. 00
14. 00 Accumul ated depreciation -43,063 0 0 18. 512, 577 0 0 0 0 0 0 0 0 0	·	12. 00 13. 00
15. 00 Buildings 18.512,577 0 0 16. 00 Accumulated depreciation -3.000,261 0 0 0 17. 00 Leasehold improvements 0 0 0 0 0 0 0 0 0		14. 00
16. 00 Accumul ated depreciation -3,000,261 0 17. 00 Leasehold improvements 0 0 18. 00 Accumul ated depreciation 0 0 19. 00 Fixed equipment 0 0 10. 00 Accumul ated depreciation 0 0 10. 00 Automobiles and trucks 0 0 0 12. 00 Accumul ated depreciation 0 0 12. 00 Accumul ated depreciation 0 0 13. 00 Accumul ated depreciation 0 0 14. 00 Accumul ated depreciation 0 0 15. 00 Accumul ated depreciation 0 0 16. 00 Accumul ated depreciation 0 0 17. 00 Accumul ated depreciation 0 0 18. 00 Accumul ated depreciation 0 0 19. 00 HIT designated Assets 0 0 0 19. 00 Accumul ated depreciation 0 0 19. 00 Minor equipment-nondepreciable 0 0 19. 00 Minor equipment-nondepreciable 0 0 10. 00 Total fixed assets (sum of lines 12-29) 37,170,454 0 19. 00 OTHER ASSETS 0 0 10. 01 OTHER ASSETS 0 0 10. 01 OTHER ASSETS 0 0 10. 02 OTHER ASSETS 0 0 0 10. 01 OTHER ASSETS 0 0 0 10. 02 OTHER ASSETS 0 0 0 10. 03 OTHER ASSETS 0 0 0 10. 00 OTHER ASSETS 0 0		15. 00
17. 00 Leasehold improvements		16. 00
19.00 Fixed equipment	0 0 1	17. 00
20. 00 Accumul ated depreciation 0 0 0 0 0 0 0 0 0		18. 00
21.00 Accumul ated depreciation 0 0 0 0 0 0 0 0 0	I I	19. 00
22.00 Accumulated depreciation 0 0 0 0 0 0 0 0 0		20. 00
23.00	·	21.00
24.00 Accumulated depreciation -9,579,331 0 25.00 Minor equipment depreciation 0 0 26.00 Accumulated depreciation 0 0 27.00 HIT designated Assets 0 0 28.00 Accumulated depreciation 0 0 29.00 Minor equipment-nondepreciable 0 0 30.00 Total fixed assets (sum of lines 12-29) 37, 170, 454 0 OTHER ASSETS 0 0 0 31.00 Investments 0 0 32.00 Deposits on leases 0 0 34.00 Other assets 5, 894, 442 0 35.00 Total other assets (sum of lines 31-34) 5, 894, 442 0 36.00 Total assets (sum of lines 11, 30, and 35) 51, 313, 774 0 CURRENT LIABILITIES Total assets (sum of lines 11, 30, and 35) 51, 314, 410 0 39.00 Payroll taxes payable 1, 677, 640 0 39.00 Payroll taxes payable 10, 677, 640 0 40.00 Notes and loans payable (short term) 0		22. 00 23. 00
25.00 Minor equipment depreciable 0 0 0 0 0 0 0 0 0	I I	23. 00 24. 00
26.00 Accumulated depreciation 0 0 0 0 0 0 0 0 0		25. 00
27.00		26. 00
29.00	0 0 2	27. 00
Total fixed assets (sum of lines 12-29) 37, 170, 454 0	0 0 2	28. 00
OTHER ASSETS Investments 0 0 0 0 0 0 0 0 0		29. 00
31.00 Investments 0 0 0 0 0 0 0 0 0	0 0 3	30. 00
32.00 Deposits on leases 30.00 Due from owners/officers 31.00 Other assets 32.00 Other assets 35.00 Total other assets (sum of lines 31-34) 35.00 Total assets (sum of lines 11, 30, and 35) 35.00 Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES 37.00 Accounts payable 38.00 Sal aries, wages, and fees payable 39.00 Payroll taxes payable (short term) 39.00 Notes and loans payable (short term) 40.00 Notes and loans payable (short term) 41.00 Deferred income 42.00 Accelerated payments 43.00 Due to other funds 44.00 Other current liabilities 45.00 Total current liabilities (sum of lines 37 thru 44) 45.00 Total current liabilities 46.00 Mortgage payable 47.00 Notes payable 48.00 Unsecured loans 49.00 Other long term liabilities 5,894,442 0 5,894,442 0 5,894,442 0 5,134,410 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 3	31. 00
33. 00	-1 -1 -	31. 00 32. 00
34.00 Other assets 5,894,442 0 35.00 Total other assets (sum of lines 31-34) 5,894,442 0 36.00 Total assets (sum of lines 11, 30, and 35) 51,313,774 0 CURRENT LIABILITIES 37.00 Accounts payable 5,134,410 0 38.00 Salaries, wages, and fees payable 105,610 0 39.00 Payroll taxes payable 105,610 0 40.00 Notes and loans payable (short term) 888,112 0 41.00 Deferred income 0 0 42.00 Accelerated payments 0 0 43.00 Due to other funds 0 0 44.00 Other current liabilities 0 0 45.00 Total current liabilities (sum of lines 37 thru 44) 7,805,772 0 LONG TERM LIABILITIES 46.00 Mortgage payable 0 0 47.00 Notes payable 36,424,362 0 48.00 Unsecured loans 0 0		33. 00
Total other assets (sum of lines 31-34) 5,894,442 0 36.00 Total assets (sum of lines 11, 30, and 35) 51,313,774 0 CURRENT LIABILITIES		34. 00
CURRENT LIABILITIES 37.00 Accounts payable 5, 134, 410 0 0 0 0 0 0 0 0 0		35. 00
37. 00 Accounts payable 5, 134, 410 0 38. 00 Salaries, wages, and fees payable 1, 677, 640 0 39. 00 Payrol I taxes payable 105, 610 0 40. 00 Notes and loans payable (short term) 888, 112 0 41. 00 Deferred income 0 0 42. 00 Accelerated payments 0 0 43. 00 Due to other funds 0 0 44. 00 Other current liabilities 0 0 45. 00 Total current liabilities (sum of lines 37 thru 44) 7, 805, 772 0 LONG TERM LIABILITIES 0 0 46. 00 Mortgage payable 0 0 47. 00 Notes payable 36, 424, 362 0 48. 00 Unsecured loans 0 0 49. 00 Other long term liabilities 0 0 50. 00 Total long term liabilities (sum of lines 46 thru 49) 36, 424, 362 0	0 0 3	36. 00
38.00 Salaries, wages, and fees payable 1,677,640 0 39.00 Payroll taxes payable 105,610 0 40.00 Notes and loans payable (short term) 888,112 0 41.00 Deferred income 0 0 42.00 Accelerated payments 0 0 43.00 Due to other funds 0 0 44.00 Other current liabilities 0 0 45.00 Total current liabilities (sum of lines 37 thru 44) 7,805,772 0 LONG TERM LIABILITIES 46.00 Mortgage payable 0 0 47.00 Notes payable 36,424,362 0 48.00 Unsecured loans 0 0 49.00 Other long term liabilities 0 0 50.00 Total long term liabilities (sum of lines 46 thru 49) 36,424,362 0		
39.00 Payroll taxes payable 105,610 0 40.00 Notes and Loans payable (short term) 888,112 0 41.00 Deferred income 0 0 42.00 Accelerated payments 0 0 43.00 Due to other funds 0 0 44.00 Other current liabilities 0 0 45.00 Total current liabilities (sum of lines 37 thru 44) 7,805,772 0 LONG TERM LIABILITIES 0 0 46.00 Mortgage payable 0 0 47.00 Notes payable 36,424,362 0 48.00 Unsecured Loans 0 0 49.00 Other Long term liabilities 0 0 50.00 Total Long term liabilities (sum of lines 46 thru 49) 36,424,362 0	· · · · · · · · · · · · · · · · · · ·	37. 00
40.00 Notes and Loans payable (short term) 888, 112 0 41.00 Deferred income 0 0 42.00 Accelerated payments 0 43.00 Due to other funds 0 0 45.00 Other current Liabilities 0 0 45.00 Total current Liabilities (sum of Lines 37 thru 44) 7,805,772 0 LONG TERM LIABILITIES 0 0 47.00 Notes payable 0 0 48.00 Unsecured Loans 0 0 49.00 Other Long term Liabilities 0 0 50.00 Total Long term Liabilities (sum of Lines 46 thru 49) 36,424,362 0		38. 00 39. 00
41.00 Deferred income 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-1 -1 -	39. 00 40. 00
42.00 Accelerated payments 0 43.00 Due to other funds 0 44.00 Other current liabilities 0 45.00 Total current liabilities (sum of lines 37 thru 44) 7,805,772 0 LONG TERM LIABILITIES 46.00 Mortgage payable 0 47.00 Notes payable 0 48.00 Unsecured loans 0 49.00 Other long term liabilities (sum of lines 46 thru 49) 36,424,362 0 50.00 Total long term liabilities (sum of lines 46 thru 49) 36,424,362 0	- 1	40. 00 41. 00
43.00 Due to other funds 0 0 0 44.00 Other current liabilities 0 0 0 45.00 Total current liabilities (sum of lines 37 thru 44) 7,805,772 0 LONG TERM LIABILITIES 46.00 Mortgage payable 0 0 0 47.00 Notes payable 36,424,362 0 48.00 Unsecured loans 0 0 49.00 Other long term liabilities 0 0 50.00 Total long term liabilities (sum of lines 46 thru 49) 36,424,362 0		42. 00
44.00 Other current liabilities 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	I I	43. 00
LONG TERM LIABILITIES	0 0 4	44. 00
46.00 Mortgage payable 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 4	45. 00
47. 00 Notes payable 36,424,362 0 48. 00 Unsecured Loans 0 0 49. 00 Other Long term Liabilities 0 0 50. 00 Total Long term Liabilities (sum of Lines 46 thru 49) 36,424,362 0		
48.00 Unsecured Loans 0 0 49.00 Other Long term Liabilities 0 0 Total Long term Liabilities (sum of Lines 46 thru 49) 36,424,362		46. 00
49.00 Other long term liabilities 0 0 50.00 Total long term liabilities (sum of lines 46 thru 49) 36,424,362 0		47.00
50.00 Total long term liabilities (sum of lines 46 thru 49) 36,424,362 0		48. 00
		49. 00 50. 00
51.00 Total liabilities (sum of lines 45 and 50) 44,230,134 0		50. 00 51. 00
CAPITAL ACCOUNTS	3	, , , , ,
52. 00 General fund balance 7, 083, 640	5	52. 00
53.00 Specific purpose fund 0	5	53.00
54.00 Donor created - endowment fund balance - restricted		54.00
55.00 Donor created - endowment fund balance - unrestricted	· · · · · · · · · · · · · · · · · · ·	55.00
56.00 Governing body created - endowment fund balance		56.00
57.00 Plant fund balance - invested in plant		57. OC
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0 5	58. 00
59. 00 Total fund balances (sum of lines 52 thru 58) 7, 083, 640 0	0 0 5	59. 00
60.00 Total liabilities and fund balances (sum of lines 51 and 51,313,774)		60. 00
59)		

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES FERRELL HOSPITAL In Lieu of Form CMS-2552-10

Peri od: Worksheet G-1 From 04/01/2022 Provi der CCN: 14-1324

					To 03/31/2023	Date/Time Pre 8/31/2023 4:0	pared: 4 pm
		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	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0	8, 235, 112 -1, 151, 472 7, 083, 640		0 0		1. 00 2. 00 3. 00 4. 00 5. 00
6. 00 7. 00 8. 00 9. 00 10. 00	Total additions (sum of line 4-9)	0 0 0 0	0		0 0 0 0	0 0 0 0	6. 00 7. 00 8. 00 9. 00 10. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0 0 0 0	7, 083, 640		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	J	0 7, 083, 640		0 0	_	18. 00 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	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	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	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	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
16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0		0		16. 00 17. 00 18. 00 19. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-1324

			To 03/31/2023	Date/Time Pre 8/31/2023 4:0	
	Cost Center Description	I npati ent	Outpati ent	Total	4 piii
	South Selection	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES		2.00	0.00	
	General Inpatient Routine Services				
1.00	Hospi tal	3, 781, 7	77	3, 781, 777	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF		0	0	5.00
6.00	Swing bed - NF		0	0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3, 781, 7	77	3, 781, 777	10.00
	Intensive Care Type Inpatient Hospital Services		<u>.</u>		
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSI VE CARE UNI T				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines		0	0	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3, 781, 7	77	3, 781, 777	17.00
18.00	Ancillary services	9, 810, 2	15 69, 255, 473	79, 065, 688	18. 00
19.00	Outpatient services		0 0	0	19.00
20.00	RURAL HEALTH CLINIC		0 8, 411, 815	8, 411, 815	20.00
20. 01	RURAL HEALTH CLINIC II		0 1, 952, 917	1, 952, 917	20. 01
20. 02	RURAL HEALTH CLINIC III		0 681, 861	681, 861	
20. 03	RURAL HEALTH CLINIC IV		0 882, 732	882, 732	20. 03
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	21.00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26.00
27. 00	SENI OR CARE CLINI C		0 1, 974, 764	1, 974, 764	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	t. 13, 591, 9			28.00
20.00	G-3, line 1)	13, 371, 7	03, 137, 302	70, 731, 334	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		47, 803, 656		29.00
30.00	ADD (SPECIFY)		0		30.00
31. 00	(or Edit 1)		0		31.00
32. 00			0		32.00
33. 00			0		33.00
34. 00			0		34.00
35. 00			0		35.00
36. 00	Total additions (sum of lines 30-35)		0		36.00
			_		
37. 00	DEDUCT (SPECIFY)		0		37.00
38.00			9		38.00
39.00			0		39.00
40.00			0		40.00
41.00	T-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1		0		41.00
42.00	Total deductions (sum of lines 37-41)	. 6.	0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tran	ster	47, 803, 656		43.00
	to Wkst. G-3, line 4)	I		I	l

111-1	Financial Contain	CDITAL	la lia	£ F CMC (DEE2 40
	Financial Systems FERRELL HOS MENT OF REVENUES AND EXPENSES	Provider CCN: 14-1324	Peri od:	u of Form CMS-2 Worksheet G-3	
			From 04/01/2022 To 03/31/2023	Date/Time Pre 8/31/2023 4:0	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, Ii			96, 751, 554	1. 00
2.00	Less contractual allowances and discounts on patients' accou	ınts		52, 907, 069	2.00
3.00	Net patient revenues (line 1 minus line 2)			43, 844, 485	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	e 43)		47, 803, 656	
5. 00	Net income from service to patients (line 3 minus line 4)			-3, 959, 171	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			2, 005, 816	
7. 00	Income from investments			92, 905	
8. 00	Revenues from telephone and other miscellaneous communication	on services		0	8. 00
9. 00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			1, 767	
11. 00	Rebates and refunds of expenses			84, 835	
12.00				0	12.00
13.00	1 · · · · · · · · · · · · · · · · · · ·			0	13.00
14.00	Revenue from meals sold to employees and guests			87, 368	
15. 00	Revenue from rental of living quarters			-39, 020	
16. 00	Revenue from sale of medical and surgical supplies to other	than patients		0	16. 00
17. 00	3			0	17. 00
18. 00				13, 944	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	3			0	20.00
21. 00				0	21.00
22.00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23.00
24.00	OTHER OPERATING INCOME			560, 084	24.00
24. 50	COVI D-19 PHE Funding			0	24. 50
25.00	Total other income (sum of lines 6-24)			2, 807, 699	25.00
	Total (line 5 plus line 25)			-1, 151, 472	26. 00
27.00	OTHER EXPENSES (SPECIFY)			0	27. 00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			-1, 151, 472	29. 00

Health Financial Systems FERRELL HOSPITAL In Lieu of Form CMS-2552-10							
	IS OF HOSPITAL-BASED RHC/FOHC COSTS	FERRELL D	Provider CO	CN: 14-1324	Peri od:	Worksheet M-1	
					From 04/01/2022 To 03/31/2023		pared:
					RHC I	Cost	т рііі
		Compensation	Other Costs	Total (col.	Reclassi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS		_		.1		
1. 00	Physi ci an	1, 881, 571	0	,		1, 854, 499	1.00
2. 00	Physician Assistant	540, 334	0	540, 33		540, 334	1
3.00	Nurse Practi ti oner	122, 463	0	122, 46	3 0	122, 463	
4.00	Visiting Nurse	0 507	0	0, 50	0	0	
5.00	Other Nurse	26, 537	0	26, 53	0	26, 537	5.00
6.00	Clinical Psychologist	124 720	0	104 70	0	0	
7.00	Clinical Social Worker	124, 730	0	124, 73	0	124, 730	
8. 00 9. 00	Laboratory Technician	U	0		0		
10.00	Other Facility Health Care Staff Costs Subtotal (sum of lines 1 through 9)	2, 695, 635	0	2, 695, 63	5 -27, 072	2, 668, 563	
11.00	Physician Services Under Agreement	2, 695, 635	0	2, 095, 03	-21,012	2, 668, 563	1
12.00	Physician Supervision Under Agreement	0	0		0 0		
13. 00	Other Costs Under Agreement	0	0		0	0	
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	
15. 00	Medical Supplies	0	278, 295	278, 29	٥	278, 316	
16. 00	Transportation (Health Care Staff)	0	270, 275	270,27	0 0	270, 310	1
17. 00	Depreciation-Medical Equipment	0	0		0 0	Ö	
18. 00	Professional Liability Insurance	0	0		0 0	0	18.00
19. 00		o	0		o o	0	
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	o	278, 295	278, 29	5 21	278, 316	21.00
22.00	Total Cost of Health Care Services (sum of	2, 695, 635	278, 295	2, 973, 93	0 -27, 051	2, 946, 879	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES				_		
23.00	Pharmacy	0	0		0	0	
24. 00	Dental	0	0		0	0	
25. 00	Optometry	0	0		0	0	
25. 01	Tel eheal th	0	0		0	0	
25. 02	Chronic Care Management	0	0		0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0	0	
27. 00	Nonallowable GME costs	_	_			_	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	28. 00
	through 27)						
20.00	FACILITY OVERHEAD	ol	74, 159	74, 15	O EE 412	10 544	29. 00
29. 00 30. 00	Facility Costs Administrative Costs	2, 842, 511	74, 159 1, 299, 899			18, 546 4, 107, 905	
31.00	Total Facility Overhead (sum of lines 29 and	· · ·	1, 299, 699				1
31.00	30)	2,042,511	1, 374, 030	4, 210, 30	- 70, 110	4, 120, 431	31.00

5, 538, 146

1, 652, 353

7, 190, 499

-117, 169

7, 073, 330

32.00

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

Health Financial Systems	FERRELL H	IOSPI TAL		In Lieu of Form CMS-2552-10			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 14-1324	Peri od: From 04/01/2022	Worksheet M-1		
		Component	CCN: 14-8506	To 03/31/2023	Date/Time Pre 8/31/2023 4:0		
				RHC I	Cost		
	Adiustments	Net Expenses		-			

Adj ustments
FACILITY HEALTH CARE STAFF COSTS
Allocation (col. 5 + col. 6) 6.00 7.00
FACILITY HEALTH CARE STAFF COSTS 1.00 Physician Description Physician Description Desc
FACILITY HEALTH CARE STAFF COSTS 1.00 Physician 2.00 Physician 3.00 Physician 3.00 Assistant 3.00 Assista
FACILITY HEALTH CARE STAFF COSTS 1.00 Physician 0 1,854,499 1.00 2.00 Physician Assistant 0 540,334 2.00 3.00 Nurse Practitioner 0 122,463 3.00 4.00 Visiting Nurse 0 0 0 4.00 5.00 Other Nurse 0 26,537 5.00 Clinical Psychologist 0 0 0 6.00 7.00 Clinical Social Worker 0 124,730 7.00 8.00 Laboratory Technician 0 0 0 8.00 9.00 Other Facility Health Care Staff Costs 0 0 0 0 0 0 0 0 0
FACILITY HEALTH CARE STAFF COSTS 1.00 Physician 0 1,854,499 1.00 2.00 Physician Assistant 0 540,334 2.00 3.00 Nurse Practitioner 0 122,463 3.00 4.00 3.00 4.00 5.00 0 0 4.00 5.00 0 0 6.00 0 0 6.00 0 0 6.00 0
1. 00 Physician 0 1,854,499 1.00 2. 00 Physician Assistant 0 540,334 2.00 3. 00 Nurse Practitioner 0 122,463 3.00 4. 00 Visiting Nurse 0 0 4.00 5. 00 Other Nurse 0 26,537 5.00 6. 00 Clinical Psychologist 0 0 6.00 7. 00 Clinical Social Worker 0 124,730 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 0 9.00 10. 00 Subtotal (sum of lines 1 through 9) 0 2,668,563 10.00 11. 00 Physician Services Under Agreement 0 0 11.00 12. 00 Physician Supervision Under Agreement 0 0 12.00 13. 00 Other Costs Under Agreement 0 0 13.00 14. 00 Subtotal (sum of lines 11 through 13) 0 0 14.00 15. 00 Medical Supplies 0 278,316
2. 00 Physician Assistant 0 540, 334 2. 00 3. 00 Nurse Practitioner 0 122, 463 3. 00 4. 00 Visiting Nurse 0 0 4. 00 5. 00 Other Nurse 0 26, 537 5. 00 6. 00 Clinical Psychologist 0 0 6. 00 7. 00 Clinical Social Worker 0 124, 730 7. 00 8. 00 Laboratory Technician 0 0 8. 00 9. 00 Other Facility Health Care Staff Costs 0 0 9. 00 10. 00 Subtotal (sum of lines 1 through 9) 0 2, 668, 563 10. 00 11. 00 Physician Services Under Agreement 0 0 11. 00 12. 00 Physician Supervision Under Agreement 0 0 12. 00 13. 00 Other Costs Under Agreement 0 0 13. 00 14. 00 Subtotal (sum of lines 11 through 13) 0 0 14. 00 15. 00 Medical Supplies 0 278, 316 15. 00 16. 00 Transportation (Health Care Staff
3. 00 Nurse Practitioner 0 122, 463 3.00 4. 00 Visiting Nurse 0 0 4.00 5. 00 Other Nurse 0 26, 537 5.00 6. 00 Clinical Psychologist 0 0 6.00 7. 00 Clinical Social Worker 0 124,730 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 0 9.00 10. 00 Subtotal (sum of lines 1 through 9) 0 2,668,563 10.00 11. 00 Physician Services Under Agreement 0 0 11.00 12. 00 Physician Services 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 0 278, 316 15.00 16. 00 Transportation (Health Care Staff) 0 16.00
4. 00 Visiting Nurse 0 0 5. 00 Other Nurse 0 26,537 5.00 6. 00 Clinical Psychologist 0 0 6.00 7. 00 Clinical Social Worker 0 124,730 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 0 10. 00 Subtotal (sum of lines 1 through 9) 0 2,668,563 10.00 11. 00 Physician Services Under Agreement 0 0 11.00 12. 00 Physician Supervision Under Agreement 0 0 12.00 13. 00 Other Costs Under Agreement 0 0 13.00 14. 00 Subtotal (sum of lines 11 through 13) 0 0 14.00 15. 00 Medical Supplies 0 278, 316 15.00 16. 00 Transportation (Health Care Staff) 0 0
5. 00 Other Nurse 0 26,537 5.00 6. 00 Clinical Psychologist 0 0 6.00 7. 00 Clinical Social Worker 0 124,730 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 0 10. 00 Subtotal (sum of lines 1 through 9) 0 2,668,563 10.00 11. 00 Physician Services Under Agreement 0 0 11.00 12. 00 Physician Supervision Under Agreement 0 0 12.00 13. 00 Other Costs Under Agreement 0 0 13.00 14. 00 Subtotal (sum of lines 11 through 13) 0 0 13.00 15. 00 Medical Supplies 0 278,316 15.00 16. 00 Transportation (Health Care Staff) 0 16.00
6.00 Clinical Psychologist 0 0 0 0 0 0 0 0 0
7. 00 Clinical Social Worker 0 124,730 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 0 9.00 10. 00 Subtotal (sum of lines 1 through 9) 0 2,668,563 10.00 11. 00 Physician Services Under Agreement 0 0 11.00 12. 00 Physician Supervision Under Agreement 0 0 12.00 13. 00 Other Costs Under Agreement 0 0 13.00 14. 00 Subtotal (sum of lines 11 through 13) 0 0 0 15. 00 Medical Supplies 0 278, 316 15.00 16. 00 Transportation (Health Care Staff) 0 0
8. 00 Laboratory Technician 0 0 0 9. 00 9. 00 Other Facility Health Care Staff Costs 0 0 0 9. 00 10. 00 Subtotal (sum of lines 1 through 9) 0 2, 668, 563 10. 00 11. 00 Physician Services Under Agreement 0 0 11. 00 12. 00 Physician Supervision Under Agreement 0 0 12. 00 13. 00 Other Costs Under Agreement 0 0 13. 00 14. 00 Subtotal (sum of lines 11 through 13) 0 0 0 15. 00 Medical Supplies 0 278, 316 15. 00 16. 00 Transportation (Health Care Staff) 0 0
9.00 Other Facility Health Care Staff Costs 0 0 9.00 10.00 Subtotal (sum of lines 1 through 9) 0 2,668,563 10.00 11.00 Physician Services Under Agreement 0 0 11.00 12.00 Physician Supervision Under Agreement 0 0 12.00 13.00 Other Costs Under Agreement 0 0 13.00 14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 278,316 15.00 16.00 Transportation (Health Care Staff) 0 0 16.00
10.00 Subtotal (sum of lines 1 through 9) 0 2,668,563 10.00 11.00 Physician Services Under Agreement 0 0 12.00 Physician Supervision Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 278,316 15.00 16.00 Transportation (Health Care Staff) 0 0 16.00
11.00 Physician Services Under Agreement 0 0 12.00 Physician Supervision Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 278,316 16.00 Transportation (Health Care Staff) 0 0
12.00 Physician Supervision Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 278,316 15.00 16.00 Transportation (Health Care Staff) 0 0 0
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 0 278,316 15.00 16.00 Transportation (Health Care Staff) 0 0 16.00
14.00 Subtotal (sum of lines 11 through 13) 0 0 14.00 15.00 Medical Supplies 0 278,316 15.00 16.00 Transportation (Health Care Staff) 0 0 0
15.00 Medical Supplies 0 278,316 15.00 16.00 Transportation (Health Care Staff) 0 0 16.00
16.00 Transportation (Health Care Staff) 0 0 16.00
17 00 Depreciation-Medical Equipment
18.00 Professional Liability Insurance 0 0 18.00
19.00 Other Health Care Costs 0 0 19.00
20.00 Allowable GME Costs 20.00
21.00 Subtotal (sum of lines 15 through 20) 0 278,316 21.00
22.00 Total Cost of Health Care Services (sum of 0 2,946,879 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 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
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 28.00
through 27)
FACILITY OVERHEAD
29. 00 Facility Costs 39, 020 57, 566 29. 00
30.00 Administrative Costs 761,702 4,869,607 30.00
31.00 Total Facility Overhead (sum of lines 29 and 800,722 4,927,173 31.00
30)
32.00 Total facility costs (sum of lines 22, 28 800,722 7,874,052 32.00
and 31)

Health Financial Systems FERRELL HOSPITAL In Lieu of Form CMS-2552-10							
	IS OF HOSPITAL-BASED RHC/FOHC COSTS	I LKKLLL II	Provider C	CN: 14-1324	Peri od:	Worksheet M-1	
AWALIS	NO OF THOSE TIME BASED KNOT QUO GOSTS				From 04/01/2022		
			Component	CCN: 14-8588	To 03/31/2023	8/31/2023 4:0	
					RHC II	Cost	
		Compensation	Other Costs		1 Reclassificat		
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1. 00	2.00	3. 00	4. 00	col . 4) 5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	3.00	
1. 00	Physi ci an	161, 712	0	161, 7	2 0	161, 712	1.00
2. 00	Physician Assistant	0	0		0 0	0	
3.00	Nurse Practitioner	214, 250	0		-	214, 250	3.00
4. 00	Visiting Nurse	0	0	,	0 0	0	4.00
5. 00	Other Nurse	411	0	4	1 0	411	5.00
6.00	Clinical Psychologist	o	0		0 0	0	6.00
7.00	Clinical Social Worker	o	0		0 0	0	7.00
8.00	Laboratory Techni ci an	o	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	o	0		0 0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	376, 373	0	376, 37	73 0	376, 373	10.00
11.00	Physician Services Under Agreement	o	0		0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	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	31, 013	31, 01	0	31, 013	1
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	0	18. 00
19. 00	Other Health Care Costs	이	0		0	0	19. 00
20.00	Allowable GME Costs		04 040			04 040	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	31, 013			31, 013	•
22. 00	Total Cost of Health Care Services (sum of	376, 373	31, 013	407, 38	0	407, 386	22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	O	0		0 0	0	23. 00
24. 00	Dental		0		0 0		
25. 00	Optometry	ام	0		0 0	Ö	1
25. 01	Tel eheal th		0			Ö	
25. 02	Chronic Care Management	ام	0		0 0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0 0	o o	
27. 00	Nonal I owable GME costs	١	· ·			Ĭ	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	ol	0		0 0	0	
	through 27)	آ ۔					
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	42, 884	42, 88	-9, 478	33, 406	29. 00
30.00	Admi ni strati ve Costs	1, 054, 586	68, 499	, , , , , , ,		1, 123, 085	1
31.00	Total Facility Overhead (sum of lines 29 and	1, 054, 586	111, 383	1, 165, 96	-9, 478	1, 156, 491	31.00
	(30)			1		l	l

1, 430, 959

-9, 478

1, 563, 877

32.00

1, 573, 355

142, 396

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

Health Financial Systems	FERRELL HOSPI TAL	In Lieu of Form CMS-2552-				
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Peri od: From 04/01/2022	Worksheet M-1			
	Component CCN: 14-8588		Date/Time Prepared: 8/31/2023 4:04 pm			
		DIIO II	<u> </u>			

			Component CCN: 14-8588	3 10	03/31/2023	8/31/2023 4:0	
					RHC II	Cost	тт рііі
		Adjustments	Net Expenses		1110 11	0001	
		,	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS		·				
1.00	Physi ci an	0	161, 712				1.00
2.00	Physician Assistant	0	o				2.00
3.00	Nurse Practitioner	0	214, 250				3.00
4.00	Visiting Nurse	0	o				4.00
5.00	Other Nurse	0	411				5.00
6.00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	0	0				7.00
8.00	Laboratory Techni ci an	0	0				8. 00
9.00	Other Facility Health Care Staff Costs	0	0				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	376, 373				10.00
11. 00	Physician Services Under Agreement	0	0				11.00
12.00	Physician Supervision Under Agreement	0	0				12.00
13.00	Other Costs Under Agreement	0	0				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0				14.00
15.00	Medical Supplies	0	31, 013				15.00
16.00	Transportation (Health Care Staff)	0	0				16.00
17.00	Depreciation-Medical Equipment	0	o				17.00
18.00	Professional Liability Insurance	0	0				18. 00
19.00	Other Health Care Costs	0	0				19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	31, 013				21.00
22.00	Total Cost of Health Care Services (sum of	0	407, 386				22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
	Pharmacy	0	0				23.00
24.00	Dental	0	0				24.00
25. 00	, ,	0	0				25. 00
25. 01	Tel eheal th	0	0				25. 01
25. 02	, ,	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)						1
	FACILITY OVERHEAD		0.4.4.0				
	Facility Costs	712	34, 118				29.00
30.00	Administrative Costs	172, 571	1, 295, 656				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	173, 283	1, 329, 774				31.00
22.02	30)	170 000	1 727 1/0				22.00
32. 00	Total facility costs (sum of lines 22, 28	173, 283	1, 737, 160				32.00
	and 31)		I				I

	Financial Systems	FERRELL H				u of Form CMS-	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od: From 04/01/2022	Worksheet M-1	
			Component	CCN: 14-8616	To 03/31/2023	Date/Time Pre 8/31/2023 4:0	
					RHC III	Cost	
		Compensation	Other Costs		1 Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
	FACULTY UEW TU CARE OTAES COOTS	1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	FACILITY HEALTH CARE STAFF COSTS	4 470			100 000	110 510	
1.00	Physi ci an	-1, 473	0			119, 519	
2.00	Physician Assistant	0	0		0 0	0	2.00
3.00	Nurse Practi ti oner	29, 837	0	29, 83	173, 752	203, 589	1
4.00	Visiting Nurse	0	0		0	0	
5.00	Other Nurse	0	0		0	0	
6.00	Clinical Psychologist	0	0		0	0	6.00
7.00	Clinical Social Worker	0	0		0	0	7.00
8.00	Laboratory Techni ci an	0	0		0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	00.00	0	0	
10.00	Subtotal (sum of lines 1 through 9)	28, 364	0	28, 36	294, 744	323, 108	
11.00	Physician Services Under Agreement	0	0		0	0	11.00
12.00	Physician Supervision Under Agreement	0	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)	U	F2 044	F2.0	0	0	14.00
15.00	Medical Supplies	U	52, 844	52, 84	14	52, 844	
16.00	Transportation (Health Care Staff)	U	0		0	0	16.00
17.00	Depreciation-Medical Equipment	U	0		0	0	
18. 00 19. 00	Professional Liability Insurance Other Health Care Costs	0	0		0	0	18. 00 19. 00
20.00	Allowable GME Costs	U	U		٥	U	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	52, 844	52, 84		52, 844	
21.00	Total Cost of Health Care Services (sum of	28, 364	52, 844 52, 844			375, 952	
22.00	lines 10, 14, and 21)	20, 304	32, 044	01, 20	274, 144	375, 752	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy Pharmacy	O	0		0 0	0	23. 00
24. 00	Dental	0	0			0	1
25. 00	Optometry	0	0			Ö	1
25. 01	Tel eheal th	0	0			Ö	1
25. 02	Chronic Care Management	0	0		0 0	Ö	1
26. 00	All other nonreimbursable costs	n	0		0 0	0	26.00
27. 00	Nonal Lowable GME costs	Ĭ	O				27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	n	Λ		0	0	
_0.00	through 27)	Ĭ	O				
	FACILITY OVERHEAD			·			1
29. 00	Facility Costs	0	47, 241	47, 24	11 0	47, 241	29. 00
30.00	Administrative Costs	696, 229	7, 751	1		409, 236	1
	Total Facility Overhead (sum of lines 20 and	606 220	5/ 002		•	· ·	

696, 229

724, 593

751, 221

832, 429

54, 992

107, 836

-294, 744

0

456, 477

832, 429

31.00

32.00

Total Facility Overhead (sum of lines 29 and

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

Health Financial Systems	FERRELL HOSPITAL				In Lieu of Form CMS-2552-10			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi de	r CCN: 14-1324	Peri od: From 04/01/2022	Worksheet M-1			
		Compone	nt CCN: 14-8616	To 03/31/2023	Date/Time Pre 8/31/2023 4:0			
				RHC III	Cost			
					•			

			Component	JCIN. 14-0010	10 03	73172023	8/31/2023 4:	
					RHC	111	Cost	
		Adjustments	Net Expenses					
		,	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7.00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	119, 519					1.00
2.00	Physician Assistant	3, 061	3, 061					2.00
3.00	Nurse Practitioner	157, 269	360, 858					3.00
4.00	Visiting Nurse	0	0					4. 00
5.00	Other Nurse	0	0					5. 00
6.00	Clinical Psychologist	0	0					6. 00
7. 00	Clinical Social Worker	0	0					7. 00
8.00	Laboratory Techni ci an	0	0					8. 00
9.00	Other Facility Health Care Staff Costs	0	0					9. 00
10. 00	Subtotal (sum of lines 1 through 9)	160, 330	483, 438					10.00
11. 00	Physician Services Under Agreement	0	0					11. 00
12. 00	Physician Supervision Under Agreement	0	0					12.00
	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	52, 844					15. 00
16. 00	Transportation (Health Care Staff)	0	0					16. 00
17. 00	Depreciation-Medical Equipment	0	0					17. 00
18. 00	1	0	0					18. 00
19. 00	y .	0	0					19.00
20.00	Allowable GME Costs	_						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	52, 844					21.00
22. 00	Total Cost of Health Care Services (sum of	160, 330	536, 282					22. 00
	lines 10, 14, and 21)							-
22.00	COSTS OTHER THAN RHC/FQHC SERVICES	0	0					1 22 00
23. 00	Pharmacy Dental	U	0					23. 00 24. 00
24. 00 25. 00	1	0	0					25.00
25. 00	Optometry Telehealth	0	0					25. 00
25. 01	Chronic Care Management	0	0					25. 01
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
20.00	through 27)	U	U					20.00
	FACILITY OVERHEAD							-
29 00	Facility Costs	0	47, 241					29. 00
30.00	Admi ni strati ve Costs	93. 778						30.00
31. 00	Total Facility Overhead (sum of lines 29 and		550, 255					31.00
550	30)	,5, ,,6	555, 255					
32.00	1 /	254, 108	1, 086, 537					32.00
	and 31)							
	•							

	Financial Systems	FERRELL H				u of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od: From 04/01/2022	Worksheet M-1	
			Component		To 03/31/2023	Date/Time Pre 8/31/2023 4:0	
					RHC IV	Cost	
		Compensation	Other Costs		1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00	2.00	2.00	4.00	col . 4)	
	FACILITY HEALTH CARE STAFF COSTS	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	Physician	14, 105	0	14, 10	136, 839	150, 944	1.00
2. 00	Physician Assistant	4, 821	0			4, 821	2.00
3. 00	Nurse Practitioner	4, 716	0	.,		157, 352	
4. 00	Vi si ti ng Nurse	4, 710	0	4, / 1	0 132,030	157, 352	
5. 00	Other Nurse	0	0			0	
6. 00	Clinical Psychologist	0	0			0	6.00
7. 00	Clinical Social Worker	1, 407	0	1, 40	17	1, 407	7.00
8. 00	Laboratory Techni ci an	1, 407	0	1,40	0	1, 407	
9. 00	Other Facility Health Care Staff Costs	0	0			0	
10.00	Subtotal (sum of lines 1 through 9)	25, 049	0	25, 04	9 289, 475	314, 524	
11. 00	Physician Services Under Agreement	23, 047	0	25,04	0 207, 473	0	11.00
12. 00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13. 00	Other Costs Under Agreement	0	0			Ö	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0 0	Ö	14.00
15. 00	Medical Supplies	0	50, 942	50, 94	2 0	50, 942	
16. 00	Transportation (Health Care Staff)	0	00,7.12		0 0	0	16.00
17. 00	Depreciation-Medical Equipment	0	0		0 0	0	
18. 00	Professional Liability Insurance	Ö	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	50, 942	50, 94	2 0	50, 942	21.00
22.00	Total Cost of Health Care Services (sum of	25, 049	50, 942	75, 99	289, 475	365, 466	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0	0	
24.00	Dental	0	0		0	0	
25.00	Optometry	0	0		0	0	
25. 01	Tel eheal th	0	0		0	0	
25. 02	Chronic Care Management	0	0		0	0	
26.00	All other nonreimbursable costs	0	0		0	0	26.00
27.00	Nonallowable GME costs						27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	28. 00
	through 27)						-
20.00	FACILITY OVERHEAD	ما	24 (20	24.45	0	24 (20	20.00
29. 00 30. 00	Facility Costs Administrative Costs	0 473, 400	24, 639 26, 222			24, 639 210, 147	1
	Total Facility Overhead (sum of lines 20 and	·		•			

473, 400

498, 449

50, 861

101, 803

524, 261

600, 252

31.00

32.00

234, 786

600, 252

-289, 475

0

Total Facility Overhead (sum of lines 29 and

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

Health Financial Systems	FERRELL H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CCN: 14-1324	Peri od: From 04/01/2022	Worksheet M-1	
		Component	CCN: 14-8627	To 03/31/2023	Date/Time Pre 8/31/2023 4:0	
				RHC IV	Cost	
	Adjustments	Net Expenses				

						8/31/2023 4:0	04 pm
					RHC IV	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	150, 94	4			1.00
2.00	Physician Assistant	0	4, 82	1			2.00
3.00	Nurse Practitioner	0	157, 35	2			3.00
4.00	Visiting Nurse	0					4.00
5. 00	Other Nurse	0	ĺ				5.00
6. 00	Clinical Psychologist	0					6.00
7. 00	Clinical Social Worker	0	1, 40				7.00
8. 00	Laboratory Techni ci an	0					8.00
9. 00	Other Facility Health Care Staff Costs	0					9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	314, 52	-			10.00
11. 00	Physician Services Under Agreement	0)			11.00
	Physician Supervision Under Agreement	0					12.00
12.00		0		1			1
13.00	9	0					13.00
14.00	Subtotal (sum of lines 11 through 13)	0					14.00
15. 00	Medical Supplies	0	50, 942	1			15. 00
16. 00	·	0					16. 00
	Depreciation-Medical Equipment	0					17.00
	Professional Liability Insurance	0		0			18. 00
	Other Health Care Costs	0	(O			19. 00
20.00	Allowable GME Costs						20.00
21. 00		0	50, 942	1			21.00
22. 00	Total Cost of Health Care Services (sum of	0	365, 466	5			22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES			,			4
	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	(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	(o			28. 00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	24, 639	9			29. 00
30.00	Administrative Costs	0	210, 14	7			30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	234, 786	5			31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	0	600, 252	2			32.00
	and 31)						

	Financial Systems	FERRELL H				u of Form CMS-2	
ALLOC/	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 04/01/2022 To 03/31/2023	Date/Time Pre 8/31/2023 4:0	
					RHC I	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	·					
1. 00	Physi ci an	2. 32			· ·		1.00
2.00	Physician Assistant	0. 78	,				2.00
3.00	Nurse Practitioner	1. 16					3. 00
4. 00	Subtotal (sum of lines 1 through 3)	4. 26		1	13, 818	· ·	4. 00
5.00	Visiting Nurse	0.00				0	5. 00
6.00	Clinical Psychologist	0.00	l .			0	6. 00
7.00	Clinical Social Worker	0.00	l .			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l .			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)	4. 26	24, 788			24, 788	8. 00
9. 00	Physician Services Under Agreements		0			0	9. 00
7.00	Fritysi Crair Services Under Agreements					U	7.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O HOSPI TAL-BASE	FD RHC/FOHC SEI	RVICES			
10.00						2, 946, 879	10.00
11. 00						0	
12.00	Cost of all services (excluding overhead) (s	·	,			2, 946, 879	1
13. 00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		4, 927, 173	1
15. 00	Parent provider overhead allocated to facili			,		3, 971, 387	
16. 00	Total overhead (sum of lines 14 and 15)	., (,			8, 898, 560	1
17. 00	Allowable GME overhead (see instructions)					0	17.00
18. 00	,					8, 898, 560	
19.00	Overhead applicable to hospital-based RHC/FQ	HC services (I	ine 13 x line	18)		8, 898, 560	ł
	Total allowable cost of hospital-based RHC/F					11, 845, 439	20.00

Heal th	Financial Systems	FERRELL H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component	CCN: 14-8588	From 04/01/2022 To 03/31/2023	Date/Time Pre 8/31/2023 4:0	
					RHC II	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	,	col. 2 or	
					1 x col. 3)	col . 4	
	LUCITO AND DESCRIPTIVITY	1. 00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
4 00	Posi ti ons	0.7/	1 445	4 00	0 100		1 00
1.00	Physician	0.76					1.00
2. 00 3. 00	Physician Assistant Nurse Practitioner	0. 00 1. 06					2.00 3.00
4. 00	Subtotal (sum of lines 1 through 3)	1. 06			5, 418		
5. 00	Visiting Nurse	0.00			3, 410	12,020	1
6. 00	Clinical Psychologist	0.00				0	
7. 00	Clinical Social Worker	0.00				0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.01
7. 02	Di abetes Self Management Training (FQHC	0.00				0	7. 02
	only)		_			_	
8.00	Total FTEs and Visits (sum of lines 4	1.82	12, 026			12, 026	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVI CES			
	Total costs of health care services (from Wk					407, 386	
	Total nonreimbursable costs (from Wkst. M-1,					0	
12.00	Cost of all services (excluding overhead) (s					407, 386	
13.00	Ratio of hospital -based RHC/FQHC services (I			21)		1.000000	
14. 00 15. 00	Total hospital-based RHC/FQHC overhead - (fr Parent provider overhead allocated to facili			ine 31)		1, 329, 774 753, 287	
16. 00	Total overhead (sum of lines 14 and 15)	ty (see mstru	Ctrons)			2, 083, 061	
	Allowable GME overhead (see instructions)					2,083,001	•
	Enter the amount from line 16					2, 083, 061	
	Overhead applicable to hospital-based RHC/FQ	HC services (ine 13 x line	18)		2, 083, 061	
	Total allowable cost of hospital based RHC/F					2, 490, 447	
	1	(!	_,,	

	Financial Systems	FERRELL H				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 04/01/2022 To 03/31/2023	Date/Time Pre	pared:
						8/31/2023 4:0	
					RHC III	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
		1.00	0.00	0.00	1 x col . 3)	col. 4	
	VI CLTC AND DRODUCTIVI TV	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY Positions						
1. 00	Physi ci an	0. 16	962	4, 20	0 672		1.00
2. 00	Physician Assistant	0.10					2.00
3. 00	Nurse Practitioner	0.70					3.00
4. 00	Subtotal (sum of lines 1 through 3)	0. 76			2, 142	6. 038	4.00
5. 00	Visiting Nurse	0.00			2, 112	0, 000	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	0			0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
8. 00	Total FTEs and Visits (sum of lines 4	0. 86	6, 038			6, 038	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9.00
						1 00	
	DETERMINATION OF ALLOWARIE COST APPLICABLE	FO HOODI TAL DAG	ED DUO (EQUID CEI	2/4 050		1. 00	
10. 00	DETERMINATION OF ALLOWABLE COST APPLICABLE Total costs of health care services (from W			RVICES		536, 282	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1	· ·				030, 202	11.00
12.00	Cost of all services (excluding overhead) (536, 282	
13. 00	Ratio of hospital-based RHC/FQHC services (1. 000000	
14. 00	Total hospital-based RHC/FQHC overhead - (f			ine 31)		550, 255	
15. 00	Parent provider overhead allocated to facili			1116 31)		394, 510	
16. 00	Total overhead (sum of lines 14 and 15)	, (500 1115114	01.0110)			944, 765	
17. 00	Allowable GME overhead (see instructions)					0	17.00
	Enter the amount from line 16					944, 765	
	Overhead applicable to hospital-based RHC/F	QHC services (I	ine 13 x line	18)		944, 765	
	Total allowable cost of hospital-based RHC/					1, 481, 047	l

Heal th	Financial Systems	FERRELL H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 04/01/2022 To 03/31/2023	Date/Time Pre 8/31/2023 4:0	
					RHC IV	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons		1 4 6/0		ol		
1.00	Physi ci an	0. 32					1.00
2.00	Physician Assistant	0.00		_,			2.00
3. 00 4. 00	Nurse Practitioner	0. 41 0. 73			0 861 2, 205	4, 792	3.00
4. 00 5. 00	Subtotal (sum of lines 1 through 3) Visiting Nurse	0.73			2, 205		4. 00 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. 01	Diabetes Self Management Training (FQHC	0.00				0	7.01
7.02	only)	0.00				١	7.02
8. 00	Total FTEs and Visits (sum of lines 4	0. 73	4, 792			4, 792	8.00
	through 7)		.,			.,	
9.00	Physician Services Under Agreements		0			0	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			RVICES			
10.00						365, 466	
11. 00		·	,			0	
12.00	Cost of all services (excluding overhead) (s					365, 466	
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		234, 786	
15. 00	Parent provider overhead allocated to facili	ty (see instru	ctions)			285, 780	
16.00	Total overhead (sum of lines 14 and 15)					520, 566	
17. 00	Allowable GME overhead (see instructions)					0	17.00
	Enter the amount from line 16	IIC comileos (I	ino 10 v li	10)		520, 566	
	Overhead applicable to hospital-based RHC/FQ Total allowable cost of hospital-based RHC/F					520, 566 886, 032	
20.00	Tiotal allowable cost of hospital-based kHC/F	UNC SELVICES (Sum ULLITIES II	Jailu 19)	ļ	000, 032	∠∪. ∪∪

Heal th	Financial Systems FERRELL HOSF	ΡΙ ΤΔΙ	Inlie	u of Form CMS-2	2552_10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	Worksheet M-3	
SERVI C	ES	Component CCN: 14-8506	From 04/01/2022 To 03/31/2023	Date/Time Pre 8/31/2023 4:0	
		Title XVIII	RHC I	Cost	т рііі
	DETERMINATION OF DATE FOR HOCKLIAL DACED DUC/FOUR CERVILORS			1. 00	
1. 00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst M ₋ 2 line 20)		11, 845, 439	1.00
2. 00	Cost of injections/infusions and their administration (from W			478, 411	2.00
3. 00	Total allowable cost excluding injections/infusions (line 1 m			11, 367, 028	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			24, 788	4. 00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			24, 788	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	458.57 of limit (1)	7. 00
			Carcuration	OI LIMIT (I)	
				Rate Period 2	
			(04/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	03/31/2023) 2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	271. 52	281. 83	8. 00
9.00	Rate for Program covered visits (see instructions)		271. 52	281. 83	
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from	-	7, 714	2, 572	
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr	•	2, 094, 505 0	724, 867 0	
13. 00	Program covered cost from mental health services (line 9 x li		0	Ö	13.00
14.00	Limit adjustment for mental health services (see instructions	,	0	0	
15.00	Graduate Medical Education Pass Through Cost (see instruction	s)			15.00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	-	0	2, 819, 372	
16. 01	Total program charges (see instructions)(from contractor's re			1, 758, 671	
16. 02 16. 03	Total program preventive charges (see instructions)(from prov Total program preventive costs ((line 16.02/line 16.01) times	•		0	16. 02 16. 03
16. 04	Total Program non-preventive costs ((Tine 16.02/Time 16.07) times	•		2, 131, 744	
	(Titles V and XIX see instructions.)	, , , , , , , , , , , , , , , , , , , ,		, , ,	
16. 05	Total program cost (see instructions)		0	2, 131, 744	
17. 00	Primary payer amounts	(6		349	
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(Trom contractor		154, 692	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		319, 024	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			2, 131, 395	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		323, 564	
22.00	,	,		2, 454, 959	
23.00	Allowable bad debts (see instructions)			0	23. 00
23. 01	1 3			0	23. 01
24.00	Allowable bad debts for dual eligible beneficiaries (see inst OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	
	Pioneer ACO demonstration payment adjustment (see instruction	5)		0	25. 50
25. 99	Demonstration payment adjustment amount before sequestration	-,		0	1
26.00	Net reimbursable amount (see instructions)			2, 454, 959	26.00
26. 01	Sequestration adjustment (see instructions)			42, 961	
26. 02				0	
	Interim payments Tentative settlement (for contractor use only)			2, 089, 112 0	•
28.00	Tentative settlement (for contractor use only) Balance due component/program (line 26 minus lines 26.01, 26.	02 27 and 28)		322, 886	28. 00 29. 00
30.00		•	,	0	•
	chapter I, §115.2				

	Financial Systems FERRELL HOSP ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC	Provider CCN: 14-1324	Period:	u of Form CMS-2 Worksheet M-3	
SERVI (Component CCN: 14-8588	From 04/01/2022 To 03/31/2023	Date/Time Pre 8/31/2023 4:0	pared:
		Title XVIII	RHC II	Cost	. p
	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, 490, 447	1.00
2. 00	Cost of injections/infusions and their administration (from Wk			240, 239	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 mi	nus line 2)		2, 250, 208	3.00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)	>		12, 026	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)	ine 9)		12 024	5. 00 6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			12, 026 187. 11	
7.00	Trail district cost per visit (Time o di vi ded by Time o)		Cal cul ati on		7.00
			Rate Period 1		
			(04/01/2022 through	(01/01/2023 through	
			12/31/2022)	03/31/2023)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	165. 91	171. 04	8. 00
9. 00	Rate for Program covered visits (see instructions)		165. 91	171. 04	9. 00
10. 00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from	contractor records)	2, 894	965	10.00
11. 00	Program cost excluding costs for mental health services (line		480, 144	165, 054	
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 lir	ne 12)	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	44E 100	15.00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's rec		0	645, 198 717, 293	
16. 02	Total program preventive charges (see instructions) (from provi	•		0	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	line 16)		0	16. 03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03	3 and 18) times .80)		460, 758	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	460, 758	16 05
17. 00	Primary payer amounts				17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		69, 251	•
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		128, 961	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			460, 516	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4. line 16)		165, 948	•
22.00	Total reimbursable Program cost (line 20 plus line 21)	•		626, 464	
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 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	uctions)		0	24. 00 25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	25. 50
25. 99	Demonstration payment adjustment amount before sequestration	•		0	1
26.00	Net reimbursable amount (see instructions)			626, 464	1
26. 01	Sequestration adjustment (see instructions)			10, 963	1
26. 02 27. 00	Demonstration payment adjustment amount after sequestration Interim payments			0 435, 956	
28. 00	1 3			433, 430	1
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.0	02, 27, and 28)		179, 545	
30. 00		nce with CMS Pub. 15-II		0	30. 00
	chapter I, §115.2				

<u>Hea</u> l th	Financial Systems FERRELL HOSF	PLTAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-1324	Peri od:	Worksheet M-3	
SERVI C	ES	Component CCN: 14-8616	From 04/01/2022 To 03/31/2023	Date/Time Pre	nared.
		Compensive Cont. 11 Co.10	10 00/01/2020	8/31/2023 4:0	
		Title XVIII	RHC III	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 (fro	m Wkst. M-2, line 20)		1, 481, 047	1.00
2.00	Cost of injections/infusions and their administration (from W	kst. M-4, line 15)		101, 437	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		1, 379, 610	1
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	11		6, 038	1
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	
6. 00 7. 00	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)			6, 038 228. 49	1
7.00	And disted cost per visit (Time 3 divided by Time 0)		Cal cul ati on		7.00
			our our a troir	01 21 1111 2 (1)	
			Rate Period 1		
			(04/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	03/31/2023)	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	. 6 or your contractor)	136, 49	141. 67	8.00
9.00	Rate for Program covered visits (see instructions)	,	136. 49	141. 67	1
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from		626	209	1
11.00	Program cost excluding costs for mental health services (line	•	85, 443	29, 609	1
12.00	Program covered visits for mental health services (from contr	*	0	0	
13. 00 14. 00	Program covered cost from mental health services (line 9 x li Limit adjustment for mental health services (see instructions	•	0	0	13.00
15.00	Graduate Medical Education Pass Through Cost (see instruction	•		U	15.00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	115, 052	1
16. 01	Total program charges (see instructions) (from contractor's re	,		130, 087	1
16. 02	Total program preventive charges (see instructions)(from prov	i der's records)		0	16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			0	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		75, 094	16.04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	75, 094	16 05
17. 00	Primary payer amounts			75, 074	1
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		21, 185	
	records)	•		,	
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		21, 477	19. 00
00.00	records)			75.0/0	00.00
20.00	Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst.	M 4 line 14)		75, 060 31, 234	1
21. 00 22. 00	Total reimbursable Program cost (line 20 plus line 21)	W-4, TITIE 10)		106, 294	
23. 00	Allowable bad debts (see instructions)			0	1
23. 01	Adjusted reimbursable bad debts (see instructions)			0	1
24.00		ructi ons)		0	24.00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	1
25. 99	Demonstration payment adjustment amount before sequestration			0 106, 294	
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			·	26.00
26. 02	1 '			1, 800	
27. 00	Interim payments			72, 883	1
	Tentative settlement (for contractor use only)			0	I
28. 00			i l		1 00 00
28. 00 29. 00 30. 00	Balance due component/program (line 26 minus lines 26.01, 26. Protested amounts (nonallowable cost report items) in accorda			31, 551 0	1

Heal th	Financial Systems FERRELL HOSE	PI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-1324	Peri od:	Worksheet M-3	
SERVI (EES	Component CCN: 14-8627	From 04/01/2022 To 03/31/2023	Date/Time Pre 8/31/2023 4:0	
		Title XVIII	RHC IV	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		<u></u>	1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		886, 032	1.00
2.00	Cost of injections/infusions and their administration (from W	kst. M-4, line 15)		53, 863	2.00
3. 00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		832, 169	3.00
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8)	Line O		4, 792 0	4. 00 5. 00
6. 00	Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5)	111le 9)		4, 792	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			173. 66	
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(04/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	03/31/2023)	
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	
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from		979	326	
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr	•	110, 627 0	41, 076 0	1
13. 00	Program covered cost from mental health services (line 9 x li	•	0	0	1
14. 00	Limit adjustment for mental health services (see instructions	•	0	0	
15.00	Graduate Medical Education Pass Through Cost (see instruction	s)			15.00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	151, 703	1
16. 01 16. 02	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov			247, 805 0	1
16. 02	Total program preventive charges (see Instructions) (Irom prov Total program preventive costs ((line 16.02/line 16.01) times	•		0	16. 02
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0			88, 743	
	(Titles V and XIX see instructions.)				
16. 05	Total program cost (see instructions)		0	88, 743	1
17. 00 18. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		40, 774	17. 00 18. 00
10.00	records)	(110iii contractor		40, 774	18.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		40, 995	19. 00
20.00	records) Net Medicare cost excluding vaccines (see instructions)			00 (10	20.00
20.00	Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		88, 618 41, 864	1
22. 00	,	,,		130, 482	1
23.00	Allowable bad debts (see instructions)			0	23. 00
23. 01	,			0	
24. 00 25. 00	Allowable bad debts for dual eligible beneficiaries (see inst OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
25. 99	Demonstration payment adjustment amount before sequestration	3)		0	ı
26. 00	Net reimbursable amount (see instructions)			130, 482	1
26. 01	Sequestration adjustment (see instructions)			2, 283	
26. 02				0 00	
27. 00 28. 00	Interim payments Tentative settlement (for contractor use only)			83, 288 0	1
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		44, 911	
30.00	Protested amounts (nonallowable cost report items) in accorda		,		30.00
	chapter I, §115.2		1		1

OMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC	CN: 14-1324	Peri od:	Worksheet M-4	
		Component C	CCN: 14-8506	From 04/01/2022 To 03/31/2023	Date/Time Pre 8/31/2023 4:0	
		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	
. 00 . 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	2, 668, 563 0. 003002	2, 668, 56 0. 01388		2, 668, 563 0. 000000	
. 00	Injection/infusion health care staff cost (line 1 x line 2)	8, 011	37, 04	42 0	0	3.0
. 00	Injections/infusions and related medical supplies costs (from your records)	36, 350	37, 6	13 0	0	4.00
. 00	Direct cost of injections/infusions (line 3 plus line 4)	44, 361	74, 65	55 0	0	5.0
. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2, 946, 879	2, 946, 87	79 2, 946, 879	2, 946, 879	6.0
. 00	Total overhead (from Wkst. M-2, line 19)	8, 898, 560	8, 898, 50	60 8, 898, 560	8, 898, 560	7. C
. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 015054	0. 02533	0. 000000	0. 000000	8.0
. 00	Overhead cost - injection/infusion (line 7 x line 8)	133, 959	225, 43		0	
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	178, 320	300, 09		0	
1. 00	Total number of injections/infusions (from your records)	266	1, 23		0	
2. 00	Cost per injection/infusion (line 10/line 11)	670. 38	243.			12.0
3. 00	Number of injection/infusion administered to Program beneficiaries	134	9!	58 0	0	
	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)	89, 831	233, 73	33 0	0	14.00
					COST OF	
					INJECTIONS / INFUSIONS AND	
					ADMI NI STRATI O	
					N	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		columns 1,		478, 411	15. C
6. 00	Total Program cost of injections/infusions and their admin		s (sum of		323, 564	16.0
	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou					

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC	CN: 14-1324	Peri od: From 04/01/2022	Worksheet M-4	
		Component C		To 03/31/2023	Date/Time Pre 8/31/2023 4:0	
		Title		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	376, 373 0. 005371	376, 37 0. 01923		376, 373 0. 000000	
3. 00	care staff time Injection/infusion health care staff cost (line 1 x line	2, 021	7, 24	41 0	0	3.00
4. 00	2) Injections/infusions and related medical supplies costs (from your records)	16, 673	13, 30	63 0	0	4.00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	18, 694	20, 60	04	0	5.00
5. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	407, 386	407, 38			
7. 00	Total overhead (from Wkst. M-2, line 19)	2, 083, 061	2, 083, 06	2, 083, 061	2, 083, 061	7.0
3. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 045888	0. 0505	0. 000000	0. 000000	8.0
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	95, 588	105, 35		0	
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	114, 282	125, 9	57 0	0	10.0
11. 00	Total number of injections/infusions (from your records)	122		37 0	0	
12.00	Cost per injection/infusion (line 10/line 11)	936. 74	288. 2			12.0
13. 00	Number of injection/infusion administered to Program beneficiaries	67	35	58 0	0	
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees		100 1	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)	62, 762	103, 18	36 0	0	14.00
					COST OF	
					INJECTIONS /	
					I NFUSIONS AND	
					ADMI NI STRATI O	
				1. 00	N 2. 00	
5. 00	Total cost of injections/infusions and their administratio	n costs (sum of	columns 1	1.00	240, 239	15.0
	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		23. 4		2.0,20	
14 00	Total Program cost of injections/infusions and their admin				165, 948	1110

OMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC		Peri od:	Worksheet M-4	
		Component C		From 04/01/2022 To 03/31/2023	Date/Time Prep 8/31/2023 4:04	
		Title	XVIII	RHC III	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	483, 438	483, 43	483, 438	483, 438	1.0
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 010958	0. 01860	0. 000000	0. 000000	2. 0
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	5, 298	8, 99	92 0	0	3. 0
. 00	Injections/infusions and related medical supplies costs (from your records)	16, 263	6, 17	77 0	0	4.0
. 00	Direct cost of injections/infusions (line 3 plus line 4)	21, 561	15, 1 <i>6</i>	59 0	0	5.0
. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	536, 282	536, 28	536, 282	536, 282	6.0
. 00	Total overhead (from Wkst. M-2, line 19)	944, 765	944, 76	944, 765	944, 765	7. C
. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 040205	0. 02828	0. 000000	0. 000000	8.0
. 00	Overhead cost - injection/infusion (line 7 x line 8)	37, 984	26, 72	23 0	o	9.0
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	59, 545	41, 89	92 0	0	10.0
1.00	Total number of injections/infusions (from your records)	119	20	02	0	11.0
2.00	Cost per injection/infusion (line 10/line 11)	500. 38	207. 3	0. 00	0. 00	12.0
3. 00	Number of injection/infusion administered to Program beneficiaries	16	11	12 0	0	13. C
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)	8, 006	23, 22	28 0	0	14.0
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMINISTRATIO	
					N	
				1. 00	2. 00	
	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			101, 437	15. C
6. 00	Total Program cost of injections/infusions and their admin	istration costs	(sum of		31, 234	16.0

	Financial Systems FERRELL HATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC	CN: 14-1324	Peri od:	Worksheet M-4	
		Component C	CCN: 14-8627	From 04/01/2022 To 03/31/2023	Date/Time Pre 8/31/2023 4:0	
		Title	XVIII	RHC IV	Cost	ı pııı
		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	314, 524 0. 003900	314, 52 0. 0263	·	314, 524 0. 000000	1. 00 2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	1, 227	8, 28	89 0	0	3.00
1. 00	Injections/infusions and related medical supplies costs (from your records)	5, 056	7, 64	45 0	0	4.00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	6, 283	15, 93	34 0	0	5.00
5. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	365, 466	365, 46	365, 466	365, 466	6.00
7. 00	Total overhead (from Wkst. M-2, line 19)	520, 566	520, 50		520, 566	7.0
3. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 017192	0. 04359		0. 000000	
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	8, 950	22, 69		0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	15, 233	38, 63		0	10.00
11.00	Total number of injections/infusions (from your records)	37		50 0	0	
12.00	Cost per injection/infusion (line 10/line 11)	411. 70	154. 5			12.0
13.00	Number of injection/infusion administered to Program beneficiaries	30	19	91 0	0	13.0
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees	10.051	20 5	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)	12, 351	29, 5	13 0	0	14.00
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI 0	
				1.00	N	
5 00	Total cost of injections/infusions and their administratio	n costs (sum of	f columns 1	1. 00	2. 00 53, 863	15. 0
5.00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		COLUMNIS I,		53, 863	15.0
6 00	Total Program cost of injections/infusions and their admin		s (sum of		41, 864	16.0
	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou				11,004	0

Health Financial Systems	FERRELL HOS	SPI TAL	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC	PROVIDER FOR	Provider CCN: 14-1324	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES			From 04/01/2022		
		Component CCN: 14-8506	To 03/31/2023		
				8/31/2023 4:0	4 pm
			RHC I	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	

			RHC I	Cost	_
				t B	
			mm/dd/yyyy	Amount	
			1.00	2. 00	
0	Total interim payments paid to hospital-based RHC/FQHC			2, 094, 626	
0	Interim payments payable on individual bills, either submit	ted or to be submitted to		l ol	1
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero	p			
00	List separately each retroactive lump sum adjustment amount	based on subsequent			İ
_	revision of the interim rate for the cost reporting period.				
	payment. If none, write "NONE" or enter a zero. (1)	7.1 35 Show data of sash			
	Program to Provider				
1	rrogram to rrovido.			0	1
2				l ől	
3				اه	
4					
5					
5	Provider to Program			U	-
0	Flovider to Flogram		10/19/2022	5, 514	1
51			10/ 19/ 2022	3, 314	
2					
3					
4	Subtatal (sum of lines 2 01 2 40 minus sum of lines 2 50 2	00)		1 - 1	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			-5, 514	
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)	rer to worksneet M-3, Tine		2, 089, 112	
	TO BE COMPLETED BY CONTRACTOR				1
00	List separately each tentative settlement payment after des	k raview. Also show date of	•		1
,0	each payment. If none, write "NONE" or enter a zero. (1)	K Teview. Also show date of			
	Program to Provider				ı
)1	1 rogi am to 1 rovi dei			0	ı
)2					
12					
3	Provider to Program			U	1
0	11 ovi dei 16 11 ogi alli			0	t
1					
2					
)2)9	 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	00)			1
0	Determined net settlement amount (balance due) based on the				1
	SETTLEMENT TO PROVIDER	cost report. (1)		222 00/	
1				322, 886	
2	SETTLEMENT TO PROGRAM			0	
00	Total Medicare program liability (see instructions)		0 1	2, 411, 998	L
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	\perp
00	Name of Contractor		1	ı	1

Health Financial Systems	FERRELL HOSE	PLTAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RESERVICES RENDERED TO PROGRAM BENEFICIARIE		Provider CCN: 14-1324 Component CCN: 14-8588	Peri od: From 04/01/2022 To 03/31/2023	
			DUC 11	C

				8/31/2023 4: 04	4 pm
			RHC II	Cost	-
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			377, 065	1.
00	Interim payments payable on individual bills, either submit	tted or to be submitted to		l	2.
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero	•			
00	List separately each retroactive lump sum adjustment amount	t based on subsequent			3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01			10/19/2022	58, 891	3.
02				l	3.
03				o	3
)4				o	3
05				0	3
-	Provider to Program			-	_
50				0	3
51				l ol	3
52				0	3
53				0	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		58, 891	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			435, 956	4
00	27)	or to worksheet w 5, 1111c		433, 730	7
	TO BE COMPLETED BY CONTRACTOR				
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)	sk review. 711 30 3110W date 0	'		ľ
	Program to Provider				
01	1 rogram to 1 rovi dei			0	5
)2				l ő	5
)3				0	5
	Provider to Program				ľ
0	. rovraci to rrogram			0	5
51				0	5
52				l ő	5
9	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 cost report. (1)				6
)1	SETTLEMENT TO PROVIDER	2 cost report. (1)		179, 545	6
)2	SETTLEMENT TO PROGRAM			179, 343	6
00	Total Medicare program liability (see instructions)			615, 501	7
00	Tiotal medicare program trability (see instructions)		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	

Health Financial Systems	FERRELL HOSPITAL		In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RESERVICES RENDERED TO PROGRAM BENEFICIARIE	S	r CCN: 14-1324 nt CCN: 14-8616	From 04/01/2022	Worksheet M-5 Date/Time Prepared: 8/31/2023 4:04 pm
			RHC LLL	Cost

		Component Con. 14-8010	03/31/2023	8/31/2023 4: 04	
			RHC III	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1.00	2. 00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			72, 228	1.00
2.00	Interim payments payable on individual bills, either submi	tted or to be submitted to		l ol	2.00
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero	•			
3.00	List separately each retroactive lump sum adjustment amoun	t based on subsequent			3.00
	revision of the interim rate for the cost reporting period	. Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01			10/19/2022	655	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. 51
3. 52				0	3. 52
3.53				0	3. 53
3.54				0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3			655	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		72, 883	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after des	sk review. Also show date d	DT		5. 00
	each payment. If none, write "NONE" or enter a zero. (1) Program to Provider				
5. 01	Program to Provider			0	5. 01
5. 01					5. 02
5. 02				0	5. 03
5.05	Provider to Program			0	5.05
5. 50	110vrder to 110graiii			0	5. 50
5. 51				Ö	5. 51
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. 99
6. 00	Determined net settlement amount (balance due) based on the				6.00
6. 01	SETTLEMENT TO PROVIDER	, , ,		31, 551	6. 01
6. 02	SETTLEMENT TO PROGRAM			o	6.02
7.00	Total Medicare program liability (see instructions)			104, 434	7.00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
8.00	Name of Contractor				8.00

Health Financial Systems	FERRELL HOSE	PLTAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RESERVICES RENDERED TO PROGRAM BENEFICIARIE			From 04/01/2022	
			DHC TV	Coct

				8/31/2023 4: 04	4 pm
			RHC IV	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			72, 281	1.
00	Interim payments payable on individual bills, either submit	tted or to be submitted to		0	2.
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero	p			
00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.
	revision of the interim rate for the cost reporting period.				
	payment. If none, write "NONE" or enter a zero. (1)	All de diidii date di dadii			
	Program to Provider				
01	i rogram to rrovias.		10/19/2022	11, 007	3.
02			107 177 2022	0	3.
03				l ől	3
04					3
05				0	3
05	Provider to Program			U	ا ا
50	Frovider to Frogram			0	3
50 51					3
				1	
2				0	3
53				0	3
54		20)		0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			11, 007	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		83, 288	4
	27)				
	TO BE COMPLETED BY CONTRACTOR		_1		
00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		T		
01				0	5
)2				0	5
)3				0	5
	Provider to Program				
50				0	5
51				0	5
52				0	5
9	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	e cost report. (1)			6
)1	SETTLEMENT TO PROVIDER			44, 911	6
)2	SETTLEMENT TO PROGRAM			0	6
00	Total Medicare program liability (see instructions)			128, 199	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	