Health Financial Systems BROWNING

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050

EXPIRES 09-30-2025

number of times reopened = 0-9.

Worksheet S Parts I-III HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-1331 From 07/01/2022 AND SETTLEMENT SUMMARY

		10 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm
PART I - COST	REPORT STATUS	
Provi der	 [X] Electronically prepared cost report 	Date: 11/27/2023 Time: 12:08 pm
use only	2. [] Manually prepared cost report	
	3. [0] If this is an amended report enter the number 4. [F] Medicare Utilization. Enter "F" for full, "L"	
Contractor		10. NPR Date:
Contractor use only	5. [1] Cost Report Status 6. Date Received: 7. Contractor No.	11. Contractor's Vendor Code:
use only	(2) Settled without Audit 8. [N] Initial Report for	r this Provider CCN 12. [0] If line 5, column 1 is 4: Enter
	(3) Settled with Audit 9. [N] Final Report for	this Provider CCN number of times reopened = 0-9.

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

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARSHALL BROWNING HOSPITAL (14-1331) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Haro	ld Calderon	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	Harol d Cal deron			2
3	Signatory Title	CF0			3
4	Date $11/28/23$	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	93, 038	-31, 607	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	248, 689	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-121, 944		0	10.00
10. 01	RURAL HEALTH CLINIC II - FHC	0		6, 019		0	10.01
200.0	O TOTAL	0	341, 727	-147, 532	0	0	200.00

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

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

Health Financial Systems

MARSHALL BF
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA In Lieu of Form CMS-2552-10
Worksheet S-2
Part I
30/2023 Date/Time Prepared:
11/27/2023 12:08 pm Provider CCN: 14-1331 Peri od: From 07/01/2022 To 06/30/2023

	1.00 2.00				3. 00			4. 00	11/2//2	023 12	:08 pm
	Hospital and Hospital Health Care Co	omplex Ad			3.00		<u> </u>	+. 00			
1. 00	Street: 900 NORTH WASHINGTON STREET	ompron na	PO Box:								1.00
2. 00	City: DUQUOIN		State: IL	Zip Cod	e: 628	332 Count	ty: PERRY				2.00
		Comp	onent Name	CCN	CB:			Payme	nt Syst	em (P,	
				Number	Numl	ber Type	Certi fi ed	T,	0, or	N)	
								V	XVIII	XIX	
			1. 00	2.00	3. (00 4.00	5. 00	6.00	7.00	8. 00	
	Hospital and Hospital-Based Componer										
3.00	Hospi tal		BROWNI NG	141331	999	714 1	01/01/2004	N	0	Р	3.00
		HOSPI TAL									
4. 00	Subprovi der - IPF										4.00
5. 00	Subprovi der - IRF										5.00
6. 00	Subprovi der - (Other)		DD011111 NO 0111 NO	4.7004			04 (04 (000)	١			6.00
7. 00	Swing Beds - SNF		BROWNING SWING	14Z331	999	714	01/01/2004	N	0	N	7.00
0 00	Cui na Dodo NE	BED									0.00
8. 00 9. 00	Swing Beds - NF Hospital-Based SNF				-						8. 00 9. 00
10.00	Hospi tal -Based NF				1						10.00
11. 00	Hospi tal -Based OLTC				1						11.00
12. 00	Hospi tal -Based OLTC				-						12.00
13. 00	Separately Certified ASC				-						13.00
14. 00	Hospi tal -Based Hospi ce										14.00
15. 00	Hospital -Based Health Clinic - RHC	MARSHALI	BROWNI NG	148504	999	014	05/01/2009	l N	0	N	15.00
10.00	Hospi tai Basea Hear tii orrii e Kilo	PHYSI CI A		1 1000 1	'''	'	007 017 2007	"			10.00
15. 01	Hospital-Based Health Clinic - RHC		BROWNING FAMILY	148597	999	14	06/28/2018	l N	0	N	15. 01
		HEALTH C						'			
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	0ther										19.00
	From: To:										
							1. 00		2.0		
	Cost Reporting Period (mm/dd/yyyy)						07/01/2	022	06/30/	2023	20.00
21. 00	Type of Control (see instructions)						2				21.00
	l					1. 00	2. 00		3.0	00	
00.00	Inpatient PPS Information										00.00
22. 00	Does this facility qualify and is it					N	N				22. 00
	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo				K						
	facility subject to 42 CFR Section §										
	hospital?) In column 2, enter "Y" for			mullem							
22. 01	Did this hospital receive interim U			al IICPs	for	l N	N				22. 01
22.01	this cost reporting period? Enter in						"				22.01
	for the portion of the cost reporting										
	1. Enter in column 2, "Y" for yes or										
	cost reporting period occurring on o										
	instructions)										
22. 02	Is this a newly merged hospital that	requires	s a final UCP to	be be		N	N				22. 02
	determined at cost report settlement				lumn						
	1, "Y" for yes or "N" for no, for the	ne portio	n of the cost re	eporti ng							
	period prior to October 1. Enter in				no,						
	for the portion of the cost reporting										
22. 03	Did this hospital receive a geograph					N	N		N		22. 03
	rural as a result of the OMB standar		9								
	adopted by CMS in FY2015? Enter in a										
	for the portion of the cost reporting in column 2, "Y" for yes or "N" for				eı						
	reporting period occurring on or af										
	Does this hospital contain at least										
	counted in accordance with 42 CFR 4			,							
	ves or "N" for no.			0,	0.						
22. 04	Did this hospital receive a geograph	nic reclas	ssification from	n urban t	О						22. 04
	rural as a result of the revised OME										
	adopted by CMS in FY 2021? Enter in	column 1,	"Y" for yes or	"N" for	no						
	for the portion of the cost reporting	ng period	prior to Octobe	er 1. Ent	er						
	in column 2, "Y" for yes or "N" for	no for the	ne portion of th	ne cost							
	reporting period occurring on or af										
	Does this hospital contain at least										
	counted in accordance with 42 CFR 4	2. 105)?	Enter in column	1 3, "Y"	ror						
22.00	yes or "N" for no.				_		2				22.00
23.00	Which method is used to determine Me		•				3 N				23. 00
	below? In column 1, enter 1 if date										
	if date of discharge. Is the method reporting period different from the				CUSI						
	reporting period different from the reporting period? In column 2, enter										
	,		J 3. 14 101			1	1	1			'

Health Financial Systems

MARSHALL BR
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1331

				To 06/3	0/2023	Date/T		
	In-State Medicaid paid days	In-State Medi cai d el i gi bl e unpai d days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicai HMO day	d C rs Me	2023 12 Ither di cai d days	: 08 pm
	1.00	2.00	3.00	4. 00	5. 00		5. 00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state	C	0	0	0	3.00	0		24. 00 25. 00
Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	e							
				Urban/R	tural S [<u>Date of</u> 2.		
26.00 Enter your standard geographic classification (not v		s at the be	ginning of		2			26. 00
cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not very reporting period. Enter in column 1, "1" for urban center the effective date of the geographic reclassif	wage) status or "2" for i fication in	rural. If a column 2.	ppl i cabl e,		2			27. 00
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	ie nulliber o	i perrous s	CH Status I	П	0			35.00
				Begi ni		Endi 2.		
36.00 Enter applicable beginning and ending dates of SCH s		script line	36 for num		30		00	36. 00
of periods in excess of one and enter subsequent da 37.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		er of perio	ds MDH stat	us	0			37. 00
37.01 Is this hospital a former MDH that is eligible for accordance with FY 2016 OPPS final rule? Enter "Y" instructions)								37. 01
38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number of enter subsequent dates.								38.00
				1. (Y, 2.		
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), on the mileage	r (iii)? En e requireme	ter in colu nts in	ume N ımn		<u> </u>		39.00
40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October	ober 1. Ente	er "Y" for				1	I	40. 00
Prospective Payment System (PPS)-Capital	(3.3.3.3.3.3.3.3.3.3.3.3.3.3.3.3.3.3.3.				V 1.00	XVIII 2. 00	XI X 3. 00	
45.00 Does this facility qualify and receive Capital payme	ent for disp	oroporti ona	te share in	accordance	e N	N	N	45. 00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks					N	N	N	46. 00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital paymen			,		N N	N N	N N	47. 00 48. 00
Teaching Hospitals 1s this a hospital involved in training residents in					N			56. 00
periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did								57. 00
residents start training in the first month of this "N" for no in column 2. If column 2 is "Y", complet complete Wkst. D, Parts III & IV and D-2, Pt. II, it beginning on or after December 27, 2020, under 42 Cl which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not complete.	cost reporte Worksheed applicable FR 413.77(educt)	ting period t E-4. If c e. For cost)(1)(iv) a if the resp	? Enter "Y olumn 2 is reporting nd (v), reg onse to lin	" for yes o "N", periods pardless of De 56 is "Y"				

Health Financial Systems

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-1331 Peri od: Worksheet S-2

From 07/01/2022

Part I

Date/Time Prepared: 06/30/2023 11/27/2023 12: 08 pm | XVIII | XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qualification Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60 00 N any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. IME Direct GME IME Direct GME 1. 00 2.00 3. 00 4. 00 5.00 0.00 61.00 Did your hospital receive FTE slots under ACA 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00

Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Heal th Fi nancial Systems MARSHALL BROWNING HOSPITAL

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-1331 Peri od: Worksheet S-2 From 07/01/2022 Part I 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + FTEs FTEs in col. 2)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.00 0.000000 64.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in 3/ (col. 3 + Nonprovi der col. 4)) Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5.00 65.00 Enter in column 1, if line 63 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col. 2)) FTEs in FTES Nonprovi der Hospi tal Si te 1. 00 2. 00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.000000 66.00 0.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in 3/(col. 3 +Nonprovi der Hospi tal col. 4)) Si te 1.00 2.00 3.00 4.00 5.00 67.00 Enter in column 1, the program 0 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column

4)). (see instructions)

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-1331

In Lieu of Form CMS-2552-10 Peri od: Worksheet S-2

From 07/01/2022

Part I

Date/Time Prepared: 06/30/2023 11/27/2023 12:08 pm 1.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 68.00 N 68.00 (August 10, 2022)? 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no 71.00 | If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 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 program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for O 76.00 no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 'Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87.00 N 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Adjustment Permanent (Y/N)Adjustments 1.00 2.00 88. 00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments Effecti ve Wkst. A Line Approved No. Date Permanent Adjustment Amount Per Di scharge 3.00 2.00 1.00 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0 00 0 89 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 di scharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90.00 Ν Υ yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 91.00 Ν 91.00 Ν Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92.00 Ν 92.00 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν Ν applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0 00 0.00 95.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 96.00 Ν Ν 96.00 applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00

Heal th Financial Systems

Health Financial Systems

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I DENTIFICATION DATA

Provider CCN: 14-1331

Period

Provi der CCN: 14-1331 Peri od: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/27/2023 12:08 pm V 1. 00 2.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in Υ 98.00 column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 98.01 C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation 98.02 bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) Ν 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of 98.04 N N outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in 98.05 column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? 105.00 106.00|If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) 107.00 Ν Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 ls this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. 108.00 Υ Physi cal Occupati onal Speech Respi ratory 3.00 1.00 2.00 4.00 109.00 If this hospital qualifies as a CAH or a cost provider, are 109.00 N therapy services provided by outside supplier? Enter for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A 110.00 Ν Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appl i cabl e. 1. 00 2.00 111.00 of this facility qualifies as a CAH, did it participate in the Frontier Community Ν 111 00 Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services. 1.00 2.00 3.00 112.00 Did this hospital participate in the Pennsylvania Rural Health Model 112.00 (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" for no Ν 0115.00 in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or 116.00 "N" for no. 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. Ν 117.00 118.00|s the malpractice insurance a claims-made or occurrence policy? Enter 1 118.00 if the policy is claim-made. Enter 2 if the policy is occurrence.

In Lieu of Form CMS-2552-10

Heal th Fi nancial Systems MARSHALL BROWNING HOSPITAL
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I DENTIFICATION DATA Provider CCN: 14-1331 Period:

Worksheet S-2 From 07/01/2022 Part I 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm Premi ums Losses Insurance 3.00 1.00 2.00 118.01 List amounts of malpractice premiums and paid losses: 307, 172 0118.01 1.00 2.00 118.02 Are mal practice premiums and paid losses reported in a cost center other than the 118. 02 Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 DO NOT USE THIS LINE 119 00 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA Ν 120.00 Ν §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devices charged to Ν 121.00 patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the 122.00 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchase professional 123.00 services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no. Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes Ν 125.00 and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 of this is a Medicare-certified kidney transplant program, enter the certification date 126,00 in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare-certified heart transplant program, enter the certification date 127.00 in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare-certified liver transplant program, enter the certification date 128.00 in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare-certified lung transplant program, enter the certification date 129.00 in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare-certified pancreas transplant program, enter the certification 130.00 date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare-certified intestinal transplant program, enter the certification 131.00 date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare-certified islet transplant program, enter the certification date 132.00 in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 133 00 134.00 If this is a hospital-based organ procurement organization (0P0), enter the 0P0 number 134.00 in column 1 and termination date, if applicable, in column 2 ALL Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, 140. 00 Ν chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 3.00 1.00 2.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 141.00 Name: Contractor's Name: Contractor's Number: 141.00 142.00 Street: PO Box: 142.00 143.00 Ci ty: 143.00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 2.00 1.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Ν 146. 00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If

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yes, enter the approval date (mm/dd/yyyy) in column 2.

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Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section

1876 Medicare days in column 2. (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-1331 Peri od: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/27/2023 12:08 pm 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147.00 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. Ν 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 149. 00 Part A Title V Title XIX Part B 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155. 00 156.00 Subprovi der - IPF N Ν Ν N 156 00 157.00 Subprovi der - IRF Ν Ν Ν Ν 157.00 158. 00 SUBPROVI DER 158. 00 159. 00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160.00 N Ν Ν N 161.00 CMHC Ν Ν 161.00 Ν 1.00 Mul ti campus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 4.00 0 1.00 2.00 3.00 5.00 166.00 If line 165 is yes, for each 0. 00 166. 00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. N 167.00 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) Υ 168 01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00169.00 transition factor. (see instructions) Endi ng Begi nni ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170.00 period respectively (mm/dd/yyyy) 1. 00 2.00 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in Ν 0171.00 section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter

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Health Financial Systems In Lieu of Form CMS-2552-10 Provi der CCN: 14-1331 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Peri od: Worksheet S-2

From 07/01/2022

Part II

Date/Time Prepared: 06/30/2023 11/27/2023 12:08 pm Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column $\hat{\textbf{3}},$ "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5.00 Ν those on the filed financial statements? If yes, submit reconciliation Legal Oper. Y/N 1.00 2.00 Approved Educational Activities 6.00 Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 N 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? Ν N 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for 17.00 Υ 08/26/2022 γ 08/26/2022 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 Ν 18.00 N Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

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HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-1331 Period:

From 07/01/2022 Part II Date/Time Prepared: 06/30/2023 11/27/2023 12:08 pm Description Y/N 1.00 3.00 20.00 | If line 16 or 17 is yes, were adjustments made to PS&R N Ν 20.00 Report data for Other? Describe the other adjustments: Y/N Date Y/N Date 3.00 1.00 2.00 4.00 21.00 Was the cost report prepared only using the provider's 21 00 N N records? If yes, see instructions. 1. 00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost Ν 23 00 reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered into during this cost reporting period? Υ 24.00 24.00 If yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 i nstructi ons. Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 26,00 instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору. Interest Expense Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 28.00 period? If yes, see instructions. Υ Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 29.00 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31 00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31 00 <u>i nstructi ons</u> Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual Ν 32.00 arrangements with suppliers of services? If yes, see instructions.

If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If 33.00 Ν 33.00 no, see instructions. Provi der-Based Physi ci ans Were services furnished at the provider facility under an arrangement with provider-based physicians? 34.00 If ves see instructions If line 34 is yes, were there new agreements or amended existing agreements with the provider-based Ν 35 00 physicians during the cost reporting period? If yes, see instructions. Date 1. 00 2.00 Home Office Costs 36.00 Were home office costs claimed on the cost report? N 36 00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 Ν If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 38.00 Ν 38.00 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 39.00 see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position ANDREW MCCABE 41.00 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. 42.00 Enter the employer/company name of the cost report WI PFLI 42.00 preparer. Enter the telephone number and email address of the cost 7158586660 AMCCABE@WIPFLI.COM 43.00

In Lieu of Form CMS-2552-10

Worksheet S-2

report preparer in columns 1 and 2, respectively.

I th Financial Systems MARSHALL BROWNING HOSPITAL

Health Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-1331 Period: Worksheet S-2
From 07/01/2022 Part II
To 06/30/2023 Date/Time Prepared:

			To 06/30/2023 Date/Time Pre 11/27/2023 12	
		3. 00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position	CPA		41.00
	held by the cost report preparer in columns 1, 2, and 3,			
	respectively.			
42.00	Enter the employer/company name of the cost report			42.00
	preparer.			
	Enter the telephone number and email address of the cost			43.00
	report preparer in columns 1 and 2, respectively.			

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Health Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-1331 Period: Worksheet S-3

From 07/01/2022 Part I 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm I/P Days / 0/P Visits / Tri ps CAH/REH Hours Component Worksheet A No. of Beds Bed Days Title V Li ne No. Avai I abl e 1.00 2.00 3.00 4.00 5.00 PART I - STATISTICAL DATA 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 25 9, 125 19, 656. 00 1.00 0 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 HMO I RF Subprovi der 3.00 3.00 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 Total Adults and Peds. (exclude observation 25 9, 125 19, 656. 00 7.00 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 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 25 9.125 19, 656. 00 0 14.00 15.00 CAH visits 15.00 15. 10 REH hours and visits 15.10 SUBPROVIDER - IPF 16.00 16.00 17.00 SUBPROVIDER - IRF 17.00 18.00 SUBPROVI DER 18.00 SKILLED NURSING FACILITY 19.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 22.00 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24.00 24.00 24.10 HOSPICE (non-distinct part) 30.00 24.10 CMHC - CMHC 25.00 25.00 RURAL HEALTH CLINIC 88.00 26 00 0 26 00 RURAL HEALTH CLINIC II - FHC 88.01 26. 01 0 26.01 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 26. 25 27.00 Total (sum of lines 14-26) 25 27.00 Observation Bed Days 0 28 00 28 00 29.00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 0 32 00 Labor & delivery days (see instructions) Ω 32 00

30.00

0

32.01

33.00

33.01

0 34.00

32.01

33.01

Total ancillary labor & delivery room

LTCH site neutral days and discharges

34.00 Temporary Expansion COVID-19 PHE Acute Care

outpatient days (see instructions)

LTCH non-covered days

Health Financial Systems

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

34.00 Temporary Expansion COVID-19 PHE Acute Care

Provi der CCN: 14-1331

0

34.00

Peri od: Worksheet S-3 From 07/01/2022 Part I 06/30/2023 Date/Time Prepared:

11/27/2023 12:08 pm I/P Days / O/P Visits / Trips Full Time Equivalents Title XVIII Title XIX Component 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 576 819 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) 74 38 2.00 HMO IRF Subprovider 3.00 C 3 00 O 4.00 0 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 1, 327 0 1,668 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 251 6.00 Total Adults and Peds. (exclude observation 7.00 1.903 2,738 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 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 1, 903 14.00 Total (see instructions) 2,738 0.00198.88 14.00 15.00 CAH visits 15.00 15. 10 REH hours and visits 15.10 SUBPROVIDER - IPF 16.00 16.00 17.00 SUBPROVIDER - IRF 17.00 18.00 SUBPROVI DER 18.00 SKILLED NURSING FACILITY 19.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 22.00 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24.00 24.00 24.10 HOSPICE (non-distinct part) 0 24.10 CMHC - CMHC 25.00 25.00 RURAL HEALTH CLINIC 3.757 14, 393 19. 25 26 00 0 00 26 00 RURAL HEALTH CLINIC II - FHC 9.46 26.01 879 3, 415 0.00 26.01 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0.00 0.00 26. 25 0 27.00 Total (sum of lines 14-26) 0.00 227.59 27.00 Observation Bed Days 28 00 C 454 28 00 29.00 Ambul ance Trips 0 29.00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 0 31.00 32 00 Labor & delivery days (see instructions) 0 Ω 0 32.00 32.01 Total ancillary labor & delivery room 0 32.01 outpatient days (see instructions) LTCH non-covered days 33.00 LTCH site neutral days and discharges 0 33.01 33.01

Health Financial Systems MARSHALL
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

In Lieu of Form CMS-2552-10

Worksheet S-3
Part I
Date/Time Prepared:
11/27/2023 12:08 pm Provider CCN: 14-1331 Peri od: From 07/01/2022 To 06/30/2023

						11/2//2023 12	: 08 pm
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	177	1	259	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
2 00	for the portion of LDP room available beds)			10	1/		2.00
2.00	HMO and other (see instructions)			18	16		2.00
3.00	HMO I PF Subprovi der				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	C	177	1	259	14.00
15. 00	CAH visits	0.00		177	'	257	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)						24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0. 00					26.00
26. 01	RURAL HEALTH CLINIC II - FHC	0. 00					26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27.00
28. 00	Observation Bed Days						28.00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						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	l		1			34.00

Heal th Fi nanci al Systems

HOSPI TAL-BASED RHC/FQHC STATI STI CAL DATA

MARSHALL BROWNING HOSPI TAL

Provi der CCN: 14-1331 | Peri od:

From 07/01/2022 Component CCN: 14-8504 06/30/2023 To Date/Time Prepared: 11/27/2023 12:08 pm RHC I Cost 1.00 Clinic Address and Identification 1.00 Street 900 N. WASHINGTON 1.00 City ZIP Code State 1.00 2.00 2.00 City, State, ZIP Code, County DU QUOIN IL 62832 2.00 1. 00 3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban 0 3.00 Grant Award Date 1.00 2.00 Source of Federal Funds Community Health Center (Section 330(d), PHS Act) 4.00 4.00 5.00 Migrant Health Center (Section 329(d), PHS Act) 5.00 6.00 Health Services for the Homeless (Section 340(d), PHS Act) 6.00 Appalachian Regional Commission 7 00 7 00 8.00 Look-Alikes 8.00 9.00 OTHER 9.00 1. 00 2.00 10.00 Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for 0 10.00 yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday Monday Tuesday from from to from 1.00 2.00 3.00 4.00 5.00 Facility hours of operations (1) 11. 00 CLINIC 08: 00 11.00 1.00 2.00 12.00 Have you received an approval for an exception to the productivity standard? N 12.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N 0 13.00 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below. Provi der name CCN 1.00 2.00 14.00 RHC/FQHC name, CCN 14. 00 Total Visits Y/N V XVIII XIX 1.00 2.00 3.00 4.00 5.00 Have you provided all or substantially all 15.00 GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) County 4.00 2.00 City, State, ZIP Code, County PERRY 2.00 Tuesday Wednesday Thursday to from to from to 6. 00 9.00 10.00 7.00 8.00

16: 30

08.00

16: 30

08: 00

16: 30

11 00

In Lieu of Form CMS-2552-10

Worksheet S-8

11. 00 CLINI C

Facility hours of operations (1)

I th Financial Systems STATE MARSHALL BROWNING HOSPITAL

Health Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA Provider CCN: 14-1331 Period: Worksheet S-8

| Facility hours of operations (1) | 11.00 | CLINIC | 08:00 | 16:30 | 11.00 |

Heal th Fi nanci al Systems

HOSPI TAL-BASED RHC/FQHC STATI STI CAL DATA

MARSHALL BROWNING HOSPI TAL

Provi der CCN: 14-1331 | Peri od:

From 07/01/2022 Component CCN: 14-8597 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm RHC II Cost 1.00 Clinic Address and Identification 1.00 Street 20 N. WASHINGTON 1.00 City ZIP Code State 1.00 2.00 2.00 City, State, ZIP Code, County DU QUION IL 62832 2.00 1. 00 3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban 0 3.00 Grant Award Date 1.00 2.00 Source of Federal Funds Community Health Center (Section 330(d), PHS Act) 4.00 4.00 5.00 Migrant Health Center (Section 329(d), PHS Act) 5.00 Health Services for the Homeless (Section 340(d), PHS Act) 6.00 6.00 Appalachian Regional Commission 7 00 7 00 8.00 Look-Alikes 8.00 9.00 OTHER (SPECIFY) 9.00 1. 00 2.00 10.00 Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for 0 10.00 yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday Monday Tuesday from from from 1.00 2.00 3.00 4.00 5.00 Facility hours of operations (1) 11. 00 CLINIC 08: 00 08: 00 16: 30 11.00 1.00 2.00 12.00 Have you received an approval for an exception to the productivity standard? N 12.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N 0 13.00 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below. Provi der name CCN 1.00 2.00 14.00 RHC/FQHC name, CCN 14. 00 Total Visits Y/N V XVIII XIX 1.00 2.00 3.00 4.00 5.00 Have you provided all or substantially all 15.00 GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) County 4.00 2.00 City, State, ZIP Code, County PERRY 2.00 Tuesday Wednesday Thursday to from to from to 6. 00 9.00 10.00 7.00 8.00

16: 30

08.00

16: 30

08: 00

16: 30

11 00

In Lieu of Form CMS-2552-10

Worksheet S-8

11. 00 CLINI C

Facility hours of operations (1)

th Financial Systems MARSHALL BROWNING HOSPITAL

Heal th Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA
Provider CCN: 14-1331 Period: From 07/01/2022 To 06/30/2023 Date/Time Prepared:

Component CCN: 14-8597 To 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm

				KHC II	COST	
	Fri day		Saturday			
	from	to	from	to		
	11. 00	12. 00	13. 00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	16: 30				11.00

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

From 07/01/2022

06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm 1. 00 Uncompensated and indigent care cost computation
Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 1.00 0.491427 1.00 Medicaid (see instructions for each line) 2.00 2.00 Net revenue from Medicaid 4, 761, 454 Did you receive DSH or supplemental payments from Medicaid? 3.00 3.00 4.00 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? Υ 4.00 5.00 If line 4 is no, then enter DSH and/or supplemental payments from Medicaid 5.00 6.00 Medicaid charges 12, 544, 534 6.00 7.00 Medicaid cost (line 1 times line 6) 6, 164, 723 7.00 8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 1, 403, 269 8.00 < zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for each line) 9 00 9 00 Net revenue from stand-alone CHIP 0 Stand-alone CHIP charges 10.00 0 10.00 11.00 Stand-alone CHIP cost (line 1 times line 10) 0 11.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then 12.00 0 12.00 enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 0 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 14.00 0 14.00 15.00 State or local indigent care program cost (line 1 times line 14) 0 15.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 16.00 16.00 0 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17 00 Private grants, donations, or endowment income restricted to funding charity care Ω 17.00 Government grants, appropriations or transfers for support of hospital operations 18.00 18.00 0 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 19.00 1, 403, 269 19.00 12 and 16) Uni nsured Insured Total (col. 1 pati ents pati ents + col. 2) 3. 00 1.00 2.00 Uncompensated Care (see instructions for each line) 271, 430 20.00 20.00 Charity care charges and uninsured discounts for the entire facility 0 271, 430 (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 133, 388 0 133, 388 21.00 instructions) Payments received from patients for amounts previously written off as 0 22.00 22.00 0 charity care 23.00 Cost of charity care (line 21 minus line 22) 133, 388 133, 388 23.00 1.00 24 00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit Ν imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of 25.00 0 25.00 stay limit Total bad debt expense for the entire hospital complex (see instructions) 2, 927, 327 26.00 26.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 246, 546 27.00 27.00 Medicare allowable bad debts for the entire hospital complex (see instructions) 379, 301 27.01 27.01 28.00 Non-Medicare bad debt expense (see instructions) 2, 548, 026 28.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 29 00 1, 384, 924 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1, 518, 312 30.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30) 2, 921, 581 31.00

eal th Fi nanci al Systems MARSHALL BROWNING HOSPITAL

Health Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 14-1331 Period: From 07/01/2022 To 06/30/2023 Date/Time Prepared:

				T	o 06/30/2023	Date/Time Pre	pared: ·08 pm
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat		. ОО ріп
				+ col . 2)	ions (See	Trial Balance	
					A-6)	(col. 3 +-	
		1. 00	2.00	3.00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		655, 201	655, 201	290, 332	945, 533	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		482, 298	482, 298	-51, 212	431, 086	2.00
3.00	00300 OTHER CAP REL COSTS		9, 142				3.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	4, 826, 015		i i		4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL	2, 266, 505	3, 187, 351		0	-,,	5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	362, 431	198, 678			561, 109	6.00
7. 00	00700 OPERATION OF PLANT	20, 025	279, 975			279, 975	7.00
8.00	00800 LAUNDRY & LI NEN SERVI CE	29, 925	51, 023			80, 948	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	449, 045 409, 824	46, 954 206, 593		0	495, 999 616, 417	9. 00 10. 00
11. 00	01100 CAFETERI A	409, 624	200, 593 0	010, 417	0	010,417	10.00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	404, 636	14, 665	1	-32, 108	_	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	11,000	117,001	02, 100	0	14. 00
15. 00	01500 PHARMACY	379, 750	60, 589	440, 339	0	440, 339	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	390, 843	38, 646		0	429, 489	16. 00
17. 00	01700 SOCIAL SERVICE	81, 678	10, 873		0	92, 551	17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	418, 500	418, 500	0	418, 500	19.00
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	1, 778, 449	986, 309	2, 764, 758	32, 108	2, 796, 866	30.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	842, 705	1/4 502	1 007 200	20, 222	1 044 F10	EO 00
53. 00	05300 ANESTHESI OLOGY	042, 703	164, 583 0		39, 222 0	1, 046, 510 0	50. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	741, 424	790, 210	_		1, 531, 634	54.00
60.00	06000 LABORATORY	693, 598	980, 759		0	1, 674, 357	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	073, 370	700, 737		0	0	62. 30
65. 00	06500 RESPIRATORY THERAPY	406, 615	76, 708	_	0	483, 323	65.00
66. 00	06600 PHYSI CAL THERAPY	1, 064, 724	73, 672				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	_	221, 448		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	103, 860	103, 860	68.00
69.00	06900 ELECTROCARDI OLOGY	32, 011	16, 065	48, 076	0	48, 076	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	461, 133	461, 133	0	461, 133	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1, 302, 157		0	1, 302, 157	73.00
73. 01	07301 CARDI AC REHABI LI TATI ON	119, 014	3, 704		0	122, 718	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	1	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	U	0	0	0	0	76. 99
88. 00	08800 RURAL HEALTH CLINIC	1, 616, 374	539, 703	2, 156, 077	237, 046	2, 393, 123	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - FHC	626, 956	88, 278				88. 01
	09000 CLI NI C	443, 041	660, 431				
90. 01	09001 EAST MEDICAL CLINIC	0	33, 903				
	09100 EMERGENCY	1, 014, 663	1, 445, 000				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE		396, 296				113.00
118.00	9 /	14, 154, 211	18, 505, 414	32, 659, 625	-46, 376	32, 613, 249	118. 00
100.00	NONREI MBURSABLE COST CENTERS	ام		_	^	_	100.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19200 PHYSICIANS PRIVATE OFFICES	0	0	0	0 8, 409		190. 00 192. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	0		δ, 409 ∩		192. 00 192. 01
	219201 PAWILT MEDICAL CLINIC	121, 810	84, 223	206, 033	37, 967	244, 000	
	19203 MEALS ON WHEELS	121, 310	04, 223 N	200, 033	0		192. 02
200.00		14, 276, 021	18, 589, 637				
	, , , , , , , , , , , , , , , , , , , ,					•	•

Health Financial Systems MARSHALL BF
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1331

Peri od: From 07/01/2022 To 06/30/2023

In Lieu of Form CMS-2552-10 Worksheet A

Date/Time Prepared: 11/27/2023 12:08 pm Cost Center Description Adjustments Net Expenses

	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
		/ 00	Allocation	-	
	CENEDAL SERVICE COST CENTERS	6. 00	7.00		
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT	-64, 856	880, 677		1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	-7, 806	l ·		2.00
3.00	00300 OTHER CAP REL COSTS	7,000	0		3.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-13, 716	ŀ	l control of the cont	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	-760, 043			5.00
6.00	00600 MAINTENANCE & REPAIRS	0	561, 109		6.00
7.00	00700 OPERATION OF PLANT	0	279, 975		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	80, 948		8. 00
9.00	00900 HOUSEKEEPI NG	0	495, 999	,	9. 00
10.00	01000 DI ETARY	-63, 905	552, 512		10.00
11. 00	01100 CAFETERI A	0	0	l e e e e e e e e e e e e e e e e e e e	11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0	l .	12.00
13.00	01300 NURSING ADMINISTRATION	0	387, 193		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	l e e e e e e e e e e e e e e e e e e e	14.00
15.00	01500 PHARMACY	-35, 456			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-5, 410			16.00
17. 00 19. 00	01700 SOCIAL SERVICE	0			17.00
20.00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM	0	418, 500 0		19. 00 20. 00
21.00	02100 &R SERVICES-SALARY & FRINGES APPRV	0		•	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0		·	22.00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		22.00
30.00	03000 ADULTS & PEDI ATRI CS	-744, 000	2, 052, 866		30.00
	ANCILLARY SERVICE COST CENTERS				1
50.00	05000 OPERATING ROOM	-495, 268	551, 242		50.00
53.00	05300 ANESTHESI OLOGY	0			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 531, 634		54.00
60.00	06000 LABORATORY	0	1, 674, 357		60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	l .	62. 30
65.00	06500 RESPI RATORY THERAPY	-16, 238			65. 00
66. 00	06600 PHYSI CAL THERAPY	0	813, 088		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	221, 448		67.00
68.00	06800 SPEECH PATHOLOGY	-970			68.00
69.00	06900 ELECTROCARDI OLOGY	10.207	48, 076		69.00
71. 00 73. 00	O7100 MEDICAL SUPPLIES CHARGED TO PATIENT O7300 DRUGS CHARGED TO PATIENTS	-10, 286			71.00 73.00
73.00	07301 CARDI AC REHABI LI TATI ON	0	1, 302, 157 122, 718		73.00
76. 97	07697 CARDIAC REHABILITATION	0	122,718		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	Ö		76. 98
76. 79	07699 LI THOTRI PSY	0	Ö	l control of the cont	76. 99
, 0, , ,	OUTPATIENT SERVICE COST CENTERS				1
88.00	08800 RURAL HEALTH CLINIC	0	2, 393, 123		88. 00
88. 01	08801 RURAL HEALTH CLINIC II - FHC	0	786, 632		88. 01
90.00	09000 CLI NI C	-618, 992	456, 308		90.00
90. 01	09001 EAST MEDICAL CLINIC	0	33, 903		90. 01
91.00	09100 EMERGENCY	0	2, 459, 663		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
	SPECIAL PURPOSE COST CENTERS				
	11300 I NTEREST EXPENSE	0			113.00
118.00		-2, 836, 946	29, 776, 303	· <u> </u>	118. 00
100.00	NONREI MBURSABLE COST CENTERS	^			100.00
) 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19200 PHYSICIANS PRIVATE OFFICES	0		•	190. 00 192. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	8, 409		192.00
	19201 FAMILY MEDICAL CLINIC	0	244, 000		192. 01
	19203 MEALS ON WHEELS	0	244, 300		192. 03
200.00		-2, 836, 946	30, 028, 712	,	200.00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	,	,	1	

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 14-1331

In Lieu of Form CMS-2552-10
Worksheet A-6

Peri od: From 07/01/2022 To 06/30/2023 Date/Ti me Prepared: 11/27/2023 12:08 pm

					11/2//2023 12:08 pm
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5. 00	
	C - TO RECLASS INTEREST EXP				
1.00	CAP REL COSTS-BLDG & FLXT	1. 00	0	390, 859	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	5, 437	2.00
3.00		0.00	0	0	3.00
4.00		0. 00	0	0	4.00
	TOTALS		0	396, 296	
	F - TO RECLASS DEPRECIATION E	EXPENSE			
1.00	RURAL HEALTH CLINIC	88. 00	0	86, 649	1.00
2.00	RURAL HEALTH CLINIC II - FHC	88. 01	o	41, 702	2.00
3.00	INDEPENDENT LIVING	192. 02	O	37, 967	3.00
	TOTALS	T		166, 318	
	G - RECLASS PT COSTS TO OT &	SP		<u>.</u>	
1.00	OCCUPATI ONAL THERAPY	67. 00	221, 448	0	1.00
2.00	SPEECH PATHOLOGY	68. 00	103, 530	330	2.00
	TOTALS		324, 978	330	
	H - RECLASS PHYSICIAN BENEFIT	S			
1.00	OPERATING ROOM	50.00	0	39, 222	1.00
2.00	RURAL HEALTH CLINIC	88. 00	o	130, 634	2.00
3.00	RURAL HEALTH CLINIC II - FHC	88. 01	o	29, 696	3.00
	TOTALS			199, 552	
	I - RECLASS SPECIALTY CLINIC	STAFFING		,	
1. 00	PHYSICIANS PRIVATE OFFICES	192. 00	8, 409	0	1.00
	TOTALS		8, 409	₀	
	J - RECLASS IP CHARGE NURSES	<u> </u>			
1. 00	ADULTS & PEDIATRICS	30.00	32, 108	0	1.00
	TOTALS		32, 108		
	K - RECLASS NURSE TIME TO RHO	,		-1	
1. 00	RURAL HEALTH CLINIC	88. 00	17, 832	1, 931	1.00
	TOTALS	— — †	17, 832	1, 931	
500.00	Grand Total: Increases		383, 327	764, 427	500.00
555.00	12. 2 10 (4 1 04.000	I.	000, 027	, 127	1000.00

Health Financial Systems RECLASSIFICATIONS

In Lieu of Form CMS-2552-10
Worksheet A-6

Heal th	Financial Systems		MARSHALL BROWNI	NG HOSPI TAL		In Lieu	u of Form CMS	-2552-10
RECLASS	SI FI CATI ONS			Provi der (Peri od:	Worksheet A-	-6
						From 07/01/2022		
						To 06/30/2023	Date/Time Pr 11/27/2023	
		Decreases					11/2//2023	12.00 piii
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref	.		
	6. 00	7. 00	8. 00	9. 00	10.00			
	C - TO RECLASS INTEREST EXP							
1.00	INTEREST EXPENSE	113. 00	0	396, 296	1	1		1.00
2.00		0.00	O	0	1	1		2.00
3.00		0.00	O	0	1	1		3.00
4.00		0. 00	0	0	1	1		4.00
	TOTALS		0	396, 296				
	F - TO RECLASS DEPRECIATION E	EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	106, 694		9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	59, 624		9		2.00
3.00		0.00	0	0		<u>o</u>		3.00
	TOTALS		0	166, 318				_
	G - RECLASS PT COSTS TO OT &	SP						
1.00	PHYSI CAL THERAPY	66. 00	324, 978	330		0		1.00
2.00		0.00	0	0		<u>o</u>		2. 00
	TOTALS		324, 978	330				_
	H - RECLASS PHYSICIAN BENEFI							
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	199, 552	1	0		1.00
2.00		0. 00	0	0		0		2. 00
3.00		0.00		0		<u>o</u>		3. 00
	TOTALS		0	199, 552				
	I - RECLASS SPECIALTY CLINIC							
1.00	CLINIC	<u>90.</u> 00	<u>8, 4</u> 09	0		0		1.00
	TOTALS		8, 409	0				
	J - RECLASS IP CHARGE NURSES							
1. 00	NURSING ADMINISTRATION	1300	3 <u>2, 1</u> 08	0		<u>이</u>		1.00
	TOTALS		32, 108	0				
	K - RECLASS NURSE TIME TO RHO				1			
1. 00	CLINIC	90.00	17, 832	1,931		<u>o</u>		1.00
	TOTALS		17, 832	1, 931				
500.00	Grand Total: Decreases		383, 327	764, 427				500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1331

In Lieu of Form CMS-2552-10

Period: Worksheet A-7
From 07/01/2022 Part I
Date/Time Prepared: 11/27/2023 12:08 pm

						11/27/2023 12	:08 pm
				Acquisitions			
		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	3, 114	0	0	0	0	
2.00	Land Improvements	1, 267, 104	18, 130		18, 130	0	2.00
3.00	Buildings and Fixtures	8, 224, 487	15, 804	0	15, 804	850	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	7, 073, 458	200, 900	0	200, 900	112, 333	5.00
6.00	Movable Equipment	5, 821, 213	842, 873	0	842, 873	348, 205	6.00
7.00	HIT designated Assets	1, 586, 972		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	23, 976, 348	1, 077, 707	0	1, 077, 707	461, 388	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	23, 976, 348		0	1, 077, 707	461, 388	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	3, 114	0				1.00
2.00	Land Improvements	1, 285, 234	0				2.00
3.00	Buildings and Fixtures	8, 239, 441	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	7, 162, 025	0				5.00
6.00	Movable Equipment	6, 315, 881	0				6. 00
7.00	HIT designated Assets	1, 586, 972	0				7. 00
8.00	Subtotal (sum of lines 1-7)	24, 592, 667	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	24, 592, 667	0				10.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS In Lieu of Form CMS-2552-10 Provider CCN: 14-1331

				1	0 06/30/2023	11/27/2023 12	
			SL	JMMARY OF CAPIT	AL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
	cost center bescription	Depi eci ati on	Lease	Tillerest	(see	instructions)	
					instructions)	This tructions)	
		9. 00	10. 00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	655, 201	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	482, 298	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1, 137, 499	0	0	0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at					
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	(SHEET A, COLU					
1. 00	CAP REL COSTS-BLDG & FIXT	0	655, 201	•			1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	0	482, 298	•			2.00
3. 00	Total (sum of lines 1-2)	0	1, 137, 499				3. 00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

In Lieu of Form CMS-2552-10

Period: Worksheet A-7
From 07/01/2022 Part III Provider CCN: 14-1331

				Ť	o 06/30/2023	Date/Time Prep 11/27/2023 12:	
		COMF	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPIT				
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
				col . 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	16, 588, 700		16, 588, 700		6, 167	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8, 000, 853		8, 000, 853			2.00
3. 00	Total (sum of lines 1-2)	24, 589, 553		24, 589, 553			3.00
		ALLOCAT	TION OF OTHER (CAPI TAL	SUMMARY 0	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS			ı		
1.00	CAP REL COSTS-BLDG & FLXT	0	0	6, 167	•		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2, 975			2.00
3.00	Total (sum of lines 1-2)	0	0	9, 142		0	3.00
			Sl 	JMMARY OF CAPIT			
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)	Capi tal -Rel at	,	
			instructions)		ed Costs (see instructions)	9 through 14)	
		11. 00	12. 00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	330, 975			0	880, 677	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4, 588	2, 975	0	0	423, 280	2.00
3.00	Total (sum of lines 1-2)	335, 563	9, 142	0	0	1, 303, 957	3.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES

Provi der CCN: 14-1331

					o 06/30/2023	Date/Time Pre 11/27/2023 12	
				Expense Classification on To/From Which the Amount is		11/2//2023 12	. Uo piii
				10/FI OIII WIII CII THE AIIIOUITT IS	to be Aujusted		
	Cost Conton Decemintion	Dania (Cada	Amount	Coat Conton	line#	Wko+ A 7	
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1. 00 B	2.00	3. 00 CAP REL COSTS-BLDG & FLXT	4. 00	5. 00	1.00
	COSTS-BLDG & FLXT (chapter 2)						
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	В		CAP REL COSTS-MVBLE EQUIP	2. 00	11	2.00
3. 00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)	В	-10, 286	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
8. 00	21) Tel evi si on and radi o servi ce (chapter 21)		0		0. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -1, 874, 498		0.00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11.00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12.00
13. 00	transactions (chapter 10) Laundry and Linen service		0		0.00	0	13.00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-59, 555 0	DI ETARY	10. 00 0. 00	0	1
16. 00	and others Sale of medical and surgical		0		0.00	0	16.00
47.00	supplies to other than patients		05.45/	DUADMAQV	45.00		47.00
	Sale of drugs to other than patients	В		PHARMACY	15. 00	0	
	Sale of medical records and abstracts	В	-5, 410	MEDICAL RECORDS & LIBRARY	16. 00	0	
19. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
	Vending machines Income from imposition of		0		0. 00 0. 00	0	
21.00	interest, finance or penalty		0		0.00	0	21.00
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00			0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	COSTS-BLDG & FLXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	, ,		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
0.5	therapy costs in excess of limitation (chapter 14)			 			05.55
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99

Health Financial Systems ADJUSTMENTS TO EXPENSES

In Lieu of Form CMS-2552-10

Provider CCN: 14-1331

Peri od: Worksheet A-8 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

				To	0 06/30/2023	Date/Time Pre 11/27/2023 12	
				Expense Classification on	Worksheet A	1172772020 12	, 00 p
				To/From Which the Amount is			
					,		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)	0.00	2.00	4.00	Ref.	
31. 00	Adjustment for speech	1. 00 A-8-3	2. 00	3.00 SPEECH PATHOLOGY	4. 00 68. 00	5. 00	31.00
31.00	pathology costs in excess of	A-8-3	0	SPEECH PATHULUGY	68.00		31.00
	limitation (chapter 14)						
32. 00		Α	_832	CAP REL COSTS-MVBLE EQUIP	2. 00	Q	32.00
32.00	Depreciation and Interest	A	032	CAL REE GOSTS WINDER EQUIT	2.00	,	32.00
33. 00	MI SCELLANEOUS I NCOME	В	-28, 601	ADMINISTRATIVE & GENERAL	5. 00	0	33.00
36. 00	IHA/AHA DUES USED FOR LOBBYING	A		ADMINISTRATIVE & GENERAL	5. 00	0	36.00
37. 00	MARKETI NG	Α		ADMINISTRATIVE & GENERAL	5. 00	0	37.00
41.00	DEPRECI ATI ON	Α	-4, 972	CAP REL COSTS-BLDG & FIXT	1.00	9	41.00
43.00	DEPRECI ATI ON	Α	-6, 125	CAP REL COSTS-MVBLE EQUIP	2. 00	9	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	44.00
	(3)						
45.00	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	45. 00
	(3)						
46. 00	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	46. 00
	(3)		500 000	ADMINI OTRATILIS à GENERAL			47.00
47.00	PROVI DER TAX ASSESSMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	17100
47. 01	DI ABETES EDUCATION	В		DI ETARY	10.00	0	47. 01
47. 02	CONTRACTED THERAPY EXPENSES	A		SPEECH PATHOLOGY	68. 00	0	47. 02
47. 03	POST RETIREMENT BENEFITS PAID	B A		EMPLOYEE BENEFITS DEPARTMENT	4.00	11	47. 03 47. 04
47. 04	LAPSE BACK LOSS ON REFINANCING	А	1, 115	CAP REL COSTS-BLDG & FIXT	1. 00	11	47.04
50. 00	TOTAL (sum of lines 1 thru 49)		-2, 836, 946				50.00
30.00	(Transfer to Worksheet A,		-2,000,740				30.00
	column 6, line 200.)						
	cerumin o, rine zeo.)			010 0 1 45 4			

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

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

B. Amount Received - if cost cannot be determined.

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

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

Heal th Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

In Lieu of Form CMS-2552-10
Worksheet A-8-2

Provider CCN: 14-1331 Peri od: Worksheet A-8-2 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

							11/27/2023 12	2:08 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l 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	744, 000	744, 000	0	0	0	1.00
2.00	91. 00	EMERGENCY	1, 241, 445	0	1, 241, 445	0	0	2.00
3.00	60.00	LABORATORY	26, 138	0	26, 138	0	0	3.00
4.00	50.00	OPERATING ROOM	495, 268	495, 268	0	0	0	4. 00
5. 00	65. 00	RESPI RATORY THERAPY	16, 238	16, 238	0	0	0	5.00
6. 00	90. 00	CLINIC	618, 992	618, 992	0	0	0	6.00
7. 00	0.00		0	0	0	0	0	7. 00
8. 00	0.00		0	0	0	0	0	8. 00
9. 00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			3, 142, 081	1, 874, 498	1, 267, 583		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Li mi t	Continuing	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00		ADULTS & PEDIATRICS	0	0	0		0	1. 00
2.00	91. 00	EMERGENCY	0	0	0	0	0	2.00
3.00	60. 00	LABORATORY	0	0	0	0	0	3.00
4.00		OPERATING ROOM	0	0	0	0	0	4.00
5.00	65. 00	RESPI RATORY THERAPY	0	0	0	0	0	5.00
6.00	90. 00	CLINIC	0	0	0	0	0	6.00
7. 00	0.00		0	0	0	0	0	7. 00
8. 00	0.00		0	0	0	0	0	8. 00
9. 00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Li mi t	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	0	0	_	,		1. 00
2.00		EMERGENCY	0	0				2. 00
3. 00		LABORATORY	0	0	_	1		3. 00
4. 00		OPERATING ROOM	0	0	0	, =		4.00
5. 00	65. 00	RESPI RATORY THERAPY	0	0	0			5.00
6.00		CLINIC	0	0	_	618, 992		6.00
7.00	0. 00		0	0	-	0		7.00
8.00	0. 00		0	0	0	0		8.00
9.00	0. 00		0	0	0	0		9.00
10.00	0. 00		0	0	0			10.00
200.00			0	0	0	1, 874, 498		200.00

I th Financial Systems MARSHALL BROWNING HOSPITAL

Health Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10
REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY Provider CCN: 14-1331 Period: Worksheet A-8-3
OUTSIDE SUPPLIERS From 07/01/2022 Parts I-VI

Date/Time Prepared:

06/30/2023

11/27/2023 12:08 pm Physical Therapy Cost 1.00 PART I - GENERAL I NFORMATION Total number of weeks worked (excluding aides) (see instructions) 47 1.00 Line 1 multiplied by 15 hours per week 705 2.00 2.00 Number of unduplicated days in which supervisor or therapist was on provider site (see instructions) 3.00 90 3.00 4.00 Number of unduplicated days in which therapy assistant was on provider site but neither supervisor 0 4.00 nor therapist was on provider site (see instructions) 5.00 Number of unduplicated offsite visits - supervisors or therapists (see instructions) 0 5.00 Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy 6.00 0 6.00 assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions) 7.00 Standard travel expense rate 6.20 7.00 Optional travel expense rate per mile 0.00 8.00 8.00 Assi stants Trai nees Supervi sors Therapi sts Ai des 1.00 2.00 3.00 4.00 5.00 9. 00 Total hours worked 0.00 708. 25 0.00 0. 00 0. 00 9.00 10.00 0.00 93.32 0.00 0.00 0.00 AHSEA (see instructions) 10.00 11.00 Standard travel allowance (columns 1 and 2, 46.66 46.66 0.00 11.00 one-half of column 2, line 10; column 3, one-half of column 3, line 10) 12.00 Number of travel hours (provider site) 12.00 0 0 0 O 12 01 Number of travel hours (offsite) 0 C 12.01 13.00 Number of miles driven (provider site) 0 C 0 13.00 13.01 Number of miles driven (offsite) 13.01 1.00 Part II - SALARY EQUIVALENCY COMPUTATION 14.00 Supervisors (column 1, line 9 times column 1, line 10) 14.00 Therapists (column 2, line 9 times column 2, line 10) 15.00 66, 094 15.00 Assistants (column 3, line 9 times column 3, line10) 16.00 16.00 Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all 66, 094 17.00 17.00 others) 18.00 Aides (column 4, line 9 times column 4, line 10) 0 18.00 Trainees (column 5, line 9 times column 5, line 10) 19 00 Λ 19.00 Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) 66, 094 20.00 If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23. 21.00 Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 0.00 21.00 for respiratory therapy or columns 1 thru 3, line 9 for all others) 22 00 Weighted allowance excluding aides and trainees (line 2 times line 21) 22 00 Total salary equivalency (see instructions) 23.00 66,094 23.00 PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE Standard Travel Allowance 24.00 Therapists (line 3 times column 2, line 11) 4, 199 24.00 25.00 Assistants (line 4 times column 3, line 11) 0 25.00 26.00 Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others) 4, 199 26.00 Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all 27.00 558 27.00 others) 28 00 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 4, 757 28 00 Optional Travel Allowance and Optional Travel Expense Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12) 0 29.00 30.00 Assistants (column 3, line 10 times column 3, line 12) 0 30.00 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 31.00 0 31.00 Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of 0 32.00 columns 1-3, line 13 for all others) 33.00 Standard travel allowance and standard travel expense (line 28) 4, 757 33.00 34.00 Optional travel allowance and standard travel expense (sum of lines 27 and 31) Ω 34.00 35.00 Optional travel allowance and optional travel expense (sum of lines 31 and 32) 0 35.00 Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE Standard Travel Expense 36.00 Therapists (line 5 times column 2, line 11) 0 36.00 37.00 Assistants (line 6 times column 3, line 11) 0 37.00 38.00 Subtotal (sum of lines 36 and 37) 0 38.00 Standard travel expense (line 7 times the sum of lines 5 and 6) 39 00 39 00 0 Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 0 40.00 Assistants (column 3, line 12.01 times column 3, line 10) 41.00 41.00 0 Subtotal (sum of lines 40 and 41) 42 00 42 00 0 43.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) 0 43.00 Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropri ate. Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 44.00 44.00 Ol 45.00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions) 0 45.00 Heal th Fi nanci al Systems MARSHALL BROW
REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY Provider CCN: 14-1331

In Lieu of Form CMS-2552-10

OUTSI DE SUPPLI ERS

Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/27/2023 12:08 pm Peri od: From 07/01/2022 To 06/30/2023

				Ph	ysi cal Therapy	11/27/2023 12 Cost	:08 pm
44 00	Ontional traval allowance and antional traval	avnanca (aum	of Lines 42 a	nd 43 - see ins	+======================================	1.00	46. 00
46.00	Optional travel allowance and optional travel	Therapi sts	Assistants	Ai des	Trai nees	Total	46.00
		1. 00	2.00	3.00	4. 00	5. 00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting	0. 00	0.00	0.00	0. 00	0.00	47. 00
	period (if column 5, line 47, is zero or						
	equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each						
	column of line 56)						
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0. 00		48. 00
49. 00	Total overtime (including base and overtime	0. 00	0.00	0.00	0. 00		49. 00
	allowance) (multiply line 47 times line 48)						
50. 00	CALCULATION OF LIMIT Percentage of overtime hours by category	0.00	0.00	0.00	0. 00	0.00	50.00
30.00	(divide the hours in each column on line 47	0.00	0.00	0.00	0.00	0.00	30.00
	by the total overtime worked - column 5,						
-4 00	line 47)						-4 00
51. 00	Allocation of provider's standard work year for one full-time employee times the	0. 00	0.00	0.00	0. 00	0.00	51.00
	percentages on line 50) (see instructions)						
	DETERMINATION OF OVERTIME ALLOWANCE						
52. 00	Adjusted hourly salary equivalency amount	93. 32	0.00	0.00	0. 00		52.00
53. 00	(see instructions) Overtime cost limitation (line 51 times line	0	0	o	0		53.00
55. 00	52)	O	Ĭ		O .		33.00
54.00	Maximum overtime cost (enter the lesser of	0	0	0	0		54.00
	line 49 or line 53)						
55. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply	0	0	0	0		55.00
	line 47 times line 52)						
56.00	Overtime allowance (line 54 minus line 55 -	0	o	0	0	0	56.00
	if negative enter zero) (Enter in column 5						
	the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3						
	for all others.)						
	D	ND EVOECE OOC	T AD ILICTAENT			1. 00	
57. 00	Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23)	IND EXCESS COS	I ADJUSTMENT			66, 094	57. 00
58. 00	Travel allowance and expense - provider site	(from lines 3	3. 34. or 35))			4, 757	1
59.00	Travel allowance and expense - Offsite service					0	1
60.00	Overtime allowance (from column 5, line 56)					0	
61. 00 62. 00	Equipment cost (see instructions) Supplies (see instructions)					0	61.00 62.00
63.00	Total allowance (sum of lines 57-62)					70, 851	
64. 00	Total cost of outside supplier services (from	n your records)			49, 540	
65.00	Excess over limitation (line 64 minus line 63					0	65. 00
400.00	LINE 33 CALCULATION						
	Line 26 = line 24 for respiratory therapy or				thore	l .	100. 00 100. 01
	00.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 00.02 Line 33 = line 28 = sum of lines 26 and 27						100.01
	LINE 34 CALCULATION					.,,,,,,	
	Line 27 = line 7 times line 3 for respiratory				thers		101. 00
	Line 31 = line 29 for respiratory therapy or	sum of lines	29 and 30 for	all others			101.01
101.02	Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION					558	101. 02
102, 00	Line 31 = line 29 for respiratory therapy or	sum of lines	29 and 30 for	all others		0	102.00
	Line 32 = line 8 times columns 1 and 2, line				ns 1-3, line	l e	102. 01
400	13 for all others					_	
102. 02	Line 35 = sum of lines 31 and 32					1 0	102. 02

n Financial Systems MARSHALL BROWNING HOSPITAL

Heal th Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10
REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY Provider CCN: 14-1331 Period: From 07/01/2022 From 07/01/2022 To 06/30/2023 Parts I-VI Date/Time Prepared: 11/27/2023 12:08 pm

Speech Pathology Cost

			Speech Pathology Cost				
						1 00	
	PART I - GENERAL INFORMATION					1. 00	
1.00	Total number of weeks worked (excluding aide	e) (see instruc	tions)			2	1.00
2.00	Line 1 multiplied by 15 hours per week	3) (300 111311 40	, (1 0113)			30	
3. 00	Number of unduplicated days in which supervi	sor or therapis	st was on provi	der site (see	instructions)	3	•
4.00	Number of unduplicated days in which therapy					3	4.00
	nor therapist was on provider site (see inst	ructions)	·		·		
5.00	Number of unduplicated offsite visits - supe					0	5.00
6. 00	Number of unduplicated offsite visits - ther					0	6. 00
	assistant and on which supervisor and/or the	rapist was not	present durino	g the visit(s))	(see		
7. 00	instructions) Standard travel expense rate					6. 20	7. 00
8. 00	Optional travel expense rate per mile					0. 20	ı
0.00	optional travel expense rate per mire	Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	0.00
		1. 00	2. 00	3. 00	4. 00	5. 00	
9. 00	Total hours worked	0.00	5. 50	0. 00	0.00	0.00	9. 00
10.00	AHSEA (see instructions)	0.00	84. 98	0. 00	0. 00	0.00	10.00
11. 00	Standard travel allowance (columns 1 and 2,	42. 49	42. 49	0. 00			11.00
	one-half of column 2, line 10; column 3,						
10.00	one-half of column 3, line 10)						40.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12. 01 13. 00	Number of travel hours (offsite) Number of miles driven (provider site)		0	0			12. 01 13. 00
13. 00	Number of miles driven (offsite)		0	0			13.00
10.01	Trainber of infres arriver (errsite)	<u> </u>		3			10.01
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14. 00	Supervisors (column 1, line 9 times column 1					0	
15. 00	Therapists (column 2, line 9 times column 2,					467	ł
16.00	Assistants (column 3, line 9 times column 3,	,				0	
17. 00	Subtotal allowance amount (sum of lines 14 a	nd 15 for respi	ratory therapy	y or lines 14-1	6 for all	467	17.00
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, l					0	19.00
20.00	1		therapy or lin	nes 17 and 18 f	or all others)	467	1
	If the sum of columns 1 and 2 for respirator						
	occupational therapy, line 9, is greater tha	n line 2, make	no entries on	lines 21 and 2	2 and enter on	line 23 the	
	amount from line 20. Otherwise complete lin						
21. 00	Weighted average rate excluding aides and tr			um of columns 1	and 2, line 9	84. 91	21.00
22 00	for respiratory therapy or columns 1 thru 3,					2 547	22.00
22. 00 23. 00	Weighted allowance excluding aides and train Total salary equivalency (see instructions)	ees (iine 2 tin	ies i i ne 21)			2, 547 2, 547	
23.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLO	WANCE AND TRAVE	I EXPENSE COME	DIITATI ON _ PROV	IDER SITE	2, 547	23.00
	Standard Travel Allowance	WARD THE	L EXI ENGE COM	OTATION TROV	TDER OF TE		
24.00						127	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25. 00
26.00	Subtotal (line 24 for respiratory therapy or	sum of lines 2	24 and 25 for a	all others)		127	26.00
27. 00	Standard travel expense (line 7 times line 3	for respirator	ry therapy or s	sum of lines 3	and 4 for all	37	27. 00
	others)						
28. 00	Total standard travel allowance and standard	travel expense	at the provid	der site (sum o	f lines 26 and	164	28. 00
	27) Optional Travel Allowance and Optional Trave	I Evnansa					
29. 00	Therapists (column 2, line 10 times the sum		nd 2 line 12 `)		0	29.00
30.00	Assistants (column 3, line 10 times column 3		2, ,	,		0	
31.00	Subtotal (line 29 for respiratory therapy or		9 and 30 for a	all others)		0	31.00
32.00	Optional travel expense (line 8 times column				or sum of	0	32.00
	columns 1-3, line 13 for all others)						
33. 00	Standard travel allowance and standard trave					164	1
34.00	Optional travel allowance and standard trave					0	34.00
35. 00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW.				CES OUTSLDE DD	OVIDED SITE	35.00
	Standard Travel Expense	ANCE AND TRAVEL	EXPENSE COMPL	JIAITUN - SERVI	CES OUTSIDE PR	OVIDER SITE	<u> </u>
36. 00	Therapists (line 5 times column 2, line 11)					0	36.00
37. 00	Assistants (line 6 times column 3, line 11)					0	ł
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39. 00	Standard travel expense (line 7 times the su	m of lines 5 an	nd 6)			0	39.00
	Optional Travel Allowance and Optional Trave						
40.00	Therapists (sum of columns 1 and 2, line 12.		1 2, line 10)			0	ı
41.00	Assistants (column 3, line 12.01 times colum	n 3, line 10)				0	
42.00	Subtotal (sum of lines 40 and 41)	m of columns 1	2 line 12 01			0	ı
43.00	Optional travel expense (line 8 times the su Total Travel Allowance and Travel Expense -				wing three lin	0 es 44 45 or	43.00
	46, as appropriate.	orrante bervice	.s, comprete or	ic of the follo	wing three iiii	C3 44, 40, UI	
44.00		l expense (sum	of lines 38 ar	nd 39 - see ins	tructions)	0	44.00
	Optional travel allowance and standard trave				, ,		45.00
						· ·	

i nanci al Systems MARSHALL BROWNING HOSPITAL

Health Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10
REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY Provider CCN: 14-1331 Period: Worksheet A-8-3

From 07/01/2022 OUTSI DE SUPPLI ERS Parts I-VI Date/Time Prepared: 06/30/2023 11/27/2023 12:08 pm Speech Pathology Cost 1.00 46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions) ol 46.00 Ai des Therapi sts Assi stants Total 5.00 2.00 3.00 PART V - OVERTIME COMPUTATION Overtime hours worked during reporting 47.00 0.00 0.00 0.00 0.00 0.00 47.00 period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56) 48.00 Overtime rate (see instructions) 0.00 0.00 0.00 0.00 48.00 Total overtime (including base and overtime 0.00 0.00 0.00 0.00 49.00 allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT 50.00 50.00 Percentage of overtime hours by category 0.00 0.00 0.00 0.00 0.00 (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47) Allocation of provider's standard work year 0.00 0.00 51.00 51.00 0.00 0.000.00 for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount 84. 98 0.00 0.00 0.00 52.00 52.00 (see instructions) Overtime cost limitation (line 51 times line 53.00 0 0 53.00 Maximum overtime cost (enter the lesser of 54.00 0 54.00 line 49 or line 53) Portion of overtime already included in 55 00 C 0 55 00 hourly computation at the AHSEA (multiply line 47 times line 52) Overtime allowance (line 54 minus line 55 0 0 56.00 if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.) 1.00 Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT 57.00 Salary equivalency amount (from line 23) 2, 547 57.00 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 58.00 164 Travel allowance and expense - Offsite services (from lines 44, 45, or 46) 59.00 59.00 0 60.00 Overtime allowance (from column 5, line 56) 0 60.00 61.00 Equipment cost (see instructions) 0 61.00 Supplies (see instructions) 62.00 62.00 63.00 Total allowance (sum of lines 57-62) 2.711 63.00 64.00 Total cost of outside supplier services (from your records) 330 64 00 Excess over limitation (line 64 minus line 63 - if negative, 65.00 65.00 0 LINE 33 CALCULATION 100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 127 100. 00 100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 37 100.01 100.02 Line 33 = line 28 = sum of lines 26 and 27 164 100. 02 LINE 34 CALCULATION 101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 37 101. 00

0 101.01

37 101. 02

0 102. 00

0 102.01

0 102.02

101.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others

102.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others

102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line

101.02 Line 34 = sum of lines 27 and 31

LINE 35 CALCULATION

13 for all others 102.02 Line 35 = sum of lines 31 and 32 Health Financial Systems

In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1331 Peri od: Worksheet B

Part I

0 201.00

30, 028, 712 202. 00

From 07/01/2022 Date/Time Prepared: 06/30/2023 11/27/2023 12:08 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 0 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 880, 677 880, 677 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 423, 280 423, 280 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4, 612, 747 4, 612, 747 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5, 871, 358 5.00 4, 693, 813 838.851 5.00 227, 963 110, 731 6.00 00600 MAINTENANCE & REPAIRS 561, 109 134, 139 695, 248 6.00 7.00 00700 OPERATION OF PLANT 279, 975 78, 244 38,006 396, 225 7.00 136, 313 00800 LAUNDRY & LINEN SERVICE 80.948 29, 810 11,075 8.00 8 00 14 480 495. 999 00900 HOUSEKEEPI NG 9.00 17,002 8, 259 166, 195 687, 455 9.00 10.00 01000 DI ETARY 552, 512 46, 325 22, 502 151, 679 773, 018 10.00 11.00 01100 CAFETERI A 11.00 0 C 0 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 0 0 0 13.00 01300 NURSING ADMINISTRATION 387, 193 8,660 4, 206 137, 876 537, 935 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 404, 883 13, 466 140, 549 15.00 6.541 565, 439 15.00 01600 MEDICAL RECORDS & LIBRARY 9,090 16.00 16.00 424.079 18, 714 144, 654 596, 537 17.00 01700 SOCIAL SERVICE 92, 551 1,836 892 30, 230 125, 509 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 418, 500 418, 500 19.00 0 02000 NURSI NG PROGRAM 0 20 00 20 00 0 C 0 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 0 C 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 2, 927, 664 30.00 2, 052, 866 137, 774 66, 922 670, 102 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 551, 242 62,738 30, 474 132, 614 777.068 05300 ANESTHESI OLOGY 53.00 53.00 0 54.00 1.531.634 9, 272 274, 407 1, 834, 401 05400 RADI OLOGY-DI AGNOSTI C 19,088 54.00 60.00 06000 LABORATORY 1, 674, 357 27, 816 13, 511 256, 706 1, 972, 390 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 06500 RESPIRATORY THERAPY 467.085 29, 028 14.100 150, 491 660, 704 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 813.088 38, 890 18, 890 273.786 1, 144, 654 66.00 7, 300 3, 546 06700 OCCUPATI ONAL THERAPY 221, 448 81, 960 314, 254 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 102, 890 1, 598 776 38, 317 143, 581 68.00 06900 ELECTROCARDI OLOGY 48.076 11, 848 61, 187 69.00 850 69.00 413 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 450, 847 0 450, 847 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 302, 157 1, 302, 157 73.00 07301 CARDIAC REHABILITATION 122, 718 7, 515 44, 048 177, 931 73.01 73.01 3,650 76.97 07697 CARDIAC REHABILITATION 76.97 \cap \cap Λ 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 2, 393, 123 209, 317 2, 602, 440 88.00 88.01 08801 RURAL HEALTH CLINIC II - FHC 786, 632 135, 912 922, 544 88.01 154, 261 90.00 09000 CLI NI C 456, 308 55,008 692, 296 90.00 26, 719 09001 EAST MEDICAL CLINIC 33.903 33.903 90.01 90 01 91.00 09100 EMERGENCY 2, 459, 663 35, 682 17, 332 375, 535 2, 888, 212 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 29, 776, 303 865, 307 420, 312 4, 564, 552 29, 709, 770 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 9 261 9, 261 190, 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 20, 598 192. 00 8, 409 6, 109 2,968 3, 112 192. 01 19201 FAMILY MEDICAL CLINIC 0 192.01 192. 02 19202 I NDEPENDENT LIVING 244,000 0 45,083 289, 083 192. 02 C 192.03 19203 MEALS ON WHEELS O 0 192 03 200.00 Cross Foot Adjustments 0 200.00

30, 028, 712

880, 677

423, 280

4, 612, 747

Negative Cost Centers

TOTAL (sum lines 118 through 201)

201.00

202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1331

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared:
11/27/2023 12:08 pm

			''	0 00/30/2023	11/27/2023 12	
Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	E & GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7. 00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	5, 871, 358					5.00
6.00 00600 MAINTENANCE & REPAIRS	168, 977	864, 225				6.00
7.00 00700 OPERATION OF PLANT	96, 301	90, 216	582, 742			7.00
8.00 00800 LAUNDRY & LINEN SERVICE	33, 130	34, 372	30, 240	234, 055		8.00
9. 00 00900 HOUSEKEEPI NG	167, 083	19, 604	17, 247	0	891, 389	9.00
10. 00 01000 DI ETARY	187, 879	53, 414	46, 992	0	67, 121	10.00
11. 00 01100 CAFETERI A	O	0	0	0	0	11.00
12.00 01200 MAINTENANCE OF PERSONNEL	o	0	0	0	0	12.00
13.00 01300 NURSING ADMINISTRATION	130, 743	9, 985	8, 784	0	12, 547	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	o	0	0	0	0	14.00
15. 00 01500 PHARMACY	137, 428	15, 526	13, 660	0	19, 510	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	144, 986	21, 577		0	27, 114	16.00
17. 00 01700 SOCI AL SERVI CE	30, 504	2, 117			2, 661	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	101, 715	0		0	0	19.00
20.00 02000 NURSING PROGRAM	o	0	0	0	0	20.00
21.00 02100 &R SERVICES-SALARY & FRINGES APPRV	o	0	0	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	o	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			-		
30. 00 03000 ADULTS & PEDIATRICS	711, 568	158, 855	139, 759	234, 055	199, 622	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	188, 863	72, 338	63, 641	0	90, 901	50.00
53. 00 05300 ANESTHESI OLOGY	O	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	445, 844	22, 008	19, 363	0	27, 656	54.00
60. 00 06000 LABORATORY	479, 381	32, 072	28, 216	0	40, 302	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	0	0		0	62.30
65. 00 06500 RESPIRATORY THERAPY	160, 581	33, 470	29, 446	0	42, 059	65.00
66. 00 06600 PHYSI CAL THERAPY	278, 204	44, 840			56, 347	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	76, 378	8, 417			10, 576	67.00
68. 00 06800 SPEECH PATHOLOGY	34, 897	1, 843		0	2, 316	68.00
69. 00 06900 ELECTROCARDI OLOGY	14, 871	980		0	1, 232	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	109, 577	0		0	. 0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	316, 484	0	0	0	0	73.00
73. 01 07301 CARDI AC REHABI LI TATI ON	43, 245	8, 665	7, 623	0	10, 888	73. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	O	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	o	0	0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	o	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	632, 513	79, 722	0	0	100, 180	88.00
88.01 08801 RURAL HEALTH CLINIC II - FHC	224, 221	31, 915	0	0	40, 105	88. 01
90. 00 09000 CLI NI C	168, 260	63, 425		0	79, 701	90.00
90. 01 09001 EAST MEDICAL CLINIC	8, 240	0	0	0	0	90.01
91. 00 09100 EMERGENCY	701, 968	41, 142	36, 196	0	51, 699	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	5, 793, 841	846, 503	567, 151	234, 055	882, 537	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	2, 251	10, 678	9, 394	0	0	190. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	5, 006	7, 044	6, 197	0	8, 852	192. 00
192.01 19201 FAMILY MEDICAL CLINIC	o	0	0	0		192. 01
192. 02 19202 I NDEPENDENT LIVING	70, 260	0	0	0		192. 02
192.03 19203 MEALS ON WHEELS	o	0	0	0	0	192. 03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	o	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	5, 871, 358	864, 225	582, 742	234, 055	891, 389	202.00
				•		

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1331

							11/27/2023 12	:08 pm
	Cost Center Description	on	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	
					OF PERSONNEL	ADMI NI STRATI O	SERVICES &	
						N	SUPPLY	
			10. 00	11. 00	12.00	13.00	14. 00	
	GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & F							1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQ							2.00
4.00	00400 EMPLOYEE BENEFITS DEPA							4. 00
5.00	00500 ADMINISTRATIVE & GENER	RAL						5.00
6.00	00600 MAINTENANCE & REPAIRS							6.00
7.00	00700 OPERATION OF PLANT							7.00
8.00	00800 LAUNDRY & LINEN SERVIC	E						8.00
9. 00	00900 HOUSEKEEPI NG							9. 00
10. 00	01000 DI ETARY		1, 128, 424					10.00
11. 00	01100 CAFETERI A		0	0				11. 00
12. 00	01200 MAINTENANCE OF PERSONN		0	0	0			12.00
13. 00	01300 NURSING ADMINISTRATION		0	0	0	699, 994		13.00
14. 00	01400 CENTRAL SERVICES & SUP	PPLY	0	0	0	0	0	14. 00
15.00	01500 PHARMACY		0	0	0	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBR	RARY	0	0	0	0	0	16.00
17. 00	01700 SOCIAL SERVICE		0	0	0	10, 762	0	17.00
19.00	01900 NONPHYSI CI AN ANESTHETI	STS	0	0	0	0	0	19.00
20.00	02000 NURSI NG PROGRAM		0	0	0	0	0	20.00
21.00	02100 I &R SERVICES-SALARY &		0	0			0	21.00
22.00	02200 I &R SERVICES-OTHER PRO		0	0	0	0	0	22.00
	INPATIENT ROUTINE SERVICE CO	OST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS		1, 128, 424	0	0	238, 551	0	30.00
	ANCILLARY SERVICE COST CENTE	ERS				,		
50. 00	05000 OPERATING ROOM		0	0			0	50.00
53. 00	05300 ANESTHESI OLOGY		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
62. 30	06250 BLOOD CLOTTING FOR HEM	MOPHI LI ACS	0	0	0	-	0	62. 30
65. 00	06500 RESPIRATORY THERAPY		0	0	0	,	0	65.00
66. 00	06600 PHYSI CAL THERAPY		0	0	0	97, 467	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY		0	0	0	29, 177	0	67.00
68. 00	06800 SPEECH PATHOLOGY		0	0	0	13, 641	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY		0	0	0	4, 218	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARG		0	0	0	0	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIE		0	0	0		0	73. 00
73. 01	07301 CARDI AC REHABI LI TATI ON		0	0	0	15, 681	0	73. 01
76. 97	07697 CARDI AC REHABI LI TATI ON		0	0		0	0	76. 97
76. 98	07698 HYPERBARIC OXYGEN THER	RAPY	0	0			0	76. 98
76. 99	07699 LI THOTRI PSY		0	0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENT	TERS						
88. 00	08800 RURAL HEALTH CLINIC	5110	0	0			0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	- FHC	0	0	0		0	88. 01
90.00	09000 CLI NI C		0	0	0	54, 916	0	90.00
90. 01	09001 EAST MEDICAL CLINIC		0	0	0	100 (00	0	90. 01
91.00	09100 EMERGENCY	DICTINGT DADT	O	0	0	133, 689	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-	•						92.00
440.00	SPECIAL PURPOSE COST CENTERS	5	1		ı			110 00
	11300 I NTEREST EXPENSE	C 1 +b 117)	1 100 404	0		(00,00)	0	113.00
118. 00	` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` `		1, 128, 424	0	0	698, 886	0	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT FLOWER COFFEE S		0	^			0	190. 00
	019000 GIFT FLOWER COFFEE S 019200 PHYSICIANS PRIVATE OFF		0	0				190. 00 192. 00
	1 1	IUES	0			,		
	1 19201 FAMILY MEDICAL CLINIC		0	0				192. 01 192. 02
	2 19202 I NDEPENDENT LIVING		0	0		-		192. 02 192. 03
192. 03 200. 00	3 19203 MEALS ON WHEELS		U	Ü			0	192. 03 200. 00
200.00				^			0	200. 00 201. 00
201.00		hrough 201)	1 120 424	0				201.00 202.00
202. UL	A LIDIAL (SUII TITIES TIS L	.iii ougii zoi)	1, 128, 424	U	ı	099, 994	0	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1331

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared:
11/27/2023 12:08 pm

			'	0 00/30/2023	11/27/2023 12	
Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	NONPHYSI CI AN	NURSI NG	
		RECORDS &	SERVI CE	ANESTHETI STS	PROGRAM	
		LI BRARY				
OFFICE A COUNTY OF	15. 00	16. 00	17. 00	19. 00	20. 00	
GENERAL SERVICE COST CENTERS			ı			4 00
1. 00 00100 CAP REL COSTS-BLDG & FLXT					i	1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					1	2.00
1 1					1	4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL					1	5.00
6. 00 00600 MAI NTENANCE & REPAI RS					1	6.00
7. 00 00700 OPERATION OF PLANT					i	7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE					1	8.00
9. 00 00900 HOUSEKEEPI NG					1	9.00
10. 00 01000 DI ETARY					i	10.00
11. 00 01100 CAFETERI A 12. 00 01200 MAI NTENANCE OF PERSONNEL					1	11.00
					1	12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON					1	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	751 5/2				1	14.00
15. 00 01500 PHARMACY	751, 563	000 107			1	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	809, 197			1	16.00
17. 00 01700 SOCIAL SERVICE	0	0	173, 416	l	1	17.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS 20. 00 02000 NURSI NG PROGRAM	0	0	0	520, 215	0	19. 00 20. 00
21.00 02100 1&R SERVICES-SALARY & FRINGES APPRV	0	0			U	21.00
22. 00 02200 1&R SERVICES-SALARY & FRINGES APPRV	0	0			i	21.00
INPATIENT ROUTINE SERVICE COST CENTERS	U _I	U				22.00
30. 00 03000 ADULTS & PEDIATRICS	ol	87, 375	173, 416	ol	0	30.00
ANCI LLARY SERVICE COST CENTERS	<u> </u>	07, 373	173, 410	<u> </u>		30.00
50. 00 05000 OPERATING ROOM	O	28, 642	0	Ol	0	50.00
53. 00 05300 ANESTHESI OLOGY	ol	9, 222	•		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	177, 993		0	0	
60. 00 06000 LABORATORY	ol	154, 867	l o	ol	0	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	0	0	ol	0	1
65. 00 06500 RESPIRATORY THERAPY	o	36, 082	0	o	0	1
66. 00 06600 PHYSI CAL THERAPY	o	38, 191	0	o	0	1
67. 00 06700 OCCUPATI ONAL THERAPY	o	11, 955	0	o	0	
68.00 06800 SPEECH PATHOLOGY	O	2, 776		o	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	12, 255	0	o	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	40, 055	0	o	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	751, 563	74, 505	0	0	0	73.00
73. 01 07301 CARDI AC REHABI LI TATI ON	0	3, 791	0	0	0	73. 01
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	
76. 99 07699 LI THOTRI PSY	0	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	61, 750			0	1
88. 01 08801 RURAL HEALTH CLINIC II - FHC	0	7, 676		0	0	
90. 00 09000 CLI NI C	0	5, 465	0	0	0	
90. 01 09001 EAST MEDI CAL CLINI C	0	0	0	0	0	
91. 00 09100 EMERGENCY	O	56, 597	0	O	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS			1			1110 00
113. 00 11300 INTEREST EXPENSE	751 572	000 107	170 417	F20 21F		113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	751, 563	809, 197	173, 416	520, 215	U	118.00
NONREI MBURSABLE COST CENTERS	٥	0	0	ol	0	100 00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS PRIVATE OFFICES	0	0		_		190. 00 192. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES	0	0		0		192.00
192. 02 19202 I NDEPENDENT LIVING	0	0	0			192.01
192.03 19203 MEALS ON WHEELS	0	0				192. 02
200.00 Cross Foot Adjustments	٩	U				200.00
201.00 Negative Cost Centers	٥	n	0			201.00
202.00 TOTAL (sum lines 118 through 201)	751, 563	809, 197	173, 416	520, 215		202.00
	,	30., .,,	1, 110	520, 210	Ö	,

Health Financial Systems

In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1331 Peri od: Worksheet B

From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/27/2023 12:08 pm INTERNS & RESIDENTS Cost Center Description SERVI CES-SALA | SERVI CES-OTHE Subtotal Intern & Total R PRGM COSTS RY & FRINGES Residents **APPRV APPRV** Cost & Post Stepdown Adjustments 21. 00 22. 00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSI NG PROGRAM 20 00 20 00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 5, 999, 289 30.00 03000 ADULTS & PEDIATRICS 0 0 5, 999, 289 0 30.00 ANCILLARY SERVICE COST CENTERS 1, 268, 663 1, 268, 663 50.00 05000 OPERATING ROOM 0 50.00 0 0 05300 ANESTHESI OLOGY 529, 437 529, 437 53.00 0 53.00 2, 527, 265 05400 RADI OLOGY-DI AGNOSTI C 2, 527, 265 54.00 0 54 00 60.00 06000 LABORATORY 00000000000 0 2, 707, 228 0 2, 707, 228 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 62.30 0 1, 015, 916 06500 RESPIRATORY THERAPY 0 1, 015, 916 65.00 65.00 06600 PHYSI CAL THERAPY 1, 699, 153 66.00 C 1, 699, 153 66.00 458, 162 0 458, 162 06700 OCCUPATI ONAL THERAPY 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 200, 675 0 0 200, 675 68.00 06900 ELECTROCARDI OLOGY 95, 605 69.00 C 95, 605 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 600, 479 600, 479 71.00 2, 444, 709 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 444, 709 0 0 73.00 07301 CARDIAC REHABILITATION 0 267, 824 267, 824 73.01 73.01 76.97 07697 CARDIAC REHABILITATION 0 76.97 \cap Ω 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY C 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 88.00 0 3, 476, 605 0 3, 476, 605 08800 RURAL HEALTH CLINIC 0 88.00 88.01 08801 RURAL HEALTH CLINIC II - FHC 0 1, 226, 461 0 1, 226, 461 88.01 0 0 90.00 09000 CLI NI C 0 1, 119, 863 1, 119, 863 90.00 09001 EAST MEDICAL CLINIC 0 0 90 01 C 42.143 42.143 90.01 91.00 09100 EMERGENCY 0 3, 909, 503 0 3, 909, 503 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 29, 588, 980 0 29, 588, 980 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 n 31 584 0 31, 584 190, 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 0 48,805 48, 805 192. 00 0 192. 01 19201 FAMILY MEDICAL CLINIC 0 0 192.01 192. 02 19202 I NDEPENDENT LIVING 0 0 0 0 359, 343 359, 343 192. 02

0

0

0

0

0

30, 028, 712

o

0

0

0 192 03

0 200.00

0 201.00

30, 028, 712 202. 00

192.03 19203 MEALS ON WHEELS

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

200.00

201.00

202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2022 Part II
To 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm Provider CCN: 14-1331

						11/27/2023 12	:08 pm
			CAPI TAL REI	_ATED COSTS			
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1.00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	1	0	0	0	4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL	0	227, 963	_	338, 694	0	5. 00
			227, 703	110, 731	330, 074	0	
6. 00	00600 MAI NTENANCE & REPAI RS	0	70 244	20.004	11/ 250	-	6.00
7.00	00700 OPERATION OF PLANT	0	78, 244		116, 250	0	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	29, 810		44, 290	0	8.00
9. 00	00900 HOUSEKEEPI NG	0	17, 002		25, 261	0	9. 00
10. 00	01000 DI ETARY	0	46, 325	22, 502	68, 827	0	10.00
11. 00	01100 CAFETERI A	0	0	0	0	0	11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300 NURSING ADMINISTRATION	0	8, 660	4, 206	12, 866	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500 PHARMACY	0	13, 466	6, 541	20, 007	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	18, 714	9, 090	27, 804	0	16.00
17.00	01700 SOCI AL SERVI CE	0	1, 836	892	2, 728	0	17.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	1	, 0	0	19.00
20. 00	02000 NURSI NG PROGRAM	0	0	o o	0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	Ö	Ö	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		Ö	0	22. 00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS			<u> </u>	<u> </u>	0	22.00
30. 00	03000 ADULTS & PEDIATRICS	0	137, 774	66, 922	204, 696	0	30. 00
30.00	ANCILLARY SERVICE COST CENTERS		137,774	00, 722	204, 090	0	30.00
EO 00	05000 OPERATING ROOM	1	40.720	20 474	93, 212	0	FO 00
50. 00 53. 00	05300 ANESTHESI OLOGY	0	62, 738			0	50.00
	l l	0	0	-	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	19, 088		28, 360	0	54.00
60.00	06000 LABORATORY	0	27, 816		41, 327	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	-	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	29, 028		43, 128	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	38, 890	18, 890	57, 780	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	7, 300	3, 546	10, 846	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	1, 598	776	2, 374	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	850	413	1, 263	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	O	0	0	73.00
73. 01	07301 CARDI AC REHABI LI TATI ON	0	7, 515	3, 650	11, 165	0	73. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	l ol	o	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	o	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0		O	0	76. 99
	OUTPATIENT SERVICE COST CENTERS			-1	-1	_	
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II - FHC	0	0		Ö	0	88. 01
90.00	09000 CLINIC	0	55, 008	1	81, 727	0	90.00
	09001 EAST MEDICAL CLINIC		33,000	20, 717	01, 727	0	
		0	25 (02	17 222	F2 014		
	09100 EMERGENCY	0	35, 682	17, 332	53, 014	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				U		92.00
	SPECIAL PURPOSE COST CENTERS		T				
	11300 INTEREST EXPENSE						113. 00
118.00		0	865, 307	420, 312	1, 285, 619	0	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	9, 261	0	9, 261	0	190.00
192.00	19200 PHYSICIANS PRIVATE OFFICES	0	6, 109	2, 968	9, 077	0	192.00
192. 01	19201 FAMILY MEDICAL CLINIC	0	0	0	o	0	192. 01
192. 02	19202 I NDEPENDENT LI VI NG	0	0	0	ol	0	192. 02
192. 03	19203 MEALS ON WHEELS	0	0	O	ol		192. 03
200.00		1]	Ō		200.00
201.00	, ,	1	l 0	n	n		201. 00
202.00		0	880, 677	423, 280	1, 303, 957		202. 00
202.00	1.57.12 (Sam 1.1.55 116 till Sagit 201)	1	1 000,077	120, 200	., 300, 707	٥١	_02.00

In Lieu of Form CMS-2552-10

Provider CCN: 14-1331

Peri od: Worksheet B
From 07/01/2022 Part II
To 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm ADMINISTRATIV MAINTENANCE & ODEDATION O

	Cost Center Description		MAINTENANCE &		LAUNDRY &	HOUSEKEEPI NG	. 00 рііі
		E & GENERAL 5.00	6. 00	7. 00	LINEN SERVICE 8.00	9. 00	
	GENERAL SERVICE COST CENTERS	3.00	0.00	7.00	0.00	7.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	338, 694					5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	9, 747					6. 00
7. 00	00700 OPERATION OF PLANT	5, 555					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 911			52, 963	20.755	8.00
9.00	00900 HOUSEKEEPI NG	9, 638			0	38, 755	9.00
10.00	01000 DI ETARY 01100 CAFETERI A	10, 838			0	2, 918 0	
11. 00 12. 00	01200 MAINTENANCE OF PERSONNEL	0	0	•	0	0	11. 00 12. 00
13. 00	01300 NURSING ADMINISTRATION	7, 542			0	546	
14. 00	01400 CENTRAL SERVI CES & SUPPLY	7, 342	0			0	14.00
15. 00	01500 PHARMACY	7, 927	175			848	
16. 00	01600 MEDICAL RECORDS & LIBRARY	8, 363	ł .			1, 179	
17. 00	01700 SOCI AL SERVI CE	1, 760			ol	116	
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	5, 867	0	i e	ol	0	19.00
20.00	02000 NURSI NG PROGRAM	0	0	0	o	0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	o	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	o	0	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	41, 055	1, 793	29, 455	52, 963	8, 677	30.00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	10, 894			0	3, 952	
53.00	05300 ANESTHESI OLOGY	0	1		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	25, 718			0	1, 202	
60.00	06000 LABORATORY	27, 653			0	1, 752	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0 2/3			0	1 020	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	9, 263			0	1, 829	
67.00	06700 OCCUPATI ONAL THERAPY	16, 048 4, 406			0	2, 450 460	1
68. 00	06800 SPEECH PATHOLOGY	2, 013			0	101	68.00
69. 00	06900 ELECTROCARDI OLOGY	858		•	o o	54	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 321	0		l ol	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	18, 256	ł .		ol	0	73.00
73. 01	07301 CARDI AC REHABI LI TATI ON	2, 495		1, 607	o	473	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		o	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	o	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	_					
88. 00	08800 RURAL HEALTH CLINIC	36, 486		•	0	4, 356	
88. 01	08801 RURAL HEALTH CLINIC II - FHC	12, 934			0	1, 744	
90.00	09000 CLINIC	9, 706			0	3, 465	
90. 01	09001 EAST MEDICAL CLINIC	475			0	0	90. 01
91.00	09100 EMERGENCY	40, 493	464	7, 629	0	2, 248	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
112 00	SPECIAL PURPOSE COST CENTERS			I			113. 00
118.00		334, 222	9, 548	119, 536	52, 963	38, 370	
110.00	NONREI MBURSABLE COST CENTERS	334, 222	7, 540	117, 550	32, 703	30, 370	110.00
190 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	130	120	1, 980	٥	0	190. 00
	19200 PHYSI CI ANS PRI VATE OFFI CES	289			l ol		192.00
	19201 FAMILY MEDICAL CLINIC	0			ol		192. 01
	19202 I NDEPENDENT LI VI NG	4, 053			o		192. 02
	19203 MEALS ON WHEELS	0	Ö		ol		192. 03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	338, 694	9, 747	122, 822	52, 963	38, 755	202. 00

Provider CCN: 14-1331

				0 06/30/2023	11/27/2023 12	
Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	
			OF PERSONNEL		SERVICES &	
	10.00	11. 00	12. 00	N 13. 00	SUPPLY 14. 00	
GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5.00
6. 00 00600 MAINTENANCE & REPAIRS						6.00
7.00 OO7OO 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	93, 089					10.00
11. 00 01100 CAFETERI A	0	0				11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	(1		12.00
13.00 O1300 NURSING ADMINISTRATION	0	0		22, 918		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	(이	0	14.00
15. 00 01500 PHARMACY	0	0	(이	0	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0		0	0	16.00
17. 00 01700 SOCIAL SERVICE	0	0		352	0	17.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0		0	0	19.00
20. 00 02000 NURSI NG PROGRAM	0	0		0	0	20.00
21. 00 02100 1 &R SERVICES-SALARY & FRINGES APPRV	0	0	(0	0	21.00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0) 0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS	02.000		1	7 011	0	20.00
30. 00 03000 ADULTS & PEDIATRICS	93, 089	0		7, 811	0	30.00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	0	0		1, 546	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		I I	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0			0	54.00
60. 00 06000 LABORATORY		0			0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0			0	62.30
65. 00 06500 RESPIRATORY THERAPY		0		1, 754	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0			0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		955	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0			0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		138	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		o	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	O	0		ol	0	73.00
73. 01 07301 CARDI AC REHABI LI TATI ON	0	0	(513	0	73. 01
76. 97 07697 CARDIAC REHABILITATION	0	0	(o o	0	76. 97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	(0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	(0	0	76. 99
OUTPAȚI ENT SERVI CE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	(0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II - FHC	0	0	(1 1	0	88. 01
90. 00 09000 CLI NI C	0	0	(1, 798	0	90.00
90.01 09001 EAST MEDICAL CLINIC	0	0	(0	0	90. 01
91. 00 09100 EMERGENCY	0	0	(4, 377	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS			1			
113. 00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	93, 089	0	(22, 882	0	118. 00
NONREI MBURSABLE COST CENTERS						100 00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	1	1		190.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	0			0	192.00
192. 01 19201 FAMILY MEDICAL CLINIC	0	0	1		0	192.01
192. 02 19202 INDEPENDENT LIVING 192. 03 19203 MEALS ON WHEELS	0	0				192. 02 192. 03
	١	0	(ا ا	0	200.00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0			^	200.00
202.00 TOTAL (sum lines 118 through 201)	93, 089	0				201.00
202. 00 TOTAL (Sum TITIES TTO CHI OUGH 201)	73,007	0	1	22, 710	O	1202.00

Provider CCN: 14-1331

						11/27/2023 12	2:08 pm
	Cost Center Description	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	
			LI BRARY	SERVICE	ANESTHETTSTS	FROGRAM	
		15. 00	16. 00	17. 00	19. 00	20. 00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FLXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00500 ADMINISTRATIVE & GENERAL						5. 00
	00600 MAINTENANCE & REPAIRS						6. 00
	00700 OPERATION OF PLANT						7. 00
	00800 LAUNDRY & LINEN SERVICE						8. 00
	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY	31, 836					15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	41, 590				16.00
17.00	01700 SOCIAL SERVICE	0	0	5, 373			17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	5, 867		19.00
20.00	02000 NURSING PROGRAM	0	0	0		0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
I	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	4, 492	5, 373			30.00
P	NCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	1, 473	0			50.00
53.00	05300 ANESTHESI OLOGY	0	474	0			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	9, 136	0			54.00
60.00	06000 LABORATORY	0	7, 962	0			60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62. 30
65.00	06500 RESPI RATORY THERAPY	0	1, 855	0			65.00
66.00	06600 PHYSI CAL THERAPY	0	1, 964	0			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	615	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	143	0			68. 00
	06900 ELECTROCARDI OLOGY	0	630	0			69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 059	0			71. 00
	07300 DRUGS CHARGED TO PATIENTS	31, 836	3, 831	0			73. 00
	07301 CARDIAC REHABILITATION	0	195	0			73. 01
76. 97	07697 CARDIAC REHABILITATION	0	0	0			76. 97
	07698 HYPERBARIC OXYGEN THERAPY	0	0	0			76. 98
	07699 LI THOTRI PSY	0	0	0			76. 99
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	3, 175	0			88. 00
	08801 RURAL HEALTH CLINIC II - FHC	0	395	0			88. 01
	09000 CLI NI C	0	281	0			90.00
	09001 EAST MEDICAL CLINIC	0	0	0			90. 01
1	09100 EMERGENCY	0	2, 910	0			91.00
_	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE	04 00/	44 500	5 070			113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	31, 836	41, 590	5, 373	0	0	118. 00
	IONREI MBURSABLE COST CENTERS	ما					100 00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0			190.00
	19200 PHYSI CLANS PRI VATE OFFI CES	0	0	0			192.00
	19201 FAMILY MEDICAL CLINIC		0	0			192. 01
	19202 INDEPENDENT LIVING		0	0			192.02
	19203 MEALS ON WHEELS	이	U	0	E 0/7	_	192.03
200.00	Cross Foot Adjustments		0	^	5, 867		200. 00 201. 00
201. 00 202. 00	Negative Cost Centers TOTAL (sum lines 118 through 201)	21 024	41, 590	U = 272	5, 867		201.00
202.00	TOTAL (Suill TITIES TTO LITTUUGIT 201)	31, 836	41, 390	5, 373	ე, ინ/	0	1202.00

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Health Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS
Provider CCN: 14-1331 Period: From 07/01/2022 Part II
To 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm

						11/27/2023 12	:08 pm
		INTERNS &	RESI DENTS				
	01.01	CEDVILOEC CALA	CEDVI OFC OTHE	6 1 1 1 1 1	1 - 1 0	T. I. I	
	Cost Center Description		SERVI CES-OTHE	Subtotal	Intern &	Total	
		RY & FRINGES APPRV	R PRGM COSTS APPRV		Residents		
		APPRV	APPRV		Cost & Post Stepdown		
					Adjustments		
		21. 00	22. 00	24. 00	25. 00	26. 00	
GEI	NERAL SERVICE COST CENTERS						
1.00 00	100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 00	200 CAP REL COSTS-MVBLE EQUIP						2.00
	400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	500 ADMINISTRATIVE & GENERAL						5. 00
	600 MAINTENANCE & REPAIRS						6.00
	700 OPERATION OF PLANT						7.00
	800 LAUNDRY & LINEN SERVICE						8.00
	900 HOUSEKEEPI NG 000 DI ETARY						9. 00 10. 00
	100 CAFETERI A						11.00
	200 MAINTENANCE OF PERSONNEL						12.00
	300 NURSI NG ADMI NI STRATI ON						13.00
	400 CENTRAL SERVICES & SUPPLY						14.00
	500 PHARMACY						15.00
16. 00 01	600 MEDICAL RECORDS & LIBRARY						16.00
17. 00 01	700 SOCIAL SERVICE						17. 00
19. 00 01	900 NONPHYSICIAN ANESTHETISTS						19. 00
	000 NURSING PROGRAM						20.00
	100 I &R SERVICES-SALARY & FRINGES APPRV	0	1				21.00
	200 1 &R SERVICES-OTHER PRGM COSTS APPRV		0				22. 00
	PATIENT ROUTINE SERVICE COST CENTERS OOO ADULTS & PEDIATRICS			449, 404	0	440 404	30.00
	CILLARY SERVICE COST CENTERS			449, 404	U	449, 404	30.00
	000 OPERATING ROOM			125, 306	0	125, 306	50.00
	300 ANESTHESI OLOGY			474	o	474	1
	400 RADI OLOGY-DI AGNOSTI C			68, 745	0	68, 745	1
60.00 06	000 LABORATORY			85, 003	0	85, 003	60.00
62. 30 06	250 BLOOD CLOTTING FOR HEMOPHILIACS			0	0	0	62. 30
	500 RESPI RATORY THERAPY			64, 412	0	64, 412	1
	600 PHYSI CAL THERAPY			90, 254	0	90, 254	1
	700 OCCUPATI ONAL THERAPY			18, 938	0	18, 938	1
	800 SPEECH PATHOLOGY 900 ELECTROCARDI OLOGY		·	5, 441	0	5, 441 3, 136	1
	100 MEDICAL SUPPLIES CHARGED TO PATIENT			3, 136 8, 380	0	8, 380	1
	300 DRUGS CHARGED TO PATIENTS			53, 923	ő	53, 923	1
	301 CARDI AC REHABI LI TATI ON			16, 546	Ö	16, 546	1
	697 CARDI AC REHABI LI TATI ON			0	0	0	1
76. 98 07	698 HYPERBARIC OXYGEN THERAPY			0	0	0	76. 98
	699 LI THOTRI PSY			0	0	0	76. 99
	TPATIENT SERVICE COST CENTERS		1				
	800 RURAL HEALTH CLINIC			44, 916	0	44, 916	1
	801 RURAL HEALTH CLINIC II - FHC			15, 433	0		88. 01
	000 CLINIC 001 EAST MEDICAL CLINIC			109, 453	0	109, 453	
	100 EMERGENCY			475 111, 135	0	475 111, 135	
	200 OBSERVATION BEDS (NON-DISTINCT PART			111, 133	0	111, 133	92.00
	ECIAL PURPOSE COST CENTERS				<u> </u>		72.00
	300 INTEREST EXPENSE						113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	1, 271, 374	0	1, 271, 374	118.00
NO	NREIMBURSABLE COST CENTERS						
	000 GIFT FLOWER COFFEE SHOP & CANTEEN			11, 491	0		190. 00
	200 PHYSICIANS PRIVATE OFFICES			11, 172	0	11, 172	
	201 FAMILY MEDICAL CLINIC			0	0		192. 01
	202 I NDEPENDENT LI VI NG			4, 053	0		192. 02
	203 MEALS ON WHEELS		_	0	0		192. 03
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers	0	0		0		200. 00 201. 00
201.00	TOTAL (sum lines 118 through 201)				0		
202.00	1.5.ME (Sam Titles Tio thiough 201)	1	1	1, 303, 737	٩	1, 303, 737	1-02.00

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MARSHALL BROWNING HOSPITAL

Health Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1331 Period: From 07/01/2022 To 06/30/2023 Date/Time Prepared:

					o 06/30/2023	Date/lime Pre	
		CAPITAL RE	LATED COSTS			1172772020 12	J. CO PIII
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
				(GROSS		(ACCOW. COST)	
		1. 00	2.00	SALARI ES) 4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00) A	5.00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT	77, 697					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		76, 880				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	12, 463, 245			4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	20, 112	20, 112			1	1
6. 00	00600 MAI NTENANCE & REPAI RS	(000	0	362, 431		695, 248	1
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	6, 903 2, 630	1		_	396, 225 136, 313	1
9. 00	00900 HOUSEKEEPI NG	1, 500				687, 455	
10.00	01000 DI ETARY	4, 087	4, 087	409, 824	0	773, 018	10.00
11. 00	01100 CAFETERI A	0	0	O	0	0	
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	070 500	0	0	
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	764	764	372, 528	0	537, 935 0	
15. 00	01500 PHARMACY	1, 188	1, 188	379, 750	0	565, 439	
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 651	1, 651	390, 843		596, 537	1
17.00	01700 SOCIAL SERVICE	162				125, 509	
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	C	0	418, 500	19.00
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	_	0	
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV I NPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	22.00
30. 00	03000 ADULTS & PEDIATRICS	12, 155	12, 155	1, 810, 557	0	2, 927, 664	30.00
00.00	ANCILLARY SERVICE COST CENTERS	127 100	12/100	1,010,001		2/12//001	1 00.00
50.00	05000 OPERATING ROOM	5, 535	5, 535	358, 311	0	777, 068	50.00
53.00	05300 ANESTHESI OLOGY	0			_		
54.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	1, 684	1			1, 834, 401	
60. 00 62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	2, 454	2, 454 0	693, 598	0	1, 972, 390 0	1
65. 00	06500 RESPIRATORY THERAPY	2, 561	2, 561	406, 615	0	660, 704	
66.00	06600 PHYSI CAL THERAPY	3, 431	3, 431	739, 746		1, 144, 654	
67.00	06700 OCCUPATI ONAL THERAPY	644	644	221, 448	0	314, 254	67.00
68. 00	06800 SPEECH PATHOLOGY	141	141	103, 530		143, 581	1
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	75				61, 187	
73.00	07300 DRUGS CHARGED TO PATIENTS		0		0	450, 847 1, 302, 157	
73. 01	07301 CARDI AC REHABI LI TATI ON	663	663	119, 014	0	177, 931	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	l .	o	0	0	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0		1	0	0	
76. 99	O7699 LI THOTRI PSY	0	0	0	0	0	76. 99
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	565, 557	0	2, 602, 440	88.00
88. 01							
	09000 CLINIC	4, 853					
90. 01	09001 EAST MEDICAL CLINIC	0	0	o	0	1	
91.00	09100 EMERGENCY	3, 148	3, 148	1, 014, 663	0	2, 888, 212	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE						113.00
118.00		76, 341	76, 341	12, 333, 026	-5, 871, 358	23, 838, 412	
	NONREI MBURSABLE COST CENTERS			, , , , , , , , , ,	.,,		1
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	817		O			190. 00
	19200 PHYSI CI ANS PRI VATE OFFI CES	539	539	8, 409	0		192.00
	19201 FAMILY MEDICAL CLINIC 19202 INDEPENDENT LIVING		0	121 010	0	0 289, 083	192. 01
	19202 MEALS ON WHEELS		0	121, 810	0		192. 02
200.00				Ĭ		Ĭ	200.00
201.00							201.00
202.00	71	880, 677	423, 280	4, 612, 747		5, 871, 358	202. 00
000 00	Part I)	44 0047/0	F F0F700	0.070400		0.04004/	000 00
203.00		11. 334762	5. 505723	0. 370108		0. 243046	
204.00	Cost to be allocated (per Wkst. B, Part II)					338, 694	204.00
205.00				0. 000000		0. 014020	205. 00
206.00							206.00
207.00	(per Wkst. B-2)						207 20
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
		Į.	l .	1	l .	1	1

Heal th Financial Systems STATE BROWNING HOSPITAL

Health Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1331 Period: Worksheet B-1

From 07/01/2022

06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE (PATI ENT **REPAIRS** PLANT (SQUARE FEET) (SQUARE FEET) (SQUARE FEET) (PATI ENT DAYS) DAYS' 6. 00 7. 00 9. 00 10.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 6.00 00600 MAINTENANCE & REPAIRS 66, 127 6.00 00700 OPERATION OF PLANT 6.903 7.00 50, 682 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 2,630 2,630 3, 192 8.00 9 00 00900 HOUSEKEEPI NG 1,500 1,500 0 54, 277 9 00 01000 DI ETARY 3, 192 4,087 10.00 4,087 0 4,087 10.00 01100 CAFETERI A 0 11.00 Λ 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 0 0 12.00 13.00 01300 NURSING ADMINISTRATION 764 764 764 0 13.00 01400 CENTRAL SERVICES & SUPPLY 0 14.00 14.00 0 0 0 0 15.00 01500 PHARMACY 1, 188 1, 188 1, 188 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 1,651 1,651 1,651 0 01700 SOCIAL SERVICE 17.00 0 0 17.00 162 162 162 01900 NONPHYSICIAN ANESTHETISTS 0 19 00 19 00 0 C 0 0 20.00 02000 NURSING PROGRAM 0 C 0 0 20.00 02100 | &R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 12, 155 12, 155 3, 192 12, 155 3, 192 30.00 ANCILLARY SERVICE COST CENTERS 5, 535 50 00 05000 OPERATING ROOM 5, 535 5, 535 n 50.00 05300 ANESTHESI OLOGY 0 53.00 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1,684 1, 684 0 1,684 54.00 0 60.00 06000 LABORATORY 2.454 2, 454 0 60.00 2.454 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 62.30 65.00 06500 RESPIRATORY THERAPY 2, 561 2, 561 2,561 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 3, 431 3, 431 3, 431 0 66.00 67 00 06700 OCCUPATIONAL THERAPY 644 0 0 67 00 644 644 0 06800 SPEECH PATHOLOGY 68.00 141 141 141 0 68.00 06900 ELECTROCARDI OLOGY 75 75 0 75 0 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 C 0 0 0 71.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 0 0 73 00 Γ 0 0 73.01 07301 CARDIAC REHABILITATION 663 663 663 0 73.01 07697 CARDIAC REHABILITATION 0 0 76.97 76.97 76.98 07698 HYPERBARIC OXYGEN THERAPY 0 C 0 ol 0 76.98 07699 LI THOTRI PSY 0 76. 99 76.99 0 0 OUTPAȚI ENT SERVI CE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 6, 100 0 6, 100 0 88.00 08801 RURAL HEALTH CLINIC II - FHC 0 88.01 2.442 2.442 0 88.01 0 90.00 90.00 09000 CLI NI C 4.853 4,853 4, 853 0 90.01 09001 EAST MEDICAL CLINIC 0 0 90.01 91.00 09100 EMERGENCY 3, 148 3, 148 0 3, 148 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 3, 192 3, 192 118.00 64, 771 49, 326 53, 738 118.00 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 817 817 C 0 190. 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 539 539 0 539 0 192.00 192. 01 19201 FAMILY MEDICAL CLINIC 0 192. 01 0 C 0 0 192. 02 19202 I NDEPENDENT LI VI NG 0 r 0 0 0 192.02 192.03 19203 MEALS ON WHEELS 0 0 0 0 192.03 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 864, 225 582, 742 234, 055 891, 389 1, 128, 424 202. 00 Part I) 353. 516291 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 13.069170 11.498007 73. 325501 16. 422960 204.00 Cost to be allocated (per Wkst. B, 9.747 122, 822 52 963 38.755 93, 089 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.147398 2. 423385 16. 592419 0.714023 29. 163221 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)

leal th Financial Systems MARSHALL BROWNING HOSPITAL

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1331 | Period: From 07/01/2022 | To 06/30/2023 | Date/Time Prepared:

				Ť	06/30/2023	Date/Time Pre 11/27/2023 12	
	Cost Center Description	CAFETERI A (GROSS SALARI ES)	MAI NTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSI NG ADMI NI STRATI O N (NURSI NG SALARI ES)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	
	GENERAL SERVICE COST CENTERS	11. 00	12. 00	13.00	14. 00	15. 00	
13. 00 14. 00 15. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0 0 0 0	000000000000000000000000000000000000000	5, 312, 782 0 0	0	1, 302, 157	1
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0	81, 678	0	0	
19. 00 20. 00 21. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS	0 0 0		0 0	0 0 0	0 0 0 0	19. 00 20. 00 21. 00
30. 00	03000 ADULTS & PEDIATRICS	0	0	1, 810, 557	0	0	30.00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	0	0	358, 311	O	0	50.00
69. 00 71. 00 73. 00 73. 01	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS 07301 CARDI AC REHABI LI TATI ON 07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	0 0 0 0 0 0 0 0 0 0		0 0 0 406, 615 739, 746 221, 448 103, 530 32, 011 0 0 119, 014	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 1, 302, 157 0	54. 00 60. 00 62. 30 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 73. 00 73. 01 76. 97
76. 99	07699 LI THOTRI PSY	o o	1	1	_	0	1
91.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II - FHC 09000 CLINIC 09001 EAST MEDICAL CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 0 0	0	0 416, 800 0	0	0 0 0 0	88. 01 90. 00 90. 01
113. 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	0	5, 304, 373	0	1, 302, 157	118.00
192. 00 192. 01 192. 02	19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19200 PHYSICIANS PRIVATE OFFICES 19201 FAMILY MEDICAL CLINIC 19202 INDEPENDENT LIVING 19203 MEALS ON WHEELS Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B,	0 0 0 0	0	8, 409 0 0 0	0 0	0 0 0	190. 00 192. 00 192. 01 192. 02 192. 03 200. 00 201. 00 202. 00
203. 00 204. 00	Cost to be allocated (per Wkst. B,	0. 000000 0	0. 000000 0	0. 131757 22, 918		0. 577168 31, 836	203. 00 204. 00
205. 00		0. 000000	0. 000000	0. 004314	0. 000000	0. 024449	205.00
206. 00							206. 00
207. 00	(per Wkst. B-2)						207. 00

Heal th Financial Systems MARSHALL BROWNING HOSPITAL

Health Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1331 Period: Worksheet B-1

From 07/01/2022

06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm INTERNS & **RESI DENTS** MEDI CAL SOCI AL NONPHYSI CI AN NURSI NG SERVI CES-SALA Cost Center Description RY & FRINGES RECORDS & SERVI CE **ANESTHETLSTS PROGRAM** (ASSI GNED (TIME SPENT) **APPRV** LI BRARY (ASSI GNED (GROSS TIME) TIME) (ASSI GNED CHARGES) TIME) 16. 00 17. 00 19.00 20.00 21.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 60, 210, 283 16.00 17.00 01700 SOCIAL SERVICE 100 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 100 19.00 0 C 02000 NURSING PROGRAM 20 00 0 20.00 Ω 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 0 C 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6, 501, 105 100 0 0 Ω 30.00 ANCILLARY SERVICE COST CENTERS 0 50.00 50.00 05000 OPERATING ROOM 2, 131, 117 0 0 0 0 05300 ANESTHESI OLOGY 100 53.00 686, 141 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 13, 245, 714 0 0 54.00 60.00 06000 LABORATORY 11, 522, 818 0 0 0 0 0 0 0 0 0 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 0 62.30 2, 684, 660 06500 RESPIRATORY THERAPY 0 0 0 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 2.841.571 C 0 66.00 06700 OCCUPATI ONAL THERAPY 889, 515 67.00 67.00 0 06800 SPEECH PATHOLOGY 68.00 206, 530 0 0 68.00 0 06900 ELECTROCARDI OLOGY 69.00 911.829 C 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 2, 980, 301 C 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 5, 543, 536 0 0 0 0 73.00 07301 CARDIAC REHABILITATION 282, 055 0 0 73.01 73.01 0 0 76.97 07697 CARDIAC REHABILITATION 0 76.97 0 0 0 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 C 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 88.00 4, 594, 527 0 0 88.00 08800 RURAL HEALTH CLINIC C 0 88.01 08801 RURAL HEALTH CLINIC II - FHC 571, 111 0 0 88.01 0 o 90.00 09000 CLI NI C 0 90.00 406, 631 0 09001 EAST MEDICAL CLINIC 0 0 90.01 90 01 C 0 91.00 09100 EMERGENCY 4, 211, 121 0 0 O 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 60, 210, 283 100 100 0 0 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN n O 0 0 190, 00 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 192.00 0 C 0 192. 01 19201 FAMILY MEDICAL CLINIC 0 0 0 0 192.01 192. 02 19202 INDEPENDENT LIVING 0 0 ol 0 192.02 C 192.03 19203 MEALS ON WHEELS 0 192.03 0 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 202.00 809, 197 173, 416 520, 215 0 0 202.00 Part I) 0. 000000 203. 00 203.00 1, 734. 160000 5, 202. 150000 Unit cost multiplier (Wkst. B, Part I) 0.013440 0.000000 Cost to be allocated (per Wkst. B, 0 204.00 204.00 41, 590 5, 373 5,867 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000691 53.730000 58. 670000 0.000000 0.000000 205.00 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 207.00 Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Provider CCN: 14-1331 Peri od: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm

				11/27/2023 12	2:08 pm
			I NTERNS & RESI DENTS		
		Cost Center Description	SERVI CES-OTHE		
			R PRGM COSTS		
			APPRV		
			(ASSI GNED TIME)		
			22. 00		
	GENER	AL SERVICE COST CENTERS			
1.00		CAP REL COSTS-BLDG & FIXT			1.00
2.00		CAP REL COSTS-MVBLE EQUIP			2.00
4. 00 5. 00	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL			4. 00 5. 00
6. 00		MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7. 00
8. 00	1	LAUNDRY & LINEN SERVICE			8. 00
9.00		HOUSEKEEPI NG			9.00
10. 00 11. 00		DI ETARY CAFETERI A	+		10.00 11.00
		MAINTENANCE OF PERSONNEL			12.00
13.00	1	NURSING ADMINISTRATION			13.00
		CENTRAL SERVICES & SUPPLY			14.00
		PHARMACY			15.00
		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE			16. 00 17. 00
		NONPHYSICIAN ANESTHETISTS			19.00
	1	NURSI NG PROGRAM			20.00
21. 00		I&R SERVICES-SALARY & FRINGES APPRV			21.00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	0		22. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	0		20.00
30.00		LARY SERVICE COST CENTERS	<u> </u>		30.00
50.00		OPERATING ROOM	0		50.00
53.00	05300	ANESTHESI OLOGY	0		53.00
		RADI OLOGY-DI AGNOSTI C	0		54.00
60. 00 62. 30		LABORATORY BLOOD CLOTTING FOR HEMOPHILIACS	0		60. 00 62. 30
65. 00	1	RESPIRATORY THERAPY	0		65. 00
66. 00	1	PHYSI CAL THERAPY	0		66.00
67.00	06700	OCCUPATI ONAL THERAPY	О		67.00
68. 00		SPEECH PATHOLOGY	0		68. 00
69. 00 71. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	0		69. 00 71. 00
		DRUGS CHARGED TO PATTENT	0		73.00
		CARDI AC REHABI LI TATI ON	o		73. 01
	1	CARDIAC REHABILITATION	0		76. 97
		HYPERBARI C OXYGEN THERAPY	0		76. 98
76. 99		LI THOTRI PSY TI ENT SERVI CE COST CENTERS	0		76. 99
88. 00		RURAL HEALTH CLINIC	0		88. 00
88. 01		RURAL HEALTH CLINIC II - FHC	0		88. 01
		CLINIC	0		90.00
		EAST MEDICAL CLINIC	0		90. 01
	1	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	O		91.00 92.00
72.00		AL PURPOSE COST CENTERS			72.00
113.00		INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0		118. 00
100.00		IMBURSABLE COST CENTERS	0		100.00
	1	GIFT FLOWER COFFEE SHOP & CANTEEN PHYSICIANS PRIVATE OFFICES	0		190. 00 192. 00
		FAMILY MEDICAL CLINIC	0		192. 00
		INDEPENDENT LIVING	0		192. 02
		MEALS ON WHEELS	0		192. 03
200. 00 201. 00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers Cost to be allocated (per Wkst. B,	0		201. 00 202. 00
202.00		Part I)	١		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0. 000000		203. 00
204.00		Cost to be allocated (per Wkst. B,	O		204. 00
205 22		Part II)	0.000000		20E 00
205. 00	1	Unit cost multiplier (Wkst. B, Part	0. 000000		205. 00
206.00		NAHE adjustment amount to be allocated			206. 00
		(per Wkst. B-2)			
207.00		NAHE unit cost multiplier (Wkst. D,			207. 00
	I	Parts III and IV)			<u> </u>

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1331 Title XVIII

			IIIIe	XVIII	nospitai	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1.00	2.00	3.00	4. 00	5. 00	
I NI	PATIENT ROUTINE SERVICE COST CENTERS	•					
30.00 03	000 ADULTS & PEDIATRICS	5, 999, 289		5, 999, 289	0	0	30.00
ANG	CILLARY SERVICE COST CENTERS						
50.00 050	OOO OPERATING ROOM	1, 268, 663		1, 268, 663	0	0	50.00
53.00 05	300 ANESTHESI OLOGY	529, 437		529, 437	0	0	53.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	2, 527, 265		2, 527, 265	0	0	54.00
60.00 06	000 LABORATORY	2, 707, 228		2, 707, 228	0	0	60.00
62. 30 06:	250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62. 30
65. 00 06	500 RESPI RATORY THERAPY	1, 015, 916	0	1, 015, 916	0	0	65.00
66.00 06	600 PHYSI CAL THERAPY	1, 699, 153	0	1, 699, 153	0	0	66.00
67. 00 06	700 OCCUPATI ONAL THERAPY	458, 162	0	458, 162	0	0	67.00
68.00 06	800 SPEECH PATHOLOGY	200, 675	0	200, 675	0	0	68.00
69. 00 06	900 ELECTROCARDI OLOGY	95, 605		95, 605	0	0	69.00
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT	600, 479		600, 479	0	0	71.00
73.00 07	300 DRUGS CHARGED TO PATIENTS	2, 444, 709		2, 444, 709	0	0	73.00
73. 01 07	301 CARDI AC REHABI LI TATI ON	267, 824		267, 824	0	0	73. 01
76. 97 07	697 CARDI AC REHABI LI TATI ON	0		0	0	0	76. 97
76. 98 07	698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76. 98
	699 LI THOTRI PSY	0		0	0	0	76. 99
OU ⁻	TPATIENT SERVICE COST CENTERS						1
88. 00 08	800 RURAL HEALTH CLINIC	3, 476, 605		3, 476, 605	0	0	88. 00
88. 01 08	801 RURAL HEALTH CLINIC II - FHC	1, 226, 461		1, 226, 461	0	0	88. 01
90.00 09	000 CLI NI C	1, 119, 863		1, 119, 863	0	0	90.00
90. 01 09	001 EAST MEDICAL CLINIC	42, 143		42, 143	0	0	90. 01
91.00 09	100 EMERGENCY	3, 909, 503		3, 909, 503	0	0	91.00
92. 00 09:	200 OBSERVATION BEDS (NON-DISTINCT PART	918, 242		918, 242		0	92.00
	ECIAL PURPOSE COST CENTERS		<u> </u>			<u> </u>	1
113. 00 11:	300 INTEREST EXPENSE						113.00
200. 00	Subtotal (see instructions)	30, 507, 222	0	30, 507, 222	0	0	200.00
201.00	Less Observation Beds	918, 242		918, 242		0	201.00
202. 00	Total (see instructions)	29, 588, 980	0	29, 588, 980	0	0	202.00

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Heal th Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1331 | Period: From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: 11/27/2023 12:08 pm

						11/2//2023 12	: 08 piii
		Title XVIII		Hospi tal	Cost		
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	·	·	+ col. 7)	Rati o	Inpati ent	
				,		Rati o	
		6. 00	7.00	8.00	9. 00	10.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS	•					
30.00 0300	O ADULTS & PEDIATRICS	1, 732, 517		1, 732, 517	'		30.00
	LLARY SERVICE COST CENTERS						
50.00 0500	O OPERATING ROOM	130, 053	2, 001, 064	2, 131, 117	0. 595304	0.000000	50.00
53.00 0530	O ANESTHESI OLOGY	16, 523	669, 618	686, 141	0. 771615	0.000000	53.00
54.00 0540	O RADI OLOGY-DI AGNOSTI C	474, 414	12, 771, 300	13, 245, 714	0. 190799	0.000000	54.00
60.00 06000	O LABORATORY	1, 207, 208	10, 315, 610	11, 522, 818	0. 234945	0.000000	60.00
62. 30 06250	D BLOOD CLOTTING FOR HEMOPHILIACS	0	0	C	0. 000000	0.000000	62.30
65.00 0650	O RESPIRATORY THERAPY	1, 345, 868	1, 338, 792	2, 684, 660	0. 378415	0.000000	65.00
66.00 0660	O PHYSI CAL THERAPY	333, 828	2, 507, 743	2, 841, 571	0. 597963	0.000000	66.00
67.00 0670	O OCCUPATI ONAL THERAPY	301, 332	588, 183	889, 515	0. 515069	0.000000	67.00
68. 00 0680	O SPEECH PATHOLOGY	8, 178	198, 352	206, 530	0. 971651	0.000000	68.00
69.00 0690	O ELECTROCARDI OLOGY	31, 098	880, 731	911, 829	0. 104850	0.000000	69.00
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENT	1, 013, 751	1, 966, 550	2, 980, 301	0. 201483	0.000000	71.00
73.00 0730	DRUGS CHARGED TO PATIENTS	1, 362, 868	4, 180, 668	5, 543, 536	0. 441002	0.000000	73.00
73. 01 0730°	1 CARDIAC REHABILITATION	O	282, 055	282, 055	0. 949545	0.000000	73. 01
76. 97 0769	7 CARDIAC REHABILITATION	O	0	l c	0. 000000	0.000000	76. 97
76. 98 0769	8 HYPERBARIC OXYGEN THERAPY	O	0	(0. 000000	0.000000	76. 98
76. 99 0769	9 LI THOTRI PSY	o	0	(0. 000000	0.000000	76. 99
OUTP	ATIENT SERVICE COST CENTERS						
88.00 0880	O RURAL HEALTH CLINIC	0	4, 594, 527	4, 594, 527	'		88. 00
88. 01 0880	1 RURAL HEALTH CLINIC II - FHC	o	571, 111	571, 111			88. 01
90.00 09000	O CLI NI C	o	406, 631	406, 631	2. 754003	0.000000	90.00
90. 01 0900	1 EAST MEDICAL CLINIC	o	1	1	42, 143. 000000	0.000000	90. 01
91.00 0910	O EMERGENCY	5, 349	4, 205, 772	4, 211, 121	0. 928376	0.000000	91.00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART	134, 466	4, 634, 122	4, 768, 588	0. 192561	0.000000	92.00
SPECI	IAL PURPOSE COST CENTERS	•		,			
113. 00 1130	O INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	8, 097, 453	52, 112, 830	60, 210, 283	;		200.00
201.00	Less Observation Beds						201.00
202. 00	Total (see instructions)	8, 097, 453	52, 112, 830	60, 210, 283	;		202.00
1					'		•

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1331 Title XVIII

			II LIE AVIII	nospi tai	COST
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				30.00
Į.	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 000000			50.00
53.00	05300 ANESTHESI OLOGY	0. 000000			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60.00	06000 LABORATORY	0. 000000			60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65.00	06500 RESPI RATORY THERAPY	0. 000000			65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000			69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
73. 01	07301 CARDI AC REHABI LI TATI ON	0. 000000			73. 01
76. 97	07697 CARDIAC REHABILITATION	0. 000000			76. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0. 000000			76. 98
76. 99	07699 LI THOTRI PSY	0. 000000			76. 99
Ī	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC				88.00
88. 01	08801 RURAL HEALTH CLINIC II - FHC				88. 01
90.00	09000 CLI NI C	0. 000000			90.00
90. 01	09001 EAST MEDICAL CLINIC	0. 000000			90. 01
91.00	09100 EMERGENCY	0. 000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
1	SPECIAL PURPOSE COST CENTERS				
113. 00	11300 INTEREST EXPENSE				113. 00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

In Lieu of Form CMS-2552-10

Worksheet C Part I Date/Time Prepared: 11/27/2023 12:08 pm Provider CCN: 14-1331 Peri od: From 07/01/2022 To 06/30/2023

						11/21/2023 12	. UO PIII
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst.	Adj.		Di sal I owance		
		B, Part I,	•				
		col . 26)					
		1. 00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	5, 999, 289		5, 999, 289	0	5, 999, 289	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 268, 663		1, 268, 663	0	1, 268, 663	50.00
53.00	05300 ANESTHESI OLOGY	529, 437		529, 437	0	529, 437	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 527, 265		2, 527, 265	0	2, 527, 265	54.00
	06000 LABORATORY	2, 707, 228		2, 707, 228		2, 707, 228	1
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0		0	62.30
	06500 RESPIRATORY THERAPY	1, 015, 916	0	1, 015, 916	0	1, 015, 916	1
	06600 PHYSI CAL THERAPY	1, 699, 153		1, 699, 153		1, 699, 153	
	06700 OCCUPATI ONAL THERAPY	458, 162		458, 162		458, 162	
	06800 SPEECH PATHOLOGY	200, 675		200, 675		200, 675	
4	06900 ELECTROCARDI OLOGY	95, 605		95, 605		95, 605	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	600, 479		600, 479		600, 479	1
	07300 DRUGS CHARGED TO PATIENTS	2, 444, 709		2, 444, 709		2, 444, 709	1
	07301 CARDI AC REHABI LI TATI ON	267, 824		267, 824		267, 824	1
	07697 CARDI AC REHABI LI TATI ON	207,021		207, 021	0	0	1
	07698 HYPERBARI C OXYGEN THERAPY	n o		١	0	0	ı
	07699 LI THOTRI PSY	0		0	0	0	ł
	OUTPATIENT SERVICE COST CENTERS				0	0	70.77
	08800 RURAL HEALTH CLINIC	3, 476, 605		3, 476, 605	0	3, 476, 605	88. 00
	08801 RURAL HEALTH CLINIC II - FHC	1, 226, 461		1, 226, 461		1, 226, 461	1
	09000 CLI NI C	1, 119, 863		1, 119, 863		1, 119, 863	1
	09001 EAST MEDICAL CLINIC	42, 143		42, 143		42, 143	1
	09100 EMERGENCY	3, 909, 503		3, 909, 503		3, 909, 503	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	918, 242		918, 242		918, 242	1
	SPECIAL PURPOSE COST CENTERS	710, 242		710, 242		710, 242	72.00
	11300 I NTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	30, 507, 222	n	30, 507, 222	0	30, 507, 222	
200.00	Less Observation Beds	918, 242	0	918, 242		918, 242	
201.00	Total (see instructions)	29, 588, 980					
202.00	Total (See Histiactions)	27, 300, 900	ı	27, 300, 900	ı U	27, 300, 900	1202.00

Heal th Financial Systems MARSHALL BROWNING HOSPITAL

Health Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-1331 Period: Worksheet C

From 07/01/2022

Part I

201.00

202 00

Date/Time Prepared: 06/30/2023 11/27/2023 12:08 pm Title XIX Hospi tal PPS Charges Total (col. 6 Cost or Other TEFRA Cost Center Description Inpati ent Outpati ent + col. 7) Ratio I npati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 732, 517 1, 732, 517 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 130, 053 2,001,064 0.595304 0.000000 50.00 2, 131, 117 50.00 53.00 05300 ANESTHESI OLOGY 16, 523 669, 618 0. 771615 0.000000 53.00 686, 141 05400 RADI OLOGY-DI AGNOSTI C 13, 245, 714 0.190799 54.00 474.414 12, 771, 300 0.000000 54.00 60.00 06000 LABORATORY 1, 207, 208 10, 315, 610 11, 522, 818 0. 234945 0.000000 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0.000000 62.30 06500 RESPIRATORY THERAPY 1, 345, 868 2, 684, 660 1, 338, 792 0.378415 0.000000 65.00 65.00 0.000000 66.00 06600 PHYSI CAL THERAPY 333, 828 2, 507, 743 2, 841, 571 0.597963 66.00 67.00 06700 OCCUPATI ONAL THERAPY 301, 332 588, 183 889, 515 0.515069 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 8, 178 198, 352 206, 530 0. 971651 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 31,098 880, 731 911, 829 0.104850 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1,013,751 1, 966, 550 2, 980, 301 0.201483 0.000000 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 362, 868 4, 180, 668 5, 543, 536 0.441002 0.000000 73.00 07301 CARDIAC REHABILITATION 0. 949545 73.01 282, 055 282, 055 0.000000 0 73.01 07697 CARDIAC REHABILITATION 76.97 0 C 0.000000 0.000000 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0.000000 0.000000 76.98 07699 LI THOTRI PSY 76. 99 0 0 0 0.000000 0.000000 76.99 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 4, 594, 527 4, 594, 527 0.756684 0.000000 88.00 88.01 08801 RURAL HEALTH CLINIC II - FHC 0 571, 111 571, 111 2.147500 0.000000 88.01 09000 CLI NI C 0 2.754003 0.000000 90.00 406, 631 406, 631 90.00 90.01 09001 EAST MEDICAL CLINIC \cap 42, 143, 000000 0.000000 90.01 91.00 09100 EMERGENCY 5, 349 4, 205, 772 4, 211, 121 0.928376 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 192561 92.00 134, 466 4, 634, 122 4, 768, 588 0.000000 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 8, 097, 453 52, 112, 830 60, 210, 283 200.00

8, 097, 453

52, 112, 830

60, 210, 283

201.00

202 00

Less Observation Beds

Total (see instructions)

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-1331 Title XIX

			II LI C ALA	nospi tai	FF3
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
I	NPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 C	03000 ADULTS & PEDIATRICS				30.00
A	NCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 595304			50.00
53.00	05300 ANESTHESI OLOGY	0. 771615			53.00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	0. 190799			54.00
60. 00 C	06000 LABORATORY	0. 234945			60.00
62. 30 C	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 C	06500 RESPIRATORY THERAPY	0. 378415			65.00
66.00	06600 PHYSI CAL THERAPY	0. 597963			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 515069			67.00
68.00	06800 SPEECH PATHOLOGY	0. 971651			68.00
69.00	06900 ELECTROCARDI OLOGY	0. 104850			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 201483			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 441002			73.00
73. 01	07301 CARDIAC REHABILITATION	0. 949545			73. 01
76. 97 C	07697 CARDIAC REHABILITATION	0. 000000			76. 97
76. 98 C	07698 HYPERBARIC OXYGEN THERAPY	0. 000000			76. 98
76. 99 C	07699 LI THOTRI PSY	0. 000000			76. 99
O	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	0. 756684			88. 00
88. 01	08801 RURAL HEALTH CLINIC II - FHC	2. 147500			88. 01
90.00	09000 CLI NI C	2. 754003			90.00
90. 01	09001 EAST MEDICAL CLINIC	42, 143. 000000			90. 01
91.00	09100 EMERGENCY	0. 928376			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 192561			92.00
	SPECIAL PURPOSE COST CENTERS				
113.001	11300 NTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200. 00
201.00	Less Observation Beds				201. 00
202.00	Total (see instructions)				202. 00
		·			· · · · · · · · · · · · · · · · · · ·

Health Financial Systems MARSHALL BROCCALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF

In Lieu of Form CMS-2552-10

REDUCTIONS FOR MEDICALD ONLY

Provider CCN: 14-1331

Peri od: Worksheet C
From 07/01/2022 Part II
To 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm

			Ti +1	e XIX	Hospi tal	PPS	00 piii
	Cost Center Description	Total Cost	Capital Cost		Capi tal	Operating	
	cost center bescription	(Wkst. B,	(Wkst. B,	Operating Cost Net of	Reduction	Cost	
		Part I, col.	Part II col.		Reduction	Reduction	
		•	26)	Capital Cost (col. 1 -		Amount	
		26)	20)	col. 2)		AIIIOUITE	
		1, 00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
	D5000 OPERATING ROOM	1, 268, 663	125, 306	1, 143, 357	n	0	50.00
	D5300 ANESTHESI OLOGY	529, 437			0	0	
	D5400 RADI OLOGY-DI AGNOSTI C	2, 527, 265			0	0	
	06000 LABORATORY	2, 707, 228			0	0	1
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	2,707,220	05,009		0	0	1
	06500 RESPIRATORY THERAPY	1, 015, 916		_	0	0	1
	06600 PHYSI CAL THERAPY	1, 699, 153			0	0	1
	06700 OCCUPATI ONAL THERAPY	458, 162			0	0	67.00
	06800 SPEECH PATHOLOGY	200, 675			0	0	68.00
	06900 ELECTROCARDI OLOGY	95, 605	·		0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	600, 479			0	0	71.00
	07300 DRUGS CHARGED TO PATIENTS	2, 444, 709			0	0	
	07301 CARDI AC REHABI LI TATI ON	267, 824			0	0	
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	
	07699 LI THOTRI PSY	0	l o	0	o	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	_	_		-1	-	1
	08800 RURAL HEALTH CLINIC	3, 476, 605	44, 916	3, 431, 689	0	0	88.00
88. 01	08801 RURAL HEALTH CLINIC II - FHC	1, 226, 461	15, 433	1, 211, 028	0	0	88. 01
90.00	09000 CLI NI C	1, 119, 863	109, 453	1, 010, 410	o	0	90.00
90. 01	09001 EAST MEDICAL CLINIC	42, 143	475	41, 668	o	0	90. 01
91.00	09100 EMERGENCY	3, 909, 503	111, 135	3, 798, 368	o	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	918, 242	68, 786	849, 456	0	0	92.00
5	SPECIAL PURPOSE COST CENTERS						1
113.001	11300 INTEREST EXPENSE						113. 00
200.00	Subtotal (sum of lines 50 thru 199)	24, 507, 933	890, 756	23, 617, 177	o	0	200.00
201.00	Less Observation Beds	918, 242	68, 786	849, 456	o	0	201.00
202. 00	Total (line 200 minus line 201)	23, 589, 691	821, 970	22, 767, 721	o	0	202. 00

Provider CCN: 14-1331

In Lieu of Form CMS-2552-10

Heal th Financial Systems

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY

Peri od: From 07/01/2022 To 06/30/2023

Worksheet C Part II Date/Time Prepared: 11/27/2023 12:08 pm

			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,				
		Operati ng	Part I,	Charge Ratio			
		Cost	column 8)	(col. 6 /			
		Reduction		col. 7)			
		6. 00	7. 00	8. 00			
	ILLARY SERVICE COST CENTERS		T	,			
	00 OPERATING ROOM	1, 268, 663					50.00
	00 ANESTHESI OLOGY	529, 437					53.00
	00 RADI OLOGY-DI AGNOSTI C	2, 527, 265					54.00
	00 LABORATORY	2, 707, 228					60.00
	50 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62. 30
	00 RESPI RATORY THERAPY	1, 015, 916					65.00
	00 PHYSI CAL THERAPY	1, 699, 153					66.00
	00 OCCUPATI ONAL THERAPY	458, 162	·				67.00
	00 SPEECH PATHOLOGY	200, 675	·				68. 00
	00 ELECTROCARDI OLOGY	95, 605	·				69. 00
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	600, 479					71.00
	00 DRUGS CHARGED TO PATIENTS	2, 444, 709					73.00
	O1 CARDIAC REHABILITATION	267, 824	282, 055				73. 01
	97 CARDIAC REHABILITATION	0	0	0.000000			76. 97
	98 HYPERBARIC OXYGEN THERAPY	0	0	0. 000000			76. 98
	99 LI THOTRI PSY	0	0	0.000000			76. 99
	PATIENT SERVICE COST CENTERS						
	00 RURAL HEALTH CLINIC	3, 476, 605	4, 594, 527				88. 00
	01 RURAL HEALTH CLINIC II - FHC	1, 226, 461					88. 01
	OO CLI NI C	1, 119, 863					90.00
	01 EAST MEDICAL CLINIC	42, 143		42, 143. 000000			90. 01
91. 00 091	OO EMERGENCY	3, 909, 503	4, 211, 121	0. 928376			91.00
92.00 092	OO OBSERVATION BEDS (NON-DISTINCT PART	918, 242	4, 768, 588	0. 192561			92.00
	CLAL PURPOSE COST CENTERS						
	00 I NTEREST EXPENSE						113. 00
200. 00	Subtotal (sum of lines 50 thru 199)	24, 507, 933					200.00
201.00	Less Observation Beds	918, 242					201.00
202. 00	Total (line 200 minus line 201)	23, 589, 691	58, 477, 766				202. 00

Heal th Fi nanci al Systems MARSHALL BROWNING HOSPITAL

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 14-1331 Period: Worksheet D

From 07/01/2022 Part II Date/Time Prepared: 06/30/2023 11/27/2023 12:08 pm Title XVIII Hospi tal Cost Total Charges Capital Costs Cost Center Description Capi tal Ratio of Cost Inpati ent to Charges (column 3 x Related Cost (from Wkst. Program (from Wkst. C, Part I, (col. 1 ÷ Charges column 4) B, Part II, col. 8) col. 2) col. 26) 1. 00 2.00 4. 00 5. 00 3.00 ANCILLARY SERVICE COST CENTERS 50 00 0.058798 50 00 05000 OPERATING ROOM 125, 306 2, 131, 117 118, 172 6, 948 53.00 05300 ANESTHESI OLOGY 474 686, 141 0.000691 11, 478 53.00 05400 RADI OLOGY-DI AGNOSTI C 68, 745 13, 245, 714 0.005190 261, 910 54.00 1, 359 54.00 06000 LABORATORY 0.007377 60.00 85,003 11, 522, 818 414, 674 3,059 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0.000000 0 62.30 65.00 06500 RESPIRATORY THERAPY 64, 412 2, 684, 660 0.023993 320, 749 7,696 65.00 66.00 06600 PHYSI CAL THERAPY 90, 254 2, 841, 571 0.031762 35, 709 1, 134 66.00 889, 515 06700 OCCUPATI ONAL THERAPY 18, 938 18, 404 67.00 0.021290 392 67.00 68.00 06800 SPEECH PATHOLOGY 5, 441 206, 530 0.026345 2, 292 60 68.00 69.00 06900 ELECTROCARDI OLOGY 3, 136 911, 829 0.003439 12, 493 43 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 8, 380 2, 980, 301 0.002812 364, 934 1,026 71.00 07300 DRUGS CHARGED TO PATIENTS 53, 923 5, 543, 536 0.009727 3, 241 73.00 333, 182 73.00 73.01 07301 CARDIAC REHABILITATION 16, 546 282, 055 0.058662 0 73.01 07697 CARDIAC REHABILITATION 76. 97 0 0 0.000000 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76.98 0.000000 0 C 0 0 76. 99 07699 LI THOTRI PSY 0.000000 0 76.99 OUTPATIENT SERVICE COST CENTERS 4, 594, 527 88.00 08800 RURAL HEALTH CLINIC 44, 916 0.009776 0 88.00 08801 RURAL HEALTH CLINIC II - FHC 88.01 15, 433 571, 111 0.027023 0 0 88.01 90.00 09000 CLI NI C 109, 453 406, 631 0.269170 0 0 90.00 09001 EAST MEDICAL CLINIC 475 475.000000 90. 01 0 0 90.01 111, 135 4, 211, 121 91. 00 09100 EMERGENCY 0.026391 4 868 128 91.00

68, 786

890, 756

4, 768, 588

58, 477, 766

0.014425

66, 576

1, 965, 441

92.00

960

26, 054 200. 00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

200.00

Health Financial Systems MARSHALL BROWNING HOSPITAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1331

In Lieu of Form CMS-2552-10

THROUGH COSTS

Peri od: From 07/01/2022 To 06/30/2023

Worksheet D Part IV Date/Time Prepared: 11/27/2023 12:08 pm

					11/2//2023 12	. 00 piii
			XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	(0	0	50.00
53. 00 05300 ANESTHESI OLOGY	520, 215	0	(0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
60. 00 06000 LABORATORY	0	0	(0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(o	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	0		o	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		o	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		o	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		o	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
73. 01 07301 CARDI AC REHABI LI TATI ON	0	0		0	0	73. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0	0		0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0		0	0	76. 99
OUTPATIENT SERVICE COST CENTERS	•	•		<u>'</u>		1
88. 00 08800 RURAL HEALTH CLINIC	0	0		0	0	88.00
88. 01 08801 RURAL HEALTH CLINIC II - FHC	0	0		0	0	88. 01
90. 00 09000 CLI NI C	0	0		0	0	90.00
90. 01 09001 EAST MEDICAL CLINIC	0	0		0	0	90. 01
91. 00 09100 EMERGENCY	0	0		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			1		0	92.00
200.00 Total (lines 50 through 199)	520, 215	0	1	0	0	200.00
	1/2.0	'	'		ľ	, ,,,,,

Health Financial Systems MARSHALL BROWNING HOSPITAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1331

In Lieu of Form CMS-2552-10

Worksheet D Part IV Date/Time Prepared: 11/27/2023 12:08 pm Peri od: From 07/01/2022 To 06/30/2023 THROUGH COSTS

			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	
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	0	0	0	2, 131, 117		
	O ANESTHESI OLOGY	0	520, 215	0	686, 141	0. 758175	53.00
	O RADI OLOGY-DI AGNOSTI C	0	0	0	13, 245, 714		
	O LABORATORY	0	0	0	11, 522, 818		60.00
	O BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
	O RESPI RATORY THERAPY	0	0	0	2, 684, 660	0. 000000	
	O PHYSI CAL THERAPY	0	0	0	2, 841, 571	0.000000	66.00
	O OCCUPATI ONAL THERAPY	0	0	0	889, 515	0.000000	67.00
68. 00 0680	O SPEECH PATHOLOGY	0	0	0	206, 530	0.000000	68.00
69. 00 0690	O ELECTROCARDI OLOGY	0	0	0	911, 829	0.000000	69.00
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2, 980, 301	0.000000	71.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	0	0	0	5, 543, 536	0.000000	73.00
73. 01 0730	1 CARDIAC REHABILITATION	0	0	0	282, 055	0.000000	73. 01
76. 97 0769	7 CARDIAC REHABILITATION	0	0	0	0	0.000000	76. 97
76. 98 0769	8 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76. 98
76. 99 0769	9 LI THOTRI PSY	0	0	0	0	0.000000	76. 99
	ATIENT SERVICE COST CENTERS						
88. 00 0880	O RURAL HEALTH CLINIC	0	0	0	4, 594, 527	0.000000	88.00
88. 01 0880	1 RURAL HEALTH CLINIC II - FHC	0	0	0	571, 111	0.000000	88. 01
90.00 0900	O CLI NI C	0	0	0	406, 631	0.000000	90.00
90. 01 0900	1 EAST MEDICAL CLINIC	0	0	0	1	0.000000	90. 01
91.00 0910	O EMERGENCY	0	0	0	4, 211, 121	0.000000	91.00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4, 768, 588	0.000000	92.00
200. 00	Total (lines 50 through 199)	0	520, 215	0	58, 477, 766		200. 00

BROWNI

Health Financial Systems In Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1331 Peri od: Worksheet D

From 07/01/2022

Part IV

0 200.00

06/30/2023 Date/Time Prepared: 11/27/2023 12:08 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 Pass-Through Pass-Through to Charges Charges Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col . 12) 13.00 x col. 10) 9. 00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0.000000 50 00 118, 172 0 05300 ANESTHESI OLOGY 0.000000 11, 478 8,702 0 53.00 0 0 0 0 0 0 0 0 0 0 0 05400 RADI OLOGY-DI AGNOSTI C 0.000000 261, 910 54.00 54.00 0 0 06000 LABORATORY 0.000000 0 60.00 60.00 414, 674 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 62.30 0 62.30 06500 RESPIRATORY THERAPY 0.000000 320, 749 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 35, 709 0 66.00 0 06700 OCCUPATI ONAL THERAPY 0.000000 18, 404 67.00 0 67.00 06800 SPEECH PATHOLOGY 68.00 0.000000 2, 292 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 12, 493 0 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 364, 934 0 71.00 0 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 73.00 73.00 333, 182 73.01 07301 CARDIAC REHABILITATION 0.000000 0 73.01 07697 CARDIAC REHABILITATION 0 76. 97 0.000000 0 0 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 76.98 0.000000 0 76.98 0 76. 99 07699 LI THOTRI PSY 0.000000 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0.000000 0 0 0 88.00 08801 RURAL HEALTH CLINIC II - FHC 0 0 0 0 0 0 88. 01 88.01 0.000000 C 0 0 90.00 09000 CLI NI C 0.000000 0 0 90.00 09001 EAST MEDICAL CLINIC 0.000000 0 90.01 90.01 0 91. 00 09100 EMERGENCY 0.000000 4.868 0 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.000000 66, 576 0 0

1, 965, 441

8, 702

THROUGH COSTS

200.00

Total (lines 50 through 199)

Health Financial Systems

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 14-1331 Peri od: Worksheet D

From 07/01/2022

15, 940, 184

06/30/2023

Part V

Date/Time Prepared:

201.00

0 202.00

11/27/2023 12:08 pm Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 4.00 5.00 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 528, 908 50.00 0. 595304 05300 ANESTHESI OLOGY 0. 771615 241, 493 0 53.00 53.00 0 0 05400 RADI OLOGY-DI AGNOSTI C 0. 190799 0 54.00 4, 131, 612 0 54.00 60.00 06000 LABORATORY 0. 234945 3, 491, 365 0 0 0 0 0 0 0 0 0 0 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 62.30 06500 RESPIRATORY THERAPY 0. 378415 65.00 437, 324 0 65.00 06600 PHYSI CAL THERAPY 66.00 0.597963 0 919, 585 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.515069 128, 725 0 67.00 68.00 06800 SPEECH PATHOLOGY 0. 971651 0 9,037 0 68.00 0 06900 ELECTROCARDI OLOGY 0.104850 282, 422 69.00 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.201483 502, 441 0 71.00 07300 DRUGS CHARGED TO PATIENTS 0. 441002 2, 428, 042 0 73.00 73.00 07301 CARDIAC REHABILITATION 0.949545 0 73.01 73 01 123,876 0 07697 CARDIAC REHABILITATION 76. 97 0.000000 0 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0 0 0 0 76.98 07699 LI THOTRI PSY 76.99 0.000000 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 88. 01 08801 RURAL HEALTH CLINIC II - FHC 88.01 90.00 09000 CLI NI C 2.754003 155, 765 0 90.00 0 0 0 0 0 09001 EAST MEDICAL CLINIC 90 01 42, 143. 000000 0 90.01 0 91.00 09100 EMERGENCY 0. 928376 0 1,008,220 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 192561 0 1, 551, 369 0 92.00 200.00 Subtotal (see instructions) 0 15, 940, 184 200.00 0

201.00

202.00

In Lieu of Form CMS-2552-10

Health Financial Systems

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Peri od: Worksheet D
From 07/01/2022 Part V
To 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm
Hospi tal Cost Provider CCN: 14-1331 Title XVIII

			IIIIe	XVIII	Hospi tai	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
ANCI	ILLARY SERVICE COST CENTERS						
50.00 0500	OO OPERATING ROOM	314, 861	0			5	50.00
53.00 0530	OO ANESTHESI OLOGY	186, 340	0			5	53.00
54.00 0540	00 RADI OLOGY-DI AGNOSTI C	788, 307	0)		5	54.00
60.00 0600	00 LABORATORY	820, 279	0			6	50.00
62. 30 062	50 BLOOD CLOTTING FOR HEMOPHILIACS	0	0			6	52. 30
65. 00 0650	00 RESPI RATORY THERAPY	165, 490	0			6	55.00
66.00 0660	00 PHYSI CAL THERAPY	549, 878	0	1		6	66.00
67. 00 0670	OO OCCUPATI ONAL THERAPY	66, 302	0	1		6	57. 00
68. 00 0680	00 SPEECH PATHOLOGY	8, 781	0	1		6	68. 00
69. 00 0690	00 ELECTROCARDI OLOGY	29, 612	0)		6	59. 00
71. 00 0710	OO MEDICAL SUPPLIES CHARGED TO PATIENT	101, 233				7	71. 00
73. 00 0730	OO DRUGS CHARGED TO PATIENTS	1, 070, 771	0			7	73. 00
73. 01 0730	O1 CARDIAC REHABILITATION	117, 626	0			7	73. 01
76, 97 076	97 CARDIAC REHABILITATION	. 0	0			7	76. 97
	98 HYPERBARIC OXYGEN THERAPY	0	0	,		1 7	76. 98
	99 LI THOTRI PSY	0	0	,		1 7	76. 99
	PATIENT SERVICE COST CENTERS						
	OO RURAL HEALTH CLINIC					8	38. 00
	01 RURAL HEALTH CLINIC II - FHC						38. 01
	DO CLINIC	428, 977	0	,			90.00
	01 EAST MEDICAL CLINIC	0	0	,			90. 01
	DO EMERGENCY	936, 007	0	,			91. 00
	OO OBSERVATION BEDS (NON-DISTINCT PART	298, 733	l .	,			92.00
200. 00	Subtotal (see instructions)	5, 883, 197	l .				00.00
201. 00	Less PBP Clinic Lab. Services-Program	0,000,177	l				01.00
	Only Charges					20	
202. 00	Net Charges (line 200 - line 201)	5, 883, 197	0	,		20	02.00
_02.00	1 900 (1 200 1 201)	1 0,000,177	1	1		120	

Health Financial Systems MARSHALL BROWN
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

In Lieu of Form CMS-2552-10

Provider CCN: 14-1331

Component CCN: 14-Z331

Peri od: Worksheet D From 07/01/2022 Part V To 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm Swing Beds - SNF Cost

		Title	XVIII S	wing Beds - SNF	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. 595304	0	0	0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 771615	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 190799	0	0	0	0	54.00
60. 00 06000 LABORATORY	0. 234945	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	0	0	0	62.30
65. 00 06500 RESPIRATORY THERAPY	0. 378415	0	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 597963	0	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 515069	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 971651	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 104850	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 201483	0	l o	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 441002	0	0	0	0	73.00
73. 01 07301 CARDI AC REHABI LI TATI ON	0. 949545	0	l o	0	0	73. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	l o	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	l e	0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0	0	0	0	76, 99
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC						88.00
88.01 08801 RURAL HEALTH CLINIC II - FHC						88. 01
90. 00 09000 CLINIC	2. 754003	0	0	0	0	90.00
90. 01 09001 EAST MEDICAL CLINIC	42, 143. 000000		0	0	0	90. 01
91. 00 09100 EMERGENCY	0. 928376		0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 192561	0	0	0	0	92.00
200.00 Subtotal (see instructions)	0. 172001	0	0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program		Ĭ	0	0		201.00
Only Charges			Ĭ			
202.00 Net Charges (line 200 - line 201)		0	0	0	0	202.00
	l .	1	١	١	Ü	

In Lieu of Form CMS-2552-10

Health Financial Systems MARSHALL BROWN
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Peri od: Worksheet D From 07/01/2022 Part V To 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm Provider CCN: 14-1331 Component CCN: 14-Z331 Title XVIII Swing Beds - SNF Cost

				E XVIII SWITING BEUS - SIVE COS	ι
			sts		
	Cost Center Description	Cost	Cost		
		Rei mbursed	Rei mbursed		
		Servi ces	Services Not		
		Subject To	Subject To		
		Ded. & Coins.	Ded. & Coins.		
		(see inst.)	(see inst.)		
		6. 00	7. 00		
	CILLARY SERVICE COST CENTERS				
	OOO OPERATING ROOM	0	0		50.00
	300 ANESTHESI OLOGY	0	0		53.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	0	0		54.00
60.00 06	000 LABORATORY	0	0		60.00
62. 30 06:	250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62. 30
65.00 06	500 RESPI RATORY THERAPY	0	0		65. 00
66. 00 06	600 PHYSI CAL THERAPY	0	0		66.00
67. 00 06	700 OCCUPATIONAL THERAPY	0	0		67.00
68. 00 06	800 SPEECH PATHOLOGY	0	0		68. 00
69. 00 06	900 ELECTROCARDI OLOGY	0	0		69.00
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
73. 00 07	300 DRUGS CHARGED TO PATIENTS	0	0		73.00
73. 01 07	301 CARDI AC REHABI LI TATI ON	0	0		73. 01
76. 97 07	697 CARDI AC REHABI LI TATI ON	0	0		76. 97
76. 98 07	698 HYPERBARIC OXYGEN THERAPY	0	0		76. 98
76. 99 07	699 LI THOTRI PSY	0	0		76. 99
OU ⁻	TPATIENT SERVICE COST CENTERS	•	•		
88. 00 08	800 RURAL HEALTH CLINIC				88. 00
88. 01 08	801 RURAL HEALTH CLINIC II - FHC				88. 01
90.00 09	000 CLI NI C	0	0		90.00
90. 01 090	001 EAST MEDICAL CLINIC	0	0		90. 01
	100 EMERGENCY	0	0		91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART	1 0	l o		92.00
200.00	Subtotal (see instructions)	0	l o		200.00
201.00	Less PBP Clinic Lab. Services-Program	1 0			201. 00
	Only Charges	1			
202. 00	Net Charges (line 200 - line 201)	0	0		202. 00
1		1	1	T. Control of the Con	

Health Financial Sy	ystems S	ΓΑΊ	MARSHALL BROWNING	G-HOSPI TAL	P'	Y
ADDODTI ONMENT OF LI	NDATIENT DOUTINE	SEDVICE CADITAL	COCTC	Drovi dor CCN.	1/ 1221	Dori od:

In Lieu of Form CMS-2552-10 Worksheet D Part I Date/Time Prepared: Peri od: From 07/01/2022 To 06/30/2023 APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS 11/27/2023 12:08 pm Hospital Total Patient Title XIX Cost Center Description Capi tal Swi ng Bed Reduced Per Diem (col. 3 / col. 4) Related Cost Adjustment Capi tal Days $(\hbox{from Wkst}.$ Related Cost (col. 1 -col. 2) B, Part II, col. 26) 3.00 1. 00 2.00 4. 00 5. 00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 ADULTS & PEDIATRICS 449, 404 256, 533 192, 871 1, 273 151. 51 30.00 200.00 Total (lines 30 through 199) 449, 404 192, 871 1, 273 200.00 Cost Center Description Inpatient I npati ent Program days Program Capital Cost (col. 5 x col. 6) 6. 00 7. 00 INPATIENT ROUTINE SERVICE COST CENTERS 2 30.00 ADULTS & PEDIATRICS 303 30.00 200.00 Total (lines 30 through 199) 303 200.00

eal th Financial Systems STATE BROWNING HOSPITAL

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 14-1331 Period: From 07/01/2022 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

					10 00/30/2023	11/27/2023 12	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	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	, ,				,	
	05000 OPERATING ROOM	125, 306		1		0	50.00
53.00		474		1		0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	68, 745		l .		0	54.00
60.00		85, 003	11, 522, 818			0	60.00
62. 30		0	0	0. 00000		0	62. 30
65. 00		64, 412	2, 684, 660	1		0	65.00
	06600 PHYSI CAL THERAPY	90, 254		1		0	66. 00
	06700 OCCUPATI ONAL THERAPY	18, 938				0	67. 00
68. 00		5, 441	206, 530	1		0	68. 00
	06900 ELECTROCARDI OLOGY	3, 136		1		0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 380	2, 980, 301	0. 00281	2 0	0	71.00
	07300 DRUGS CHARGED TO PATIENTS	53, 923	5, 543, 536	0. 00972	7 0	0	73.00
73. 01	07301 CARDI AC REHABI LI TATI ON	16, 546	282, 055	0. 05866	2 0	0	73. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0. 00000	0 0	0	76. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0. 00000	0 0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0. 00000	0 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	44, 916	4, 594, 527			0	00.00
88. 01	08801 RURAL HEALTH CLINIC II - FHC	15, 433	571, 111	0. 02702	3 0	0	88. 01
90.00	09000 CLI NI C	109, 453	406, 631	0. 26917	0 0	0	90.00
90. 01		475	1	475. 00000	0 0	0	90. 01
91.00	09100 EMERGENCY	111, 135	4, 211, 121	0. 02639	1 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	68, 786	4, 768, 588	0. 01442	5 0	0	92.00
200. 0	O Total (lines 50 through 199)	890, 756	58, 477, 766	1	0	0	200. 00

Health Financial Systems	STA	MARS	HALL BROWNING	HOSPLTAL	b,	Y	In
near th i i nanoral bystoms		140 (1 (5)	TIVLE DICOMINITION	10011111			
ADDODIL ONMENT OF INDATIENT DO	OUTLINE CEDVI OF	OTHER DACC T	UDOLLOU COCTO	Describilities CON 1	4 1001	D =! = -I	

Peri od: From 07/01/2022 To 06/30/2023 Worksheet D Part III Date/Time Prepared: APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1331 11/27/2023 12:08 pm Title XIX Hospi tal Cost Center Description Nursi ng Allied Health Allied Health All Other Nursi ng Post-Stepdown Cost Medi cal Program Program Post-Stepdown Adjustments Educati on Adjustments Cost 1.00 2A 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 30.00 0 0 200.00 Total (lines 30 through 199) 0 200.00 Cost Center Description Swi ng-Bed Total Costs Total Patient Per Diem I npati ent (sum of cols. Days Program Days Adjustment (col. 5 ÷ Amount (see 1 through 3, col. 6) instructions) minus col. 4) 7.00 8.00 4.00 5.00 6.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 0.00 0 1, 273 30.00 Total (lines 30 through 199) 2 200. 00 200.00 1, 273 Cost Center Description I npati ent Program Pass-Through Cost (col. x col. 8) 9.00 INPATIENT ROUTINE SERVICE COST CENTERS 0 30. 00 03000 ADULTS & PEDIATRICS 30.00

Lieu of Form CMS-2552-10

200.00

200.00

Total (lines 30 through 199)

Health Financial Systems MARSHALL BROWNING HOSPITAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1331

In Lieu of Form CMS-2552-10

THROUGH COSTS

Peri od: From 07/01/2022 To 06/30/2023

Worksheet D Part IV Date/Time Prepared: 11/27/2023 12:08 pm

					11/2//2020 12	. 00 piii
		Ti tl	Title XIX F		PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	(0	0	50.00
53. 00 05300 ANESTHESI OLOGY	520, 215	0	(0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
60. 00 06000 LABORATORY	0	0	(0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0	62.30
65. 00 06500 RESPIRATORY THERAPY	0	0	(0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	(0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	(0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73.00
73. 01 07301 CARDI AC REHABI LI TATI ON	0	0	(0	0	73. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	(0	0	76. 97
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0	0	(0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	(0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	(0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II - FHC	0	0	(0	0	88. 01
90. 00 09000 CLI NI C	0	0	(0	0	90.00
90.01 09001 EAST MEDICAL CLINIC	0	0	(0	0	90. 01
91. 00 09100 EMERGENCY	0	0	(0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	92.00
200.00 Total (lines 50 through 199)	520, 215	0	(0	0	200. 00
	•	•	•	•	•	•

ealth Financial Systems MARSHALL BROWNING HOSPITAL In L

Heal th Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1331 Period: Worksheet D
From 07/01/2022 To 06/30/2023 Part IV
Date/Time Prepared: 11/27/2023 12:08 pm

					11/2//2023 12	:08 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col . 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS				_		
50.00 05000 OPERATING ROOM	0	0	(2, 131, 117		1
53. 00 05300 ANESTHESI OLOGY	0	520, 215	(686, 141	l .	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(13, 245, 714		54.00
60. 00 06000 LABORATORY	0	0	(11, 522, 818		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0.000000	
65. 00 06500 RESPI RATORY THERAPY	0	0	(2, 684, 660		
66. 00 06600 PHYSI CAL THERAPY	0	0	(2, 841, 571	l e	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(889, 515		67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	(206, 530		
69. 00 06900 ELECTROCARDI OLOGY	0	0	(911, 829	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(2, 980, 301		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	(5, 543, 536		73.00
73. 01 07301 CARDI AC REHABI LI TATI ON	0	0	(282, 055	l e	1
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	(0	0.000000	1
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0	0	(0	0.000000	
76. 99 07699 LI THOTRI PSY	0	0	(0	0.000000	76. 99
OUTPATIENT SERVICE COST CENTERS				T		
88. 00 08800 RURAL HEALTH CLINIC	0	0	(4, 594, 527		
88.01 08801 RURAL HEALTH CLINIC II - FHC	0	0	(571, 111	•	88. 01
90. 00 09000 CLI NI C	0	0	(406, 631		
90.01 09001 EAST MEDICAL CLINIC	0	0	() 1	0.000000	1
91. 00 09100 EMERGENCY	0	0	(4, 211, 121	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(4, 768, 588		1
200.00 Total (lines 50 through 199)	0	520, 215	(58, 477, 766		200. 00

Health Financial Systems MARSHALL BROWNING HOSPITAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1331

In Lieu of Form CMS-2552-10

Peri od: Worksheet D
From 07/01/2022 Part IV
To 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm THROUGH COSTS

			 		11/2//2023 12.00 piii	
		Ti tl	Title XIX		Hospi tal PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		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	0	0	0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0	0	0	0	54.00
60. 00 06000 LABORATORY	0. 000000	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	0	0	0	62.30
65. 00 06500 RESPIRATORY THERAPY	0. 000000	0	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0	0	0	0	73.00
73. 01 07301 CARDIAC REHABILITATION	0. 000000	0	0	0	0	73. 01
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0	0	0	0	76. 99
OUTPATLENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II - FHC	0. 000000	0	0	0	0	88. 01
90. 00 09000 CLI NI C	0. 000000	0	0	0	0	90.00
90.01 09001 EAST MEDICAL CLINIC	0. 000000	0	0	0	0	90. 01
91. 00 09100 EMERGENCY	0. 000000	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	0	0	0	92.00
200.00 Total (lines 50 through 199)		0	0	0	0	200.00
		•	•	•	•	•

Heal th Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1331
Period:
From 07/01/2022
To 06/30/2023
Date/Time Prepared:
11/27/2023 12:08 pm

		Title XVIII	Hospi tal	Cost	. 00 piii	
	Cost Center Description					
	DART I ALL DROWNER COMPONENTS			1. 00		
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed day	s. excludina newborn)		3, 192	1.00	
2.00) Inpatient days (including private room days, excluding swing-bed and newborn days) 1,2					
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, 0 3.					
	do not complete this line.			0.4.0		
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		21 of the cost	819 880	4. 00 5. 00	
5.00	reporting period	olli days) tili odgi becelliber	31 of the cost	000	5.00	
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December 31	of the cost	788	6. 00	
	reporting period (if calendar year, enter 0 on this line)					
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December 3	31 of the cost	125	7. 00	
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 31	of the cost	126	8. 00	
0.00	reporting period (if calendar year, enter 0 on this line)	iii days) arter becember 31	or the cost	120	0.00	
9.00	Total inpatient days including private room days applicable t	o the Program (excluding s	swing-bed and	576	9. 00	
40.00	newborn days) (see instructions)				40.00	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		om days)	680	10. 00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		m days) after	647	11. 00	
	December 31 of the cost reporting period (if calendar year, e		days) ares.	317	00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private	room days)	0	12.00	
40.00	through December 31 of the cost reporting period	Variable Charles Barrier and Charles			40.00	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13. 00	
14. 00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed da	ıvs)	0	14. 00	
15. 00	Total nursery days (title V or XIX only)	(.5-7	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 service reporting period	es through December 31 of	the cost		17. 00	
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of th	ne cost		18. 00	
	reporting period					
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of t	he cost	195. 99	19. 00	
20.00	reporting period	ft D 21 -f th-		200 71	20.00	
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of the	e cost	209. 71	20. 00	
21. 00	Total general inpatient routine service cost (see instruction	s)		5, 999, 289	21. 00	
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost reportin	ng period (line	0	22.00	
	5 x line 17)					
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	23. 00	
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporting	period (line	24, 499	24. 00	
200	7 x line 19)	. c. c. the edst reporting	, por ou (21,177	21100	
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting p	eriod (line 8	26, 423	25. 00	
27 00	x line 20)			2 424 570	27 00	
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 424, 569 2, 574, 720		
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	(Tric 21 millus Tric 20)		2, 314, 120	27.00	
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed char	ges)	0	28. 00	
	Private room charges (excluding swing-bed charges)			0		
30.00	Semi -pri vate room charges (excluding swing-bed charges)	11 20)		0	30.00	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ IIne 28)		0. 000000 0. 00		
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00		
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instructi	ons)	0. 00		
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	35.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36.00	
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost diff	erential (line	2, 574, 720	37. 00	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS				
38. 00	Adjusted general inpatient routine service cost per diem (see			2, 022. 57	38. 00	
39. 00	Program general inpatient routine service cost (line 9 x line	•		1, 165, 000		
40.00	Medically necessary private room cost applicable to the Progr			1 165 000	40.00	
41.00	Total Program general inpatient routine service cost (line 39	+ 111le 40)		1, 165, 000	41.00	

Heal th Financial Systems

COMPUTATION OF INPATIENT OPERATING COST

MARSHALL BROWNING HOSPITAL

Provider CCN: 14-1331 | Period:

In Lieu of Form CMS-2552-10

Worksheet D-1

From 07/01/2022 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm Title XVIII Hospi tal Cost Cost Center Description Total Total Average Per Program Days Program Cost (col. 3 x Inpati ent Inpati ent Diem (col. Cost Days ÷ col. 2) col. 4) 1.00 2.00 3.00 4.00 5.00 42.00 NURSERY (title V & XIX only) 42.00 Intensive Care Type Inpatient Hospital Units 43 00 INTENSIVE CARE UNIT 43 00 44.00 CORONARY CARE UNIT 44.00 BURN INTENSIVE CARE UNIT 45.00 45.00 46.00 SURGICAL INTENSIVE CARE UNIT 46.00 OTHER SPECIAL CARE (SPECIFY) 47.00 47.00 Cost Center Description 1 00 48.00 48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 620, 149 48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 48 01 Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions) 1, 785, 149 49.00 PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and 50.00 50.00 0 $\Pi\Pi$ 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II 0 51.00 and IV) Total Program excludable cost (sum of lines 50 and 51) 52.00 52.00 0 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 53.00 0 53.00 medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program di scharges 54.00 55.00 Target amount per discharge 0.00 55.00 55.01 Permanent adjustment amount per discharge 0.00 55.01 0.00 55.02 Adjustment amount per discharge (contractor use only) Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 56.00 56, 00 0 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57 00 Bonus payment (see instructions) 58.00 0 58.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, 0.00 59.00 59.00 updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the 0.00 60.00 60.00 market basket) Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 0 61.00 61.00 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62.00 Relief payment (see instructions) 0 62.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 1, 375, 348 64.00 64.00 instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See 1, 308, 603 65.00 65.00 instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for 2, 683, 951 66.00 66.00 CAH, see instructions Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period 67.00 0 67.00 (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period 68.00 68.00 0 (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 69.00 69.00 0 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 70.00 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 72.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 73.00 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 74.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 75.00 75.00 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) 76.00 76.00 77.00 Program capital-related costs (line 9 x line 76) 77.00 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79 00 79 00 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 81.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82 00 82 00 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 84.00 Program inpatient ancillary services (see instructions) 84.00 85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 454 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 2, 022. 56 88. 00 Heal th Fi nanci al Systems

MARSHALL BROWNING HOSPITAL

ONLY HEALTH OF THE STATE O

In Lieu of Form CMS-2552-10 COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 14-1331 Worksheet D-1 Peri od: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm Title XVIII Hospi tal Cost Cost Center Description 1.00 918, 242 89.00 Observation bed cost (line 87 x line 88) (see instructions) 89.00 Cost Center Description Routine Cost column 1 ÷ Total Observati on (from line column 2 Observati on Bed Pass Bed Cost Through Cost 21) (col. 3 x col. 4) (see (from line 89) instructions) 1. 00 2.00 3.00 4. 00 5. 00 COMPUTATION OF OBSERVATION BED PASS THROUGH COST 90.00 0. 074910 90.00 Capital-related cost 449, 404 5, 999, 289 918, 242 68, 786 91.00 Nursing Program cost 0 5, 999, 289 0.000000 918, 242 0 91.00 5, 999, 289 5, 999, 289 0 92.00 Allied health cost 0.000000 918, 242 0 92.00 93.00 All other Medical Education 0.000000 0 93.00 918, 242

Health Financial Systems

COMPUTATION OF INPATIENT OPERATING COST In Lieu of Form CMS-2552-10
Worksheet D-1

Peri od: From 07/01/2022 To 06/30/2023 Date/Ti me Prepared: 11/27/2023 12:08 pm PPS Provider CCN: 14-1331 Title XIX

		Title XIX Hospital	PPS	
	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 day	ys, excluding newborn)	3, 192	1.00
2.00	Inpatient days (including private room days, excluding swing-		1, 273	2.00
3.00	Private room days (excluding swing-bed and observation bed days	ays). If you have only private room days	6,	3.00
	do not complete this line.			
4. 00	Semi-private room days (excluding swing-bed and observation between the contraction between the contra		819	4.00
5. 00	Total swing-bed SNF type inpatient days (including private reporting period	oom days) through December 31 of the cos	st 880	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private ro	nom days) after December 31 of the cost	788	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days, area becomber or or the east	700	0.00
7.00	Total swing-bed NF type inpatient days (including private roo	om days) through December 31 of the cost	125	7. 00
	reporting period			
8. 00	Total swing-bed NF type inpatient days (including private roo	om days) after December 31 of the cost	126	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	to the Dreamen (evaluating swing had and		0 00
9. 00	Total inpatient days including private room days applicable 1 newborn days) (see instructions)	to the Program (excruding swing-bed and	2	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instruc			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, e			40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including private room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private room days)	0	13. 00
10.00	after December 31 of the cost reporting period (if calendar y			10.00
14.00	Medically necessary private room days applicable to the Progr		0	14.00
15. 00	Total nursery days (title V or XIX only)		0	
16. 00	Nursery days (title V or XIX only)		0	16. 00
17 00	SWING BED ADJUSTMENT	cos through Dosombor 21 of the cost		17 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces through becember 31 of the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of the cost		18. 00
	reporting period			
19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of the cost	195. 99	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of the cost	209. 71	20. 00
20.00	reporting period	arter becomber 31 of the cost	207.71	20.00
21.00	Total general inpatient routine service cost (see instruction	ns)	5, 999, 289	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost reporting period (lir	ne O	22. 00
00.00	5 x line 17)	24 - 6 11 1 11 1 - 1		00.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting period (The	6 0	23. 00
24. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporting period (line	24, 499	24. 00
	7 x line 19)	3 1 1 1		
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting period (line 8	26, 423	25. 00
27 00	x line 20)		2 424 5/0	27.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)	3, 424, 569 2, 574, 720	
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	(TTHE 21 IIITHUS TTHE 20)	2,314,120	27.00
28.00	General inpatient routine service charges (excluding swing-be	ed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		0	
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	
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	•
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instructions)	0.00	•
35.00	Average per diem private room cost differential (line 34 x li		0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost differential (lir	2, 574, 720	
	27 minus line 36)	·		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	HICTMENTS		
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		2 022 54	38. 00
38.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line		2, 022. 56 4, 045	
40.00	Medically necessary private room cost applicable to the Progr	,	0	
	Total Program general inpatient routine service cost (line 39	,	4, 045	41.00

Heal th Fi nanci al Systems MARSHALL BROWNING HOSPITAL

In Lieu of Form CMS-2552-10 COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 14-1331 Peri od: Worksheet D-1 From 07/01/2022 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm Title XIX Hospi tal Average Per Cost Center Description Total Total Program Days Program Cost (col. 3 x Inpati ent Inpati ent Diem (col. Cost Days ÷ col. 2) col. 4) 1.00 2.00 3.00 4.00 5.00 42.00 NURSERY (title V & XIX only) 42.00 Intensive Care Type Inpatient Hospital Units 43 00 INTENSIVE CARE UNIT 43 00 44.00 CORONARY CARE UNIT 44.00 BURN INTENSIVE CARE UNIT 45.00 45.00 46.00 SURGICAL INTENSIVE CARE UNIT 46.00 OTHER SPECIAL CARE (SPECIFY) 47.00 47.00 Cost Center Description 1.00 48. 00 48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 0 48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) Λ 48 01 Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions) 4,045 49.00 PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and 50.00 50.00 303 $\Pi\Pi$ 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II 0 51.00 and IV) Total Program excludable cost (sum of lines 50 and 51) 303 52.00 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 53.00 3, 742 53.00 medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program di scharges n 54.00 55.00 Target amount per discharge 0.00 55.00 55.01 Permanent adjustment amount per discharge 0.00 55.01 Adjustment amount per discharge (contractor use only) 0.00 55.02 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 56.00 56,00 0 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 Bonus payment (see instructions) 58.00 0 58.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, 0.00 59.00 59.00 updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the 0.00 60.00 60.00 market basket) Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 0 61.00 61.00 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62.00 62.00 Relief payment (see instructions) 0 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 64.00 0 64.00 instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See 0 65.00 65.00 instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for 0 66.00 66.00 CAH, see instructions Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period 67.00 0 67.00 (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period 0 68.00 68.00 (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 69.00 69.00 0 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 70.00 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 72.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 73.00 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 74.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 75.00 75.00 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) 76.00 76.00 77.00 Program capital-related costs (line 9 x line 76) 77.00 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79 00 79 00 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 81.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82 00 82 00 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 84.00 Program inpatient ancillary services (see instructions) 84.00 85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 86.00

454

2, 022. 56 88. 00

87.00

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

Total observation bed days (see instructions)

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MARSHALL BROWNING HOSPITAL

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COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 14-1331 Worksheet D-1 Peri od: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm Title XIX Hospi tal PPS Cost Center Description 1.00 89.00 Observation bed cost (line 87 x line 88) (see instructions) 918, 242 89.00 Cost Center Description Routine Cost column 1 ÷ Total Observati on (from line column 2 Observati on Bed Pass Bed Cost Through Cost 21) (col. 3 x col. 4) (see (from line 89) instructions) 1. 00 2.00 3.00 4. 00 5. 00 COMPUTATION OF OBSERVATION BED PASS THROUGH COST 90.00 0. 074910 90.00 Capital-related cost 449, 404 5, 999, 289 918, 242 68, 786 91.00 Nursing Program cost 0 5, 999, 289 0.000000 918, 242 0 91.00 5, 999, 289 5, 999, 289 0 92.00 Allied health cost 0.000000 918, 242 0 92.00 93.00 All other Medical Education 0.000000 0 93.00 918, 242

In Lieu of Form CMS-2552-10

Heal th Fi nancial Systems MARSHALL BROWNING HOSPITAL

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provi der CCN: 14-1331 Peri od: Worksheet D-3 From 07/01/2022 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm Title XVIII Hospi tal Cost Cost Center Description Inpati ent Ratio of Cost Inpati ent To Charges Program Costs Program Charges (col. 1 x col. 2) 1.00 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 30.00 646, 944 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0.595304 118, 172 70, 348 50.00 53.00 05300 ANESTHESI OLOGY 0.771615 11, 478 8, 857 53.00 261, 910 05400 RADI OLOGY-DI AGNOSTI C 0.190799 49, 972 54.00 54.00 60.00 06000 LABORATORY 0.234945 414, 674 97, 426 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 62.30 06500 RESPIRATORY THERAPY 0.378415 320, 749 121, 376 65.00 65.00 06600 PHYSI CAL THERAPY 0.597963 35, 709 66.00 21, 353 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.515069 18, 404 9, 479 67.00 68.00 06800 SPEECH PATHOLOGY 0. 971651 2, 292 2, 227 68.00 12, 493 1, 310 06900 ELECTROCARDI OLOGY 69.00 0.104850 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0.201483 364, 934 73, 528 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.441002 333, 182 146, 934 73.00 73. 01 07301 CARDIAC REHABILITATION 0.949545 0 0 73.01 07697 CARDIAC REHABILITATION 76.97 0.000000 76.97 0 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0.000000 0 0 76.98 76. 99 07699 LI THOTRI PSY 0.000000 0 0 76. 99 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 88.01 08801 RURAL HEALTH CLINIC II - FHC 0.000000 0 88.01 09000 CLI NI C 90.00 2.754003 0 0 90.00 90 01 09001 EAST MEDICAL CLINIC 42. 143. 000000 90.01 0 0 09100 EMERGENCY 4, 519 91.00 0.928376 4, 868 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.192561 66, 576 12, 820 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 1, 965, 441 620, 149 200, 00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 201.00

In Lieu of Form CMS-2552-10

1, 965, 441

202.00

202.00

Net charges (line 200 minus line 201)

eal th Fi nanci al Systems MARSHALL BROWNING HOSPITAL

Heal th Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1331
Component CCN: 14-2331

Period: From 07/01/2022
To 06/30/2023
Date/Time Prepared: 11/27/2023 12:08 pm

				11/2//2023 12	:08 pm
		Title XVIII	Swing Beds - SN	Cost	
Cost Center De	escription	Ratio of (Cost Inpatient	I npati ent	
		To Charg	es Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
		1.00	2.00	3. 00	
INPATIENT ROUTINE S	ERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIA	ATRI CS				30.00
ANCILLARY SERVICE C	OST CENTERS				
50. 00 05000 OPERATING ROOM	Л	0. 59	5304	0	50.00
53. 00 05300 ANESTHESI OLOG	(0. 77	1615 (0	53.00
54. 00 05400 RADI OLOGY-DI AG	GNOSTIC	0. 19	0799 75, 960	14, 493	54.00
60. 00 06000 LABORATORY		0. 23	4945 424, 284	99, 683	60.00
62. 30 06250 BLOOD CLOTTING	G FOR HEMOPHILIACS	0.00	0000	0	62.30
65. 00 06500 RESPIRATORY TH	HERAPY	0. 37	8415 702, 415	265, 804	65.00
66. 00 06600 PHYSI CAL THERA	APY	0. 59	7963 228, 347	136, 543	66.00
67. 00 06700 OCCUPATI ONAL	THERAPY	0. 51	5069 224, 634	115, 702	67.00
68. 00 06800 SPEECH PATHOLO	DGY	0. 97	1651 4, 068	3, 953	68. 00
69. 00 06900 ELECTROCARDI OI	_OGY	0. 10	4850 10, 732	1, 125	69.00
71. 00 07100 MEDI CAL SUPPLI	ES CHARGED TO PATIENT	0. 20	1483 304, 583	61, 368	71.00
73. 00 07300 DRUGS CHARGED	TO PATIENTS	0. 44	1002 583, 998	257, 544	73.00
73. 01 07301 CARDI AC REHABI	LI TATI ON	0. 94	9545	0	73. 01
76. 97 07697 CARDI AC REHABI	LI TATI ON	0.00	0000	0	76. 97
76. 98 07698 HYPERBARI C 0X	GEN THERAPY	0.00	0000	0	76. 98
76. 99 07699 LI THOTRI PSY		0.00	0000	0	76. 99
OUTPATIENT SERVICE	COST CENTERS				
88.00 08800 RURAL HEALTH (CLINIC	0.00	0000	0	88. 00
88. 01 08801 RURAL HEALTH (CLINIC II - FHC	0.00	0000	0	88. 01
90. 00 09000 CLINIC		2. 75	4003	0	90.00
90. 01 09001 EAST MEDICAL (CLINIC	42, 143. 00	0000	0	90. 01
91.00 09100 EMERGENCY		0. 92	8376	0	91.00
92. 00 09200 OBSERVATION BI	EDS (NON-DISTINCT PART	0. 19.	2561 (0	92.00
200.00 Total (sum of	lines 50 through 94 and 96 through 98)		2, 559, 021	956, 215	200. 00
201.00 Less PBP Clini	c Laboratory Services-Program only charges	(line 61))	201. 00
202.00 Net charges (I	ine 200 minus line 201)		2, 559, 021		202. 00

Health Financial Systems

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provi der CCN: 14-1331 Peri od: Worksheet D-3 From 07/01/2022 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm Title XIX Hospi tal Cost Center Description Ratio of Cost Inpati ent Inpati ent To Charges Program Costs Program (col. 1 x Charges col. 2) 1.00 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 30.00 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0.595304 0 50.00 0 53.00 05300 ANESTHESI OLOGY 0.771615 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.190799 54.00 54.00 0 60.00 06000 LABORATORY 0. 234945 0 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 62.30 06500 RESPIRATORY THERAPY 0.378415 0 65.00 65.00 06600 PHYSI CAL THERAPY 0.597963 0 66.00 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.515069 0 67.00 68.00 06800 SPEECH PATHOLOGY 0. 971651 0 68.00 06900 ELECTROCARDI OLOGY 69.00 0.104850 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0.201483 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.441002 0 73.00 07301 CARDIAC REHABILITATION 0 73. 01 0.949545 73.01 07697 CARDIAC REHABILITATION 76.97 0.000000 0 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0.000000 0 76.98 76. 99 07699 LI THOTRI PSY 0.000000 0 0 76. 99 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.756684 0 0 88.00 0 88.01 08801 RURAL HEALTH CLINIC II - FHC 2.147500 0 88.01 09000 CLI NI C 90.00 2.754003 0 0 0 0 90.00 90 01 09001 EAST MEDICAL CLINIC 42. 143. 000000 Ω 90.01 09100 EMERGENCY 91.00 91.00 0.928376 0

0.192561

In Lieu of Form CMS-2552-10

0 92.00

0 200, 00

201.00

202.00

0

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

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

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

200.00

201.00

202.00

Health Financial Systems

In Lieu of Form CMS-2552-10 CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 14-1331 Peri od: Worksheet E From 07/01/2022 Part B Date/Time Prepared:

06/30/2023

0 94.00

11/27/2023 12:08 pm Title XVIII Hospi tal Cost 1.00 PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) 5, 883, 197 Medical and other services reimbursed under OPPS (see instructions) 2.00 0 2.00 OPPS or REH payments 3.00 0 3 00 4.00 Outlier payment (see instructions) 0 4.00 4.01 Outlier reconciliation amount (see instructions) 0 4.01 5.00 Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.00 6.00 Line 2 times line 5 0 6.00 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 0.00 7.00 8.00 Transitional corridor payment (see instructions) 0 8.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 9 00 9 00 0 10.00 Organ acquisitions 0 10.00 Total cost (sum of lines 1 and 10) (see instructions) 5, 883, 197 11.00 11.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 0 12.00 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 0 13.00 14.00 Total reasonable charges (sum of lines 12 and 13) 0 14.00 Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 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 17.00 18.00 Total customary charges (see instructions) 0 18.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 0 19.00 instructions) 20 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 20 00 0 instructions) 21.00 Lesser of cost or charges (see instructions) 5, 942, 029 21.00 22.00 Interns and residents (see instructions) 0 22.00 Cost of physicians' services in a teaching hospital (see instructions) 23.00 0 23.00 Total prospective payment (sum of lines 3, 24.00 4. 4.01. 8 and 9) 0 24.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions) 25.00 59, 840 25.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2, 474, 026 26.00 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 3, 408, 163 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 REH facility payment amount 28.50 28.50 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) Λ 29.00 30.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 3, 408, 163 30.00 Primary payer payments 31.00 31.00 3, 408, 163 Subtotal (line 30 minus line 31) 32.00 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) 33.00 372, 715 34.00 Allowable bad debts (see instructions) 34.00 Adjusted reimbursable bad debts (see instructions) 35.00 242, 265 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 372, 715 36.00 37.00 Subtotal (see instructions) 3, 650, 428 37.00 38 00 MSP-LCC reconciliation amount from PS&R 38 00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.50 39. 75 N95 respirator payment adjustment amount (see instructions) 39.75 39 97 39 97 Demonstration payment adjustment amount before sequestration 0 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 3, 650, 428 40.00 Sequestration adjustment (see instructions) 40.01 73,009 40 01 40.02 Demonstration payment adjustment amount after sequestration 40.02 40.03 Sequestration adjustment-PARHM pass-throughs 40.03 41.00 Interim payments 3, 609, 026 41.00 Interim payments-PARHM 41.01 41.01 Tentative settlement (for contractors use only) 42.00 42.00 Tentative settlement-PARHM (for contractor use only) 42.01 42.01 -31, 607 43.00 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 0 44.00 §115. 2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 90.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 92.00 The rate used to calculate the Time Value of Money 0.00 Time Value of Money (see instructions) 93.00 93.00 0

Total (sum of lines 91 and 93)

94.00

Heal th Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1331 | Period: From 07/01/2022 | Part B Date/Time Prepared: 11/27/2023 12:08 pm

Title XVIII | Hospital | Cost | Co

0 200. 00

MEDICARE PART B ANCILLARY COSTS 200.00 Part B Combined Billed Days Health Financial Systems MARSHANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

In Lieu of Form CMS-2552-10

Peri od: | Worksheet E-1
From 07/01/2022 | Part |
To 06/30/2023 | Date/Time Prepared: | 11/27/2023 12:08 pm |
Hospi tal | Cost Provider CCN: 14-1331

Title XVIII						11/27/2023 12	08 pm
1.00					Hospi tal	Cost	
1.00 Total interim payments paid to provider 1.480,084 3.609,026 1.00 2.00 1.100 1.100 1.100 1.100 2.00 3.00 4.00 2.00 1.100 1.100 1.100 2.00 3.00 4.00 2.00 1.100 3.609,026 1.00 2.00 3.609,026 1.00 3.609,026 1.00 3.609,026 1.00 3.00			I npati er	nt Part A	Pai	-t B	
Total interim payments paid to provider 1,480,084 3,609,026 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.			1.00				
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 70 70 70 70 70 70 70 7				1, 480, 08	4	3, 609, 026	
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero (1)	2.00				O	0	2.00
write "NONE" or enter a zero							
List separately each retroactive Lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
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)	2 00						2 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	3.00						3.00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider ADJUSTMENTS TO PROVIDER 0 0 0 3.01 3.01							
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02 3.03 3.04 0 0 0 3.02 3.03 3.04 3.05 3.03 3.04 3.05 3.	3 01)	0	3 01
3.03 3.04 3.05 3.04 3.05 3.04 3.05 3.04 3.05		THE TO THE TELL		1			
3.05 Provider to Program					o o	0	
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.50	3. 04				o	0	3. 04
3. 50 ADJUSTMENTS TO PROGRAM	3.05				0	0	3.05
3.51 3.52 3.53 0 0 0 3.51 3.52 3.53 0 0 0 3.53 3.54 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 3.50-3.98 1.480,084 3.609,026 4.00 4.		Provider to Program					
3.52	3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.53 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.55 3.59 3.50-3.98 3.50-3.98 3.50-3.98 3.50-3.98 3.609,026 4.00 4.0							
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,480,084 3,609,026 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR				1	~		
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98) 1.480,084 3.609,026 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 1.480,084 3.609,026 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 1.480,084 3.609,026 4.00					-		
3. 50-3. 98 Total interim payments (sum of lines 1, 2, and 3. 99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					-		
1,480,084 3,609,026 4.00	3. 99				O	0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR				4 400 00		0 (00 00)	
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			1, 480, 08	4	3, 609, 026	4.00
To BE COMPLETED BY CONTRACTOR							
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5 00			I			5 00
Write "NONE" or enter a zero. (1) Program to Provider	0.00						0.00
Program to Provider							
Solition Solition				•	•	•	
Tentative to Program	5. 01	TENTATI VE TO PROVI DER			O	0	5. 01
Provider to Program	5.02					0	5.02
TENTATI VE TO PROGRAM	5. 03				O	0	5.03
5.51 0							
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.52 0		TENTATI VE TO PROGRAM		1			
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 93,038 0 6. 01 6. 02 SETTLEMENT TO PROGRAM 0 31,607 6. 02 7. 00 Total Medicare program liability (see instructions) 1,573,122 3,577,419 7. 00 Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00				l .			
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 93,038 0 6.01 31,607 6.02 7.700 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				1	~		
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 93,038 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 31,607 6.02 7.00 Total Medicare program liability (see instructions) 1,573,122 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 99	· ·			J	0	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 93,038 0 6.01 31,607 6.02 1,573,122 3,577,419 7.00 Contractor NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr) 0 1.00 2.00	4 00						4 00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) SETTLEMENT TO PROGRAM	0.00	,					0.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6 01			93 03	R		6 01
7.00 Total Medicare program liability (see instructions) 1,573,122 3,577,419 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				1			
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00				1	~		
Number (Mo/Day/Yr) 0 1.00 2.00		(222		., ., ., ., .,			
8.00 Name of Contractor WI SCONSI N PHYSI CI AN SERVI CES 05901 8.00						2. 00	
	8.00	Name of Contractor	WISCONSIN PHYS	SICIAN SERVICE	05901		8.00

Health Financial Systems MARSHANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

In Lieu of Form CMS-2552-10

Provider CCN: 14-1331

Peri od: Worksheet E-1
From 07/01/2022 Part | Part |
To 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm
Swing Beds - SNF Cost Component CCN: 14-Z331 Swina Beds -Title XVIII

Inpatient Part A Part B		
This et one tale A		
mm/dd/yyyy Amount mm/dd/yyyy Amount		
1.00 2.00 3.00 4.00		
1.00 Total interim payments paid to provider 3,328,114	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 0	0	3.01
3. 02	0	3.02
3. 03	0	3.03
3.04	0	3.04
3. 05	0	3.05
Provider to Program		
3.50 ADJUSTMENTS TO PROGRAM 0	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 0	0	3. 99
3, 50-3, 98)	-	
4.00 Total interim payments (sum of lines 1, 2, and 3.99) 3,328,114	ol	4.00
(transfer to Wkst. E or Wkst. E-3, line and column as		
appropriate)		
TO BE COMPLETED BY CONTRACTOR		
5.00 List separately each tentative settlement payment after		5.00
desk review. Also show date of each payment. If none,		
write "NONE" or enter a zero. (1)		
Program to Provider		
5. 01 TENTATI VE TO PROVI DER 0	0	5.01
5. 02	0	5.02
5. 03	0	5.03
Provider to Program		
5.50 TENTATI VE TO PROGRAM 0	0	5.50
5. 51	0	5. 51
5. 52	0	5. 52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 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 248,689	0	6.01
6.02 SETTLEMENT TO PROGRAM 0	0	6.02
7.00 Total Medicare program Liability (see instructions) 3,576,803	0	7.00
Contractor NPR Date		
Number (Mo/Day/Yr)	
0 1.00 2.00		
8.00 Name of Contractor WI SCONSI N PHYSI CI AN SERVI CES 05901		8. 00

Health Financial Systems
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1331 Title XVIII

	THE XVIII HOSPITAL	0031	
		1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2. 00	Medicare days (see instructions)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4. 00	Total inpatient days (see instructions)		4.00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt.	1	7.00
	line 168		
8. 00	Calculation of the HIT incentive payment (see instructions)		8.00
9. 00	Sequestration adjustment amount (see instructions)		9.00
10. 00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31. 00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

If the Financial Systems STATE BROWNING HOSPITAL BROWNING HOSPITAL

Health Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Provider CCN: 14-1331 Period: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm

Title XVIII Swing Beds - SNF Cost

	Title XVIII	Swing Beds - SNF	Cost	
		Part A	Part B	
		1.00	2. 00	
4 00	COMPUTATION OF NET COST OF COVERED SERVICES	0.740.704		1 00
1. 00 2. 00	Inpatient routine services - swing bed-SNF (see instructions) Inpatient routine services - swing bed-NF (see instructions)	2, 710, 791	0	1. 00 2. 00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wks	st. D, 965,777	0	3.00
3.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through		O	3.00
	instructions)	, , , ,		
3. 01	Nursing and allied health payment-PARHM (see instructions)			3. 01
4.00	Per diem cost for interns and residents not in approved teaching program (see		0.00	4. 00
	instructions)	4 007		
5.00	Program days	1, 327	0	5.00
6. 00 7. 00	Interns and residents not in approved teaching program (see instructions) Utilization review - physician compensation - SNF optional method only		0	6. 00 7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	3, 676, 568	0	8.00
9. 00	Primary payer payments (see instructions)	0, 0, 0, 300	0	9.00
10. 00	Subtotal (line 8 minus line 9)	3, 676, 568	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable to physician	0	0	11.00
	professional services)			
12.00	Subtotal (line 10 minus line 11)	3, 676, 568	0	12.00
13. 00	Coinsurance billed to program patients (from provider records) (exclude coinsura	ance 26, 769	0	13.00
14 00	for physician professional services)		0	14 00
14. 00 15. 00	80% of Part B costs (line 12 x 80%) Subtotal (see instructions)	3, 649, 799	0	14. 00 15. 00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	3, 049, 799	0	16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)		O	16.50
16. 55	Rural community hospital demonstration project (§410A Demonstration) payment	o		16. 55
	adjustment (see instructions)			
16. 99	Demonstration payment adjustment amount before sequestration	0	0	16. 99
17. 00	Allowable bad debts (see instructions)	0	0	17. 00
17. 01	Adjusted reimbursable bad debts (see instructions)	0	0	17. 01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19. 00 19. 01	Total (see instructions) Sequestration adjustment (see instructions)	3, 649, 799	0	19. 00 19. 01
19. 01		72, 996	0	19.01
19. 02			O	19.02
19. 25		o	0	19. 25
20.00	Interim payments	3, 328, 114	0	20.00
20. 01	Interim payments-PARHM			20. 01
21. 00	Tentative settlement (for contractor use only)	0	0	21.00
21. 01	Tentative settlement-PARHM (for contractor use only)			21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 2	21) 248, 689	0	22.00
22. 01	Balance due provider/program-PARHM (see instructions)	15.0	0	22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 1 chapter 1, §115.2	15-2, 0	0	23. 00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st	t		200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.			
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II,	line		201. 00
202.00	66 (title XVIII hospital))	2 1:		202 00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3 200 (title XVIII swing-bed SNF))	3, TTNE		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	current 5-year demons		
	peri od)			
	D Medicare swing-bed SNF target amount			205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206. 00
007.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			007.00
	Program reimbursement under the §410A Demonstration (see instructions)	lines 1		207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of I and 3)	Thes I		208. 00
209 00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			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 209 plus line 210)	(see		215. 00
	instructions)			l

In Lieu of Form CMS-2552-10
Worksheet E-3
11/2022 Part V
30/2023 Date/Time Prepared:
11/27/2023 12:08 pm
tal Cost Health Financial Systems

CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 14-1331 Peri od: From 07/01/2022 To 06/30/2023

Title XVIII

Hospi tal

PART V - CALCULATION OF RELIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST RELIMBURSEMENT 1.00		THE AVITT HESPITEI	0031	
Name			1 00	
Inpatient services 1,785,149 1,00		DADT V _ CALCILLATION OF DELMBLIDSEMENT SETTLEMENT FOR MEDICADE DADT A SEDVICES _ CAST DELMBLIDSEMENT	1.00	
Nursing and Allied Health Managed Care payment (see instructions)	1 00		1 785 149	1 00
Organ acquisition cost (see instructions)				
Cell ular therapy acquisition cost (see instructions)				
Subtotal (sum of lines 1 through 3.01)				
Primarry payer payments			1, 785, 149	
COMPUTATION OF LESSER OF COST OR CHARGES	5.00	Primary payer payments		
Reasonable charges	6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1, 803, 000	6.00
Noutline service charges 0 7.00 0 8.00 0 8.00 0 8.00 0 9.00 0		COMPUTATION OF LESSER OF COST OR CHARGES		
8.00		Reasonable charges		
0	7.00			
10.00 Total reasonable charges				
Customary charges				
11.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 11.00	10. 00		0	10. 00
12.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with M2 CFR 413. 13(e) 0.000000 13.00 0.000000 13.00 0.000000 15.00 0.000000 15.00 0.000000 15.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 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 0.00000000				44.00
had such payment been made in accordance with 42 CFR 413.13(e) 0.00000 13.00 13.00 13.00 13.00 15.00 1				
13.00 Ratio of line 11 to line 12 (not to exceed 1.000000) 13.00 14.00 14.00 15.00 Excess of customary charges (see instructions) 14.00 15.00 Excess of customary charges (see instructions) 16.00 17.	12.00		U	12.00
14. 00 Total customary charges (see instructions) 0 14. 00 15. 00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see 0 15. 00 15.	12 00		0 000000	12 00
15. 00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 16. 00 Instructions) 17. 00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see 17. 00				
Instructions Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see				
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 18.00 18.00 19.00 18.00 19.0	13.00		J	13.00
Instructions	16, 00		0	16.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT 18. 00 18. 00 19.			_	
18. 00 Direct graduate medical education payments (from Worksheet E-4, line 49) 0 1,800,00 1,800,00 19.00 20.00 20.00 20.00 19.00 21.00 22.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00	17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
19.00 Cost of covered services (sum of lines 6, 17 and 18) 1,803,000 19.00 20.00 Deductibles (exclude professional component) 198,344 20.00 22.00 Subtotal (line 19 minus line 20 and 21) 1,604,656 22.00 23.00 Coinsurance 3,710 23.00 24.00 Subtotal (line 22 minus line 23) 1,600,946 24.00 25.00 All owable bad debts (exclude bad debts for professional services) (see instructions) 6,586 25.00 26.00 Adjusted reimbursable bad debts (see instructions) 6,586 25.00 27.00 All owable bad debts for dual eligible beneficiaries (see instructions) 6,586 25.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 1,605,227 28.00 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.50 29.50 Recovery of accelerated depreciation. 0 29.50 29.9 Demonstration payment adjustment amount before sequestration 0 29.50 30.01 Sequestration adjustment (see instructions) 32.01 30.01 30.02 Sequestration payment adjustment amount after sequestration 30.02		COMPUTATION OF REIMBURSEMENT SETTLEMENT		
20. 00 Deductibles (exclude professional component) 198, 344 20. 00 21. 00 Excess reasonable cost (from line 16) 0 21. 00 22. 00 Subtotal (line 19 minus line 20 and 21) 1,604,656 22. 00 24. 00 Subtotal (line 22 minus line 23) 3,710 23. 00 25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 6,586 25. 00 26. 00 Adjusted reimbursable bad debts (see instructions) 4,281 26. 00 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 6,586 27. 00 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 1,605,227 28. 00 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29. 00 29. 50 Pioneer ACO demonstrati on payment adjustment (see instructions) 0 29. 98 29. 99 Becovery of accelerated depreciation. 0 29. 98 29. 99 Subtotal (see instructions) 32. 105 30. 01 Sequestration adjustment (see instructions) 32. 105 30. 02 Sequestration adjustment (see instructions) 32. 00 30. 03 <t< td=""><td>18.00</td><td>Direct graduate medical education payments (from Worksheet E-4, line 49)</td><td>0</td><td>18.00</td></t<>	18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
21.00 Excess reasonable cost (from line 16) 0 21.00 22.00 Subtotal (line 19 minus line 20 and 21) 1,604,656 22.00 23.00 Coinsurance 3,710 23.00 24.00 Subtotal (line 22 minus line 23) 1,600,946 24.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 6,586 25.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 6,586 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 1,605,227 28.00 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.50 29.90 Pioneer ACO demonstration payment adjustment (see instructions) 0 29.50 29.98 Recovery of accelerated depreciation. 0 29.98 29.99 Demonstration payment adjustment amount before sequestration 0 29.99 30.01 Sequestration adjustment (see instructions) 32,105 30.01 30.02 Demonstration payment adjustment amount after sequestration 0 29.99 31.00 Interim payments 1,480,084 31.00 31.01 <td>19.00</td> <td></td> <td></td> <td></td>	19.00			
22.00 Subtotal (line 19 minus line 20 and 21) 1,604,656 22.00 23.00 Coinsurance 3,710 23.00 24.00 Subtotal (line 22 minus line 23) 1,600,946 24.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 6,586 25.00 26.00 Adjusted reimbursable bad debts (see instructions) 4,281 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 6,586 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 1,605,227 28.00 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.00 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 29.90 29.99 Recovery of accelerated depreciation. 0 29.99 30.00 Subtotal (see instructions) 1,605,227 30.00 30.01 Sequestration payment adjustment amount before sequestration 32,105 30.01 30.02 Demonstration payment adjustment sequestration 32,105 30.01 31.01 Interim payments 1,480,084 31.00 31.01 </td <td></td> <td></td> <td></td> <td></td>				
23.00 Coinsurance 3,710 23.00 24.00 Subtotal (line 22 minus line 23) 1,600,946 24.00 24.00 3,001 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 6,586 25.00 26.00 Adjusted reimbursable bad debts (see instructions) 4,281 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 6,586 27.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 6,586 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 1,605,227 28.00 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.00 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 29.50 29.90		· /		
24.00 Subtotal (line 22 minus line 23) 1,600,946 24.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 6,586 25.00 26.00 Adjusted reimbursable bad debts (see instructions) 4,281 25.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 6,586 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 1,605,227 28.00 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.00 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 29.50 29.99 Recovery of accel erated depreciation. 0 29.99 29.99 Demonstration payment adjustment amount before sequestration 0 29.99 30.01 Sequestration adjustment (see instructions) 32,105 30.01 30.02 Demonstration payment adjustment amount after sequestration 0 29.99 31.01 Interim payments 1,480,084 31.00 31.01 Interim payments-PARHM 31.00 32.01 Tentative settlement (for contractor use only) 32.01 33.01 <				
25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 6,586 25.00 26.00 Adjusted reimbursable bad debts (see instructions) 7.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 8.00 Subtotal (sum of lines 24 and 25, or line 26) 9.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 9.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 9.00 Pi oneer ACO demonstration payment adjustment (see instructions) 9.00 Subtotal (see instructions) 9.00 Sequestration adjustment (see instructions) 9.00 Sequestration adjustment adjustment amount after sequestration 9.00 Sequestration adjustment adjustment amount after sequestration 9.00 Sequestration adjustment (see instructions) 9.00 Interim payments 1.480,084 31.00 1.01 Interim payments Allowable (for contractor use only) 3.00 Tentative settlement (for contractor use only) 3.00 Bal ance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 3.01 Bal ance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,				
26.00 Adjusted reimbursable bad debts (see instructions) 4, 281 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 6,586 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 1,605,227 28.00 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.00 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 29.50 29.98 Recovery of accelerated depreciation. 0 29.98 29.99 Demonstration payment adjustment amount before sequestration 0 29.90 30.01 Sequestration adjustment (see instructions) 1,605,227 30.00 30.02 Sequestration adjustment amount after sequestration 32,105 30.01 30.02 Sequestration adjustment amount after sequestration 0 30.02 31.01 Interim payments 1,480,084 31.00 31.01 1nterim payments 1,480,084 31.00 32.01 Tentative settlement (for contractor use only) 0 32.00 32.01 Bal ance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 93,038 33.01 33.01 Bal ance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 93,038 33.01 3		, ,		
27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 6,586 27. 00 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 1,605,227 28. 00 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29. 00 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 0 29. 50 29. 99 Recovery of accelerated depreciation. 0 29. 99 30. 00 Subtotal (see instructions) 0 29. 99 30. 01 Subtotal (see instructions) 30. 03 30. 02 Sequestration adjustment (see instructions) 32, 105 30. 01 30. 03 Sequestration payment adjustment amount after sequestration 0 30. 02 31. 00 Sequestration adjustment-PARHM 0 30. 02 31. 01 Interim payments 1, 480, 084 31. 00 31. 01 Tentative settlement (for contractor use only) 31. 01 32. 01 Tentative settlement (For contractor use only) 32. 01 33. 01 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 93, 038 33. 00 33. 01 Balance due provider/program-PARHM				
28.00 Subtotal (sum of lines 24 and 25, or line 26) 1,605,227 28.00 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.00 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 29.50 29.98 Recovery of accelerated depreciation. 0 29.98 29.99 Demonstration payment adjustment amount before sequestration 0 29.99 30.01 Sequestration adjustment (see instructions) 1,605,227 30.00 30.02 Demonstration payment adjustment amount after sequestration 0 30.02 30.03 31.00 Interim payments 1,480,084 31.00 31.01 Interim payments-PARHM 31.01 32.00 Tentative settlement (for contractor use only) 32.00 33.00 Bal ance due provi der/program (line 30 minus lines 30.01, 30.02, 31, and 32) 93,038 33.00 33.01 Bal ance due provi der/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 33.01 34.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00		, , , , , , , , , , , , , , , , , , ,		
29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 9 ioneer ACO demonstration payment adjustment (see instructions) 10 29.00 29.50 Recovery of accelerated depreciation. 10 29.98 Recovery of accelerated depreciation. 10 29.98 Demonstration payment adjustment amount before sequestration 10 29.99 Subtotal (see instructions) 11,605,227 30.00 Sequestration adjustment (see instructions) 120 Demonstration payment adjustment amount after sequestration 130.01 Demonstration payment adjustment amount after sequestration 130.02 Sequestration adjustment-PARHM 130.03 Interim payments 1480,084 31.00 Interim payments 15 Interim payments (for contractor use only) 17 Intative settlement (for contractor use only) 18 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 18 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 18 OPTOTESTED ADJUSTMENTS (SEE INSTRUCTIONS) 19 29.90 29.90 29.90 1,605,227 30.00 30.02 30.03 31.01 Interim payments 1,480,084 31.00 31.01 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 32.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 33.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,				
29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 29. 98 Recovery of accelerated depreciation. Demonstration payment adjustment amount before sequestration Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Sequestration adjustment (see instructions) 30. 02 30. 03 Sequestration adjustment amount after sequestration Sequestration adjustment-PARHM Interim payments Interim payments Interim payments-PARHM Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 29. 98 0 29. 99 1, 605, 227 30. 00 32. 01 32. 01 32. 01 34. 00				
29. 98 Recovery of accel erated depreciation. 0 29. 98 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Demonstration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 30. 03 31. 00 Interim payments Interim payments Interim payments-PARHM 31. 01 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,				
29. 99 Demonstration payment adjustment amount before sequestration 0 29. 99 30. 00 Subtotal (see instructions) 1,605,227 30. 00 30. 01 Sequestration adjustment (see instructions) 32,105 30. 01 30. 02 Demonstration payment adjustment amount after sequestration 0 30. 02 30. 03 Sequestration adjustment-PARHM 30. 03 31. 01 Interim payments 1,480,084 31. 00 31. 01 Tentative settlement (for contractor use only) 31. 01 32. 01 Tentative settlement-PARHM (for contractor use only) 32. 01 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 93, 038 33. 00 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 33. 01 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34. 00				
30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.00 Interim payments 31.01 Interim payments-PARHM 31.01 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 32.01 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 30.00 32, 00 30.02 30.02 31.00 32.01 32.01				
30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 31. 00 Interim payments 31. 00 Interim payments-PARHM 31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 34. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34. 00				
30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.00 Interim payments 31.01 Interim payments-PARHM 31.01 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 32.01 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 30.02 30.02 30.03 3.100 31.00 31.00				
30. 03 Sequestration adjustment-PARHM 30. 03 31. 00 1. nterim payments 1, 480, 084 31. 00 31. 01 1. nterim payments-PARHM 31. 01 32. 00 32. 01 32. 01 33. 00 33. 01 34. 00 36. 01 36. 02 36. 03 36. 01 36. 02 36. 03 36. 01 36. 02 36. 03 36. 01 36. 02 36. 03 36. 01 36. 02 36. 03 36. 01 36. 02 36. 03 36. 01 36. 02 36. 03 36. 01 36. 02 36. 03 36. 01 36. 02 36. 03 36. 01 36. 02 36. 03 36. 01 36. 02 36. 03 36. 01 36. 02 36. 03 36. 01 36. 02 36. 03 36. 01 36. 02 36. 03				
31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 31.01 32.00 32.00 32.01 33.01 34.00	30. 03			30. 03
32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	31.00		1, 480, 084	31.00
32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	31.01	Interim payments-PARHM		31.01
33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	32.00	Tentative settlement (for contractor use only)	0	32.00
33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00				
34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00			93, 038	
§115. 2	34.00		0	34.00
		9115. 2		

th Financial Systems MARSHALL BROWNING HOSPITAL

Health Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 14-1331 Period: Worksheet E-3
From 07/01/2022 Part VII

06/30/2023

Date/Time Prepared: 11/27/2023 12:08 pm

43.00

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Title XIX Hospi tal Inpati ent Outpati ent 1.00 2.00 PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 1.00 1.00 Inpatient hospital/SNF/NF services Medical and other services 0 2.00 2.00 3.00 Organ acquisition (certified transplant programs only) 0 3.00 Subtotal (sum of lines 1, 2 and 3) 0 4.00 4.00 5.00 Inpatient primary payer payments 0 5.00 Outpatient primary payer payments 6.00 0 6.00 7.00 Subtotal (line 4 less sum of lines 5 and 6) 0 7.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 0 8.00 Ancillary service charges 0 O 9.00 9.00 Organ acquisition charges, net of revenue ol 10.00 10.00 Incentive from target amount computation 0 11 00 11 00 12.00 Total reasonable charges (sum of lines 8 through 11) 0 0 12.00 CUSTOMARY CHARGES Amount actually collected from patients liable for payment for services on a charge 13.00 0 0 13.00 basi s Amounts that would have been realized from patients liable for payment for services on 14.00 0 0 14.00 a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 0.000000 Ratio of line 13 to line 14 (not to exceed 1.000000) 15.00 Total customary charges (see instructions) 16.00 16.00 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 0 0 17.00 line 4) (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0 0 18.00 18.00 16) (see instructions) 19.00 19.00 Interns and Residents (see instructions) 0 0 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 Ω 20.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 21.00 21.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 0 22.00 Other than outlier payments 0 22.00 23.00 Outlier payments 0 23.00 Program capital payments 0 24.00 24.00 25.00 Capital exception payments (see instructions) 0 0 25.00 Routine and Ancillary service other pass through costs 26,00 26,00 0 27.00 Subtotal (sum of lines 22 through 26) 0 27.00 Customary charges (title V or XIX PPS covered services only) o 28.00 0 28.00 Titles V or XIX (sum of lines 21 and 27) 29.00 0 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18) 0 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 0 0 0 0 0 0 0 0 0 0 0 0 31.00 32.00 Deductibles 0 32.00 33.00 Coi nsurance 0 33.00 34.00 Allowable bad debts (see instructions) 34.00 Utilization review 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 0 36.00 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 37.00 38.00 Subtotal (line 36 \pm line 37) 0 38.00 39 00 Direct graduate medical education payments (from Wkst. E-4) 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 0 40.00 0 41.00 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 0 42.00

Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,

43 00

chapter 1, §115.2

In Lieu of Form CMS-2552-10

Health Financial Systems

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

Provider CCN: 14-1331 Peri od: From 07/01/2022 To 06/30/2023 Worksheet G

Date/Time Prepared: 11/27/2023 12:08 pm

——————————————————————————————————————					11/27/2023 12	:08 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund	Fund	4.00	
	CHIDDENT ACCETS	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	2, 223, 469	O	o	0	1.00
2. 00	Temporary investments	2,223,407		ő	Ö	
3. 00	Notes recei vabl e	l o	Ö	ol	Ö	
4.00	Accounts receivable	6, 593, 331	0	O	0	1
5.00	Other recei vabl e	0	0	o	0	
6.00	Allowances for uncollectible notes and accounts receivable	-522, 736	0	0	0	6.00
7.00	Inventory	641, 218	1	0	0	
8. 00	Prepai d expenses	1, 512, 195	l	0	0	
9.00	Other current assets	0	0	0	0	
10.00	Due from other funds	0	0	0	0	
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	10, 447, 477	0	0	0	11. 00
12. 00	Land	3, 114	0	ol	0	12.00
13. 00	Land improvements	1, 285, 234		Ö	Ö	13.00
14. 00	Accumulated depreciation	-1, 191, 573	- 1	ō	Ō	1
15.00	Bui I di ngs	8, 239, 442	1	o	0	15.00
16.00	Accumulated depreciation	-5, 790, 747	0	o	0	16.00
17.00	Leasehold improvements	0	0	0	0	17. 00
18. 00	Accumulated depreciation	0	0	0	0	
19. 00	Fi xed equipment	7, 064, 024		0	0	
20.00	Accumulated depreciation	-6, 065, 804	1	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22. 00	Accumulated depreciation Major movable equipment	4 412 001	0	U O	0	22. 00 23. 00
23. 00 24. 00	Accumulated depreciation	6, 413, 881 -5, 055, 718		0	0	1
25. 00	Mi nor equi pment depreciable	-5,055,716	1	0	0	1
26. 00	Accumulated depreciation			0	0	
27. 00	HIT designated Assets	1, 586, 972		Ö	ő	1
28. 00	Accumulated depreciation	-1, 586, 972	1	Ö	0	1
29.00	Mi nor equi pmen't-nondepreci abl e	2, 329, 548	1	o	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	7, 231, 401	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	8, 270, 808	1	0	0	
32.00	Deposits on leases	0	0	0	0	
33.00	Due from owners/officers	0	0	0	0	
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	222, 251 8, 493, 059		0	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	26, 171, 937		ol	0	
30.00	CURRENT LIABILITIES	20, 171, 737	١	<u></u>		30.00
37.00	Accounts payable	1, 102, 085	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1, 470, 184		o	0	38. 00
39.00	Payrol I taxes payable	0	0	o	0	39. 00
40.00	Notes and Loans payable (short term)	355, 983	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	
44.00	Other current liabilities	33, 427	1	0	0	1
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	2, 961, 679	0	0	0	45.00
46. 00	Mortgage payable	T 0	O	o	0	46. 00
47. 00	Notes payable	10, 284, 514		o	0	1
48. 00	Unsecured Loans	0	l o	Ö	ő	
49. 00	Other long term liabilities	699, 396		Ö	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	10, 983, 910		O	0	1
51.00	Total liabilities (sum of lines 45 and 50)	13, 945, 589	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	12, 226, 348	1		I	52.00
53.00	Specific purpose fund		0		l	53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0	I	55.00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56.00 57.00
58.00	Plant fund balance - reserve for plant improvement,				0	
55.00	replacement, and expansion				ı	55.50
59. 00	Total fund balances (sum of lines 52 thru 58)	12, 226, 348	o	О	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	26, 171, 937	1	O	0	
	59)				I	

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2552-10
Worksheet G-1 Provider CCN: 14-1331 Peri od: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm

		Genera	I Fund	Speci al Pui	rpose Fund	Endowment Fund	. Oo piii
		1. 00	2. 00	3.00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 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	12, 050, 669 175, 680 12, 226, 349		C	000000000000000000000000000000000000000	5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING	1 0 0 0 0	0 12, 226, 349	0 0 0 0 0	C	0 0 0	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 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	1 12, 226, 348	0	C	1	17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund			
	T=	6. 00	7. 00	8. 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	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) ROUNDING	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 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			17. 00 18. 00 19. 00

Health Financial Systems MASTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

In Lieu of Form CMS-2552-10

Peri od: Worksheet G-2 From 07/01/2022 Parts I & II To 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm Provider CCN: 14-1331

				11/2//2023 12	: 08 piii
	Cost Center Description	I npati ent	Outpati ent	Total	
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1. 00	Hospi tal	1, 241, 554		1, 241, 554	1. 00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	853, 801		853, 801	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)	2, 095, 355		2, 095, 355	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	o		0	
	11-15)			_	
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2, 095, 355		2, 095, 355	17. 00
18. 00	Ancillary services	6, 142, 645	39, 027, 165	45, 169, 810	
19. 00	Outpatient services	0	9, 436, 883	9, 436, 883	
20. 00	RURAL HEALTH CLINIC	o	4, 594, 527	4, 594, 527	20. 00
20. 01	RURAL HEALTH CLINIC II - FHC	Ö	571, 111	571, 111	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	0/1/11	0	21. 00
22. 00	HOME HEALTH AGENCY	Ŭ	Ĭ	J	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	OTHER PATIENT REVENUES	0	925, 956	925, 956	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	8, 238, 000	54, 555, 642	62, 793, 642	
26.00	G-3, line 1)	6, 236, 000	34, 333, 642	02, 193, 042	26.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		32, 865, 658		29. 00
30.00	BAD DEBT EXPENSE	0	32, 000, 000		30.00
31.00	BAU DEBT EXPENSE	0			
					31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35. 00		0	_		35. 00
36. 00	Total additions (sum of lines 30-35)	_	0		36.00
37. 00	DEDUCT (SPECIFY)	0			37.00
38. 00		0			38. 00
39. 00		0			39. 00
40.00		0			40.00
41. 00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		32, 865, 658		43.00
	to Wkst. G-3, line 4)				

alth Financial Systems MARSHALL BROWNING HOSPITAL

Heal th Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 14-1331 Period: From 07/01/2022 To 06/30/2023 Date/Time Prepared:

	10 00730720	11/27/2023 12:	
		1172772020 12	, oo p
		1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	62, 793, 642	1.00
2.00	Less contractual allowances and discounts on patients' accounts	32, 184, 235	2.00
3.00	Net patient revenues (line 1 minus line 2)	30, 609, 407	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32, 865, 658	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2, 256, 251	5.00
	OTHER I NCOME		
6.00	Contributions, donations, bequests, etc	107, 150	6.00
7.00	Income from investments	601, 518	7. 00
8.00	Revenues from telephone and other miscellaneous communication services	0	8. 00
9.00	Revenue from television and radio service	0	9. 00
10.00	Purchase discounts	10, 286	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking Lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	59, 555	14.00
15.00	Revenue from rental of living quarters	204, 166	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	35, 456	17.00
18.00	Revenue from sale of medical records and abstracts	5, 410	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	7, 050	22.00
23.00	Governmental appropriations	0	23.00
24.00	340B PROGRAM (NET OF EXPENSES)	349, 162	24.00
24. 01	OTHER INCOME	162, 996	24. 01
24. 02	LOSS ON EXTINGUISHMENT OF DEBT	-231, 959	24. 02
24. 03	OTHER (SPECIFY)	0	24. 03
24.04	OTHER (SPECIFY)	0	24.04
24.05	OTHER (SPECIFY)	0	24.05
24.06	OTHER (SPECIFY)	0	24.06
24.07	OTHER (SPECIFY)	0	24. 07
24. 50	COVI D-19 PHE Funding	1, 122, 602	24.50
25.00	Total other income (sum of lines 6-24)	2, 433, 392	25.00
26.00	Total (line 5 plus line 25)	177, 141	26.00
27.00	LOSS ON SALE OF EQUIPMENT	1, 461	27.00
27. 01	OTHER EXPENSES (SPECIFY)	0	27. 01
28.00	Total other expenses (sum of line 27 and subscripts)	1, 461	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)	175, 680	29. 00

eal th Fi nanci al Systems MARSHALL BROWNING HOSPITAL

Heal th Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1331
Component CCN: 14-8504
Period:
From 07/01/2022
To 06/30/2023 Date/Time Prepared:
11/27/2023 12: 08 pm

						11/27/2023 12	:08 pm
					RHC I	Cost	
	·	Compensation	Other Costs	Total (col.	1 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	1.00	2.00	3.00	4.00	3.00	
1. 00	Physician	413, 952	401, 543	815, 49	95 59, 498	874, 993	1.00
	,						
2.00	Physician Assistant	263, 425	0				2.00
3.00	Nurse Practitioner	413, 092	0	413, 09	92 45, 152		3.00
4.00	Visiting Nurse	0	0	1	0	0	4. 00
5.00	Other Nurse	314, 627	0	314, 62	17, 832	332, 459	5. 00
6.00	Clinical Psychologist	0	0		0	0	6.00
7.00	Clinical Social Worker	0	0)	0 0	0	7.00
8.00	Laboratory Techni ci an	ol	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	ol	0		0 0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1, 405, 096	401, 543	1, 806, 63	148, 466	1, 955, 105	10.00
11. 00	Physician Services Under Agreement	1, 100, 070	101, 010	1,000,00	0	0	11.00
12. 00	Physician Supervision Under Agreement	0	0			0	12.00
		0	0		0	1	1
13.00	Other Costs Under Agreement	U	U	1	0	0	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14.00
15. 00	Medical Supplies	0	87, 081				15. 00
16. 00	Transportation (Health Care Staff)	0	7, 956	7, 95	56 0	7, 956	
17.00	Depreciation-Medical Equipment	0	0	1	0	0	17.00
18.00	Professional Liability Insurance	0	0)	0 0	0	18.00
19.00	Other Health Care Costs	o	0		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	95, 037	95, 03	1, 931	96, 968	21.00
22. 00	Total Cost of Health Care Services (sum of	1, 405, 096	496, 580				
22.00	lines 10, 14, and 21)	1, 403, 070	470, 300	1, 701, 0	130, 377	2,032,073	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
22 00	Pharmacy	٥	0	ı	0 0	0	23. 00
		0	0				24.00
24. 00	Dental	U	U	1	0	_	
25. 00	Optometry	0	Ü	1	0	0	25.00
25. 01	Tel eheal th	0	0	1	0	0	25. 01
25. 02	Chronic Care Management	0	0	1	0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	ol	0		0 0	l 0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	O	10, 838	10, 83	86, 649	97, 487	29.00
30.00	Admi ni strati ve Costs	211, 278	32, 285				30.00
	Total Facility Overhead (sum of lines 29 and						
31. 00		211, 2/8	43, 123	254, 40	86, 649	341, 050	31.00
22.00	30)	1 (1(074	F20 700	0.45/.05	227 244	0 202 402	22.00
32. 00	Total facility costs (sum of lines 22, 28	1, 616, 374	539, 703	2, 156, 07	237, 046	2, 393, 123	32.00
	and 31)	l l		I		I	l

In Lieu of Form CMS-2552-10

Heal th Financial Systems

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS Provider CCN: 14-1331 Peri od: From 07/01/2022 To 06/30/2023 Worksheet M-1 Date/Time Prepared: 11/27/2023 12:08 pm Component CCN: 14-8504

					RHC I	Cost
		Adiustmonts	Net Expenses		KIIC I	COST
		Adjustments	for			
			Allocation			
			(col. 5 +			
		4 00	col. 6) 7.00	-		
	FACILITY HEALTH CARE STAFF COSTS	6. 00	7.00			
1 00	Physician	-304	874, 689	1		1.00
1.00				1		
2.00	Physician Assistant	-100				2.00
3.00	Nurse Practitioner	-159		1		3.00
4.00	Visiting Nurse	0	0	I		4.00
5.00	Other Nurse	0	332, 459	I .		5. 00
6. 00	Clinical Psychologist	0	0	1		6.00
7. 00	Clinical Social Worker	0	0	1		7.00
8. 00	Laboratory Techni ci an	0	0	•		8.00
9.00	Other Facility Health Care Staff Costs	0	0	I .		9.00
10.00	Subtotal (sum of lines 1 through 9)	-563	1, 954, 542			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	89, 012			15.00
16.00	Transportation (Health Care Staff)	0	7, 956			16.00
17.00	Depreciation-Medical Equipment	0	l			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	96, 968			21.00
22. 00	Total Cost of Health Care Services (sum of	-563	1			22.00
22.00	lines 10, 14, and 21)	303	2,031,310			22.00
	COSTS OTHER THAN RHC/FQHC SERVICES					
23. 00	Pharmacy	0	0			23.00
24. 00	Dental	0	Ö			24.00
25. 00	Optometry	0	ĺ	1		25. 00
25. 00	Tel eheal th	563				25. 00
25. 01	Chronic Care Management	503	0	1		25. 02
26. 00	All other nonreimbursable costs	0		1		26.00
		U	U			
27. 00	Nonallowable GME costs	F/0	F/0			27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	563	563			28. 00
	through 27)					
00.00	FACILITY OVERHEAD		07.407			
29. 00	Facility Costs	0				29.00
30.00	Administrative Costs	0	,			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	341, 050			31.00
	30)					
32. 00	Total facility costs (sum of lines 22, 28	0	2, 393, 123			32.00
	and 31)					

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Heal th Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1331
Component CCN: 14-8597
Period:
From 07/01/2022
To 06/30/2023 Date/Time Prepared:
11/27/2023 12: 08 pm

						11/27/2023 12	:08 pm
					RHC II	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
		'		+ col . 2)	i ons	Trial Balance	
				<i>'</i>		(col. 3 +	
						col . 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	3.00	
1. 00	Physician	0	40, 000	40, 00	00 0	40, 000	1.00
		ŭ					
2.00	Physician Assistant	141, 421	0				2.00
3.00	Nurse Practitioner	142, 819	0	142, 81	· ·		
4.00	Visiting Nurse	0	0	1	0	_	4. 00
5.00	Other Nurse	205, 919	0	205, 91	9 0	205, 919	5. 00
6.00	Clinical Psychologist	0	0	1	0	0	6. 00
7.00	Clinical Social Worker	0	0)	0 0	0	7. 00
8.00	Laboratory Techni ci an	o	0	1	0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	ol	0)	0 0	l 0	9.00
10.00	Subtotal (sum of lines 1 through 9)	490, 159	40, 000	530, 15	29, 696	559, 855	10.00
11. 00	Physician Services Under Agreement	.,0,.0,	.0,000]	0 27,070	0	11.00
12.00	Physician Supervision Under Agreement	0	0			Ö	12.00
13. 00	Other Costs Under Agreement	0	0		0	0	13.00
		0	0	1	0		
14.00	Subtotal (sum of lines 11 through 13)	U	00.100		0	0	14.00
15. 00	Medical Supplies	0	23, 622			23, 622	15. 00
16. 00	Transportation (Health Care Staff)	0	1, 668	1, 66	0 8	1, 668	
17. 00	Depreciation-Medical Equipment	0	0	1	0	0	17. 00
18. 00	Professional Liability Insurance	0	0	1	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)	o	25, 290	25, 29	0 0	25, 290	21.00
22. 00	Total Cost of Health Care Services (sum of	490, 159	65, 290				
22.00	lines 10, 14, and 21)	170, 107	00/2/0]	27,070	0007 . 10	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23 00	Pharmacy	0	0		0 0	0	23. 00
24. 00	Dental	0	0				24.00
25. 00	Optometry	0	0			0	25.00
	1 .	0	0		0	0	25.00
25. 01	Tel eheal th	U	U	1	0	1	
25. 02	Chronic Care Management	0	0	1	0	0	25. 02
26. 00	All other nonreimbursable costs	0	0	1	0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	1	0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	12, 798	12, 79	98 41, 702	54, 500	29. 00
30.00	Administrative Costs	136, 797	10, 190	146, 98			30.00
31.00	Total Facility Overhead (sum of lines 29 and		22, 988				1
	30)		, 700		1.,,52	===, .0,	
32. 00	Total facility costs (sum of lines 22, 28	626, 956	88, 278	715, 23	71, 398	786, 632	32.00
32. 00	and 31)	323, 700	55, 276	1, 20	7.7070	, 55, 662	32.00
	1	'		1	I	1	1

Heal th Financial Systems

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

In Lieu of Form CMS-2552-10
Worksheet M-1 Provider CCN: 14-1331 Peri od: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm Component CCN: 14-8597

					RHC II	Cost
		Adjustments	Net Expenses		I KIIC II	COST
		Aujustillerits	for			
			Allocation			
			(col. 5 +			
		4 00	col. 6) 7.00	-		
	FACILITY HEALTH CARE STAFF COSTS	6. 00	7.00			
1 00	Physician	-337	39, 663	1		1.00
1.00				1		
2.00	Physician Assistant	-1, 307				2.00
3. 00	Nurse Practitioner	-1, 337	1	1		3.00
4. 00	Visiting Nurse	0	0	I		4.00
5.00	Other Nurse	0	205, 919			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)	-2, 981	556, 874			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	23, 622			15.00
16.00	Transportation (Health Care Staff)	0	1, 668			16.00
17. 00	Depreciation-Medical Equipment	0	0	1		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	Ü	Ĭ			20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	25, 290			21.00
22. 00	Total Cost of Health Care Services (sum of	-2, 981	582, 164	1		22.00
22.00	lines 10, 14, and 21)	-2, 701	302, 104			22.00
	COSTS OTHER THAN RHC/FQHC SERVICES					
23. 00	Pharmacy	0	0			23.00
24. 00	Dental	0				24.00
25.00	Optometry	0	0			25.00
25. 00	Tel eheal th	2, 981	2, 981	1		25.00
	1	2, 901	2, 901	1		25. 01
25. 02	Chronic Care Management	0	1	1		•
26.00	All other nonreimbursable costs	0	0			26.00
27. 00	Nonallowable GME costs	0.004	0.001			27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	2, 981	2, 981			28. 00
	through 27)					
00.00	FACILITY OVERHEAD		F4 500			
29. 00	Facility Costs	0	1 .,			29.00
30.00	Administrative Costs	0		1		30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	201, 487			31.00
	30)					
32. 00	Total facility costs (sum of lines 22, 28	0	786, 632			32.00
	and 31)					

th Financial Systems MARSHALL BROWNING HOSPITAL

Heal th Financial Systems

ALLOCATION OF OVERHEAD TO HOSPITAL—BASED RHC/FQHC SERVICES

Provider CCN: 14-1331 | Period: From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: 11/27/2023 12:08 pm |

Number of FTE Personnel | Total Visits | Productivity | Standard (1) | Visits (col. col. 2 or 1 x col. 3) | col. 4

					KHC I	COST	
		Number of FTE	Total Visits	Producti vi ty	Mi ni mum	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	1. 95	4, 266	4, 200	8, 190		1.00
2.00	Physi ci an Assi stant	1. 23	3, 577	2, 100	2, 583		2.00
3.00	Nurse Practitioner	2. 40	6, 550	2, 100	5, 040		3.00
4.00	Subtotal (sum of lines 1 through 3)	5. 58	14, 393		15, 813	15, 813	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7. 01
7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	only)						
8.00	Total FTEs and Visits (sum of lines 4	5. 58	14, 393			15, 813	8.00
	through 7)						
9.00	Physician Services Under Agreements		0			0	9. 00
	· · · · · · · · · · · · · · · · · · ·						
						4 00	

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	2, 051, 510	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	563	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	2, 052, 073	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0. 999726	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	341, 050	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1, 083, 482	15.00
16.00	Total overhead (sum of lines 14 and 15)	1, 424, 532	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	1, 424, 532	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	1, 424, 142	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	3, 475, 652	20.00

Health Financial Systems

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES Provider CCN: 14-1331 Peri od: Worksheet M-2 From 07/01/2022 Component CCN: 14-8597 06/30/2023 To Date/Time Prepared: 11/27/2023 12:08 pm RHC II Cost Number of FTE Total Visits Producti vi ty Mi ni mum Greater of Standard (1) Visits (col. Personnel col. 2 or col. 4 1 x col. 3) 1.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY Posi ti ons 1 00 4, 200 0.00 421 1 00 Physi ci an 2.00 Physician Assistant 0.66 1,590 2, 100 1, 386 2.00 3.00 Nurse Practitioner 0.73 1, 404 2, 100 1, 533 3.00 4.00 Subtotal (sum of lines 1 through 3) 1.39 3, 415 2, 919 3.415 4.00 5.00 Visiting Nurse 0.00 C 0 5.00 6.00 Clinical Psychologist 0.00 0 6.00 7.00 Clinical Social Worker 0.00 0 0 7.00 7.01 Medical Nutrition Therapist (FQHC only) 0.00 7.01 C 0 Diabetes Self Management Training (FQHC 7.02 0.00 C 0 7.02 only) 8.00 Total FTEs and Visits (sum of lines 4 1.39 3, 415 3, 415 8.00 through 7) Physician Services Under Agreements 9.00 Ω 9.00 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES Total costs of health care services (from Wkst. M-1, col. 7, line 22) 10 00 582, 164 10 00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 2, 981 11.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 12.00 585, 145 12.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 0. 994906 13.00 13 00 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 201, 487 14.00 Parent provider overhead allocated to facility (see instructions) 439, 829 15.00 16.00 Total overhead (sum of lines 14 and 15) 641, 316 16.00 17 00 Allowable GME overhead (see instructions) 17.00 0 18.00 Enter the amount from line 16 641, 316 18.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 638, 049 19.00 20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)

In Lieu of Form CMS-2552-10

1, 220, 213 20.00

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Heal th Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10 CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC Provider CCN: 14-1331 Period: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/27/2023 12: 08 pm

		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wks			3, 475, 652	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M			44, 495	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus l	ine 2)		3, 431, 157	3.00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			15, 813	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)			15, 813	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			216. 98	7. 00
			Cal cul ati on	OT LIMIT (I)	
			Rate Period 1	Rate Period 2	
			(07/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	06/30/2023)	
			1. 00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or	your contractor)	264. 93	275. 00	8. 00
9. 00	Rate for Program covered visits (see instructions)		216. 98	216. 98	9. 00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from conti		1, 834	1, 923	
11. 00	Program cost excluding costs for mental health services (line 9 x l		397, 941	417, 253	
12.00	Program covered visits for mental health services (from contractor	,	0	0	12.00
13.00	,)	0	0	13.00
14.00			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3	•	0	815, 194	
16. 01	Total program charges (see instructions)(from contractor's records)			623, 879	
16. 02	Total program preventive charges (see instructions) (from provider's			13, 644	16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times line	,		17, 828	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03 and	18) times .80)		588, 848	16. 04
	(Titles V and XIX see instructions.)		_		
16. 05	Total program cost (see instructions)		0	606, 676	
17.00	Primary payer amounts			0	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) (from	m contractor		61, 306	18. 00
10 00	records)	6		100 (50	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (1	from contractor		109, 650	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			606, 676	20. 00
21.00	Program cost of vaccines and their administration (from Wkst. M-4,	Lino 16)		34, 173	
22. 00	Total reimbursable Program cost (line 20 plus line 21)	Title 10)		640, 849	
23. 00	Allowable bad debts (see instructions)			040, 849	23.00
23. 00	Adjusted reimbursable bad debts (see instructions)			0	23. 00
24. 00		one)		0	24.00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	5113)		0	25.00
25. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25. 50
25. 99	Demonstration payment adjustment amount before sequestration			0	25. 99
26. 00	Net reimbursable amount (see instructions)			640, 849	
26. 00	Sequestration adjustment (see instructions)			12, 817	26. 00
26. 02				12, 817	26. 02
27. 00				749, 976	
28. 00	Tentative settlement (for contractor use only)			749, 970	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 2	7 and 28)		-121, 944	
30.00	Protested amounts (nonallowable cost report items) in accordance wi			-121, 744	
55. 55	chapter I, §115.2	OMO TOD. TO TT,		O	00.00
	Terral en 17 Octobre		1	ļ	1

alth Financial Systems MARSHALL BROWNING HOSPITAL

Heal th Financial Systems MARSHALL BROWNING HOSPITAL In Lieu of Form CMS-2552-10 CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC Provider CCN: 14-1331 Period: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/27/2023 12: 08 pm

	T	itle XVIII	RHC II	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst.			1, 220, 213	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4			6, 911	2. 00
3. 00	Total allowable cost excluding injections/infusions (line 1 minus lin	ne 2)		1, 213, 302	3.00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			3, 415	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)			3, 415	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		0.1	355. 29	7. 00
			Cal cul ati on	OT LIMIT (I)	
			Rate Period 1	Rate Period 2	
			(07/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	06/30/2023)	
			1. 00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or yo	our contractor)	260. 39	270. 28	8. 00
9. 00	Rate for Program covered visits (see instructions)		260. 39	270. 28	9. 00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contract		432	447	10.00
11.00	1 3	,	112, 488	120, 815	
12.00	,	ecords)	0	0	12.00
13.00	, ,		0	0	13.00
14.00	, , , , , , , , , , , , , , , , , , , ,		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	.		222 202	15.00
16. 00 16. 01	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3)		0	233, 303	
16. 01	Total program charges (see instructions)(from contractor's records) Total program preventive charges (see instructions)(from provider's records)	cocorde)		168, 602 10, 101	16.01
16. 02	Total program preventive charges (see instructions) (from provider sale			13, 977	16. 02
16. 03	Total Program non-preventive costs ((Tine 16.02/Tine 16.07) times Tine 16.03 and 18			162, 222	
10.04	(Titles V and XIX see instructions.)) times .00)		102, 222	10.04
16. 05	Total program cost (see instructions)		0	176, 199	16. 05
17. 00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) (from o	contractor		16, 549	18.00
	records)				
19.00		m contractor		28, 390	19.00
	records)				
20.00	Net Medicare cost excluding vaccines (see instructions)			176, 199	20.00
21. 00	Program cost of vaccines and their administration (from Wkst. M-4, li	ne 16)		5, 206	21. 00
22. 00	Total reimbursable Program cost (line 20 plus line 21)			181, 405	22. 00
23.00	Allowable bad debts (see instructions)			0	23.00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24. 00		5)		0	24. 00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25. 50
25. 99	Demonstration payment adjustment amount before sequestration			0	25. 99
26. 00	Net reimbursable amount (see instructions)			181, 405	
26. 01	Sequestration adjustment (see instructions)			3, 628	
26. 02				0	26. 02
27. 00	1 7			171, 758	
28. 00	1	1 20)		0	28. 00
29. 00				6, 019	
30. 00	Protested amounts (nonallowable cost report items) in accordance with	I UMS PUD. 15-11,		0	30. 00
	chapter I		l l		

Heal th Fi nanci al Systems

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

MARSHALL BROWNING HOSPITAL

Provi der CCN: 14-1331 Peri od:

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

Worksheet M-4 From 07/01/2022 Component CCN: 14-8504 То 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm Title XVIII RHC I Cost PNEUMOCOCCAL INFLUENZA COVI D-19 MONOCLONAL VACCI NES **VACCINES** VACCI NES ANTI BODY **PRODUCTS** 1.00 2.00 2.01 2.02 1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10) 1, 954, 542 1, 954, 542 1, 954, 542 1, 954, 542 1.00 Ratio of injection/infusion staff time to total health 2.00 0.000516 0.000574 0.000000 0.000000 2.00 care staff time 3.00 Injection/infusion health care staff cost (line 1 x line 1,009 1.122 0 3.00 4.00 Injections/infusions and related medical supplies costs 18, 732 5, 400 0 4.00 (from your records) Direct cost of injections/infusions (line 3 plus line 4) 5 00 19, 741 5 00 6.522 0 6.00 Total direct cost of the hospital-based RHC/FQHC (from 2,051,510 2,051,510 2, 051, 510 2, 051, 510 6.00 Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 7.00 1, 424, 142 1, 424, 142 1, 424, 142 1, 424, 142 Ratio of injection/infusion direct cost to total direct 0.009623 0.000000 0.000000 8.00 0.003179 8.00 cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8) 13, 705 4,527 9.00 10.00 Total injection/infusion costs and their administration 33, 446 11,049 0 0 10.00 costs (sum of lines 5 and 9) 11 00 Total number of injections/infusions (from your records) 11 00 80 89 0 12.00 Cost per injection/infusion (line 10/line 11) 418.08 124.15 0.00 0.00 12.00 13.00 Number of injection/infusion administered to Program 13.00 66 53 0 benefi ci ari es Number of COVID-19 vaccine injections/infusions 13.01 0 0 13.01 administered to MA enrollees Program cost of injections/infusions and their 14.00 27, 593 6,580 0 14.00 administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMI NI STRATI O 1.00 2.00 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 44 495 15.00 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of 34, 173 16.00

In Lieu of Form CMS-2552-10

Heal th Fi nanci al Systems

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

MARSHALL BROWNING HOSPITAL

Period:
Provi der CCN: 14-1331

Period:

From 07/01/2022 Component CCN: 14-8597 То 06/30/2023 Date/Time Prepared: 11/27/2023 12:08 pm Title XVIII RHC II Cost PNEUMOCOCCAL INFLUENZA COVI D-19 MONOCLONAL VACCI NES **VACCINES** VACCI NES ANTI BODY **PRODUCTS** 2.00 2.01 1.00 2.02 1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10) 556, 874 556, 874 556, 874 556, 874 1.00 Ratio of injection/infusion staff time to total health 2.00 0.000085 0.000160 0.000000 0.000000 2.00 care staff time 3.00 Injection/infusion health care staff cost (line 1 x line 47 89 0 3.00 4.00 Injections/infusions and related medical supplies costs 2, 130 1,031 0 4.00 (from your records) Direct cost of injections/infusions (line 3 plus line 4) 5 00 2 177 5 00 1, 120 0 6.00 Total direct cost of the hospital-based RHC/FQHC (from 582, 164 582, 164 582, 164 582, 164 6.00 Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 638, 049 7.00 638, 049 638, 049 638, 049 Ratio of injection/infusion direct cost to total direct 0.000000 0.001924 0.000000 8.00 0.003739 8.00 cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8) 2, 386 1, 228 9.00 10.00 Total injection/infusion costs and their administration 4,563 2, 348 0 0 10.00 costs (sum of lines 5 and 9) 11 00 Total number of injections/infusions (from your records) 11 00 17 0 12.00 Cost per injection/infusion (line 10/line 11) 507.00 138.12 0.00 0.00 12.00 13.00 Number of injection/infusion administered to Program 12 13.00 0 benefi ci ari es Number of COVID-19 vaccine injections/infusions 13.01 0 0 13.01 administered to MA enrollees Program cost of injections/infusions and their 14.00 3, 549 1,657 0 14.00 administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMI NI STRATI O 1.00 2.00 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 6, 911 15 00 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of injections/infusions and their administration costs (sum of 5, 206 16.00 columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

In Lieu of Form CMS-2552-10

Worksheet M-4

Health Financial Systems MARSHALL FANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR In Lieu of Form CMS-2552-10

Peri od: From 07/01/2022 To 06/30/2023 Date/Ti me Prepared: 11/27/2023 12:08 pm Cost Provider CCN: 14-1331 SERVICES RENDERED TO PROGRAM BENEFICIARIES Component CCN: 14-8504

			RHC I	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
00	Total interim normante noid to been tal based DUC/FOUC		1.00	749, 976	1 /
	Total interim payments paid to hospital-based RHC/FQHC				1. (
. 00	Interim payments payable on individual bills, either submit			0	2.
	the contractor for services rendered in the cost reporting	period. If none, write			
	"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.				
	payment. If none, write "NONE" or enter a zero. (1)	THE SHOW WATER OF SUCH			
	Program to Provider				
	Program to Provider			0	_
01				0	3.
02				0	3.
03				0	3.
04				0	3.
05				0	3
	Provider to Program			0	٥.
	Provider to Program			0	_
50				0	3
51				0	3
52				0	3
53				ol	3
54				0	3
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	00)		Ö	3
				- 1	-
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	ster to worksheet M-3, line		749, 976	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	sk review. Also show date of			5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		1		
01	riogram to riotido.			0	5.
02				0	5
				- 1	
03				0	5
	Provider to Program				
50				0	5
51				0	5
52				0	5
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	00)		0	5
				ا	
	Determined net settlement amount (balance due) based on the	e cost report. (I)			6
01	SETTLEMENT TO PROVIDER			0	6
02	SETTLEMENT TO PROGRAM			121, 944	6
00	Total Medicare program liability (see instructions)			628, 032	7
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Contractor	NPR Date	Ė
			Number	(Mo/Day/Yr)	
		0			
		0	1. 00	2.00	
. 00	Name of Contractor	WISCONSIN PHYSICIAN SERVICES	05901		8.

In Lieu of Form CMS-2552-10

Health Financial Systems

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES Peri od: From 07/01/2022 To 06/30/2023 Date/Ti me Prepared: 11/27/2023 12:08 pm Cost______ Provider CCN: 14-1331 Component CCN: 14-8597 Cost

			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			171, 758	1.00
2.00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2. 00
2.00	the contractor for services rendered in the cost reporting				2.00
	"NONE" or enter a zero	perrod. It hone, witte			
3. 00	List separately each retroactive lump sum adjustment amount	- based on subsequent			3. 00
3.00	revision of the interim rate for the cost reporting period.				3.00
		ALSO Show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01				0	3. 01
3.02				0	3. 02
3.03				0	3.03
3.04				ol	3.04
3. 05				0	3. 05
0.00	Provider to Program				0.00
3. 50	Trovider to rrogium			0	3.50
3. 51					3. 51
				1 - 1	
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.			0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		171, 758	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	sk review. Also show date of			5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5. 01	1 Togram to 11 ottaol			0	5. 01
5. 02				l ől	5. 02
5. 02					5. 02
5. 03	Describing to Describe			U	5.03
	Provider to Program				
5. 50				0	5.50
5. 51				0	5. 51
5. 52				0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5. 99
6.00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6.00
6. 01	SETTLEMENT TO PROVIDER	•		6, 019	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	6. 02
7.00	Total Medicare program liability (see instructions)			177, 777	7. 00
7.00	Total modicale program trabitity (see this tractions)		Contractor	NPR Date	7.00
		0	Number	(Mo/Day/Yr)	
0.00	No. of Contraction	0	1. 00	2. 00	0.00
8.00	Name of Contractor				8. 00