This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0115 Worksheet S Peri od: From 07/01/2022 Parts I-III AND SETTLEMENT SUMMARY 06/30/2023 Date/Time Prepared: 1/25/2024 11:51 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date:] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 12/01/2023 10. NPR Date:
(1) As Submitted 7. Contractor No. 08001 11. Contractor's Vendor Code: 4
(2) Settled without Audit 8. [N] Initial Report for this Provider CCN 12. [0] If line 5, column 1 is 4: Enter (3) Settled with Audit 9. [N] Final Report for this Provider CCN number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSP & HEALTH CARE CTR (15-0115) 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 FINAN	ICIAL OFFICER OR ADMINISTRATOR	CHECKBOX 2	ELECTRONI C SI GNATURE STATEMENT	
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title				3
4	Date				4

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	850, 532	44, 833	0	0	1. 00
2.00	SUBPROVI DER - I PF	0	4, 954	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	5, 770	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		7, 678		0	10.00
10. 01	RURAL HEALTH CLINIC II	0		10, 126		0	10. 01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200.00	TOTAL	0	861, 256	62, 638	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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0115 Peri od: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/25/2024 11:51 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 800 WEST 9TH STREET PO Box: 1.00 State: IN Zi p Code: 47546 2.00 City: JASPER County: DUBOIS 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal MEMORIAL HOSP & HEALTH 150115 99915 07/01/1966 Ν Р 0 3.00 1 CARE CTR Р 4.00 Subprovider - IPF MEMORIAL HOSP & HCC 99915 07/01/1985 0 15S115 4 Ν 4.00 (PSYCH) 5.00 Subprovider - IRF MEMORIAL HOSP & HCC 15T115 99915 5 07/01/2005 Ν Ρ 0 5.00 (REHAB) 6.00 6.00 Subprovider - (Other) Swing Beds - SNF 7.00 7.00 8.00 Swing Beds - NF 8.00 9.00 Hospital-Based SNF MEMORIAL HOSP & HEALTH 155305 99915 08/04/1987 Ν Р 0 9.00 CARE CTR 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11 00 12.00 Hospi tal -Based HHA MEMORIAL HOSP & HEALTH 99915 08/28/1991 12.00 157222 Ν Ρ Ν CARE CTR Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 15.00 Hospital-Based Health Clinic - RHC FRENCH LICK FAMILY 158507 99915 06/19/2009 Ν 0 N 15.00 MEDI CI NE Hospital-Based Health Clinic - RHC LOOGOOTEE FAMILY 158508 15. 01 99915 12/14/2009 0 15.01 MEDICINE 16 00 Hospital-Based Health Clinic - FQHC 16, 00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2022 06/30/2023 20.00 21.00 Type of Control (see instructions) 21.00 1 1. 00 2. 00 3.00 Inpatient PPS Information 22 00 22 00 Does this facility qualify and is it currently receiving payments for Υ N disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22 01 Υ 22 01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for lyes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

yes or "N" for no.

	1.00	2. 00	3. 00	4. 00	
61.10 Of the FTEs in line 61.05, specify each new program			0. 00	0. 00	61. 10
specialty, if any, and the number of FTE residents					
for each new program. (see instructions) Enter in					
column 1, the program name. Enter in column 2, the					
program code. Enter in column 3, the IME FTE					
unweighted count. Enter in column 4, the direct GME					
FTE unweighted count.					
61.20 Of the FTEs in line 61.05, specify each expanded			0. 00	0. 00	61. 20
program specialty, if any, and the number of FTE					
residents for each expanded program. (see					
instructions) Enter in column 1, the program name.					
Enter in column 2, the program code. Enter in column					
3, the IME FTE unweighted count. Enter in column 4,					
the direct GME FTE unweighted count.					

Program Name

Program Code Unweighted IME Unweighted

FTE Count

Direct GME FTE Count

Health Financial Systems	MEMORIAL HO	OSP & HEALTH CARE CTI	₹	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP			CN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Pre 1/25/2024 11:	pared:
					1.00	
ACA Provisions Affecting the Hea					1.00	
62.00 Enter the number of FTE resident your hospital received HRSA PCRE			reporting pe	riod for which	0.00	62. 00
62.01 Enter the number of FTE resident during in this cost reporting pe	ts that rotated from a eriod of HRSA THC prog	Teaching Health Cen ram. (see instructio		your hospital	0.00	62. 01
Teaching Hospitals that Claim Re 63.00 Has your facility trained reside	ents in nonprovider se	ttings during this c			Υ	63. 00
"Y" for yes or "N" for no in col	umn 1. If yes, comple	te lines 64 through	67. (see insti	ructions) Unweighted	Ratio (col. 1/	
			FTEs Nonprovi der Si te	FTEs in	(col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year period that begins on or after a			This base yea	r is your cost i	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in your of (column 1 divided by (column 1)	s yes, or your facilit nber of unweighted non otations occurring in e number of unweighted our hospital. Enter in	y trained residents -primary care all nonprovider non-primary care column 3 the ratio	0. (0.00	0. 000000	64. 00
is. (ss. a di vi ded by (coi dilli	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
65.00 Enter in column 1, if line 63	1.00	2. 00	3.00	4.00	5. 00 0. 000000	
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 FTEs Nonprovi der Si te	·	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Current	Vear FTE Residents in	Nonnrovider Setting	1.00	2.00	3.00	
beginning on or after July 1, 20	010					
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 divided by (column 1 divided by (column 1 divided by	occurring in all nonpr unweighted non-primar tal. Enter in column 3 column 2)). (see ins	ovider settings. y care resident the ratio of	0. (0. 50	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	·	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2. 00	3. 00	4. 00	5. 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	1
	Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80. 00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting	period? Enter	N	81.00
	"Y" for yes and "N" for no.			
	TEFRA Provi ders			
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes o	r "N" for no.	N	85. 00
86.00	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.			
87.00	Is this hospital an extended neoplastic disease care hospital classified under section		N	87. 00
	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	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target	N	C	88. 00
	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.			

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C		Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I Date/Time Pre 1/25/2024 11:	epared:
		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1. 00	2.00	3. 00	
O.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A I on which the per discharge permanent adjustment approval was Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA taper discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	based. period rget amount	0.0			0 89.0
			V 1. 00	XI X 2. 00	+
Title V and XIX Services			1.00	2.00	
Does this facility have title V and/or XIX inpatient hospita	I services? E	nter "Y" for	N	Υ	90.0
yes or "N" for no in the applicable column. 1.00 Is this hospital reimbursed for title V and/or XIX through t full or in part? Enter "Y" for yes or "N" for no in the appl			N	Υ	91.0
2.00 Are title XIX NF patients occupying title XVIII SNF beds (du		ion)? (see		N	92.0
instructions) Enter "Y" for yes or "N" for no in the applica 3.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N	N	93. 0
4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for n	o in the	N	N	94. 0
5.00 Filine 94 is "Y", enter the reduction percentage in the app 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			0. 00 N	0. 00 N	95. C
applicable column. 7.00 If line 96 is "Y", enter the reduction percentage in the app 3.00 Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f	terns and res	idents post	0. 00 Y	0. 00 Y	97. C
column 1 for title V, and in column 2 for title XIX. 3.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti			Y	Υ	98. 0
title XIX. 3.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o			Y	Υ	98. 0
for title V, and in column 2 for title XIX. 3.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye			N	N	98. 0
for title V, and in column 2 for title XIX. 3.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in			N	N	98. 0
in column 2 for title XIX. 3.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c			Y	Υ	98. 0
column 2 for title XIX. 3.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Υ	98. 0
Rural Providers			NI NI		105.0
D5.00 Does this hospital qualify as a CAH? D6.00 If this facility qualifies as a CAH, has it elected the all-	inclusive met	hod of payment	N :		105. 0 106. 0
for outpatient services? (see instructions) 07.00 Column 1: If line 105 is Y, is this facility eligible for co training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IP Enter "Y" for yes or "N" for no in column 2. (see instructi	1. (see ins you train I&R F and/or IRF	tructions) s in an			107. 0
O8.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche		N Spooch	Doeni netam	108. 0
	Physi cal 1.00	0ccupati onal 2.00	Speech 3.00	Respiratory 4.00	-
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	00	2.00	2.00	00	109. 0

130.00 If this is a Medicare-certified pancreas transplant program, enter the certification

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

Health Financial Systems	MEMORIAL HOSP & H	IEALTH CARE CTR			In Lie	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provi der CCN		Peri od:		Worksheet S-	2
				From 07/0 To 06/3	01/2022 30/2023		epared.
						1/25/2024 11	
				1	00	2. 00	\perp
131.00 If this is a Medicare-certified intes	stinal transplant progra	am, enter the co	erti fi cati on		00	2.00	131. 00
date in column 1 and termination date	e, if applicable, in col	umn 2.					
132.00 If this is a Medicare-certified islet			cation date				132. 00
in column 1 and termination date, if 133.00 Removed and reserved	applicable, in column 2	2.					133. 00
134.00 If this is a hospital-based organ pro	ocurement organization ((OPO), enter the	e OPO number				134. 00
in column 1 and termination date, if							
All Providers 140.00 Are there any related organization or	s hama affi as sasta as a	dofined in CMC [Dub 1E 1		Υ		140.00
chapter 10? Enter "Y" for yes or "N"					ī		140. 00
are claimed, enter in column 2 the ho							
1.00	2. 0				3. 00	6.11	
If this facility is part of a chain of home office and enter the home office				ame and a	address	of the	
141. 00 Name: MEMORI AL HOSPI TAL AND HEALTH	Contractor's Name: WP			or's Numb	er: 0810)1	141. 00
CENTER						•	
142.00 Street: 800 W 9TH STREET	PO Box:		L				142. 00
143. 00 Ci ty: JASPER	State: IN		Zi p Code:		4754	ł6 	143. 00
						1.00	+
144.00 Are provider based physicians' costs	included in Worksheet A	A ?				Y	144. 00
					-		
145 001 f costs for repair convices are alsign	and on Wiset A line 74	ana tha asata	for	1.	00	2.00	145.00
145.00 If costs for renal services are clair inpatient services only? Enter "Y" for							145. 00
no, does the dialysis facility include	de Medicare utilization						
period? Enter "Y" for yes or "N" for							
146.00 Has the cost allocation methodology of Enter "Y" for yes or "N" for no in co					N		146. 00
yes, enter the approval date (mm/dd/y		15-2, Chapter 40	J, 94020) II				
						1.00	
147.00 Was there a change in the statistical 148.00 Was there a change in the order of al						N N	147. 00 148. 00
149.00 Was there a change to the simplified				no.		N N	149. 00
		Part A	Part B		le V	Title XIX	
		1.00	2.00	_	00	4. 00	
Does this facility contain a provider or charges? Enter "Y" for yes or "N"							
155. 00 Hospi tal	Tot tio tot each compone	N I	N		N 3413	N N	155. 00
156.00 Subprovi der - IPF		N	N		N	N	156. 00
157. 00 Subprovi der - IRF		N	N		N	N	157. 00
158. 00 SUBPROVI DER 159. 00 SNF		N.	NI .		N	N	158. 00 159. 00
160.00 HOME HEALTH AGENCY		N N	N N		N N	N N	160. 00
161. 00 CMHC		.,,	N		N	N N	161. 00
				<u>'</u>			
lu						1.00	
Multicampus 165.00 s this hospital part of a Multicampu	is hospital that has one	e or more campus	ses in diffe	rent CRSA	s?	N	165. 00
Enter "Y" for yes or "N" for no.							
	Name	County		p Code	CBSA	FTE/Campus	
144 00 lf line 145 is yes for each	0	1. 00	2.00	3. 00	4. 00	5. 00	0144 00
166.00 If line 165 is yes, for each campus enter the name in column						0.0	0 166. 00
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)							
corumn 5 (see Thatructrons)							
						1.00	
Health Information Technology (HIT)				it Act			ļ <u>.</u>
167.00 Is this provider a meaningful user ur				ontor t	ho	Y	167. 00 168. 00
168.00 If this provider is a CAH (line 105 i reasonable cost incurred for the HIT			10/ IS Y)	, enter t	ile		108.00
168.01 If this provider is a CAH and is not			qualify for	a hardsh	ıi p		168. 01
exception under §413.70(a)(6)(ii)? Er					, .		04.6 55
169.00 If this provider is a meaningful user transition factor. (see instructions)		is not a CAH (I	ine 105 is '	์"N"), ent	er the	9.9	9169.00
transition ractor. (See Instructions,	•					I	I

Health Financial Systems	MEMORIAL HOSP & HE	EALTH CARE CTR	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CCN: 15-0115	Period: From 07/01/2022	Worksheet S-2	2
				Date/Time Pre 1/25/2024 11:	
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170. 00
			1. 00	2.00	
171.00 f line 167 is "Y", does this provider have any days for individuals enrolled in			N	(171. 00
section 1876 Medicare cost plans re					
"Y" for yes and "N" for no in colum		enter the number of sectio	n		
1876 Medicare days in column 2. (se	e instructions)				

Ν

N

19.00

If line 16 or 17 is yes, were adjustments made to PS&R

Report data for corrections of other PS&R Report

information? If yes, see instructions.

Heal th	Financial Systems MEMORIAL HOSP & HE	EALTH CARE CT	R	In Lie	u of Form CN	IS-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der 0	CN: 15-0115	Peri od: From 07/01/2022 To 06/30/2023	Worksheet S Part II	S-2 Prepared:
		Descr	i pti on	Y/N	Y/N	
			0	1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		_	N	N	20. 00
		Y/N	Date	Y/N	Date	
04.00	III	1.00	2.00	3. 00	4. 00	01.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEP	T CHILDRENS I	HOSPI TALS)			
	Capital Related Cost		,			
22.00	Have assets been relifed for Medicare purposes? If yes, see	instructions				22. 00
23. 00	Have changes occurred in the Medicare depreciation expense d	due to apprais	sals made du	ing the cost		23. 00
	reporting period? If yes, see instructions.					
24. 00	Were new leases and/or amendments to existing leases entered	d into during	this cost re	eporting period?		24. 00
25 00	If yes, see instructions Have there been new capitalized leases entered into during t	the cost range	rting period	2 If was saa		25. 00
20.00	linstructions.	те созт герог	ting period	i i yes, see		25.00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the	e cost reporti	ng period? I	f yes, see		26. 00
	instructions.	opol ti	3	J = = 1		_5.55
27. 00	Has the provider's capitalization policy changed during the	cost reporti	ng period? It	f yes, submit		27. 00
	copy.					
	Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit ent	tered into du	ring the cost	t reporting		28. 00
20 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or b	ond funds (D	obt Sorvice I	Posorvo Fund)		29. 00
29.00	treated as a funded depreciation account? If yes, see instru		ebt Service i	reserve runu)		29.00
30.00	Has existing debt been replaced prior to its scheduled matur		debt? If ves	s. see		30.00
	instructions.	,		-,		
31.00	Has debt been recalled before scheduled maturity without iss	suance of new	debt? If yes	s, see		31.00
	i nstructi ons.					
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care servarrangements with suppliers of services? If yes, see instruc	/ices furnish	ed through co	ontractual		32. 00
33 00	If line 32 is yes, were the requirements of Sec. 2135.2 appl		na to competi	tive hidding? If		33. 00
33. 00	no, see instructions.	rea per tariiri	ig to competi	tive brading: 11		33.00
	Provi der-Based Physi ci ans					
34.00	Were services furnished at the provider facility under an ar	rangement wi	th provider-l	pased physicians?		34. 00
	If yes, see instructions.					
35. 00	If line 34 is yes, were there new agreements or amended exis		nts with the	provi der-based		35. 00
	physicians during the cost reporting period? If yes, see ins	structions.		\/ /N	D-+-	
				Y/N 1. 00	2. 00	
	Home Office Costs			1.00	2.00	
36. 00	Were home office costs claimed on the cost report?					36.00
37. 00	If line 36 is yes, has a home office cost statement been pre	epared by the	home office	?		37. 00
	If yes, see instructions.	. ,				
38. 00	If line 36 is yes , was the fiscal year end of the home offi			f		38. 00
20.00	the provider? If yes, enter in column 2 the fiscal year end					20.00
39.00	If line 36 is yes, did the provider render services to other	cnain compoi	nents? If yes	s,		39. 00
40.00	see instructions. If line 36 is yes, did the provider render services to the h	nome office?	If yes see			40. 00
4 0.00	instructions.	ione dilice!	ii yes, see			40.00
	The true true true true true true true tru		_			
		1.	00	2.	00	
	Cost Report Preparer Contact Information					
41. 00	Enter the first name, last name and the title/position	-				41. 00
	held by the cost report preparer in columns 1, 2, and 3,					
42.00	respectively.					42.00
42. UU	Enter the employer/company name of the cost report					42. 00
43 00	preparer. Enter the telephone number and email address of the cost					43. 00
.5. 55	report preparer in columns 1 and 2, respectively.					.5. 55
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			T.		"

Health Financial Systems MEMORIAL HOSP &	HEALTH CARE CTR	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Peri od: From 07/01/2022 To 06/30/2023	Date/Time Pre	pared:
			1/25/2024 11:	51 am
	3.00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position				41.00
held by the cost report preparer in columns 1, 2, and 3,				
respecti vel y.				
42.00 Enter the employer/company name of the cost report				42.00
preparer.				
43.00 Enter the telephone number and email address of the cost				43.00
report preparer in columns 1 and 2, respectively.				

Heal th	Financial Systems MEMORIAL HOSP & HEAL	_TH CARE CTR		Non-CMS HFS Wo	rksheet
HFS Su	pplemental Information	Provider CCN: 15-0115	Peri od: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part IX Date/Time Pre 1/25/2024 11:	pared:
			Title V	Title XIX	
			1. 00	2. 00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Intern	s and Residence post	Υ	Υ	1.00
	stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)			·	
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the report	ing of charges on W/S C	Υ	Υ	2.00
2.00	Part I (e.g. net of Physician's component)? Enter Y/N in column		'		2.00
	lin column 2 for Title XIX. (see S-2, Part I, line 98.01)	iii i ioi iitte v and i/N			
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calcul	ation of Observation Do	ı Y	Υ	3.00
3.00				Y	3.00
	Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for T	itle v and Y/N in column)		
	2 for Title XIX. (see S-2, Part I, line 98.02)				
3. 01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3. 01
3.02	Does Title XIX transfer managed care (HMO) days from Worksheet	: S-3, Part I, column 7,		Υ	3. 02
	sum of lines 2, 3, and 4 to Worksheet E-4, column 2, line 26?				
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access	Hospitals (CAH) being	N	N	4.00
00	reimbursed 101% of cost? Enter Y or N in column 1 for inpatien				55
	for outpatient. (see S-2, Part I, Lines 98.03 and 98.04)	it and i or it in corumn 2	-		
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Acce	oss Hospitals (CAH) boing	ı N	N	5.00
5.00				IN	3.00
	reimbursed 101% of cost? Enter Y or N in column 1 for inpatien	it and y or N in column 2	<u>′</u>		
	for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		T' 11 1/	T' 11 VIV	
			Title V	Title XIX	
	[1. 00	2. 00	
	RCE DI SALLOWANCE				1
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallo		Υ	Υ	6. 00
	column 4? Enter Y/N in column 1 for Title V and Y/N in column	2 for Title XIX. (see			
	S-2, Part I, line 98.05)]
	PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (paymen	nt system is "O") for	Υ	Υ	7. 00
	worksheets D, parts I through IV? Enter Y/N in column 1 for Ti	tle V and Y/N in column			
	2 for Title XIX. (see S-2, Part I, line 98.06)				
	RHC				1
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Ente	er Y/N in column 1 for	N	N	8.00
5. 00	Title V and Y/N in column 2 for Title XIX.		14	l v	0.00
	FOHC				1
9. 00	For fiscal year beginning on/after 10/01/2014, use M-series fo	or Title V and/or Title	N	N	9.00
9.00			IN	IN IN	9.00
XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.					

Health Financial Systems MEMORIAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0115

					'	0 00/30/2023	1/25/2024 11:	
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.			Avai I abl e			
		1. 00] :	2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		70	25, 550	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)							
2. 00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider		ŀ					3. 00
4. 00	HMO IRF Subprovider							4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		ŀ				0	6. 00
7. 00	Total Adults and Peds. (exclude observation			70	25, 550	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		26	9, 490	0.00	0	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	43. 00					0	13.00
14. 00	Total (see instructions)			96	35, 040	0.00	0	14. 00
15. 00	CAH visits						0	15. 00
15. 10	REH hours and visits	40.00		4.0	0 (50			15. 10
16.00	SUBPROVIDER - I PF	40. 00	l .	10	3, 650		0	16.00
17. 00 18. 00	SUBPROVI DER - I RF SUBPROVI DER	41. 00	-	8	2, 920	,	U	17. 00 18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		14	5, 110	,	0	19. 00
20. 00	NURSING FACILITY	44.00	}	14	5, 110		U	20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						_	23. 00
24. 00	HOSPI CE	116. 00		О	C)		24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25.00
26.00	RURAL HEALTH CLINIC	88. 00					0	26.00
26. 01	RURAL HEALTH CLINIC II	88. 01					0	26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			128				27.00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			0	C)		32. 00
32. 01	Total ancillary labor & delivery room							32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days			ŀ				33. 00
33. 00	LTCH site neutral days and discharges							33. 00
	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	C		0	
00	1 - 1 - 3 J = 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	23.00	1	ગ		1	١	00

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

Provider CCN: 15-0115

Peri od: Worksheet S-3
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared: 1/25/2024 11:51 am

						1/25/2024 11:	51 am
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Companent	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	Component	II tie xviii	II tie xix	Patients	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA	0.00	7.00	0.00	7.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	2, 663	104	6, 387			1.00
1.00	8 exclude Swing Bed, Observation Bed and	2,000	101	0,007			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 576	1, 872				2. 00
3.00	HMO IPF Subprovider	11	0				3. 00
4.00	HMO IRF Subprovider	34	79				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7.00	Total Adults and Peds. (exclude observation	2, 663	104	6, 387			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	1, 601	29	3, 105			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)		0.5	1 //2			12.00
13.00		4 244	85	1, 662		020 40	13.00
14. 00 15. 00	Total (see instructions) CAH visits	4, 264	218 0	11, 154 0		938. 60	14. 00 15. 00
15. 00	REH hours and visits	٩	٩	U			15. 00
16. 00	SUBPROVI DER - I PF	138	375	923	0. 27	13. 36	1
17. 00	SUBPROVIDER - IRF	585	0	987		l e	1
18. 00	SUBPROVI DER	303	Ÿ.	707	0.00	7.57	18.00
19. 00		3, 221	79	3, 847	0.00	19. 42	
20. 00	NURSING FACILITY	0,221	′ ′	0,017	0.00	17.12	20.00
21. 00							21.00
22. 00	HOME HEALTH AGENCY	10, 833	o	18, 799	0.00	31. 49	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)			·			23. 00
24.00	HOSPI CE	o	0	0	0.00	0.00	24. 00
24. 10	HOSPICE (non-distinct part)			20			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	1, 324	0	4, 522	0.00	5. 37	26. 00
26. 01	RURAL HEALTH CLINIC II	1, 680	0	3, 971	0.00	6. 14	26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		l	
27. 00	Total (sum of lines 14-26)				14. 74	1, 021. 75	
28. 00	Observation Bed Days		502	3, 568			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30. 00	Employee discount days (see instruction)			0			30.00
31. 00	Employee discount days - IRF	_		0			31. 00
32. 00	, , , , , , , , , , , , , , , , , , , ,	0	167	672			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
33. 00	outpatient days (see instructions)	o					33. 00
33. 00	LTCH non-covered days LTCH site neutral days and discharges	0					33.00
	Temporary Expansion COVID-19 PHE Acute Care		0	0			34. 00
54.00	Transportary Expansion Govern 17 The Acute Care	١	Ч	0	1	I	1 34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

34.00 Temporary Expansion COVID-19 PHE Acute Care

Provider CCN: 15-0115

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

1/25/2024 11:51 am Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 15.00 12.00 13.00 14.00 11.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 175 1.00 1,556 2,602 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 0 2.00 3.00 HMO IPF Subprovider 0 3.00 4.00 HMO IRF Subprovider ol 4.00 Hospital Adults & Peds. Swing Bed SNF 5.00 5 00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 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 Total (see instructions) 2,602 14.00 0.00 1,556 175 14.00 CAH visits 15.00 15.00 15.10 REH hours and visits 15. 10 16.00 SUBPROVIDER - IPF 0.00 45 188 502 16.00 SUBPROVIDER - IRF 17.00 0.00 53 93 17.00 18 00 SUBPROVI DER 18 00 SKILLED NURSING FACILITY 19.00 0.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 0.00 22 00 22 00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 24. 00 HOSPI CE 0.00 24.00 24. 10 HOSPICE (non-distinct part) 24. 10 CMHC - CMHC 25.00 25 00 26.00 RURAL HEALTH CLINIC 0.00 26.00 26.01 RURAL HEALTH CLINIC II 0.00 26.01 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26, 25 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 Labor & delivery days (see instructions) 32.00 32.00 Total ancillary labor & delivery room 32. 01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00 33. 01 LTCH site neutral days and discharges 33.01

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0115 Peri od: Worksheet S-3 From 07/01/2022 Part II Date/Time Prepared: 06/30/2023 1/25/2024 11:51 am Wkst. A Line Recl assi fi cati Adj usted Paid Hours Average Hourly Amount Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col.2 ± col (from Wkst. Salaries in col. 5) A-6)3) col. 4 5.00 2.00 6.00 1.00 3.00 4.00 PART II - WAGE DATA SALARI ES 1.00 Total salaries (see 200. 00 105, 184, 512 -1, 042, 381 104, 142, 131 2, 096, 092. 00 49. 68 1.00 instructions) 2.00 Non-physician anesthetist Part 0 C 0.00 0.00 2.00 3.00 Non-physician anesthetist Part 3, 510, 599 3, 510, 599 31, 871. 20 110.15 3.00 4.00 Physician-Part A -149, 707 149, 707 433.00 345.74 4.00 Administrative 4.01 Physicians - Part A - Teaching 993, 223 993, 223 6, 404. 34 155.09 4.01 Physician and Non 11, 790, 555 11, 790, 555 37, 385. 31 315. 38 5.00 5.00 Physician-Part B Non-physician-Part B for 6.00 614, 192 614, 192 15, 598. 94 39. 37 6.00 hospital-based RHC and FQHC servi ces 7.00 Interns & residents (in an 21.00 0 0.00 0.00 7.00 0 approved program) 7.01 Contracted interns and 1, 297, 819 1, 297, 819 30, 098. 00 43.12 7.01 residents (in an approved programs) 8.00 Home office and/or related 0 0.00 0.00 8.00 organization personnel 9.00 44.00 1, 408, 217 -19, 273 1, 388, 944 39, 316. 00 35. 33 9.00 40, 071, 502 10.00 Excluded area salaries (see -85, 178 39, 986, 324 746, 762.00 53. 55 10.00 instructions) OTHER WAGES & RELATED COSTS 11.00 Contract labor: Direct Patient 6,049,953 6,049,953 101, 970. 49 59. 33 11.00 12.00 Contract labor: Top level 0 0.00 0.00 12.00 management and other management and administrative servi ces 13.00 Contract labor: Physician-Part 120, 996 120, 996 1, 015. 00 119.21 13.00 A - Administrative 14.00 Home office and/or related 0.00 0.00 14.00 organization salaries and wage-related costs 450, 080. 67 14.01 Home office salaries 16, 182, 323 16, 182, 323 35. 95 14.01 14.02 Related organization salaries 0.00 0.00 14.02 15.00 Home office: Physician Part A 0 0 0.00 0.00 15.00 - Administrative Home office and Contract 0 0 0.00 0.00 16.00 16.00 Physicians Part A - Teaching 16.01 Home office Physicians Part A 0 0.00 0.00 16.01 Teachi ng 16. 02 Home office contract C 0.00 0.00 16.02 Physicians <u>Part A - Teaching</u> WAGE-RELATED COSTS 17.00 Wage-related costs (core) (see 13, 090, 525 13, 090, 525 17.00 instructions) 18.00 Wage-related costs (other) 18.00 (see instructions) 19.00 Excluded areas 7, 773, 590 7, 773, 590 19.00 Non-physician anesthetist Part 20.00 20.00 21.00 Non-physician anesthetist Part 331, 627 331, 627 21.00 22.00 Physician Part A -22.00 4, 364 4, 364 Admi ni strati ve 22.01 Physician Part A - Teaching 67.634 67.634 22 01 23.00 Physician Part B 388, 352 388, 352 23.00 24.00 Wage-related costs (RHC/FQHC) 161, 450 161, 450 24.00 Interns & residents (in an 25.00 0 25.00 approved program) 25.50 Home office wage-related 3, 173, 354 0 3, 173, 354 25.50 (core) 25.51 Related organization 25.51 wage-related (core) Home office: Physician Part A 0 0 25, 52 25. 52 - Administrative -

wage-related (core)

16.00

17.00

18.00

5, 379. 00

0.00

0.00

0.00

394, 241

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73. 29

40.00

0.00 41.00

0.00 42.00

0.00 43.00

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0115 Peri od: Worksheet S-3 From 07/01/2022 Part II 06/30/2023 Date/Time Prepared: 1/25/2024 11:51 am Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly Number on of Salaries Sal ari es Related to Wage (col. 4 Reported col . 5) (from Wkst. (col. 2 ± col. Salaries in A-6)3) col. 4 1.00 2.00 5.00 6.00 3.00 4.00 25.53 Home office: Physicians Part A 0 25.53 - Teaching - wage-related (core) OVERHÉAD COSTS - DIRECT SALARIES 26.00 4 00 0 00 26.00 Employee Benefits Department 0.00 27.00 Administrative & General 5.00 1, 772, 100 -203, 687 1, 568, 413 72, 363. 00 21.67 27.00 28.00 Administrative & General under 2, 808, 269 2, 808, 269 13, 656. 70 205. 63 28.00 contract (see inst.) 19, 229. 00 Maintenance & Repairs 6.00 29.00 633, 083 630, 942 32. 81 29.00 -2, 141Operation of Plant 0.00 30.00 7.00 0.00 30.00 31.00 Laundry & Linen Service 8.00 299, 370 -7, 234 292, 136 15, 823.00 18. 46 31.00 32.00 Housekeepi ng 9.00 0.00 0.00 32.00 Housekeeping under contract 18. 99 33.00 1, 342, 800 0 1, 342, 800 70, 696. 44 33.00 (see instructions) Di etary 34.00 10.00 1, 166, 582 -944, 098 222, 484 9, 906. 00 22. 46 34.00 Di etary under contract (see instructions) 0.00 35.00 0.00 35.00 42, 856. 00 36, 00 Cafeteri a 11.00 0 920, 900 920, 900 21. 49 36.00 Maintenance of Personnel 0. 00 37.00 12.00 0 0.00 37.00 38.00 Nursing Administration 13.00 1,001,282 -36, 705 964, 577 21, 983. 00 43.88 38.00 39.00 Central Services and Supply 14.00 326, 883 -10, 857 316, 026 13, 364. 00 23. 65 39.00

2, 148, 469

0

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-1, 754, 228

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ol

40.00

41.00

42.00

Pharmacy

Records Library Social Service

43.00 Other General Service

Medical Records & Medical

7.00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 15-0115 Peri od: From 07/01/2022 To 06/30/2023 1/25/2024 11:51 am Average Hourly Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . Salaries in col . 5) (from Worksheet A-6) 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 91, 129, 193 -1, 042, 381 90, 086, 812 2, 059, 087. 35 43. 75 1.00 instructions) 2.00 41, 479, 719 41, 375, 268 786, 078. 00 52.64 2.00 Excluded area salaries (see -104, 451 instructions) 3.00 Subtotal salaries (line 1 49, 649, 474 -937, 930 48, 711, 544 1, 273, 009. 35 38. 26 3.00 minus line 2) 4.00 Subtotal other wages & related 22, 353, 272 22, 353, 272 553, 066. 16 40.42 4.00 costs (see inst.) Subtotal wage-related costs 5.00 16, 268, 243 Ω 16, 268, 243 0.00 33. 40 5.00 (see inst.) Total (sum of lines 3 thru 5) 1, 826, 075. 51 6.00 6.00 88, 270, 989 -937, 930 87, 333, 059 47.83

-2, 038, 050

9, 460, 788

285, 256. 14

11, 498, 838

7.00

Total overhead cost (see

instructions)

Provider CCN: 15-0115

	To 06/30/2023	Date/Time Prep 1/25/2024 11:	
		Amount	
		Reported	
		1, 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 671, 252	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	11, 797, 411	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	85, 707	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	1, 405, 725	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	343, 326	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Noncumul ati ve porti on)		
	TAXES		
17. 00	FICA-Employers Portion Only	6, 437, 849	1
18. 00	Medicare Taxes - Employers Portion Only	0	
19. 00	Unempl oyment Insurance	0	
20. 00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00		0	21. 00
	instructions))	· '	
22. 00	Day Care Cost and Allowances	0	
23. 00		76, 271	1
24. 00	Total Wage Related cost (Sum of lines 1 -23)	21, 817, 541	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	 	25. 00

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lieu of Form CM		
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0115	Peri od: From 07/01/2022	Worksheet S-3 Part V	

		To	06/30/2023	Date/Time Pre 1/25/2024 11:	
	Cost Center Description		Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1. 00	Total facility's contract labor and benefit cost		0	0	1. 00
2.00	Hospi tal		0	0	2. 00
3.00	SUBPROVI DER - I PF		0	0	3. 00
4.00	SUBPROVI DER - I RF		0	0	4. 00
5.00	Subprovi der - (0ther)		0	0	5. 00
6. 00	Swing Beds - SNF		0	0	6. 00
7. 00	Swing Beds - NF		0	0	7. 00
8. 00	SKILLED NURSING FACILITY		0	0	8. 00
9. 00	NURSING FACILITY				9. 00
10. 00	OTHER LONG TERM CARE I				10.00
11. 00	Hospi tal -Based HHA		0	0	11. 00
12. 00	AMBULATORY SURGICAL CENTER (D. P.) I				12.00
	Hospi tal -Based Hospi ce		0	0	13. 00
	Hospital-Based Health Clinic RHC		0	0	14. 00
14. 01	Hospital-Based Health Clinic RHC 1		0	0	14. 01
15. 00	Hospital-Based Health Clinic FQHC		0	0	15. 00
16. 00	Hospi tal -Based-CMHC				16. 00
	RENAL DIALYSIS I		0	0	17. 00
18. 00	Other		0	0	18. 00

Heal th	Financial Systems ME	MORIAL HOSP &	HEALTH CARE CTI	₹	In Lie	eu of Form CMS-2	2552-10
	EALTH AGENCY STATISTICAL DATA		Provider C		Period: From 07/01/2022	Worksheet S-4	
			Component		Го 06/30/2023	Date/Time Pre 1/25/2024 11:	
					Home Health	PPS	
					Agency I		
0.00	County	-			DUBOI S	00	0. 00
0.00	County	Title V	Title XVIII	Title XIX	0ther	Total	0.00
	HOME HEALTH AGENCY STATISTICAL DATA	1. 00	2. 00	3.00	4. 00	5. 00	
1.00	Home Health Aide Hours	0	2, 708	154	1 2, 032	4, 894	1. 00
2.00	Unduplicated Census Count (see instructions)	0. 00	441. 00		331.00 Loyees (Full Ti		2. 00
				Number of Emp	royees (Furi II	me Equivarent)	
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal	l work week				
			0	1.00	2.00	3. 00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		40. 00	0.00		l e	
5. 00	Other Administrative Personnel			4. 88	0.00	ł	
6.00	Direct Nursing Service			11. 9			6. 00 7. 00
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			0. 80 6. 30			
9.00	Physical Therapy Supervisor			0.00		l e	
10. 00 11. 00	Occupational Therapy Service Occupational Therapy Supervisor			3. 7		•	•
12. 00	Speech Pathology Service			0. 22		l e	12. 00
13.00	Speech Pathology Supervisor			0.00		l	
14. 00 15. 00	Medical Social Service Medical Social Service Supervisor			0. 17		l	15.00
16. 00	Home Health Aide			2. 3!		l .	
17. 00 18. 00	Home Health Aide Supervisor Other (specify)			0.00		0.00	17. 00 18. 00
	()				-,	CBSA Data	
	HOME HEALTH AGENCY CBSA CODES					1. 00	
19. 00	Enter in column 1 the number of CBSAs where					1	19. 00
20. 00	List those CBSA code(s) in column 1 serviced first code).	during this co	ost reporting p	period (line 20) contains the	99915	20. 00
			pi sodes	1,1104 E : 1	DED 0 1	T	
		Without Outliers	With Outliers	LUPA Epi sodes	PEP Only Epi sodes	Total (cols. 1-4)	
		1.00	2.00	3. 00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	2, 649	1, 433	8:	36	4, 201	21. 00
22. 00	Skilled Nursing Visit Charges	673, 236	364, 148	23, 132	9, 456	1, 069, 972	22. 00
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	1, 689 455, 232		1			23. 00 24. 00
25. 00	Occupational Therapy Visits	620	l .	i .	19	l	•
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	167, 374 32			5, 111	484, 284 74	26. 00 27. 00
28. 00	Speech Pathology Visit Charges	8, 608			538	19, 906	•
29. 00	Medical Social Service Visits	11		1		21	29. 00
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	3, 366 674		l .	0 3 7	6, 426 1, 489	
32. 00	Home Health Aide Visit Charges	78, 858	94, 185	35		174, 213	32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5, 675	4, 932	140	86	10, 833	33. 00
34. 00	Other Charges	0	_			0	34.00
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1, 386, 674	1, 183, 884	38, 009	21, 842	2, 630, 409	35. 00
36. 00	Total Number of Episodes (standard/non	5, 675		140	27	5, 842	36. 00
37. 00	outlier) Total Number of Outlier Episodes		4, 932		59		37. 00
38. 00	Total Non-Routine Medical Supply Charges	28, 448	10, 001	45	209	39, 109	38. 00

Heal th I	Financial Systems MEI	MORIAL HOSP & F	HEALTH CARE CT	R	In Li	eu of Form CMS	S-255	52-10
HOSPI TA	L-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-0115	Period: From 07/01/2022	Worksheet S	-8	
			Component	CCN: 15-8507	To 06/30/2023			
					RHC I	Cost		alli
			<u> </u>					
Iz.					1	. 00		
	Clinic Address and Identification Street				522 SOUTH MAPL	F STREET	_	1. 00
1.00	511 661		Ci	ty	State	ZIP Code		1.00
				00	2. 00	3. 00		
2.00	City, State, ZIP Code, County		FRENCH LICK		11	N 47432		2. 00
						1.00		
3.00 I	HOSPITAL-BASED FOHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for ι	ırban			0	3. 00
					nt Award	Date		
lc	Source of Federal Funds				1. 00	2. 00		
	Community Health Center (Section 330(d), PHS	Act)				T		4. 00
	Migrant Health Center (Section 329(d), PHS Ac							5.00
1	Health Services for the Homeless (Section 340	O(d), PHS Act)						6. 00
	Appalachian Regional Commission Look-Alikes							7. 00 8. 00
	CONTRACTION OF THE CONTRACT OF							9.00
7.00	omen (erearry)		,					7. 00
					1. 00	2. 00		
2	Does this facility operate as other than a ho yes or "N" for no in column 1. If yes, indica 2.(Enter in subscripts of line 11 the type of hours.)	ite number of d	other operation	ns in column	N		0 1	0. 00
	nour of y	Sun	ıday	N	londay	Tuesday		
		from	to	from	to	from		
lr.		1.00	2. 00	3.00	4. 00	5. 00		
11. 00	Facility hours of operations (1)			08: 00	17: 00	07: 00	1	1. 00
			•	100.00				
10.00					1. 00	2. 00		
13. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.	lin CMS Pub. 1 umn 1. If yes,	100-04, chapter enter in colum	9, section nn 2 the	N N		0 1	2. 00 3. 00
1.				Prov	ider name	CCN		
					1.00	2. 00		
14.00 [1	RHC/FQHC name, CCN	Y/N	V	XVIII	XIX	Total Visits		4. 00
			V	AVIII	ΛΙΛ		3	
		1. 00	2.00	3.00	4. 00	5.00		
1	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX. as applicable. Enter in column 5 the	1.00	2.00	3.00	4. 00	5. 00	1	5. 00
1	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	1.00			4.00	5. 00	1	5. 00
1	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1.00	Cou	3.00 Inty 00	4.00	5. 00	1	5. 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.		Cou 4. ORANGE	inty 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)	Tuesday	Cou 4. ORANGE Wedn	inty 00 esday	Thu	rsday		
((((((((((GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Tuesday to	Cou 4. ORANGE Wedn from	inty 00 esday to	Thu from	rsday		2. 00
2.00	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)	Tuesday	Cou 4. ORANGE Wedn	inty 00 esday	Thu	rsday		

Health Financial Systems ME	EMORIAL HOSP & F	HEALTH CARE CT	R	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od:	Worksheet S-8	
				From 07/01/2022		
		Component	CCN: 15-8507	To 06/30/2023	Date/Time Pre	pared:
		·			1/25/2024 11:	<u>51 am</u>
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	06: 00	15: 00				11. 00

Health Financial Systems MEI	MORIAL HOSP & F	HEALTH CARE CT	₹	In Lie	eu of Form CN	S-2552-1
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-0115	Peri od: From 07/01/2022	Worksheet S	8-8
		Component	CCN: 15-8508	To 06/30/2023		
				RHC II	Cos	
				1.	. 00	
Clinic Address and Identification 1.00 Street				105 COOPER STR	DEET	1.00
1.00 Street		Ci	ty	State	ZIP Code	1.00
			00	2. 00	3. 00	
2.00 City, State, ZIP Code, County		L00G00TEE		1 N	47553	2. 00
					1 00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ente	or "D" for rure	al or "II" for i	ırhan		1.00	0 3.00
3.00 HOSPITAL-BASED FUNCS ONLY. Designation - Ente	er K TOLTULA	11 01 0 101 0		nt Award	Date	0 3.00
				1. 00	2.00	
Source of Federal Funds						
4.00 Community Health Center (Section 330(d), PHS						4. 00
5.00 Migrant Health Center (Section 329(d), PHS Ac						5. 00
6.00 Health Services for the Homeless (Section 340 Appalachian Regional Commission	J(u), PHS ACT)					6. 00 7. 00
8. 00 Look-Alikes						8. 00
9.00 OTHER (SPECIFY)						9. 00
10.00		501100 5	1 111/11 6	1. 00	2. 00	0 10 0
10.00 Does this facility operate as other than a hoyes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of o	other operation	ns in column	N		0 10.00
(modified)	Sun	ıday	N	londay	Tuesday	
	from	to	from	to	from	
	1. 00	2. 00	3. 00	4. 00	5. 00	
Facility hours of operations (1) 11.00 CLINIC		1	08: 00	17: 00	08: 00	11.00
11. 00 CLINIC			06.00	17.00	06.00	11.00
				1. 00	2. 00	
12.00 Have you received an approval for an exception				N		12. 00
13.00 Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.	umn 1. If yes,	enter in colum	nn 2 the	N		0 13.00
Humber 3 ber ow.			Prov	ider name	CCN	
				1. 00	2. 00	
14.00 RHC/FQHC name, CCN						14. 00
	Y/N	V 2.00	XVIII	XIX	Total Visit	S
15.00 Have you provided all or substantially all	1.00	2.00	3. 00	4. 00	5. 00	15. 00
						13.00
IGME COST? ENTER "Y" FOR YES OR "N" FOR NO IN						
GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and						
column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by						
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						
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						
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						
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.			ınty			
column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		4.	inty 00			
column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.		4. MARTI N	00	Thu	reday	2. 00
column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Tuesday	4. MARTIN Wedn	00 esday		rsday T to	2.00
column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Tuesday to	4. MARTI N	esday to	Thui from 9,00	rsday to 10.00	2.00
column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Tuesday	4. MARTIN Wedn from	00 esday	from	to	2.00

Health Financial Systems ME	MORIAL HOSP & I	HEALTH CARE CT	R	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 15-0115	Peri od:	Worksheet S-8	
		Component	CCN, 1E 0E00	From 07/01/2022		narad.
		Component	CCN: 15-8508	To 06/30/2023	Date/Time Pre 1/25/2024 11:	
				RHC II	Cost	
	Fri	day	Sa	turday		
	Fri from	day to	Sa from	turday to		
		J				
Facility hours of operations (1)	from	to	from	to		
, , , , , , , , , , , , , , , , , , , ,	from 11.00	to	from	to		11. 00

Heal th	Financial Systems MEMORIAL HOSP & HEALT	TH CARE CTR		In Lie	u of Form CMS-2	2552-10
		Provider CCN: 1		Peri od:	Worksheet S-10	
				From 07/01/2022 To 06/30/2023	Date/Time Pre	nared·
					1/25/2024 11:	
					1. 00	
	Uncompensated and indigent care cost computation					
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div Medicaid (see instructions for each line)	rided by line 2	202 column	8)	0. 215854	1.00
2.00	Net revenue from Medicaid				16, 258, 166	2. 00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3. 00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement		4. 00			
5. 00 6. 00	If line 4 is no, then enter DSH and/or supplemental payments fr Medicaid charges	om wedicald			0 67, 346, 479	
7. 00	Medicaid cost (line 1 times line 6)		14, 537, 007	1		
8. 00	Difference between net revenue and costs for Medicaid program (line 7 minus s	sum of line	es 2 and 5; if	0	ı
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line)			_	
9.00	Net revenue from stand-alone CHIP				0	
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)					10. 00 11. 00
12. 00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus	line 9: i1	<pre>< zero then</pre>		12.00
.2.00	enter zero)		,	2010 111011		12.00
	Other state or local government indigent care program (see inst					
13. 00	Net revenue from state or local indigent care program (Not incl					13. 00
14. 00	Charges for patients covered under state or local indigent care 10)	e program (Not	included i	n lines 6 or	0	14. 00
15. 00	State or local indigent care program cost (line 1 times line 14	.)			0	15. 00
16. 00	Difference between net revenue and costs for state or local ind	ligent care pro	ogram (line	e 15 minus line	0	16. 00
	13; if < zero then enter zero)	D and atata/la	anal indias	n+ ooro program	1000	
	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)	P and State/IC	ocar indige	ent care program	is (see	
17. 00	Private grants, donations, or endowment income restricted to fu					17. 00
18.00	Government grants, appropriations or transfers for support of h			(6.1.	0	
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	indigent care	e programs	(Sull of Titles	0	19. 00
			Ini nsured	Insured	Total (col. 1	
		<u> </u>	patients	pati ents	+ col . 2)	
	Uncompensated Care (see instructions for each line)		1. 00	2. 00	3. 00	
20. 00	Charity care charges and uninsured discounts for the entire fac	ility	4, 365, 73	518, 394	4, 884, 128	20. 00
21. 00	(see instructions) Cost of patients approved for charity care and uninsured discou	ints (see	942, 36	518, 394	1, 460, 755	21 00
21.00	instructions)	11113 (366	742, 30	310, 374	1, 400, 733	21.00
22. 00	Payments received from patients for amounts previously written	off as	(0	0	22. 00
23. 00	charity care Cost of charity care (line 21 minus line 22)		942, 36	518, 394	1, 460, 755	23. 00
					1 00	
24 00	Does the amount on line 20 column 2, include charges for patien	it days beyond	a Length (of stay limit	1. 00 N	24. 00
	imposed on patients covered by Medicaid or other indigent care	program?		•		
25. 00	If line 24 is yes, enter the charges for patient days beyond th stay limit	ie indigent car	re program	s rength of	0	25. 00
26. 00	Total bad debt expense for the entire hospital complex (see ins	,			8, 056, 059	
27. 00	Medicare reimbursable bad debts for the entire hospital complex	•	,		100, 849	1
27. 01	Medicare allowable bad debts for the entire hospital complex (s	see instruction	ns)		155, 153	
28. 00 29. 00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see inst	tructions)		7, 900, 906 1, 759, 746	1
	Cost of uncompensated care (line 23 column 3 plus line 29)	(300 1113)	40 (1 0113)		3, 220, 501	1
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			3, 220, 501	1

		WURLAL HUSP & HE				Worksheet A	2332-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der CO		Period: From 07/01/2022	worksneet A	
					o 06/30/2023	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	1/25/2024 11: Recl assi fi ed	51 am
	cost center bescription	Sai ai i es	other	+ col . 2)	ons (See A-6)	Tri al Balance	
				1 001. 2)	0113 (300 71 0)	(col . 3 +-	
						col . 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		6, 458, 437	6, 458, 437		6, 458, 437	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		5, 536, 543	5, 536, 543	0	5, 536, 543	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	(0	0	4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 772, 100	1, 676, 043	3, 448, 143		3, 273, 573	5. 00
6. 00 8. 00	00600 MAINTENANCE & REPAIRS 00800 LAUNDRY & LINEN SERVICE	633, 083 299, 370	3, 420, 528			4, 053, 611 372, 440	6. 00 8. 00
9. 00	00900 HOUSEKEEPING	299, 370	73, 070	372, 440		372, 440	9.00
10.00	01000 DI ETARY	1, 166, 582	696, 329	-	_		10.00
11. 00	01100 CAFETERI A	0	0,0,02,	1,002,711	1, 496, 103	1, 496, 103	11. 00
13. 00	01300 NURSING ADMINISTRATION	1, 001, 282	120, 837	1, 122, 119			
14.00	01400 CENTRAL SERVICES & SUPPLY	326, 883	180, 761	507, 644		496, 413	14. 00
15.00	01500 PHARMACY	2, 148, 469	20, 288, 346	22, 436, 815	-21, 825, 157	611, 658	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	(1	0	16. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0	(1
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	1, 362, 936	1, 423, 996	2, 786, 932	-1, 297, 821	1, 489, 111	22. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	7 770 000	1 572 /05	0.244.70	2 277 000	/ 0// 700	1 20 00
30. 00 31. 00	03100 NTENSI VE CARE UNIT	7, 770, 923	1, 573, 685 318, 453			6, 966, 700 3, 027, 216	30. 00 31. 00
40.00	04000 SUBPROVI DER – I PF	2, 814, 077 1, 438, 493	79, 978			1, 516, 459	
41. 00	04100 SUBPROVIDER - IRF	578, 298	139, 497	717, 795			41.00
43. 00	04300 NURSERY	0	137, 477	/ / / / /			
44. 00	04400 SKILLED NURSING FACILITY	1, 408, 217	207, 507	1, 615, 724			
	ANCILLARY SERVICE COST CENTERS	.,,		.,,,,,,,		.,,,	
50.00	05000 OPERATI NG ROOM	5, 758, 754	10, 006, 932	15, 765, 686	-74, 793	15, 690, 893	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(1, 446, 167	1, 446, 167	52.00
53.00	05300 ANESTHESI OLOGY	3, 948, 599	524, 861	4, 473, 460			53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	7, 493, 170	1, 927, 846	9, 421, 016		9, 053, 841	54. 00
56. 00	05600 RADI OI SOTOPE	202, 106	726, 567			927, 751	
60.00	06000 LABORATORY	3, 505, 585	5, 427, 741	8, 933, 326		8, 932, 801	1
65. 00	06500 RESPI RATORY THERAPY	1, 399, 136	851, 138			2, 215, 157	
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	3, 108, 298 2, 922, 060	219, 969 1, 828, 280			3, 241, 700 4, 669, 525	66. 00 69. 00
69. 00	06901 PULMONARY	2, 922, 000	1, 020, 200	4, 750, 540		4, 669, 525	69. 00
69. 02	06902 CARDI OPULMONARY	115, 643	57, 066	`	ή	172, 709	69. 02
69. 03	06903 SLEEP LAB	253, 074	12, 345	265, 419		265, 419	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(o	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	О	0	(1, 810, 928	1, 810, 928	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	5, 285, 095	5, 285, 095		5, 285, 095	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	(22, 223, 968	22, 223, 968	
74. 00	07400 RENAL DI ALYSI S	0	0	(0	0	74. 00
77. 00	07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0	(0	0	77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	418, 977	125, 603	544, 580	ار	544, 580	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	583, 911	86, 741	670, 652		670, 652	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	303, 711	00, 741	070,032		070,032	89. 00
90.00	09000 CLI NI C	513, 302	533, 751	1, 047, 053	-139, 991	907, 062	90.00
90. 01	09001 I MED	0	0	, , , , , ,	o	0	90. 01
90. 02	09002 ONCOLOGY	2, 826, 357	1, 054, 875	3, 881, 232	-100, 142	3, 781, 090	90. 02
90. 03	09003 OUTPATIENT CENTER	0	0	(0	0	90. 03
90. 04	09004 HBURG URGENT CARE CLINIC	1, 312, 624	726, 845	2, 039, 469		1, 559, 731	90. 04
90. 05	09005 DI ABETES MGMT CLINIC	64, 012	3, 590	67, 602		67, 602	90. 05
91. 00	09100 EMERGENCY	9, 983, 480	808, 370	10, 791, 850	-261, 619	10, 530, 231	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	2 000 (72	170 707	2 072 450	22.257	2 050 102	05 00
95. 00 96. 00	1 1	2, 899, 672	172, 787	3, 072, 459	-22, 357	3, 050, 102 0	95. 00 96. 00
	10100 HOME HEALTH AGENCY	2, 250, 604	332, 700	2, 583, 304	-75, 831	2, 507, 473	
	10200 OPI OI D TREATMENT PROGRAM	2, 230, 004	332, 700	2, 303, 30-	, 5, 651		102.00
.02.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>		, <u> </u>		102.00
116.00	11600 HOSPI CE	0	0	(0	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	72, 280, 077	72, 907, 112	145, 187, 189	-168, 853	145, 018, 336	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	(-		190. 00
	19200 PHYSICIANS PRIVATE OFFICES	31, 024, 143	6, 265, 731	37, 289, 874		37, 289, 874	
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	848, 396	16, 645			865, 041	
	07950 LODGE	5, 100	12, 896	17, 996		17, 996	
	07951 OTHER NRCC 07952 MEMORIAL HOSPITAL FOUNDATION	139 271	0 744	148, 037		0 148, 037	194. 01
	07952 MEMORIAL HOSPITAL FOUNDATION 07953 MKT/PHY SERVICES	138, 271 263, 730	9, 766 56, 190			319, 920	
	07954 COMMUNITY EDUCATION	346, 737	139, 971	486, 708		486, 708	
	07955 VOLUNTEER	249, 873	15, 162			265, 035	
	1 1		-, -, -, -,	,	, 9	,	

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu						2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		Period: From 07/01/2022	Worksheet A	
				o 06/30/2023		
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Reclassi fied	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
194. 06 07956 MAB	0	0	(0	0	194. 06
194. 07 07957 OFFSITE COVID SCREENING	0	0	(168, 853	168, 853	194. 07
194. 08 07958 PUBLIC RELATIONS	0	0	(0	0	194. 08
194. 09 07959 UNUSED SPACE	0	0	(0	0	194. 09
194. 10 07960 EMERGENCY PREPAREDNESS	28, 185	194, 352	222, 537	0	222, 537	194. 10
194. 11 07961 HOME OFFICE	o	0	(0	0	194. 11
200.00 TOTAL (SUM OF LINES 118 through 199)	105, 184, 512	79, 617, 825	184, 802, 337	0	184, 802, 337	200. 00

		MEMORIAL HOSP & H				u of Form CMS-2552-
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der CCN	N: 15-0115	Peri od: From 07/01/2022 To 06/30/2023	Worksheet A Date/Time Prepared 1/25/2024 11:51 am
	Cost Center Description	Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00			
	GENERAL SERVICE COST CENTERS	0.00	7.00			
1.00	00100 CAP REL COSTS-BLDG & FLXT	801, 902	7, 260, 339			1. (
2.00	00200 CAP REL COSTS-MVBLE EQUIP	2, 759	5, 539, 302			2. 0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	32, 213, 703	32, 213, 703			4. 0
5.00	00500 ADMINISTRATIVE & GENERAL	24, 574, 802	27, 848, 375			5. 0
6.00	00600 MAINTENANCE & REPAIRS	1, 050, 666				6.0
8.00	00800 LAUNDRY & LINEN SERVICE	0	372, 440			8.0
9.00	00900 HOUSEKEEPI NG	1, 668, 838				9. 0
10.00	01000 DI ETARY	-1, 486	358, 946			10.0
11.00	01100 CAFETERI A	-632, 765	863, 338			11. (
13.00	01300 NURSI NG ADMI NI STRATI ON	-13, 643				13.0
14.00	01400 CENTRAL SERVI CES & SUPPLY	-3, 082	493, 331			14. 0
15.00	01500 PHARMACY	-473, 546	138, 112			15.0
16. 00	01600 MEDI CAL RECORDS & LI BRARY	1, 535, 525	1, 535, 525			16.0
21. 00 22. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	222 721	1, 297, 819			21. 0
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	-232, 721	1, 256, 390			
30. 00	03000 ADULTS & PEDIATRICS	-1, 750	6, 964, 950			30.0
31. 00	03100 I NTENSI VE CARE UNI T	-1,750	3, 027, 216			31. 0
40. 00	04000 SUBPROVI DER - I PF	-132, 851	1, 383, 608			40. 0
41. 00	04100 SUBPROVI DER – I RF	-27, 667	684, 860			41. 0
43. 00	04300 NURSERY	0	723, 084			43. 0
44. 00	04400 SKILLED NURSING FACILITY	0	1, 584, 008			44. 0
	ANCILLARY SERVICE COST CENTERS		.,, .,, .,,			
50.00	05000 OPERATI NG ROOM	-1, 530, 409	14, 160, 484			50.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 446, 167			52.0
53.00	05300 ANESTHESI OLOGY	-4, 074, 744	291, 260			53. 0
54.00	05400 RADI OLOGY-DI AGNOSTI C	-4, 714, 173	4, 339, 668			54. 0
56.00	05600 RADI OI SOTOPE	0	927, 751			56.0
60.00	06000 LABORATORY	-208, 790	8, 724, 011			60.0
65.00	06500 RESPI RATORY THERAPY	-1, 210	2, 213, 947			65. 0
66. 00	06600 PHYSI CAL THERAPY	-317, 794	2, 923, 906			66.0
69. 00	06900 ELECTROCARDI OLOGY	-550, 112	4, 119, 413			69. 0
69. 01	06901 PULMONARY	0	0			69. 0
69. 02	06902 CARDI OPULMONARY	0	172, 709			69.0
69. 03	06903 SLEEP LAB	0	265, 419			69.0
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 810, 928			71. 0
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	5, 285, 095			72.0
73.00	07300 DRUGS CHARGED TO PATIENTS	0	22, 223, 968			73.0
74. 00 77. 00	07400 RENAL DIALYSIS 07700 ALLOGENEIC HSCT ACQUISITION	0	0			74. 0 77. 0
77.00	OUTPATIENT SERVICE COST CENTERS	0	U			
88. 00	08800 RURAL HEALTH CLINIC	-640	543, 940			88. 0
	08801 RURAL HEALTH CLINIC II	-119	670, 533			88. 0
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	1 0	070, 555			89. 0
90.00	09000 CLINIC	-318, 162	588, 900			90.0
90. 01	09001 I MED	0.07.02	0			90.0
90. 02	09002 ONCOLOGY	0	3, 781, 090			90.0
90. 03	09003 OUTPATIENT CENTER	0	0			90. 0
90.04	09004 HBURG URGENT CARE CLINIC	-315, 699	1, 244, 032			90.0
90. 05	09005 DIABETES MGMT CLINIC	0	67, 602			90.0
91. 00	09100 EMERGENCY	-5, 591, 828	4, 938, 403			91. 0
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92. 0
	OTHER REIMBURSABLE COST CENTERS					
95. 00	09500 AMBULANCE SERVI CES	-235, 803	2, 814, 299			95. 0
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0			96. 0
	10100 HOME HEALTH AGENCY	0	2, 507, 473			101. 0
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0			102. 0
	SPECIAL PURPOSE COST CENTERS					
	11600 HOSPI CE	0	- 1			116. 0
118.00		42, 469, 201	187, 487, 537			118. 0
100.5	NONREI MBURSABLE COST CENTERS					
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0				190. 0
	19200 PHYSI CI ANS PRI VATE OFFI CES	0				192. (
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	865, 041			192. 0
	07950 LODGE	0	17, 996			194. 0
	07951 OTHER NRCC	0	140 007			194. 0
	07952 MEMORIAL HOSPITAL FOUNDATION	2 (00 054	148, 037			194. 0
	3 O7953 MKT/PHY SERVICES	3, 602, 354	3, 922, 274			194. 0
	07954 COMMUNITY EDUCATION	0	486, 708			194. 0 194. 0
	07955 VOLUNTEER 07956 MAB	0	265, 035 0			194. 0
	707950 MAB 707957 OFFSITE COVID SCREENING	0				194. 0
174.07	OTTOTION STILL COVID SCREENING	ı	100,000			

Health Financial Systems	MEMORIAL HOSP & HEA	LTH CARE CTR	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRI	AL BALANCE OF EXPENSES	Provider CCN: 15-0115	Peri od: From 07/01/2022	Worksheet A
				Date/Time Prepared:

			1/25/2024 11:51 am
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6. 00	7.00	
194. 08 07958 PUBLIC RELATIONS	0	0	194. 08
194. 09 07959 UNUSED SPACE	0	0	194. 09
194. 10 07960 EMERGENCY PREPAREDNESS	0	222, 537	194. 10
194. 11 07961 HOME OFFICE	0	0	194. 11
200.00 TOTAL (SUM OF LINES 118 through 199)	46, 071, 555	230, 873, 892	200. 00

Health Financial Systems
COST CENTERS USED IN COST REPORT In Lieu of Form CMS-2552-10 Peri od: Worksheet Non-CMS W From 07/01/2022 To 06/30/2023 Date/Time Prepared: Provider CCN: 15-0115 Worksheet Non-CMS W

Cast Center Description				1/25/2024 1	
		Cost Center Description	CMS Code		
BOWERN SERVICE COST - CHORDES				Non-Standard Codes	
BOWERN SERVICE COST - CHORDES					
APP ILL DOS S-BLE & FIX			1.00	2.00	
2.00 CAP MEL COSIS - MINISTER LEGURY 0.000 CAP MEL COSIS					
### A-00 PAPENDER SERVET S GENARMENT			l l		- 11
ADMINISTRATIVE SCREENAL 00500 5.00			•		- 11
MINTENNICE & REPAIRS 00000 8.0			l l		- 11
NOUSEKEEPING			l l		- 11
10.00 DEFARY DISCONDING 10.00			· ·		11
11.00 CAFETERIA 10.00 11.00 11.00 13.00			· ·		11
13.00 MIRST NR. ADMINISTRATION 0.1300 13.00			l l		11
14.00 CENTRAL SERVICES & SUPPLY 01400 14.00 15.00 16.00			l l		11
15.00 MEDICAL RECORDS & LIBRARY 01600 15.00 15.00 16.00			l l		11
10.00 MEDICAL RECORDS & LIBRARY 0.1000 21.00 22.00			l l		11
ABSTERVICES-OTHER PROJECTORS APPROVED 18	16. 00	MEDICAL RECORDS & LIBRARY	01600		16. 00
IMPAILENT ROUTINE SERVICE COST CENTERS 30,000 30,000 31,00			l l		11
ADULT'S & PEDIATRICS 03000 30, 00 31, 00 40, 00	22. 00		02200		22. 00
INTERNITY CARE UNIT	20.00		02000		20.00
40.00 SUBPROVIDER - IPF					- 11
1.00 SUBPROVIDER - IRE					
43.00 NURSERY 04400					
ANCILLARY SERVICE COST CENTERS 50.00 DEFATTING ROOM 05000 55.00					
50.00	44.00	SKILLED NURSING FACILITY	04400		44. 00
15.2.00 MELI MERK PROOM & LABOR ROOM 55.00 55.					
53.00 MRSTHESI OLOGY 53.00 55.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 66.			l l		- 11
54.00 ADDI CLOY-) DI AGNOSTIC 05600 55.00 60			l l		- 11
56. 00 ADDIOSOTOPE			l l		- 11
60.00 LABORATORY 0.6000 6.600			l l		- 11
66.00 PHYSICAL THERAPY 06690 66.00 69.00 6			l l		- 11
69.00 ELECTROCARDIOLOGY 69.00	65.00	RESPI RATORY THERAPY	06500		65. 00
69. 01 PULMONARY 0.6901 6.9 01 6.9 01 6.9 02 6.9 03			· ·		11
69, 02 CARDI OPULINOMARY 0,6902 69, 02 69, 02 69, 03			•		11
69. 03 SLEEP LAB			l l		11
10, 00 ELECTROENCEPHALLOGRAPHY			l l		- 11
71.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 07100 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 74.00 74.00 74.00 77.0			•		11
73. 00 DRUGS CHARGED TO PATIENTS 07300 73. 00 74. 00 74. 00 74. 00 77. 00 7			l l		11
74, 00 RENAL DI ALYSIS 07400 77, 00 07700	72. 00	IMPL. DEV. CHARGED TO PATIENTS	07200		72. 00
ALLOGENEIC HSCT ACQUISITION 07700					11
DUTPATIENT SERVICE COST CENTERS			l l		11
88. 00 RURAL HEALTH CLINIC 08800 88. 00 89. 00 RURAL HEALTH CLINIC I 08801 88. 00 89. 00 RURAL HEALTH CLINIC I 08801 88. 01 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 90. 00	77.00		07700		//.00
88 01 RURAL HEALTH CLINIC I 08801 88 01 FEDERALLY QUALIFIED HEALTH CENTER 08900 89, 00 90, 00	88 00		08800		88 00
90. 00 CLINI C 09000 90. 00 90.					
90. 01 MED	89. 00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89. 00
90. 02 0NCOLOGY 09002 09002 90. 02 09003 90. 02 90. 03 09003 90. 03 90. 03 90. 03 90. 03 90. 03 90. 04 90. 04 90. 05 90. 04 90. 05 90. 0		CLINIC	09000		
90. 03 OUTPATI ENT CENTER 09003 90. 03 90. 03 90. 04 4BURG URGENT CARE CLINIC 09004 90. 04 90. 05 90. 05 90. 05 90. 05 90. 05 90. 05 90. 05 90. 05 90. 05 90. 05 90. 05 90. 05 90. 05 90. 05 90. 05 90. 05 90. 00 90			l l		
90. 04 BBURG URGENT CARE CLINIC 09004 90. 04 90. 04 90. 05 09005 90. 0			•		- 11
90. 05 DI ABETES MGMT CLINI C 09005 91. 00 91. 00 91. 00 91. 00 91. 00 92. 00 09500 92. 00 09500 92. 00 09500 92. 00 09500 95. 00 09500 95. 00 09500 95. 00 09500 95. 00 09600 96. 00 09600 96. 00 09600 96. 00 09600 96. 00 09600 09600 09600 096. 00 09600 096. 00 09600 096. 00 09600 096. 00 09600 096. 00 09600 096. 00 09600 096. 00 09600 096. 00 09600 096. 00 096.			•		- 11
91. 00 MSERGENCY 09100 92. 00 08SERVATION BEDS (NON-DISTINCT PART 09200 92. 00 070			l l		- 11
92. 00 OBSERVATI ON BEDS (NON-DI STI NCT PART OPEN OPEN OPEN OPEN OPEN OPEN OPEN OPEN			l l		
OTHER REIMBURSABLE COST CENTERS O9500 95.00			•		- 11
96. 00 DURABLE MEDI CAL EQUI P-RENTED 09600 9600 101. 00 101. 00 101. 00 101. 00 101. 00 102. 00 9F		OTHER REIMBURSABLE COST CENTERS			
101.00 HOME HEALTH AGENCY 10100 101.00 102.00			l l		11
102.00 OPI OI D TREATMENT PROGRAM 102.00 SPECI AL PURPOSE COST CENTERS 116.00 HOSPI CE 116.00 HOSPI CE 116.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 190.00 GI FT FLOWER COFFEE SHOP & CANTEEN 190.00 192.00 PHYSI CI ANS PRI VATE OFFI CES 19200 192.00 192.01 194.00 1			•		
SPECIAL PURPOSE COST CENTERS 116.00 HOSPI CE 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 NONREIMBURSABLE COST CENTERS 190.00 GI FT FLOWER COFFEE SHOP & CANTEEN 19000 192.00 PHYSI CI ANS PRI VATE OFFI CES 19200 192.00 192.01 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 19201 192.01 194.00 19			•		- 11
116. 00 HOSPI CE	102.00		10200		102.00
NONREI MBURSABLE COST CENTERS 190.00 GI FT FLOWER COFFEE SHOP & CANTEEN 190.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.01 192.01 192.01 192.01 192.01 193.00 193.00 193.00 193.00 193.00 194.00 194.00 194.01 19	116.00		11600		116. 00
190. 00 GI FT FLOWER COFFEE SHOP & CANTEEN 190. 00 PHYSI CI ANS PRI VATE OFFI CES 192. 01 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 192. 01 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 194. 00 LODGE 07950 194. 00 194. 01 194. 02 MEMORI AL HOSPI TAL FOUNDATI ON 194. 03 MKT/PHY SERVI CES 194. 04 COMMUNI TY EDUCATI ON 194. 04					
192. 00 PHYSI CI ANS PRI VATE OFFI CES 19200 192. 00 192. 01 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 19201 192. 01 194. 00 LODGE 07950 194. 00 194. 01 OTHER NRCC 07951 194. 01 194. 02 MEMORI AL HOSPI TAL FOUNDATION 07952 194. 02 194. 03 MKT/PHY SERVI CES 07953 194. 03 194. 04 COMMUNI TY EDUCATION 07954 194. 04					
192. 01 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 192. 01 194. 00 LODGE 07950 194. 00 194. 01 OTHER NRCC 07951 194. 01 194. 02 MEMORI AL HOSPI TAL FOUNDATION 07952 194. 02 194. 03 MKT/PHY SERVI CES 07953 194. 03 194. 04 COMMUNI TY EDUCATION 07954 194. 04			l l		
194.00 LODGE 07950 194.00 194.01 OTHER NRCC 07951 194.01 194.02 MEMORI AL HOSPITAL FOUNDATION 07952 194.02 194.03 MKT/PHY SERVICES 07953 194.03 194.04 COMMUNITY EDUCATION 07954 194.04			•		
194.01 OTHER NRCC 07951 194.01 194.02 MEMORI AL HOSPITAL FOUNDATION 07952 194.02 194.03 MKT/PHY SERVICES 07953 194.03 194.04 COMMUNITY EDUCATION 07954 194.04					
194.02 MEMORIAL HOSPITAL FOUNDATION 07952 194.02 194.03 MKT/PHY SERVICES 07953 194.03 194.04 COMMUNITY EDUCATION 07954 194.04					
194.03 MKT/PHY SERVICES 07953 194.03 194.04 COMMUNITY EDUCATION 07954 194.04					
194. 05 VOLUNTEER 07955 194. 05					
	194. 05	VOLUNTEER	07955		194. 05

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lieu of Form CMS-2552-10
COST CENTERS USED IN COST REPORT	Provider CCN: 15-0115	Period: Worksheet Non-CMS W
		To 06/30/2023 Date/Time Prepared:

		1/25/2024 11:	51 am
Cost Center Description	CMS Code	Standard Label For	
		Non-Standard Codes	
	1.00	2.00	1
194. 06 MAB	07956		194. 06
194.07 OFFSITE COVID SCREENING	07957		194. 07
194.08 PUBLIC RELATIONS	07958		194. 08
194.09 UNUSED SPACE	07959		194. 09
194. 10 EMERGENCY PREPAREDNESS	07960		194. 10
194.11 HOME OFFICE	07961		194. 11
200.00 TOTAL (SUM OF LINES 118 through 199)			200.00

Health Financial Systems RECLASSIFICATIONS MEMORI AL HOSP & HEALTH CARE CTR
Provi der CCN: 15-0115 In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 1/25/2024 11:51 am

		Increases			1/25/2024 11: 5	1 am
	Cost Center	Li ne #	Sal ary	Other		
	2.00	3.00	4.00	5. 00		
	A - LABOR AND DELIVERY		<u> </u>			
1.00	NURSERY	43.00	637, 747	85, 337		1. 00
2.00	DELIVERY ROOM & LABOR ROOM _	5200	<u>1, 275, 4</u> 93	17 <u>0, 6</u> 74		2. 00
	TOTALS		1, 913, 240	256, 011		
1. 00	B - CAFETERI A CAFETERI A	11. 00	920, 900	575, 203		1. 00
1.00	TOTALS		920, 900	575, 203		1.00
	C - BILLABLE SUPPLES		720, 700	373, 203		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 810, 928		1. 00
	PATI ENT					
2.00		0.00	0	0		2.00
3. 00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5. 00 6. 00		0. 00 0. 00	0	0		5. 00 6. 00
7. 00		0.00	o	0		7. 00
8.00		0.00	Ö	Ö		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13. 00 14. 00	+	0. 00 0. 00	0	0		13. 00 14. 00
15. 00		0.00	o	0		15. 00
16. 00		0.00	o	Ö		16. 00
17. 00		0.00	O	0		17. 00
18.00		0.00	O	0		18.00
19. 00		0.00	0	0		19. 00
20.00		0.00	0	0		20.00
21. 00		0.00	0	0		21.00
22. 00 23. 00		0. 00 0. 00	o	0		22. 00 23. 00
23.00	TOTALS — — — —		j	1, 810, 928		23.00
	D - DRUGS RECLASS	<u> </u>	-1	.,		
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	20, 485, 748		1. 00
2.00	LABORATORY	60.00	0	39		2.00
3.00		0.00	0	0		3.00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
6. 00		0.00	o	0		6. 00
7. 00		0.00	Ö	O		7. 00
8.00		0.00	O	0		8.00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00 12. 00		0. 00 0. 00	0	0		11. 00 12. 00
13. 00		0.00	o	0		13. 00
14. 00		0.00	o	Ö		14. 00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18.00		0.00	0	0		18.00
19. 00 20. 00		0. 00 0. 00	0	0		19. 00 20. 00
21. 00		0.00	o	0		21. 00
21.00	TOTALS — — — —		 	20, 485, 787		200
	E - INTERN AND RESIDENT RECLA					
1. 00	I &R SERVICES-SALARY &	21. 00	0	1, 297, 819		1. 00
	FRI NGES APPRV	+		1, 297, 819		
	F - DISABILITY LEAVE RECLASS		Ŋ	1, 271, 019		
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	46, 294		1. 00
2.00	MAINTENANCE & REPAIRS	6.00	О	2, 141		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	7, 234		3. 00
4.00	DI ETARY	10.00	0	23, 198		4. 00
5. 00 6. 00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13. 00 14. 00	0	36, 705 10, 857		5. 00 6. 00
7. 00	PHARMACY	15. 00	ol Ol	16, 008		7. 00
8. 00	I &R SERVICES-OTHER PRGM	22. 00	o	4, 616		8. 00
	COSTS APPRV		٦	,, 5.0		
9.00	ADULTS & PEDIATRICS	30. 00	О	91, 629		9. 00
10. 00	INTENSIVE CARE UNIT	31.00	O	73, 614		10.00
11.00	SUBPROVI DER - I PF	40.00	0	21, 782		11.00
12. 00	SUBPROVI DER - I RF	41. 00	0	14, 241		12. 00

Health Financial Systems RECLASSIFICATIONS Peri od: From 07/01/2022 To 06/30/2023 Date/Ti me Prepared: 1/25/2024 11:51 am Provider CCN: 15-0115

Cost Center						
2.00 3.00 4.00 5.00						
13.00 SKILLED NURSING FACILITY		Cost Center	Li ne #	Sal ary	0ther	
14. 00 OPERATI NG ROOM 50. 00 0 56, 459 14. 00 15. 00 ANESTHESI OLOGY 53. 00 0 46, 047 15. 01 15. 01 16. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 68, 866 16. 00 17. 00 LABORATORY 60. 00 0 26, 593 17. 00 18. 00 RESPI RATORY THERAPY 65. 00 0 26, 131 18. 00 19. 00 PHYSI CAL THERAPY 66. 00 0 33, 082 19. 00 0 0 0 0 0 0 0 0 0			3. 00	4. 00	5.00	
15. 00	13.00	SKILLED NURSING FACILITY	44.00	0	19, 273	13. (
16. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 68, 866 17. 00 LABORATORY 60. 00 0 26, 593 17. 0 18. 00 RESPI RATORY THERAPY 65. 00 0 26, 131 19. 00 PHYSI CAL THERAPY 66. 00 0 33, 082 18. 00 20. 00 ELECTROCARDI OLOGY 69. 00 0 68, 882 20. 0 21. 00 RURAL HEALTH CLINIC II 88. 01 0 1, 018 21. 0 22. 00 CLINIC 90. 00 10, 055 22. 0 23. 00 ONCOLOGY 90. 02 0 44, 231 23. 0 24. 00 HBURG URGENT CARE CLINIC 90. 04 0 19, 264 24. 0 25. 00 EMERGENCY 91. 00 67, 613 25. 0 26. 00 AMBULANCE SERVI CES 95. 00 0 33, 872 26. 0 27. 00 HOME HEALTH AGENCY 101. 00 0 3, 199 27. 0 28. 00 PHYSI CIANS PRI VATE OFFI CES 192. 00 0 149, 692 29. 0 29. 00 PSYCHI ATRI C/PSYCHOLOGI CAL 192. 01 0 8, 832 29. 0 SERVI CES 194. 05 0 1, 105 30. 0 30. 00 COMMUNITY EDUCATION 194. 04 0 1, 105 30. 0 SERVI CES 19. 00 1, 042, 381 30. 0 TOTALS 0 1, 738, 220 0 1 1. 00 OFFSI TE COVID SCREENING 194. 07 157, 393 11, 460 107 11, 400 107 157, 393 11, 460 107 17 160 17 17, 400 107 17, 400 107 11, 400 107 17, 393 11, 460 107 17, 400 107 107 107 107 107 107 107 107 107 1	14.00	OPERATING ROOM	50.00	0	56, 459	14. 0
17. 00 LABORATORY	15.00	ANESTHESI OLOGY	53.00	0	46, 047	15. 0
18. 00 RESPIRATORY THERAPY 65. 00 0 20, 131 19. 00 PHYSI CAL THERAPY 66. 00 0 33, 082 20. 00 ELECTROCARDIOLOGY 69. 00 0 68, 882 21. 00 RURAL HEALTH CLINIC II 88. 01 0 1, 018 22. 00 CLINIC 90. 00 0 10, 055 23. 00 ONCOLOGY 90. 02 0 44, 231 24. 00 HBURG URGENT CARE CLINIC 90. 04 0 19, 264 25. 00 EMERGENCY 91. 00 0 67, 613 26. 00 AMBULANCE SERVICES 95. 00 0 33, 872 27. 00 HOME HEALTH AGENCY 101. 00 0 3, 199 28. 00 PHYSI CLANS PRI VATE OFFICES 192. 00 0 149, 692 29. 00 PSYCHIATRIC/PSYCHOLOGICAL 192. 01 0 8, 832 SERVICES 30. 00 COMMUNITY EDUCATION 194. 04 0 1, 105 30. 00 COMMUNITY EDUCATION 194. 04 0 1, 105 31. 00 TOTALS 0 1, 738, 220 0 1 1. 00 DRUGS CHARGED TO PATIENTS 73. 00 1, 738, 220 0 1 1. 00 OFFSI TE COVID SCREENING 194. 07 157, 393 11, 460 TOTALS 157, 393 11, 460	16.00	RADI OLOGY-DI AGNOSTI C	54.00	0	68, 866	16.0
19. 00 PHYSI CAL THERAPY 66. 00 0 33, 082 20. 00 ELECTROCARDI OLOGY 69. 00 0 68, 882 21. 00 RURAL HEALTH CLINIC II 88. 01 0 1, 018 22. 00 CLINIC 90. 00 0 10, 055 23. 00 ONCOLOGY 90. 02 0 44, 231 24. 00 HBURG URGENT CARE CLINIC 90. 04 0 19, 264 25. 00 EMERGENCY 91. 00 0 67, 613 26. 00 AMBULANCE SERVI CES 95. 00 0 33, 872 27. 00 HOME HEALTH AGENCY 101. 00 0 3, 199 28. 00 PHYSI CLANS PRI VATE OFFI CES 192. 00 0 149, 692 29. 00 PSYCHI ATRI CSPSYCHOLOGI CAL 5ERVI CES 90. 00 9, 848 TOTALS 194. 05 0 9, 848 TOTALS 194. 05 0 9, 848 TOTALS 194. 05 0 9, 848 TOTALS 1738, 220 0 1. 00 1. 0	17.00	LABORATORY	60.00	0	26, 593	17. 0
20. 00 ELECTROCARDI OLOGY 69. 00 0 68, 882 20. 0 21. 00 RURAL HEALTH CLINIC II 88. 01 0 1, 018 21. 0 22. 00 CLINIC 90. 00 0 10, 055 22. 0 30. 00 ONCOLOGY 90. 02 0 44, 231 23. 0 24. 00 HBURG URGENT CARE CLINIC 90. 04 0 19, 264 24. 0 25. 00 EMERGENCY 91. 00 0 67, 613 25. 0 26. 00 AMBULANCE SERVI CES 95. 00 0 33, 872 26. 0 27. 00 HOME HEALTH AGENCY 101. 00 0 3, 199 27. 0 28. 00 PHYSI CI ANS PRI VATE OFFI CES 192. 00 0 149, 692 28. 0 29. 00 PSYCHI ATRI C/PSYCHOLOGI CAL 192. 01 0 8, 832 29. 0 30. 00 COMMUNITY EDUCATI ON 194. 04 0 1, 105 30. 0 31. 00 OLOMINITY EDUCATION 194. 04 0 1, 042, 381 0 TOTALS 194. 05 0 9, 848 31. 0 TOTALS 17, 38, 220 0 H - VOLUNTEER/GUEST SVC 1. 00 OFFSI TE COVI D SCREENING 194. 07 157, 393 11, 460 10. 00 TOTALS 157, 393 11, 460 1. 00 TOTALS 157, 394 11,	18.00	RESPIRATORY THERAPY	65.00	0	26, 131	18.0
21. 00 RURAL HEALTH CLINIC II 88. 01 0 1,018 22. 00 22. 00 CLINIC 90. 00 0 10,055 22. 0 23. 00 ONCOLOGY 90. 02 0 44,231 23. 0 24. 00 HBURG URGENT CARE CLINIC 90. 04 0 19, 264 24. 00 25. 00 EMERGENCY 91. 00 0 67, 613 25. 0 26. 00 AMBULANCE SERVICES 95. 00 0 33, 872 26. 0 27. 00 HOME HEALTH AGENCY 101. 00 0 3,199 27. 0 28. 00 PHYSICIANS PRIVATE OFFICES 192. 00 0 149, 692 28. 0 29. 00 PSYCHIATRIC/PSYCHOLOGICAL 192. 01 0 8, 832 29. 0 30. 00 COMMUNITY EDUCATION 194. 04 0 1, 105 30. 0 31. 00 VOLUNTEER 194. 05 0 9, 848 70TALS 70. 00 1, 042, 381 70TALS 70. 00 1, 738, 220 0 70 70TALS 70. 00 1, 738, 220 70 70TALS 70. 00 70TALS 70	19.00	PHYSI CAL THERAPY	66.00	o	33, 082	19. (
22. 00 CLINIC 90. 00 0 10, 055 22. 0 23. 00 0NCOLOGY 90. 02 0 44, 231 23. 0 24. 00 BURG URGENT CARE CLINIC 90. 04 0 19, 264 24. 00 25. 00 26. 00 26. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 29. 00	20.00	ELECTROCARDI OLOGY	69.00	o	68, 882	20.0
23.00 ONCOLOGY 90.02 0 44, 231 24.00 HBURG URGENT CARE CLINIC 90.04 0 19, 264 25.00 EMERGENCY 91.00 0 67, 613 26.00 AMBULANCE SERVICES 95.00 0 33, 872 27.00 HOME HEALTH AGENCY 101.00 0 3, 199 28.00 PHYSICIANS PRIVATE OFFICES 192.00 0 149, 692 29.00 PSYCHIATRIC/PSYCHOLOGICAL 192.01 0 8, 832 SERVICES 30.00 COMMUNITY EDUCATION 194.04 0 1, 105 31.00 VOLUNTEER 194.05 0 9, 848 TOTALS 0 1, 042, 381 G - PHARMACY RECLASS 1.00 DRUGS CHARGED TO PATIENTS 73.00 1, 738, 220 0 H - VOLUNTEER/GUEST SVC 1.00 OFFSITE COVID SCREENING 194.07 157, 393 11, 460 TOTALS 11, 460 TOTALS 194.07 157, 393 11, 460 TOTALS 11, 460	21.00	RURAL HEALTH CLINIC II	88. 01	o	1, 018	21. 0
24. 00 HBURG URGENT CARE CLINIC 90. 04 0 19, 264 25. 00 EMERGENCY 91. 00 0 67, 613 25. 0 26. 00 AMBULANCE SERVICES 95. 00 0 33, 872 26. 0 27. 00 HOME HEALTH AGENCY 101. 00 0 3, 199 27. 0 28. 00 PHYSI CI ANS PRI VATE OFFICES 192. 00 0 149, 692 28. 0 29. 00 PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES 95. 00 149, 692 29. 00 COMMUNITY EDUCATION 194. 04 0 1, 105 30. 0 31. 00 VOLUNTEER 194. 05 0 9, 848 31. 0 TOTALS 0 1, 738, 220 0 0 DRUGS CHARGED TO PATIENTS 73. 00 1, 738, 220 0 0 H - VOLUNTEER/GUEST SVC 1. 00 OFFSI TE COVI D SCREENING 194. 07 157, 393 11, 460 70 11, 460 70 71 71, 710 710 710 710 710 710 710 710 710 710	22.00	CLINIC	90.00	O	10, 055	22.0
25. 00 EMERGENCY 91. 00 0 67, 613 25. 0 26. 00 AMBULANCE SERVI CES 95. 00 0 33, 872 26. 00 27. 00 HOME HEALTH AGENCY 101. 00 0 3, 199 27. 0 28. 00 PHYSI CI ANS PRI VATE OFFI CES 192. 00 0 149, 692 29. 00 29. 00 PSYCHI ATRI C/PSYCHOLOGI CAL 192. 01 0 8, 832 29. 0 30. 00 COMMUNI TY EDUCATI ON 194. 04 0 1, 105 30. 0 31. 00 VOLUNTEER 194. 05 0 9, 848 70TALS 0 1, 738, 220 0 1 1. 00 DRUGS CHARGED TO PATIENTS 73. 00 1, 738, 220 0 0	23.00	ONCOLOGY	90. 02	O	44, 231	23. 0
26. 00 AMBULANCE SERVICES 95. 00 0 33, 872 27. 00 HOME HEALTH AGENCY 101. 00 0 3, 199 28. 00 PHYSI CI ANS PRI VATE OFFICES 192. 00 0 149, 692 29. 00 PSYCHI ATRI C/PSYCHOLOGI CAL 192. 01 0 8, 832 SERVICES 30. 00 COMMUNI TY EDUCATI ON 194. 04 0 1, 105 31. 00 VOLUNTEER 194. 05 0 9, 848 TOTALS 0 1, 042, 381 G - PHARMACY RECLASS 1. 00 DRUGS CHARGED TO PATIENTS 73. 00 1, 738, 220 0 TOTALS 0 1, 738, 220 0 H - VOLUNTEER/GUEST SVC 1. 00 OFFSI TE COVI D SCREENING 194. 07 157, 393 11, 460 TOTALS 194. 07 157, 393 11, 460	24.00	HBURG URGENT CARE CLINIC	90. 04	O	19, 264	24. 0
27. 00 HOME HEALTH AGENCY 101. 00 0 3, 199 28. 00 PHYSI CI ANS PRI VATE OFFI CES 192. 00 0 149, 692 29. 00 PSYCHI ATRI C/PSYCHOLOGI CAL 192. 01 0 8, 832 SERVI CES 30. 00 COMMUNI TY EDUCATI ON 194. 04 0 1, 105 31. 00 VOLUNTEER 194. 05 0 9, 848 TOTALS 0 1, 042, 381 G - PHARMACY RECLASS 1. 00 DRUGS CHARGED TO PATI ENTS 73. 00 1, 738, 220 0 TOTALS 0 1, 738, 220 0 H - VOLUNTEER/GUEST SVC 1. 00 OFFSI TE COVI D SCREENING 194. 07 157, 393 11, 460 TOTALS 194. 07 157, 393 11, 460	25.00	EMERGENCY	91.00	O	67, 613	25. 0
28. 00 PHYSI CI ANS PRI VATE OFFI CES 192. 00 0 149, 692 29. 00 PSYCHI ATRI C/PSYCHOLOGI CAL 192. 01 0 8, 832 SERVI CES 30. 00 COMMUNI TY EDUCATI ON 194. 04 0 1, 105 31. 00 VOLUNTEER 194. 05 0 9, 848 TOTALS 0 1, 042, 381 1. 00 DRUGS CHARGED TO PATIENTS 73. 00 1, 738, 220 0 H - VOLUNTEER/GUEST SVC 1. 00 OFFSI TE COVI D SCREENI NG 194. 07 157, 393 11, 460 TOTALS 194. 07 157, 393 11, 460 TOTALS 194. 07 157, 393 11, 460	26.00	AMBULANCE SERVICES	95.00	O	33, 872	26.0
29. 00 PSYCHI ATRI C/PSYCHOLOGI CAL 192. 01 0 8, 832 29. 0 30. 00 COMMUNI TY EDUCATI ON 194. 04 0 1, 105 30. 0 31. 00 VOLUNTEER 194. 05 0 9, 848 70TALS 0 1, 042, 381 G - PHARMACY RECLASS 1. 00 DRUGS CHARGED TO PATIENTS 73. 00 1, 738, 220 0 0	27.00	HOME HEALTH AGENCY	101.00	O	3, 199	27. 0
SERVICES 30.00 COMMUNITY EDUCATION 194.04 0 1,105 30.00	28.00	PHYSICIANS PRIVATE OFFICES	192.00	O	149, 692	28.0
30.00 COMMUNITY EDUCATION 194.04 0 1,105 30.0 31.00 VOLUNTEER 194.05 0 9,848 7TOTALS 0 1,042,381 G - PHARMACY RECLASS 1.00 DRUGS CHARGED TO PATIENTS 73.00 1,738,220 0 1 1.00 H - VOLUNTEER/GUEST SVC 1.00 OFFSITE COVID SCREENING 194.07 157,393 11,460 100 1.00 TOTALS 157,393 11,460	29.00	PSYCHI ATRI C/PSYCHOLOGI CAL	192. 01	0	8, 832	29. 0
31. 00 VOLUNTEER 194. 05 0 9, 848 TOTALS 0 1, 042, 381 G - PHARMACY RECLASS 1. 00 DRUGS CHARGED TO PATIENTS 73. 00 1, 738, 220 0 TOTALS 0 1, 738, 220 0 TOTALS 1. 00 OFFSITE COVID SCREENING 194. 07 157, 393 11, 460 TOTALS 157, 393 11, 460		SERVI CES				
TOTALS 0 1,042,381 G - PHARMACY RECLASS 1. 00 DRUGS CHARGED TO PATIENTS 73.00 1,738,220 0 1.00 TOTALS 0 1,738,220 0 1.00 H - VOLUNTEER/GUEST SVC 1. 00 OFFSITE COVI D SCREENING 194.07 157,393 11,460 1.00 TOTALS 157,393 11,460	30.00	COMMUNITY EDUCATION	194. 04	O	1, 105	30.0
G - PHARMACY RECLASS 1. 00 DRUGS CHARGED TO PATIENTS 73. 00 1, 738, 220 0 1. 0 TOTALS 1, 738, 220 0 H - VOLUNTEER/GUEST SVC 1. 00 OFFSITE COVID SCREENING 194. 07 157, 393 11, 460 1. 0 TOTALS 157, 393 11, 460	31.00	VOLUNTEER	194. 05	0	9, 848	31. 0
1. 00 DRUGS CHARGED TO PATLENTS 73. 00 1, 738, 220 0 1 TOTALS 1, 738, 220 0 H - VOLUNTEER/GUEST SVC 1. 00 OFFSITE COVID SCREENING 194. 07 157, 393 11, 460 1. 0 TOTALS 157, 393 11, 460		TOTALS		0	1, 042, 381	
TOTALS 1,738,220 0 H - VOLUNTEER/GUEST SVC 1. 00 OFFSITE COVI D SCREENI NG 194.07 157,393 11,460 1.00 TOTALS 157,393 11,460		G - PHARMACY RECLASS				
H - VOLUNTEER/GUEST SVC 1. 00 OFFSITE COVID SCREENING 194. 07 157, 393 11, 460 1. 0 TOTALS 157, 393 11, 460	1.00	DRUGS CHARGED TO PATIENTS	73.00	1, 738, 220	0	1. (
1. 00 OFFSI TE COVI D SCREENI NG 194. 07 157, 393 11, 460 1. 0 TOTALS 157, 393 11, 460		TOTALS		1, 738, 220		
TOTALS 157, 393 11, 460		H - VOLUNTEER/GUEST SVC				
	1.00	OFFSITE COVID SCREENING	194. 07	157, 393	11, 460	1. (
500.00 Grand Total: Increases 4,729,753 25,479,589 500.0		TOTALS		157, 393	11, 460	
	500.00	Grand Total: Increases		4, 729, 753	25, 479, 589	500. 0

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0115

| Period: | Worksheet A-6 | From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: 1/25/2024 11:51 am

						1/25/20	24 11: 51 am
		Decreases					
	Cost Center	Li ne #	Salary		Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10. 00		
1. 00	A - LABOR AND DELIVERY ADULTS & PEDIATRICS	30.00	1, 913, 240	256, 011	0		1.00
2. 00	ADOLTS & TEDIATRICS	0.00	1, 713, 240	230, 011	o		2. 00
2.00	TOTALS	— — 	1, 913, 240	256, 011	<u> </u>		2.00
	B - CAFETERIA	<u>'</u>	<u> </u>	·			
1.00	DI ETARY	1000	920, 900	57 <u>5, 2</u> 03	0		1. 00
	TOTALS		920, 900	575, 203			
4 00	C - BILLABLE SUPPLES	40.00	ما	200			4.00
1. 00 2. 00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13. 00 14. 00	0	398 10, 867	0		1. 00 2. 00
3.00	PHARMACY	15. 00	0	10, 867	0		3. 00
4. 00	I&R SERVICES-OTHER PRGM	22. 00	Ö	2	l ol		4. 00
	COSTS APPRV						
5.00	ADULTS & PEDIATRICS	30.00	0	208, 402	0		5. 00
6.00	INTENSIVE CARE UNIT	31. 00	0	105, 280	0		6. 00
7.00	SUBPROVI DER - I PF	40.00	0	1, 970	0		7. 00
8. 00 9. 00	SUBPROVIDER - IRF	41.00	0	5, 255	0		8. 00
10. 00	SKILLED NURSING FACILITY OPERATING ROOM	44. 00 50. 00	0	31, 710 74, 543	0		9. 00 10. 00
11. 00	ANESTHESI OLOGY	53.00	0	2, 013	0		11.00
12. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	196, 698	Ö		12. 00
13.00	RADI OI SOTOPE	56.00	O	918	o		13. 00
14. 00	LABORATORY	60.00	0	564	0		14. 00
15. 00	RESPIRATORY THERAPY	65. 00	0	34, 178	0		15. 00
16.00	PHYSI CAL THERAPY	66.00	0	83, 586	0		16. 00
17. 00	ELECTROCARDI OLOGY	69. 00	0	51, 730	0		17. 00
18. 00 19. 00	CLINIC ONCOLOGY	90. 00 90. 02	0	129, 128 100, 142	0		18. 00 19. 00
20. 00	HBURG URGENT CARE CLINIC	90. 04	0	466, 095	0		20.00
21. 00	EMERGENCY	91.00	Ö	245, 725	o		21. 00
22. 00	AMBULANCE SERVICES	95.00	О	11, 097	o		22. 00
23. 00	HOME HEALTH AGENCY	101. 00	o_	5 <u>0, 5</u> 40	0		23. 00
	TOTALS		0	1, 810, 928			
4 00	D - DRUGS RECLASS	F 00		F 747			4.00
1. 00 2. 00	ADMINISTRATIVE & GENERAL DIETARY	5. 00 10. 00	0	5, 717	0		1. 00 2. 00
3.00	CENTRAL SERVICES & SUPPLY	14. 00	0	6, 376 364	0		3. 00
4. 00	PHARMACY	15. 00	Ö	20, 086, 850	o o		4. 00
5. 00	ADULTS & PEDIATRICS	30.00	o	255	Ö		5. 00
6.00	INTENSIVE CARE UNIT	31.00	0	34	o		6. 00
7.00	SUBPROVI DER - I PF	40. 00	0	42	0		7. 00
8. 00	SUBPROVI DER - I RF	41.00	0	13	0		8. 00
9.00	SKILLED NURSING FACILITY	44.00	0	6	0		9.00
10. 00 11. 00	OPERATING ROOM ANESTHESIOLOGY	50. 00 53. 00	0	250 105, 443	0		10. 00 11. 00
12. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	170, 477	0		12.00
13. 00	RADI OI SOTOPE	56. 00	Ö	4	o		13. 00
14.00	RESPIRATORY THERAPY	65.00	O	939	o		14. 00
15. 00	PHYSI CAL THERAPY	66. 00	0	2, 981	o		15. 00
16. 00	ELECTROCARDI OLOGY	69. 00	0	29, 085	0		16. 00
17. 00	CLINIC	90.00	0	10, 863	0		17. 00
18. 00	HBURG URGENT CARE CLINIC EMERGENCY	90. 04 91. 00	0	13, 643	0		18. 00 19. 00
19. 00 20. 00	AMBULANCE SERVICES	91.00 95.00	0	15, 894 11, 260			20.00
21. 00	HOME HEALTH AGENCY	101.00	0	25, 291	0		21. 00
55	TOTALS			20, 485, 787	$$ $ ^{4}$		55
	E - INTERN AND RESIDENT RECLA						
1.00	I&R SERVICES-OTHER PRGM	22. 00	0	1, 297, 819	0		1. 00
	COSTS APPRV	+					
	TOTALS		0	1, 297, 819			
1.00	F - DISABILITY LEAVE RECLASS ADMINISTRATIVE & GENERAL	5. 00	46, 294	0	O		1.00
2. 00	MAINTENANCE & REPAIRS	6.00	2, 141	0	l ol		2.00
3. 00	LAUNDRY & LINEN SERVICE	8. 00	7, 234	0	o		3. 00
4. 00	DI ETARY	10.00	23, 198	0	o		4. 00
5.00	NURSING ADMINISTRATION	13. 00	36, 705	0	0		5. 00
6.00	CENTRAL SERVICES & SUPPLY	14. 00	10, 857	0	0		6. 00
7.00	PHARMACY	15. 00	16, 008	0	0		7. 00
8. 00	I&R SERVICES-OTHER PRGM	22. 00	4, 616	0	0		8. 00
9. 00	COSTS APPRV ADULTS & PEDIATRICS	30. 00	91, 629	0			9. 00
10. 00	INTENSIVE CARE UNIT	31. 00	73, 614	0	0		10.00
11. 00	SUBPROVI DER - I PF	40. 00	21, 782	0	o		11. 00
12.00	SUBPROVI DER - I RF	41.00	14, 241	0	o		12. 00
-		•					

Health Financial Systems RECLASSIFICATIONS Peri od: From 07/01/2022 To 06/30/2023 Date/Time Prepared: 1/25/2024 11:51 am Provider CCN: 15-0115

		Decreases				172572024 11.	J I dill
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
13. 00	SKILLED NURSING FACILITY	44. 00	19, 273	0	0		13. 00
14.00	OPERATING ROOM	50.00	56, 459	0	0	,	14. 00
15.00	ANESTHESI OLOGY	53.00	46, 047	0	0		15. 00
16.00	RADI OLOGY-DI AGNOSTI C	54.00	68, 866	0	0	,	16. 00
17.00	LABORATORY	60.00	26, 593	0	0	,	17. 00
18.00	RESPIRATORY THERAPY	65.00	26, 131	0	0	,	18. 00
19.00	PHYSI CAL THERAPY	66.00	33, 082	0	0	,	19. 00
20.00	ELECTROCARDI OLOGY	69. 00	68, 882	0	0	,	20. 00
21.00	RURAL HEALTH CLINIC II	88. 01	1, 018	0	0	,	21. 00
22.00	CLINIC	90.00	10, 055	0	0	,	22. 00
23.00	ONCOLOGY	90. 02	44, 231	0	0	,	23. 00
24.00	HBURG URGENT CARE CLINIC	90. 04	19, 264	0	0	,	24. 00
25.00	EMERGENCY	91.00	67, 613	0	0	,	25. 00
26.00	AMBULANCE SERVICES	95.00	33, 872	0	0	,	26. 00
27.00	HOME HEALTH AGENCY	101.00	3, 199	0	0	,	27. 00
28. 00	PHYSICIANS PRIVATE OFFICES	192. 00	149, 692	0	0	,	28. 00
29. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	192. 01	8, 832	0	0	,	29. 00
	SERVI CES						
30.00	COMMUNITY EDUCATION	194. 04	1, 105	0	0		30. 00
31.00	VOLUNTEER	<u> </u>	9, 848	0	0		31. 00
	TOTALS		1, 042, 381	0			
	G - PHARMACY RECLASS						
1.00	PHARMACY	<u>15.</u> 00	1, 738, 220	0	0		1. 00
	TOTALS		1, 738, 220	0			
	H - VOLUNTEER/GUEST SVC						
1.00	ADMI NI STRATI VE & GENERAL		157, 393	11, 460		_	1. 00
	TOTALS		157, 393	11, 460]	
500.00	Grand Total: Decreases		5, 772, 134	24, 437, 208			500. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0115

In Lieu of Form CMS-2552-10

Period: Worksheet A-6
From 07/01/2022 Non-CMS Worksheet
To 06/30/2023 Date/Time Prepared:
1/25/2024 11:51 am

								1/25/2024 11:	
	Cost Center	Increa	ases Sal ary	Other	Cost Center	Decrea	ases Sal ary	Other	
	2.00	3.00	4. 00	5. 00	6.00	7.00	8. 00	9. 00	
	A - LABOR AND DELIVERY								
1.00	NURSERY	43. 00	637, 747		ADULTS & PEDIATRICS	30.00	1, 913, 240	256, 011	1. 00
2. 00	DELIVERY ROOM & LABOR ROOM	52. 00	1, 275, 493	170, 674		0.00	0	0	2. 00
	TOTALS	\vdash	1, 913, 240	256, 011	TOTALS — — —	\vdash	1, 913, 240		
	B - CAFETERIA		.,	200,000			., ,		
1.00	CAFETERI A	11. 00	920, 900		DI ETARY	10. 00	920, 900	57 <u>5, 2</u> 03	1. 00
	TOTALS		920, 900	575, 203	TOTALS		920, 900	575, 203	
1. 00	C - BILLABLE SUPPLES MEDICAL SUPPLIES	71. 00	0	1, 810, 928	NURSI NG	13.00	ol	398	1. 00
1.00	CHARGED TO PATIENT	71.00	J	1,010,720	ADMI NI STRATI ON	10.00		370	1.00
2.00		0. 00	0	0	CENTRAL SERVICES &	14. 00	0	10, 867	2. 00
2 00		0.00	0	0	SUPPLY	15 00		0.7	2 00
3. 00 4. 00		0.00	0		PHARMACY I&R SERVICES-OTHER	15. 00 22. 00	0	87 2	3. 00 4. 00
4.00		0.00		O	PRGM COSTS APPRV	22.00	٩	-	4. 00
5.00		0. 00	0		ADULTS & PEDIATRICS	30.00	0	208, 402	5. 00
6.00		0.00	0		INTENSIVE CARE UNIT	31.00	0	105, 280	6. 00
7. 00 8. 00		0.00	0		SUBPROVIDER - IPF SUBPROVIDER - IRF	40. 00 41. 00	0	1, 970 5, 255	7. 00 8. 00
9. 00		0.00	0		SKILLED NURSING	44.00	0	31, 710	9. 00
				_	FACILITY			2.,	
10.00		0. 00	0		OPERATING ROOM	50.00	0	74, 543	10.00
11.00		0.00	0		ANESTHESI OLOGY	53.00	0	2, 013	11. 00
12. 00 13. 00		0.00	0		RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	54. 00 56. 00	0	196, 698 918	12. 00 13. 00
14. 00		0.00	0		LABORATORY	60.00	0	564	14. 00
15. 00		0.00	O		RESPI RATORY THERAPY	65.00	Ö	34, 178	15. 00
16. 00		0. 00	0		PHYSI CAL THERAPY	66. 00	0	83, 586	16. 00
17. 00		0.00	0		ELECTROCARDI OLOGY	69.00	0	51, 730	17. 00
18. 00 19. 00		0.00	0		CLI NI C ONCOLOGY	90.00	0	129, 128 100, 142	18. 00 19. 00
20. 00		0.00	0		HBURG URGENT CARE	90.02	0	466, 095	20. 00
				_	CLI NI C			,	
21. 00		0. 00	0		EMERGENCY	91.00	0	245, 725	21. 00
22. 00		0.00	0		AMBULANCE SERVICES	95.00	0	11, 097	22. 00
23. 00	TOTALS — — —	0. 00	0	<u>0</u> 1, 810, 928	HOME HEALTH AGENCY TOTALS	101.00	0	5 <u>0, 5</u> 40 1, 810, 928	23. 00
	D - DRUGS RECLASS	<u> </u>	<u> </u>	1,010,720	1017120	<u> </u>	<u> </u>	1,010,720	
1.00	DRUGS CHARGED TO	73. 00	0	20, 485, 748	ADMINISTRATIVE &	5. 00	0	5, 717	1.00
2.00	PATI ENTS	(0.00		20	GENERAL	10.00		(27(2 00
2. 00 3. 00	LABORATORY	60. 00 0. 00	0		DI ETARY CENTRAL SERVICES &	10.00 14.00	0	6, 376 364	2. 00 3. 00
3.00		0.00		O	SUPPLY	14.00	٩	304	3. 00
4.00		0.00	0		PHARMACY	15.00	0	20, 086, 850	4.00
5.00		0.00	0		ADULTS & PEDIATRICS	30.00	0	255	5. 00
6. 00 7. 00		0.00	ol ol		INTENSIVE CARE UNIT SUBPROVIDER - IPF	31. 00 40. 00	0	34 42	6. 00 7. 00
8. 00		0.00	0		SUBPROVI DER - I RF	41.00	o	13	8. 00
9.00		0.00	O		SKILLED NURSING	44.00	O	6	9. 00
					FACI LI TY				
10. 00 11. 00		0.00	0		OPERATING ROOM ANESTHESIOLOGY	50. 00 53. 00	0	250 105, 443	10. 00 11. 00
12. 00		0.00	o		RADI OLOGY-DI AGNOSTI C	54.00		170, 477	12. 00
13. 00		0.00	ő		RADI OI SOTOPE	56.00	o	4	13. 00
14.00		0.00	О	0	RESPI RATORY THERAPY	65.00	0	939	14.00
15. 00		0. 00	0		PHYSI CAL THERAPY	66.00	0	2, 981	15. 00
16. 00 17. 00		0.00	0		ELECTROCARDI OLOGY CLI NI C	69. 00 90. 00	0	29, 085	16.00
18. 00		0.00	0		HBURG URGENT CARE	90.00	0	10, 863 13, 643	17. 00 18. 00
.0.00		0.00	Ĭ	3	CLI NI C	, , , , ,		10, 0.10	.0.00
19. 00		0. 00	0		EMERGENCY	91.00	О	15, 894	19. 00
20.00		0.00	0		AMBULANCE SERVICES	95.00	0	11, 260	20.00
21. 00	TOTALS — — —	0. 00	0	00 20, 485, 787	HOME HEALTH AGENCY	101. 00	0	25, 291 20, 485, 787	21. 00
	E - INTERN AND RESIDEN	T RECLAS		20, 400, 767	IOUNES		υ	20, 400, 767	
1.00	I &R SERVI CES-SALARY &	21. 00	0	1, 297, 819	I &R SERVI CES-OTHER	22. 00	0	1, 297, 819	1. 00
	FRI NGES APPRV	$\vdash \bot$	+		PRGM_COSTS_APPRV	$\vdash \bot$	↓		
	TOTALS	ECLASS	0	1, 297, 819	IOTALS		0	1, 297, 819	
1. 00	F - DISABILITY LEAVE R ADMINISTRATIVE &	5. 00	ol	46 204	ADMINISTRATIVE &	5.00	46, 294	0	1. 00
1.00	GENERAL	3.00	٩	70, 274	GENERAL	3.00	70, 274	٩	1.00
2.00	MAINTENANCE & REPAIRS	6. 00	О	2, 141	MAINTENANCE & REPAIRS	6. 00	2, 141	o	2. 00

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 15-0115

								1/25/2024 11:	51 am
		Incre	ases			Decre	ases		
	Cost Center	Line #	Sal ary	0ther	Cost Center	Li ne #	Sal ary	0ther	
	2.00	3. 00	4, 00	5. 00	6.00	7.00	8. 00	9, 00	
3.00	LAUNDRY & LINEN	8. 00	0	7. 234	LAUNDRY & LINEN	8.00	7, 234	0	3. 00
0.00	SERVI CE	0.00	٦	7,20.	SERVI CE	0.00	,, 20	ŭ	0.00
4.00	DI ETARY	10.00	0	23 108	DI ETARY	10.00	23, 198	0	4. 00
5.00	NURSI NG	13. 00	0	· ·	NURSI NG	13.00	36, 705	0	5. 00
5.00		13.00	٩	30, 703		13.00	30, 703	U	3.00
	ADMI NI STRATI ON	4.00		40.057	ADMI NI STRATI ON	4.00	40.053		,
6.00	CENTRAL SERVICES &	14. 00	0	10, 857	CENTRAL SERVICES &	14.00	10, 857	0	6. 00
	SUPPLY				SUPPLY				
7.00	PHARMACY	15. 00	0		PHARMACY	15.00	16, 008	0	7. 00
8.00	I&R SERVICES-OTHER	22. 00	0	4, 616	I &R SERVI CES-OTHER	22.00	4, 616	0	8. 00
	PRGM COSTS APPRV				PRGM COSTS APPRV				
9.00	ADULTS & PEDIATRICS	30.00	ol	91, 629	ADULTS & PEDIATRICS	30.00	91, 629	0	9. 00
10.00	INTENSIVE CARE UNIT	31.00	ol	73 614	INTENSIVE CARE UNIT	31.00	73, 614	0	10. 00
11. 00	SUBPROVI DER - I PF	40.00	0	· ·	SUBPROVIDER - IPF	40.00	21, 782	0	11. 00
12. 00	SUBPROVI DER - I RF	41. 00	o	, .	SUBPROVIDER - IRF	41.00	14, 241	0	12.00
		l l	-					0	
13. 00	SKILLED NURSING	44. 00	0	19, 2/3	SKI LLED NURSI NG	44.00	19, 273	U	13. 00
	FACILITY		_		FACILITY			_	
14. 00	OPERATING ROOM	50.00	0	· ·	OPERATING ROOM	50.00	56, 459	0	14. 00
15. 00	ANESTHESI OLOGY	53. 00	0		ANESTHESI OLOGY	53.00	46, 047	0	15. 00
16.00	RADI OLOGY-DI AGNOSTI C	54.00	0	68, 866	RADI OLOGY-DI AGNOSTI C	54.00	68, 866	0	16.00
17.00	LABORATORY	60.00	o	26, 593	LABORATORY	60.00	26, 593	0	17. 00
18. 00	RESPIRATORY THERAPY	65.00	اه	26 131	RESPIRATORY THERAPY	65.00	26, 131	0	18. 00
19. 00	PHYSI CAL THERAPY	66. 00	o		PHYSI CAL THERAPY	66.00	33, 082	0	19. 00
20. 00	ELECTROCARDI OLOGY	69.00	0		ELECTROCARDI OLOGY	69.00	68, 882	0	20. 00
			U O					ŭ,	
21. 00	RURAL HEALTH CLINIC	88. 01	0	1,018	RURAL HEALTH CLINIC	88. 01	1, 018	0	21. 00
	11		_					_	
22. 00	CLINIC	90.00	0		CLINIC	90.00	10, 055	0	22. 00
23.00	ONCOLOGY	90. 02	0		ONCOLOGY	90.02	44, 231	0	23. 00
24.00	HBURG URGENT CARE	90. 04	0	19, 264	HBURG URGENT CARE	90.04	19, 264	0	24.00
	CLINIC				CLI NI C				
25.00	EMERGENCY	91.00	ol	67, 613	EMERGENCY	91.00	67, 613	0	25. 00
26, 00	AMBULANCE SERVICES	95.00	ol	33, 872	AMBULANCE SERVICES	95.00	33, 872	0	26. 00
27. 00	HOME HEALTH AGENCY	101. 00	اَ		HOME HEALTH AGENCY	101.00	3, 199	0	27. 00
28. 00	PHYSI CLANS PRI VATE	192. 00	0		PHYSI CLANS PRI VATE	192.00	149, 692	0	28. 00
20.00	OFFI CES	192.00	٩	147, 072	OFFICES	192.00	147, 072	U	20.00
20.00	•	100 01		0 022		100 01	0.000	0	20.00
29. 00	PSYCHI ATRI C/PSYCHOLOG	192. 01	0	8, 832	PSYCHI ATRI C/PSYCHOLOG	192. 01	8, 832	U	29. 00
	I CAL SERVI CES				I CAL SERVI CES				
30.00	COMMUNITY EDUCATION	194. 04	0	· ·	COMMUNITY EDUCATION	194.04	1, 105	0	30.00
31. 00	VOLUNTEER	194. 05	0	9, 848	VOLUNTEER	194.05	9, 848	0	31. 00
	TOTALS		0	1, 042, 381	TOTALS		1, 042, 381	0	
	G - PHARMACY RECLASS		·						
1.00	DRUGS CHARGED TO	73.00	1, 738, 220	0	PHARMACY	15.00	1, 738, 220	0	1. 00
00	PATI ENTS	70.00	1,700,220	ŭ			1,700,220	ŭ	00
	TOTALS	-	1, 738, 220		TOTALS — — —	\vdash \vdash	1, 738, 220		
	H - VOLUNTEER/GUEST SV		1, 730, 220	U	TIVIALS		1, 730, 220	U	
4 00			457 000	44	ADMINISTRATIVE O	F 65	457 000	44	4 00
1.00	OFFSITE COVID	194. 07	157, 393	11, 460	ADMINISTRATIVE &	5.00	157, 393	11, 460	1. 00
	SCREENI NG	\perp	+		GENERAL	$\vdash \vdash \vdash$			
	TOTALS		157, 393	11, 460	TOTALS		157, 393	11, 460	
500.00	Grand Total:		4, 729, 753	25, 479, 589	Grand Total:		5, 772, 134	24, 437, 208	500.00
	Increases				Decreases				
	•	. '	'		•		'		

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0115 Peri od: Worksheet A-7 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/25/2024 11:51 am Acqui si ti ons Begi nni ng Total Di sposal s and Purchases Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 11, 188, 088 20, 585 20, 585 0 1.00 0 2.00 Land Improvements 0 2.00 0 3.00 122, 498, 934 1, 528, 159 3.00 Buildings and Fixtures 1, 528, 159 0 Building Improvements 0 4.00 0 4.00 5.00 Fixed Equipment 0 5.00 0 8, 056, 630 6.00 Movable Equipment 158, 911, 560 8, 056, 630 0 6.00 0 7.00 HIT designated Assets 7.00 0 0 8.00 Subtotal (sum of lines 1-7) 292, 598, 582 9, 605, 374 9, 605, 374 0 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 292, 598, 582 9, 605, 374 O 9, 605, 374 10.00 10.00 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 11, 208, 673 0 1.00 2.00 Land Improvements 0 2.00 3.00 Buildings and Fixtures 124, 027, 093 0 3.00 0 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 0 6.00 166, 968, 190 6.00 7.00 HIT designated Assets 0 7.00

302, 203, 956

302, 203, 956

0

0

Health Financial Systems ME	MORIAL HOSP & F	HEALTH CARE CTR	?	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der CO		eri od:	Worksheet A-7	
				rom 07/01/2022 o 06/30/2023		narod:
			'	0 00/30/2023	Date/Time Pre 1/25/2024 11:	
		SU	JMMARY OF CAPIT	ΓAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
				instructions)	instructions)	
	9. 00	10.00	11. 00	12.00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	3, 325, 369	797, 020	2, 148, 337	187, 711	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	5, 536, 543	0	C	0	0	2.00
3.00 Total (sum of lines 1-2)	8, 861, 912	797, 020	2, 148, 337	187, 711	0	3. 00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1) (sum				
	Capi tal -Relate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
DART LL DESCRIPTION OF ANOTHER EDGIL WORL	14. 00	15. 00				

0 0 0

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2
CAP REL COSTS-BLDG & FIXT
CAP REL COSTS-MVBLE EQUIP
0 6, 458, 437
0 5, 536, 543

6, 458, 437 5, 536, 543 11, 994, 980

1. 00 2. 00 3. 00

1. 00 2. 00

3.00 Total (sum of lines 1-2)

Heal th	Financial Systems ME	MORIAL HOSP & F	HEALTH CARE CTF	?	In Lie	eu of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 07/01/2022 Fo 06/30/2023	Worksheet A-7 Part III Date/Time Prep 1/25/2024 11:5	oared: 51 am
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	CAP REL COSTS-BLDG & FLXT	135, 235, 766	0	135, 235, 766	0. 447498	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	166, 968, 190	0	166, 968, 190	0. 552502	ol	2.00
3.00	Total (sum of lines 1-2)	302, 203, 956	0	302, 203, 956	1. 000000	ol	3.00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other Capi tal -Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	(6, 275, 608	797, 020	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(5, 539, 302	0	2.00
3.00	Total (sum of lines 1-2)	0	0	(11, 814, 910	797, 020	3. 00
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
			ŕ		d Costs (see instructions)	through 14)	
		11. 00	12.00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	187, 711		0	7, 260, 339	1.00
2 00	CAD DEL COSTS MADIE FOLLID	0				5 520 202	

0 0

0

7, 260, 339 1. 00 5, 539, 302 2. 00 12, 799, 641 3. 00

0 0 0

2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-0115 Peri od: Worksheet A-8 From 07/01/2022 06/30/2023 Date/Time Prepared: 1/25/2024 11:51 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL -2.148.337 CAP REL COSTS-BLDG & FLXT 1. 00 В 1.00 11 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 4 00 0 00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 0.00 7.00 stations excluded) (chapter 8.00 Tel evi si on and radio servi ce 0.00 8.00 (chapter 21) Parking lot (chapter 21) 9.00 9.00 0.00 A-8-2 -13, 516, 569 10.00 10.00 Provider-based physician adj ustment -22, 836 ADMI NI STRATI VE & GENERAL 11.00 Sale of scrap, waste, etc. В 5.00 11.00 (chapter 23) Related organization 12.00 A-8-1 66, 989, 181 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00

-632, 765 CAFETERI A

0

-473, 546 PHARMACY

-30, 587 MEDI CAL RECORDS & LI BRARY

ORESPIRATORY THERAPY

0 *** Cost Center Deleted ***

OCAP REL COSTS-BLDG & FIXT

OCAP REL COSTS-MVBLE EQUIP

0 *** Cost Center Deleted ***

0 *** Cost Center Deleted ***

0 *** Cost Center Deleted ***

OADULTS & PEDIATRICS

-3, 856 NURSING ADMINISTRATION

OPHYSICAL THERAPY

11.00

0.00

0.00

15.00

16.00

0 00

0.00

0.00

0.00

65.00

66.00

114.00

1.00

2.00

19.00

0.00

67.00

30.00

68.00

0.00

13.00

14.00

15.00

16.00

18.00

19 00

20.00

21.00

22.00

23.00

24 00

25.00

26.00

27.00

28.00

29 00

30.00

30.99

31.00

32.00

0 33.00

0 17.00

14.00

15.00

16.00

17.00

18.00

19 00

20.00

21.00

22.00

23.00

24.00

25.00

26.00

27.00

28.00

29.00

30.00

30.99

31.00

32.00

and others

pati ents

pati ents

abstracts

books, etc.)

Vending machines

Cafeteria-employees and guests

Rental of quarters to employee

Sale of medical and surgical

Sale of drugs to other than

Sale of medical records and

Nursing and allied health

education (tuition, fees,

Income from imposition of

interest, finance or penalty charges (chapter 21)

Interest expense on Medicare

Adjustment for respiratory

therapy costs in excess of limitation (chapter 14)

therapy costs in excess of limitation (chapter 14)

physicians' compensation

Depreciation - CAP REL

Depreciation - CAP REL

Adjustment for speech

Depreciation and Interest
33.00 ADVERTISING - NURSING ADMIN

Non-physician Anesthetist Physicians' assistant

Adjustment for occupational

therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see

pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for

Adjustment for physical

Utilization review

COSTS-BLDG & FLXT

COSTS-MVBLE EQUIP

(chapter 21)

instructions)

overpayments and borrowings to repay Medicare overpayments

supplies to other than

В

В

В

A-8-3

A-8-3

A-8-3

A-8-3

Α

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

Expense Classification on Worksheet A	T din
To/From Which the Amount is to be Adjusted	
Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref	
1.00 2.00 3.00 4.00 5.00	
33. 01 ADVERTISING - SKILLED NURSING A -1, 750 ADULTS & PEDIATRICS 30. 00	33. 01
33.02 ADVERTISING - CARING HANDS A -34 SUBPROVIDER - IPF 40.00	33. 02
33. 03 ADVERTI SI NG - PT A -242 PHYSI CAL THERAPY 66. 00	33. 03
33.05 ADVERTISING - FRENCH LICK A -640 RURAL HEALTH CLINIC 88.00	33. 05
33.06 ADVERTISING - LOOGOOTEE A -119 RURAL HEALTH CLINIC II 88.01	33. 06
33.08 ADVERTISING - HUNTINGBURG A -243 HBURG URGENT CARE CLINIC 90.04	33. 08
33.09 ADVERTISING - AMBULANCE A -1,870 AMBULANCE SERVICES 95.00	33. 09
33. 10 PHYSI CI AN RECRUI TMENT A -7, 861 8 R SERVI CES-OTHER PRGM 22. 00	33. 10
COSTS APPRV	
33. 11 MISCELLANEOUS REVENUE - ADMIN B -150, 954 ADMINISTRATIVE & GENERAL 5. 00	33. 11
33. 12 MISCELLANEOUS - ENGINEERING B -83 MAINTENANCE & REPAIRS 6.00	33. 12
33. 13 MI SCELLANEOUS - DI ETARY B -1, 486 DI ETARY 10. 00	33. 13
33.15 MISCELLANEOUS - CLINICAL B -9,787 NURSING ADMINISTRATION 13.00	33. 15
33.16 MISCELLANEOUS - STERI LE PROC B -3,082 CENTRAL SERVI CES & SUPPLY 14.00	33. 16
33. 18 MI SCELLANEOUS - REHAB B -27, 663 SUBPROVI DER - I RF 41. 00	33. 18
33. 19 MI SCELLANEOUS - RADI OLOGY B -391 RADI OLOGY-DI AGNOSTI C 54. 00	33. 19
33. 20 MI SCELLANEOUS - LABS B -58, 790 LABORATORY 60. 00	33. 20
33. 21 MI SCELLANEOUS - THERAPY B -314, 976 PHYSI CAL THERAPY 66. 00	33. 21
33. 26 MI SCELLANEOUS - AMBULANCE B -232, 613 AMBULANCE SERVI CES 95. 00	33. 26
33. 27 CRNA EXPENSE A -728, 332 OPERATING ROOM 50. 00	33. 27
33. 28 CRNA EXPENSE A -2, 782, 227 ANESTHESI OLOGY 53. 00	33. 28
33. 29 I/R START UP COSTS A 2, 759 CAP REL COSTS-MVBLE EQUIP 2. 00	33. 29
AMORTI ZATI ON	
33.30 I/R START UP COSTS A 11,370 MAINTENANCE & REPAIRS 6.00	33. 30
AMORTI ZATI ON	
7 217, 00 11 dit 05010 1 22. 00	33. 31
AMORTI ZATI ON COSTS APPRV	
50.00 TOTAL (sum of lines 1 thru 49) 46,071,555	50. 00
(Transfer to Worksheet A,	
column 6, line 200.)	

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0115

Peri od: Worksheet A-8-1 From 07/01/2022

06/30/2023 Date/Time Prepared: 1/25/2024 11:51 am Li ne No. Cost Center Expense I tems Amount of Amount Allowable Cost Included in Wks. A, column 1.00 3.00 4.00 5.00 2.00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS 50. 00 OPERATING ROOM 1.00 AMBULATORY SURGERY CENTER 3, 430, 722 4, 230, 758 1.00 1. 00 CAP REL COSTS-BLDG & FIXT NEW CAPITAL 2.00 2, 950, 239 0 2.00 4. 00 EMPLOYEE BENEFITS DEPARTMENT 3.00 BENEFITS 32, 213, 703 0 3.00 4.00 5. 00 ADMINISTRATIVE & GENERAL A&G 24, 748, 592 0 4.00 4.01 6. 00 MAINTENANCE & REPAIRS PLANT ENGINEERING 1, 039, 379 0 4.01 9. 00 HOUSEKEEPI NG ENVIRONMENTAL SERVICES 0 4 02 1, 668, 838 4 02 16.00 MEDICAL RECORDS & LIBRARY 0 4.03 MEDICAL RECORDS 1, 566, 112 4.03 4.04 194. 03 MKT/PHY SERVICES PHYSICIAN SERVICES 3, 602, 354 0 4.04 TOTALS (sum of lines 1-4) 71, 219, 939 4, 230, 758 5 00 5 00 Transfer column 6, line 5 to Worksheet A-8, column 2, line 12

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

				Related Organization(s) and/	or Home Office	
				norated organization(e) and	0 0 00	
	0 1 1 (1)				5	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownership		Ownarahi n	
			Owner Sni p		Ownershi p	
	1. 00	2.00	3.00	4. 00	5. 00	
	1.00	2.00	3.00	4.00	3.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						
	B. THIERRELATIONSHIT TO RELAT	LD ORGANIZATION(3) AND OR THE	WL OITTOL.			d .

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

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

6. 00	C	MHHCC	0.00	MEM HOS OP SURG	40. 00	6. 00
7.00	В		0.00	MEMORIAL HOME O	100. 00	7. 00
8.00			0.00		0. 00	8. 00
9.00			0.00		0. 00	9. 00
10.00			0.00		0. 00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

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

							1/25/2024 11:	51 am
	Net	Wkst. A-7 Ref.						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6. 00	7. 00						
			ENTS REQUIRED AS A R	ESULT OF TRAN	ISACTIONS WITH RELATED	ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO							
1. 00	-800, 036							1. 00
2.00	2, 950, 239	9						2. 00
3.00	32, 213, 703	0						3. 00
4.00	24, 748, 592	0						4. 00
4.01	1, 039, 379	0						4. 01
4.02	1, 668, 838	0						4. 02
4.03	1, 566, 112	0						4. 03
4.04	3, 602, 354	0						4. 04
5.00	66, 989, 181							5. 00
* Tho	amounts on Lin	os 1 / (and sub	scripte as appropria	to) are trans	formed in detail to We	ckshoot A column	6 Lines as	

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

1103 1101	been posted to norkaneet A,	cordinas i and or 2, the amount arrowable should be mareated in cordina 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
-	B. INTERRELATIONSHIP TO RELAT	TED_ORGANIZATION(S)_AND/OR_HOME_OFFICE:	

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

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

i ci ilibui	Termbur Schieft under trete Avere.								
6.00	SURGERY CENTER	6.00							
7.00	HOME OFFICE	7.00							
8.00		8.00							
9.00		9.00							
9. 00 10. 00		10.00							
100.00		100.00							

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0115

					'	0 06/30/2023	1/25/2024 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	01 4
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1. 00	22. 00	I&R SERVICES-OTHER PRGM	1, 052, 816	0	1, 052, 816	197, 500	6, 404	1. 00
		COSTS APPRV				·	·	
2.00	40.00	SUBPROVIDER - IPF	132, 817	132, 817	0	181, 300	o	2. 00
3.00		SUBPROVIDER - IRF	4	4	0	179, 000		3.00
4.00	50.00	OPERATING ROOM	2, 041	2, 041	0	246, 400		4.00
5.00	53. 00	ANESTHESI OLOGY	1, 292, 517	1, 292, 517	0	239, 400	o	5. 00
6.00	54.00	RADI OLOGY-DI AGNOSTI C	4, 713, 782	4, 713, 782	0	271, 900		6. 00
7.00	60.00	LABORATORY	150, 000	150, 000	0	271, 900	o	7. 00
8.00	65. 00	RESPI RATORY THERAPY	1, 210	1, 210	0	211, 500	o	8. 00
9.00	66. 00	PHYSI CAL THERAPY	2, 576	2, 576	0	211, 500	o	9. 00
10.00	69. 00	ELECTROCARDI OLOGY	550, 112	550, 112	0	211, 500	O	10.00
11.00	90.00	CLI NI C	318, 162	318, 162	0	211, 500	0	11.00
12.00	90. 04	HBURG URGENT CARE CLINIC	315, 456	315, 456	0	211, 500	0	12.00
13.00	91.00	EMERGENCY	5, 591, 828	5, 591, 828	0	211, 500		13.00
14.00	95. 00	AMBULANCE SERVICES	1, 320	1, 320	0	211, 500	0	14.00
200.00			14, 124, 641	13, 071, 825	1, 052, 816		6, 404	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00	22. 00	I&R SERVICES-OTHER PRGM	608, 072	30, 404	0	0	0	1. 00
		COSTS APPRV						
2.00		SUBPROVIDER - IPF	0	0		0	0	2. 00
3.00		SUBPROVIDER - IRF	0	0	_	0	0	3. 00
4.00		OPERATING ROOM	0	0		0	0	4. 00
5. 00		ANESTHESI OLOGY	0	0		0	0	5. 00
6.00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	6. 00
7.00		LABORATORY	0	0	_	0	0	7. 00
8. 00		RESPI RATORY THERAPY	0	0	0	0	0	8. 00
9. 00		PHYSI CAL THERAPY	0	0	0	0	0	9. 00
10. 00		ELECTROCARDI OLOGY	0	0	0	0	0	10. 00
11. 00		CLINIC	0	0	0	0	0	11. 00
12. 00		HBURG URGENT CARE CLINIC	0	0	0	0	0	12. 00
13. 00		EMERGENCY	0	0	0	0	0	13.00
14. 00	95. 00	AMBULANCE SERVICES	0	0	0	0	0	14. 00
200.00		0 1 0 1 (8)	608, 072	30, 404		0	0	200. 00
	Wkst. A Line #	1	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		I &R SERVICES-OTHER PRGM	15.00			444, 744		1. 00
1.00	22.00	COSTS APPRV		000,072	444, 744	777, /77		1.00
2.00	40 00	SUBPROVIDER - IPF	0	n	0	132, 817		2. 00
3.00		SUBPROVIDER - IRF	0	o o	_	4		3. 00
4. 00		OPERATI NG ROOM	0	Ö	_	2, 041		4. 00
5. 00		ANESTHESI OLOGY	0			1, 292, 517		5. 00
6. 00		RADI OLOGY-DI AGNOSTI C	Ö			4, 713, 782		6. 00
7. 00		LABORATORY				150, 000		7. 00
8. 00		RESPI RATORY THERAPY		-		1, 210		8. 00
9. 00		PHYSI CAL THERAPY		-	_	2, 576		9. 00
10. 00		ELECTROCARDI OLOGY				550, 112		10. 00
11. 00		CLI NI C		_	0	318, 162		11. 00
12. 00		HBURG URGENT CARE CLINIC		-	0	315, 456		12. 00
13. 00		EMERGENCY			0	5, 591, 828		13. 00
14. 00		AMBULANCE SERVICES				1, 320		14. 00
200.00	,5.00				444, 744			200. 00
200.00	1	ı	,	000,072	111,,,,,,	1 .5,515,567		_55.00

| Period: | Worksheet B | From 07/01/2022 | Part | To 06/30/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0115

					o 06/30/2023	Date/Time Pre	pared:
			CAPI TAL REI	LATED COSTS		1/25/2024 11:	51 am
			DI DO A FLAT	1,1015 501115	5451 0V55		
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7) 0	1. 00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4. 00	4A	
1.00	00100 CAP REL COSTS-BLDG & FIXT	7, 260, 339	7, 260, 339				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	5, 539, 302		5, 539, 302			2. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	32, 213, 703 27, 848, 375				28, 668, 895	4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS	5, 104, 277	6, 893			5, 311, 595	1
8.00	00800 LAUNDRY & LINEN SERVICE	372, 440				503, 298	8. 00
9.00	00900 HOUSEKEEPI NG	1, 668, 838		1		1, 668, 838	1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	358, 946 863, 338	22, 755 73, 542			467, 882 1, 277, 845	10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	1, 108, 078				1, 434, 605	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	493, 331	13, 319			614, 566	
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	138, 112	41, 881 0	1		333, 895	1
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRV	1, 535, 525 1, 297, 819		1		1, 535, 525 1, 297, 819	
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	1, 256, 390	59, 051			1, 780, 655	
	INPATIENT ROUTINE SERVICE COST CENTERS		050.050	1 070 700	1 700 570	2 221 172	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	6, 964, 950 3, 027, 216				9, 381, 170 4, 165, 373	
40. 00	04000 SUBPROVI DER - I PF	1, 383, 608				2, 051, 298	1
41. 00	04100 SUBPROVI DER - I RF	684, 860				979, 056	
43.00	04300 NURSERY	723, 084				995, 474	43.00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	1, 584, 008	73, 851	56, 345	429, 634	2, 143, 838	44. 00
50. 00	05000 OPERATING ROOM	14, 160, 484	487, 761	372, 139	1, 763, 857	16, 784, 241	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 446, 167	85, 221			1, 990, 948	
53.00	05300 ANESTHESI OLOGY	291, 260		1	, , , , , ,	1, 498, 413	1
54. 00 56. 00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	4, 339, 668 927, 751	164, 531 11, 179			6, 926, 243 1, 009, 975	1
60.00	06000 LABORATORY	8, 724, 011	79, 405			9, 940, 134	60.00
65. 00	06500 RESPI RATORY THERAPY	2, 213, 947	29, 141			2, 690, 024	65. 00
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	2, 923, 906 4, 119, 413	70, 167 155, 031			3, 998, 845 5, 275, 282	1
69. 01	06901 PULMONARY	4, 119, 413	155, 051			5, 275, 282	69. 01
69. 02	06902 CARDI OPULMONARY	172, 709	19, 269			242, 450	
69. 03	06903 SLEEP LAB	265, 419	22, 137	1		382, 728	1
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0 1, 810, 928	0	C		0 1, 810, 928	70. 00 71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	5, 285, 095	0	ď		5, 285, 095	
73. 00	07300 DRUGS CHARGED TO PATIENTS	22, 223, 968	0	C		22, 761, 641	73. 00
74. 00 77. 00	07400 RENAL DIALYSIS 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0		0	74. 00 77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	0	0		U U	0	77.00
88. 00	08800 RURAL HEALTH CLINIC	543, 940			129, 600	713, 670	
88. 01	08801 RURAL HEALTH CLINIC II	670, 533				943, 416	1
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 588, 900	_			0 863, 462	
90. 01	09001 I MED	0	0,,111	01, 100	0	0	90. 01
90. 02	09002 ONCOLOGY	3, 781, 090	143, 852			4, 895, 272	1
90. 03	09003 OUTPATIENT CENTER 09004 HBURG URGENT CARE CLINIC	1 244 022	0	40.243		1 755 (20	90. 03 90. 04
90. 04 90. 05	09005 DI ABETES MGMT CLINIC	1, 244, 032 67, 602	63, 258 6, 529			1, 755, 620 98, 912	1
91. 00	09100 EMERGENCY	4, 938, 403				8, 230, 142	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
95. 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	2, 814, 299	25, 639	19, 561	886, 461	3, 745, 960	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	2, 614, 299	25, 039			3, 743, 900	1
101.00	10100 HOME HEALTH AGENCY	2, 507, 473	29, 775	22, 717	695, 176	3, 255, 141	101. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	C	0	0	102. 00
116 00	SPECIAL PURPOSE COST CENTERS 0 11600 HOSPI CE	0	0	C	O	0	116. 00
118.00		187, 487, 537				169, 710, 169	
	NONREI MBURSABLE COST CENTERS						
	019000 GIFT FLOWER COFFEE SHOP & CANTEEN 019200 PHYSICIANS PRIVATE OFFICES	0 37, 289, 874	11, 797 1, 206, 964			20, 798 48, 967, 948	
	19200 PHYSICIANS PRIVATE OFFICES 19201 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	37, 289, 874 865, 041	1, 206, 964			48, 967, 948 1, 176, 169	
194.00	07950 LODGE	17, 996				622, 924	194. 00
	07951 OTHER NRCC	0	0				194. 01
194.02	2 07952 MEMORIAL HOSPITAL FOUNDATION	148, 037	18, 017	13, 746	42, 771	222, 571	194. 02

					1/25/2024 11:	51 am
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost			BENEFI TS		
	Allocation			DEPARTMENT		
	(from Wkst A					
	col . 7)	1.00	0.00	4.00		
	0	1. 00	2. 00	4. 00	4A	
194. 03 07953 MKT/PHY SERVI CES	3, 922, 274	951	725	81, 578	4, 005, 528	194. 03
194.04 07954 COMMUNITY EDUCATION	486, 708	58, 544	44, 666	106, 912	696, 830	194. 04
194. 05 07955 VOLUNTEER	265, 035	0	0	74, 245	339, 280	194. 05
194. 06 07956 MAB	0	0	0	0	0	194. 06
194. 07 07957 OFFSITE COVID SCREENING	168, 853	0	0	48, 685	217, 538	194. 07
194. 08 07958 PUBLIC RELATIONS	0	0	0	0	0	194. 08
194. 09 07959 UNUSED SPACE	0	0	0	0	0	194. 09
194. 10 07960 EMERGENCY PREPAREDNESS	222, 537	0	0	8, 718	231, 255	194. 10
194. 11 07961 HOME OFFICE	0	2, 644, 925	2, 017, 957	0	4, 662, 882	194. 11
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers		0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	230, 873, 892	7, 260, 339	5, 539, 302	32, 213, 703	230, 873, 892	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0115

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared: 1/25/2024 11:51 am

				. '	0 06/30/2023	1/25/2024 11:	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	REPAI RS 6. 00	LINEN SERVICE 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	0.00	0.00	0.00	7. 00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	28, 668, 895					4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS	753, 083	6, 064, 678				6.00
8. 00	00800 LAUNDRY & LINEN SERVICE	71, 358	19, 722				8. 00
9.00	00900 HOUSEKEEPI NG	236, 610	0	1	1, 905, 448		9. 00
10.00	01000 DI ETARY	66, 337	19, 538		· · ·	563, 975	10. 00
11.00	01100 CAFETERI A	181, 174	63, 145		19, 904	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	203, 400	13, 715		4, 323	0	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	87, 134 47, 340	11, 436 35, 961		·	0	14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	217, 708	33, 701	1	0	0	16. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	184, 006	O	Ö	ō	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	252, 463	50, 703	0	15, 982	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30.00	03000 ADULTS & PEDIATRICS	1, 330, 072	308, 121			220, 956	30.00
31. 00 40. 00	03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	590, 571 290, 835	141, 468 111, 760		l	101, 205 30, 084	31. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	138, 812	58, 308		· · ·	32, 170	41.00
43. 00	04300 NURSERY	141, 139	36, 586	1	· · · · · · · · · · · · · · · · · · ·	54, 171	43. 00
44.00	04400 SKILLED NURSING FACILITY	303, 955	63, 411	1	l	125, 389	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 379, 686	418, 806		· · ·	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	282, 279	73, 173	1	23, 065	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	212, 446 982, 010	141, 271	0 77, 569	44, 530	0	53. 00 54. 00
56. 00	05600 RADI OLOGI - DI AGNOSTI C	143, 195	9, 599		3, 026	0	56.00
60. 00	06000 LABORATORY	1, 409, 322	68, 180	1	l	0	60.00
65. 00	06500 RESPIRATORY THERAPY	381, 394	25, 021		l	0	65. 00
66.00	06600 PHYSI CAL THERAPY	566, 960	60, 247	21, 999	18, 991	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	747, 935	133, 114	37, 765	41, 959	0	69. 00
69. 01	06901 PULMONARY	0	0	0	0	0	69. 01
69. 02	06902 CARDI OPULMONARY	34, 375	16, 545			0	69. 02
69. 03	06903 SLEEP LAB	54, 264 0	19, 008	3, 834	5, 991	0	69. 03
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	256, 755	0		0	0	70. 00 71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	749, 326	o o	0		0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 227, 168	O	o o	o	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	o	0	74. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	101, 185	19, 545 45, 090	•	-,	0	88. 00 88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	133, 758	45, 090		14, 213	0	89. 00
90. 00	09000 CLINIC	122, 423	57, 907	1	18, 253	0	90.00
90. 01	09001 I MED	0	0	0	0	0	90. 01
90. 02	09002 ONCOLOGY	694, 057	123, 515	15, 666	38, 934	0	90. 02
90. 03	09003 OUTPATIENT CENTER	0	0	0	0	0	90. 03
90. 04	09004 HBURG URGENT CARE CLINIC	248, 914	54, 315		17, 121	0	90. 04
90.05	09005 DI ABETES MGMT CLINIC 09100 EMERGENCY	14,024	5, 606		1, 767	0	90.05
91. 00 92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 166, 878	109, 351	84, 966	34, 469	Ü	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS			1	<u> </u>		/2.00
95. 00		531, 106	22, 014	3, 436	6, 939	0	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	O	0	o	0	96. 00
	10100 HOME HEALTH AGENCY	461, 517	25, 566	0	8, 059		101. 00
102. 0	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
114 0	SPECIAL PURPOSE COST CENTERS 0 11600 HOSPI CE		0	0	ام		116. 00
118. 0		19, 996, 974	2, 361, 747		· ·	563, 975	
110.0	NONREI MBURSABLE COST CENTERS	17,770,771	2,001,717	1 007,000	700, 200	000, 710	1110.00
190. 0	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	2, 949	10, 130	0	3, 193	0	190. 00
	19200 PHYSICIANS PRIVATE OFFICES	6, 942, 792	1, 036, 334	7, 295	326, 666		192. 00
	1 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	166, 758	25, 049	1	7, 896		192. 01
	007950 LODGE	88, 319	293, 855	0	92, 627		194. 00
	107951 OTHER NRCC	21 554	15 470	0	0		194. 01
	2 07952 MEMORIAL HOSPITAL FOUNDATION 3 07953 MKT/PHY SERVICES	31, 556 567, 908	15, 470 816	1	4, 876 257		194. 02 194. 03
	4 O7954 COMMUNITY EDUCATION	98, 797	50, 267		15, 845		194. 03
	5 07955 VOLUNTEER	48, 103	30, 207	1	0		194. 05
194.0	6 07956 MAB	0	O	o o	o	0	194. 06
	7 07957 OFFSITE COVID SCREENING	30, 843		0	<u> </u>		194. 07

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0115
From 07/01/2022
To 06/30/2023
Date/Time Prepared:
1/25/2024 11:51 am

					1/25/2024 11:	<u>51 am</u>
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	REPAI RS	LINEN SERVICE			
	5. 00	6. 00	8. 00	9. 00	10.00	
194. 08 07958 PUBLIC RELATIONS	0	0	0	0	0	194. 08
194. 09 07959 UNUSED SPACE	0	0	0	0	0	194. 09
194. 10 07960 EMERGENCY PREPAREDNESS	32, 788	0	0	0	0	194. 10
194.11 07961 HOME OFFICE	661, 108	2, 271, 010	0	715, 850	0	194. 11
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	28, 668, 895	6, 064, 678	594, 378	1, 905, 448	563, 975	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0115

| Period: | Worksheet B | From 07/01/2022 | Part | | Date/Time Prepared: | 1/25/2024 | 11: 51 am

		OAFFTED! A	AUJDOL NO	OFNEDAL	DUADWA 01/	1/25/2024 11:	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	
		11. 00	13.00	SUPPLY 14.00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 00	OO400						4. 00 5. 00
6. 00	00600 MAI NTENANCE & REPAI RS						6. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	1 540 0/0					10.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	1, 542, 068 18, 407	1				11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	10, 992		750, 076			14. 00
15. 00	01500 PHARMACY	4, 686	1	3, 041	436, 258		15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	1, 753, 233	
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRV	0 170	0	0	0	0	
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV I NPATI ENT ROUTI NE SERVICE COST CENTERS	9, 173	0	134	0	0	22. 00
30. 00	03000 ADULTS & PEDIATRICS	109, 664	739, 802	21, 557	0	24, 374	30. 00
31. 00	03100 NTENSIVE CARE UNIT	61, 619		5, 525	0	17, 041	1
40.00	04000 SUBPROVI DER - I PF	21, 730	1	628	0	3, 757	40. 00
41. 00	04100 SUBPROVI DER - I RF	11, 985	1	333	0	3, 354	1
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	11, 618	1	1 901	0	3, 665	
44.00	ANCILLARY SERVICE COST CENTERS	31, 595	213, 141	1, 801	U	3, 208	44.00
50.00	05000 OPERATING ROOM	102, 018	0	224, 434	0	188, 056	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	23, 235	0	0	0	5, 677	52. 00
53. 00	05300 ANESTHESI OLOGY	26, 597	1	13, 932	0	12, 779	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	66, 723	1	14, 466	0	238, 268	
56. 00 60. 00	05600 RADI OI SOTOPE 06000 LABORATORY	3, 339 67, 220	1	205 191, 350	0	32, 734 169, 738	56. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY	32, 174	1	42, 791	0	18, 471	65. 00
66. 00	06600 PHYSI CAL THERAPY	64, 084	1	2, 240	0	33, 938	
69. 00	06900 ELECTROCARDI OLOGY	45, 311	0	43, 602	0	105, 480	
69. 01	06901 PULMONARY	0 700	0	0	0	0	69. 01
69. 02 69. 03	06902 CARDI OPULMONARY 06903 SLEEP LAB	2, 708 6, 549	1	379 616	0	3, 440 4, 811	69. 02 69. 03
70. 00	07000 ELECTROENCEPHALOGRAPHY	0, 347	1	010	0	4, 011	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		113, 121	0	27, 198	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	50, 530	
73. 00	07300 DRUGS CHARGED TO PATIENTS	33, 585	1	0	436, 258	275, 009	
74. 00 77. 00	07400 RENAL DIALYSIS 07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	74. 00 77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	0	ή	O _I	<u> </u>	0	77.00
88. 00	08800 RURAL HEALTH CLINIC	8, 734	. 0	884	0	2, 535	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	9, 987	1	869	0	2, 261	1
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	
90. 00 90. 01	09000 CLI NI C 09001 I MED	11, 322 0		2, 468 0	0	9, 059 0	
90. 01	09002 ONCOLOGY	67, 764	1	8, 539	0	68, 875	
90. 03	09003 OUTPATIENT CENTER	0	o o	0	0	0	90. 03
	09004 HBURG URGENT CARE CLINIC	23, 815	1	4, 913	0	14, 179	
90. 05	09005 DI ABETES MGMT CLINIC	1, 449	1	129	0	398	
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	96, 735	0	12, 006	0	161, 376	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95.00	09500 AMBULANCE SERVICES	70, 605	0	2, 999	0	18, 836	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	
	10100 HOME HEALTH AGENCY	51, 233		1, 589	0		101.00
102.00	10200 OPIOLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
116 00	11600 HOSPI CE	0	ol ol	0	0	0	116. 00
118.00	1 1	1, 106, 656		714, 551	436, 258	1, 508, 830	
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0		0	0		190. 00
	19200 PHYSI CLANS PRI VATE OFFI CES	385, 266		31, 781	0	239, 477	
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 07950 LODGE	18, 945 183	1	133 16	O O		192. 01 194. 00
	07951 OTHER NRCC	.03		0	ő		194. 01
194. 02	07952 MEMORIAL HOSPITAL FOUNDATION	2, 917	1	43	o		194. 02
	07953 MKT/PHY SERVI CES	3, 070	1	23	0		194. 03
	07954 COMMUNITY EDUCATION 07955 VOLUNTEER	12, 917 4, 997		1, 719 62	0		194. 04 194. 05
194.00	07955 VOLUNTEER 07956 MAB	4, 997		02	0		194. 05
	11		<u>, </u>	0	<u> </u>	0	1

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS MEMORIAL HOSP & HEALTH CARE CTR Provider CCN: 15-0115

						1/25/2024 11:	51 am_
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13. 00	14.00	15. 00	16.00	
194. 07 07957	OFFSITE COVID SCREENING	5, 706	0	0	0	0	194. 07
194. 08 07958	PUBLIC RELATIONS	0	0	0	0	0	194. 08
194. 09 07959	UNUSED SPACE	0	0	0	0	0	194. 09
194. 10 07960	EMERGENCY PREPAREDNESS	1, 411	0	1, 748	0	0	194. 10
194. 11 07961	HOME OFFICE	0	o	0	0	0	194. 11
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	o	0	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	1, 542, 068	1, 674, 450	750, 076	436, 258	1, 753, 233	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0115

				Т	o 06/30/2023	Date/Time Pre 1/25/2024 11:	
		INTERNS &	RESI DENTS			172372024 11.	J I dill
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	T	21. 00	22.00	24. 00	25.00	26. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 4. 00 5. 00 6. 00 8. 00 9. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY						2. 00 4. 00 5. 00 6. 00 8. 00 9. 00
10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 21. 00	01100 DILIARI 01100 CAFETERIA 01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LI BRARY 02100 I &R SERVI CES-SALARY & FRINGES APPRV	1 401 925					10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	1, 481, 825	2, 109, 110				22. 00
30. 00 31. 00 40. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	399, 544 0	568, 679 0	13, 312, 247 5, 578, 353	0	12, 344, 024 5, 578, 353 2, 699, 995	30. 00 31. 00 40. 00
40.00 41.00 43.00 44.00	04100 SUBPROVIDER - IFF 04300 NURSERY 04400 SKILLED NURSING FACILITY	30, 734	43, 745 0 0 0	2, 774, 474 1, 332, 842 1, 332, 855 2, 931, 792	0 0	1, 332, 842 1, 332, 855 2, 931, 792	41. 00
	ANCILLARY SERVICE COST CENTERS	111 051	-1				
50. 00 52. 00 53. 00	O5000 OPERATI NG ROOM O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY	161, 354 0 0	229, 659 0 0	20, 711, 229 2, 427, 569 1, 764, 167	o	20, 320, 216 2, 427, 569 1, 764, 167	50. 00 52. 00 53. 00
54. 00 56. 00 60. 00 65. 00 66. 00	O5400 RADI OLOGY-DI AGNOSTI C O5600 RADI OI SOTOPE O6000 LABORATORY O6500 RESPI RATORY THERAPY O6600 PHYSI CAL THERAPY	0 0 0	0 0 0 0	8, 491, 080 1, 202, 073 11, 869, 365 3, 197, 762 4, 767, 304	0 0	8, 491, 080 1, 202, 073 11, 869, 365 3, 197, 762 4, 767, 304	54. 00 56. 00 60. 00 65. 00 66. 00
69. 00	06900 ELECTROCARDI OLOGY	46, 101	65, 617	6, 542, 166	-111, 718	6, 430, 448	69. 00
69. 01 69. 02 69. 03	06901 PULMONARY 06902 CARDI OPULMONARY 06903 SLEEP LAB	46, 101 0	65, 617 0	417, 350 477, 801	-111, 718 0	0 305, 632 477, 801	69. 01 69. 02 69. 03
70. 00 71. 00 72. 00 73. 00 74. 00 77. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07700 ALLOGENEIC HSCT ACQUISITION	0 0 0 0 0	0 0 0 0 0	2, 208, 002 6, 084, 951 26, 733, 661	0 0	0 2, 208, 002 6, 084, 951 26, 733, 661 0	70. 00 71. 00 72. 00 73. 00 74. 00 77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	852, 714		852, 714	88. 00
88. 01 89. 00 90. 00	08801 RURAL HEALTH CLINIC II 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	8, 781 0 0	12, 498 0 0	1, 170, 873 0 1, 086, 206	0	1, 149, 594 0 1, 086, 206	88. 01 89. 00 90. 00
90. 01 90. 02 90. 03	09001 I MED	0 4, 391 0	0 6, 249 0	5, 923, 262 0		0 5, 912, 622 0	90. 01 90. 02 90. 03
90. 04 90. 05	09004 HBURG URGENT CARE CLINIC 09005 DI ABETES MGMT CLINIC	60, 371 0	85, 927 0	2, 266, 816 122, 285	0	2, 120, 518 122, 285	90. 05
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	60, 371	85, 927	10, 042, 221	-146, 298 0	9, 895, 923	91. 00 92. 00
96. 00 101. 00	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED)10100 HOME HEALTH AGENCY 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0 0 0 0	0 0 0 0	4, 401, 895 C 3, 812, 888	0 0	4, 401, 895 0 3, 812, 888 0	96. 00
118. 00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	817, 748	1, 163, 918	153, 836, 203	-1, 981, 666	151, 854, 537	
192. 00 192. 01 194. 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19200 PHYSICIANS PRIVATE OFFICES 19201 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 07950 LODGE	401, 739 0 0	0 571, 801 0 0	37, 070 58, 911, 099 1, 398, 755 1, 097, 924	-973, 540 0 0	57, 937, 559 1, 398, 755 1, 097, 924	192. 01 194. 00
	07951 OTHER NRCC 07952 MEMORIAL HOSPITAL FOUNDATION	0 0	0 0	277, 433		277, 433	194. 01 194. 02

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0115

						1/23/2024 11.	JI alli
		INTERNS &	RESI DENTS				
	Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	Subtotal	Intern &	Total	
		Y & FRINGES	PRGM COSTS		Residents Cost		
		APPRV	APPRV		& Post		
					Stepdown		
					Adjustments		
		21.00	22. 00	24. 00	25. 00	26.00	
194. 03 07953	MKT/PHY SERVICES	0	0	4, 578, 723	0	4, 578, 723	194. 03
194. 04 07954	COMMUNITY EDUCATION	237, 092	337, 458	1, 450, 925	-574, 550	876, 375	194. 04
194. 05 07955	VOLUNTEER	0	0	392, 442	0	392, 442	194. 05
194. 06 07956	MAB	0	0	0	0	0	194. 06
194. 07 07957	OFFSITE COVID SCREENING	0	0	254, 087	0	254, 087	194. 07
194. 08 07958	PUBLIC RELATIONS	0	0	0	0	0	194. 08
194. 09 07959	UNUSED SPACE	0	0	0	0	0	194. 09
194. 10 07960	EMERGENCY PREPAREDNESS	0	0	267, 202	0	267, 202	194. 10
194. 11 07961	HOME OFFICE	25, 246	35, 933	8, 372, 029	-61, 179	8, 310, 850	194. 11
200.00	Cross Foot Adjustments	0	0	0	0	0	200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	1, 481, 825	2, 109, 110	230, 873, 892	-3, 590, 935	227, 282, 957	202. 00

Health Financial Systems
COST ALLOCATION STATISTICS MEMORI AL HOSP & HEALTH CARE CTR
Provi der CCN: 15-0115 In Lieu of Form CMS-2552-10
Worksheet Non-CMS W

Peri od: From 07/01/2022 To 06/30/2023 Date/Ti me Prepared: 1/25/2024 11:51 am

	Cost Center Description		Statistics Description	
		Code		
		1.00	2. 00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6. 00
8.00	LAUNDRY & LINEN SERVICE	2	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPI NG	1	SQUARE FEET	9. 00
10.00	DI ETARY	3	PATIENT DA YS	10.00
11. 00	CAFETERI A	4	HOURS	11. 00
13.00	NURSING ADMINISTRATION	5	DIRECT NRSING HRS	13. 00
14.00	CENTRAL SERVICES & SUPPLY	6	COSTED REQUIS.	14. 00
15.00	PHARMACY	7	COSTED REQUIS.	15. 00
16.00	MEDICAL RECORDS & LIBRARY	8	REVENUE	16. 00
21.00	I &R SERVI CES-SALARY & FRI NGES APPRV	9	ASSIGNED TIME	21. 00
22. 00	I&R SERVICES-OTHER PRGM COSTS APPRV	9	ASSIGNED TIME	22. 00

Provider CCN: 15-0115

Peri od:

ALLOCATION OF CAPITAL RELATED COSTS

Part II

From 07/01/2022 Date/Time Prepared: 06/30/2023 1/25/2024 11:51 am CAPITAL RELATED COSTS Directly BLDG & FIXT MVBLE EQUIP Subtotal **EMPLOYEE** Cost Center Description Assigned New **BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 2A 4.00 0 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 0 0 0 190, 233 145, 139 335, 372 5.00 0 00600 MAINTENANCE & REPAIRS 6, 893 6 00 5, 259 6 00 12, 152 0 00800 LAUNDRY & LINEN SERVICE 8.00 22, 969 17, 524 40, 493 0 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 00000 10.00 10 00 22 755 17 361 40 116 0 01100 CAFETERI A 129, 651 11.00 73, 542 56, 109 0 11.00 13.00 01300 NURSING ADMINISTRATION 15, 973 12, 187 28, 160 0 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 13, 319 10, 162 23, 481 0 14.00 01500 PHARMACY 31, 954 15 00 41, 881 73.835 15 00 0 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 16.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 21.00 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 59,051 45,053 22.00 22.00 104, 104 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 358, 853 273, 788 632, 641 0 30.00 03100 INTENSIVE CARE UNIT 0 0 31.00 164, 761 125, 705 290, 466 31.00 0 04000 SUBPROVI DER - I PF 99, 306 229, 467 40.00 40.00 130, 161 0 04100 SUBPROVI DER - I RF 67, 909 119, 720 41.00 51, 811 0 41.00 0 43.00 04300 NURSERY 42, 610 32, 510 75, 120 0 43.00 04400 SKILLED NURSING FACILITY 0 44.00 73,851 56, 345 130, 196 0 44.00 ANCILLARY SERVICE COST CENTERS 50 00 50 00 05000 OPERATING ROOM 0 487.761 372 139 859 900 0 65, 019 05200 DELIVERY ROOM & LABOR ROOM 150, 240 0 52.00 52.00 0000000 85, 221 05300 ANESTHESI OLOGY 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 164, 531 125, 529 290, 060 54.00 0 56.00 05600 RADI OI SOTOPE 11, 179 8, 529 19, 708 0 56.00 60, 582 06000 LABORATORY 79, 405 139, 987 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 29, 141 22, 233 51, 374 0 65.00 06600 PHYSI CAL THERAPY 70. 167 123, 701 66,00 53.534 Λ 66,00 69. 00 06900 ELECTROCARDI OLOGY 155, 031 118, 282 273, 313 0 69.00 06901 PULMONARY 69.01 0 0 69.01 06902 CARDI OPULMONARY 19, 269 33.970 69.02 69.02 14.701 0 69.03 06903 SLEEP LAB 22, 137 16, 890 39, 027 0 69.03 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 0 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 Ω Λ 73.00 07300 DRUGS CHARGED TO PATIENTS C 0 0 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 74.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 22, 763 17, 367 40, 130 0 88.00 88.01 08801 RURAL HEALTH CLINIC II 00000000 52, 514 40,066 92, 580 0 88.01 89 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 90.00 09000 CLI NI C 67, 441 51, 455 118, 896 0 90.00 90.01 09001 I MED 90.01 0 90.02 09002 ONCOLOGY 90.02 143, 852 109, 752 253, 604 0 09003 OUTPATIENT CENTER 90 03 90.03 0 09004 HBURG URGENT CARE CLINIC 90.04 63, 258 48, 263 111, 521 0 90.04 09005 DIABETES MGMT CLINIC 6, 529 4, 981 90.05 90.05 11, 510 0 127, 356 97, 167 91.00 09100 EMERGENCY 224, 523 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 25, 639 19, 561 45, 200 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 101.00 10100 HOME HEALTH AGENCY 01101.00 29, 775 22, 717 52, 492 102.00 10200 OPIOID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 116 00 0 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 2, 947, 730 2, 248, 980 5, 196, 710 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 11. 797 9.001 20, 798 0 190. 00 1, 206, 964 920, 857 2, 127, 821 0 192, 00 192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 29, 173 22, 258 51, 431 0 192. 01 194. 00 07950 LODGE 0 342, 238 261, 112 603, 350 0 194.00 194. 01 07951 OTHER NRCC 0 194, 01 C 194.02 07952 MEMORIAL HOSPITAL FOUNDATION 18, 017 0 194. 02 13, 746 31, 763 194. 03 07953 MKT/PHY SERVICES 951 725 1, 676 0 194. 03

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 07/01/2022 | Part II | Date/Time Prepared: 1/25/2024 | 11:51 am

					1/25/2024 11:	51 am_
		CAPI TAL REL	_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	
194. 04 07954 COMMUNITY EDUCATION	0	58, 544	44, 666	103, 210	0	194. 04
194. 05 07955 VOLUNTEER	0	0	0	0	0	194. 05
194. 06 07956 MAB	0	0	0	0	0	194. 06
194.07 07957 OFFSITE COVID SCREENING	0	0	0	0	0	194. 07
194.08 07958 PUBLIC RELATIONS	o	0	0	0	0	194. 08
194. 09 07959 UNUSED SPACE	o	0	0	0	0	194. 09
194. 10 07960 EMERGENCY PREPAREDNESS	o	0	0	0	0	194. 10
194. 11 07961 HOME OFFICE	o	2, 644, 925	2, 017, 957	4, 662, 882	0	194. 11
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	o	7, 260, 339	5, 539, 302	12, 799, 641	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0115

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 07/01/2022 Part II
To 06/30/2023 Date/Time Prepared: 1/25/2024 11:51 am

				, '	0 06/30/2023	1/25/2024 11:	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5. 00	6.00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS			ı			
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	335, 372					5.00
6.00	00600 MAINTENANCE & REPAIRS	8, 812	20, 964				6. 00
8.00	00800 LAUNDRY & LINEN SERVICE	835	68				8. 00
9.00	00900 HOUSEKEEPI NG	2, 769	0		2, 769	44 252	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	776 2, 120	68 218	l .	29	41, 252 0	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	2, 380	47	l .	6	0	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 020	40			0	1
15. 00	01500 PHARMACY	554	124	0	16	0	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	2, 547	0		0	0	
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV	2, 153 2, 954	0 175	· -	23	0	1
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	2, 934	173	<u> </u>	23	0	22.00
30.00	03000 ADULTS & PEDIATRICS	15, 563	1, 065	7, 745	141	16, 161	30. 00
31.00	03100 INTENSIVE CARE UNIT	6, 910	489	2, 456	65	7, 403	31.00
40.00	04000 SUBPROVI DER - I PF	3, 403	386	1		2, 201	1
41.00	04100 SUBPROVI DER - I RF 04300 NURSERY	1, 624	202	1	27	2, 353	1
43. 00 44. 00	04400 SKILLED NURSING FACILITY	1, 651 3, 557	126 219		17 29	3, 962 9, 172	
44.00	ANCI LLARY SERVI CE COST CENTERS	3,337	217	1, 7, 7	2/	7, 172	1 44. 00
50.00	05000 OPERATI NG ROOM	27, 845	1, 448	6, 335	192	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 303	253	1		0	1
53.00	05300 ANESTHESI OLOGY	2, 486	0	· ·	0	0	1
54. 00 56. 00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	11, 491 1, 676	488 33	1	65	0	
60.00	06000 LABORATORY	16, 491	236	l .	31	0	1
65.00	06500 RESPI RATORY THERAPY	4, 463	86	ı	11	0	1
66. 00	06600 PHYSI CAL THERAPY	6, 634	208		28	0	
69. 00	06900 ELECTROCARDI OLOGY	8, 752	460	1	61	0	
69. 01 69. 02	06901 PULMONARY 06902 CARDI OPULMONARY	0 402	0 57		0	0	1
69. 02	06903 SLEEP LAB	635	66		9	0	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	ó	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 004	0	0	o	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 768	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	37, 762	0	0	0	0	
74. 00 77. 00	07400 RENAL DIALYSIS 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0		0	
77.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		77.00
88. 00	08800 RURAL HEALTH CLINIC	1, 184	68	0	9	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	1, 565	156	1	21	0	1
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	_	0	0	
90. 00 90. 01	09000 CLI NI C 09001 I MED	1, 432	200 0	1	27	0	
90. 02	1 1	8, 121	427	_	57	0	
90. 03	09003 OUTPATIENT CENTER	0	0	1	o	0	
90. 04	09004 HBURG URGENT CARE CLINIC	2, 913	188	l .	25	0	
90. 05 91. 00	09005 DI ABETES MGMT CLINIC 09100 EMERGENCY	164	19 378		3 50	0	1
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	13, 654	3/8	5, 918	50	U	91.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95.00		6, 215	76	239	10	0	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	
	0 10100 HOME HEALTH AGENCY	5, 400	88	l .	12		101.00
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
116. 00	11600 HOSPI CE	0	0	0	o	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	233, 988	8, 162	40, 888	1, 075	41, 252	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	35	35				190.00
	D 19200 PHYSICIANS PRIVATE OFFICES 1 19201 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	81, 151 1, 951	3, 582 87	1	475 11		192. 00 192. 01
	07950 LODGE	1, 931	1, 016	1	135		194. 00
	1 07951 OTHER NRCC	0	0	Ö	0		194. 01
	07952 MEMORIAL HOSPITAL FOUNDATION	369	53	0	7		194. 02
	3 O7953 MKT/PHY SERVI CES	6, 645	3	0	0		194. 03
	4 07954 COMMUNITY EDUCATION 5 07955 VOLUNTEER	1, 156 563	174 0		23		194. 04 194. 05
	07955 VOLUNTEER 607956 MAB	0	0				194. 05
	7 07957 OFFSITE COVID SCREENING	361	0	1	- 1		194. 07
	· · · · · · · · · · · · · · · · · · ·				·		

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0115 Period: Worksheet B

elegation of an internet against			From 07/01/2022	Part II	
			10 06/30/2023	Date/Time Prep	
				1/25/2024 11: 5	51 am_
Cost Contan Decemintion	ADMINICEDATIVE MAINTENANCE O	I ALIMDDY 0	HOUSEKEEDING	DIETADV	

						172072021 11.	O I GIII
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	REPAI RS	LINEN SERVICE			
		5. 00	6.00	8. 00	9. 00	10.00	
194. 08 07958	PUBLIC RELATIONS	0	0	0	0	0	194. 08
194. 09 07959	UNUSED SPACE	0	0	0	0	0	194. 09
194. 10 07960	EMERGENCY PREPAREDNESS	384	0	0	0	0	194. 10
194. 11 07961	HOME OFFICE	7, 736	7, 852	0	1, 038	0	194. 11
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	335, 372	20, 964	41, 396	2, 769	41, 252	202. 00

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0115 Peri od: Worksheet B From 07/01/2022 Part II Date/Time Prepared: 06/30/2023 1/25/2024 11:51 am Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL RECORDS & SERVICES & ADMI NI STRATI ON SUPPLY LI BRARY 11. 00 13.00 15. 00 14.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 6.00 8.00 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 11.00 01100 CAFETERI A 132,018 01300 NURSING ADMINISTRATION 13.00 1,576 32, 169 01400 CENTRAL SERVICES & SUPPLY 14.00 941 27.043 15.00 01500 PHARMACY 401 110 75,040 16.00 01600 MEDICAL RECORDS & LIBRARY 2, 547 0 C 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 0 0 C 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 785 5 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 9, 388 14, 213 777 0 34 03100 INTENSIVE CARE UNIT 7. 986 199 0 23 31.00 5.275 40.00 04000 SUBPROVI DER - I PF 1,860 2, 816 23 0 5 04100 SUBPROVI DER - I RF 0 41.00 1,026 1, 553 12 5 o 04300 NURSERY 43.00 995 1,506 C 5 4, 095 04400 SKILLED NURSING FACILITY 44.00 2,705 65 0 4 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 8, 734 8, 091 0 259 05200 DELIVERY ROOM & LABOR ROOM 52 00 1.989 Ω 0 C 8 05300 ANESTHESI OLOGY 53.00 2, 277 0 502 18 54.00 05400 RADI OLOGY-DI AGNOSTI C 5, 712 0 328 522 56.00 05600 RADI OI SOTOPE 286 0 0 45 06000 LABORATORY 6, 898 60.00 5, 755 0 234 65.00 06500 RESPIRATORY THERAPY 2,754 1,543 25 06600 PHYSI CAL THERAPY 66.00 5, 486 81 0 47 69 00 06900 ELECTROCARDI OLOGY 3.879 1,572 145 06901 PULMONARY 69.01 C 0 06902 CARDI OPULMONARY 232 0 0 5 69.02 14 69.03 06903 SLEEP LAB 561 22 07000 ELECTROENCEPHALOGRAPHY 70 00 Ω 0 0 C 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 C 4,078 0 37 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 70 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2.875 0 0 75.040 511 07400 RENAL DIALYSIS 0 74.00 0 Ω 0 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0

MCRI F32 - 21. 2. 177. 1

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MEMORIAL HOSP & HEALTH CARE CTR Provider CCN: 15-0115

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: | 1/25/2024 | 11:51 am

						1/25/2024 11:	<u>sıam</u>
Cost Center Desc	cription	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11.00	13. 00	14.00	15. 00	16. 00	
194. 07 07957 OFFSITE COVID SO	CREENI NG	488	0	0	0	0	194. 07
194.08 07958 PUBLIC RELATIONS	5	0	0	0	0	0	194. 08
194.09 07959 UNUSED SPACE		0	0	0	0	0	194. 09
194. 10 07960 EMERGENCY PREPAR	REDNESS	121	0	63	0	0	194. 10
194.11 07961 HOME OFFICE		0	0	0	0	0	194. 11
200.00 Cross Foot Adjus	stments						200. 00
201.00 Negative Cost Co	enters	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines	s 118 through 201)	132, 018	32, 169	27, 043	75, 040	2, 547	202. 00

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0115 Period: Worksheet B

ALLUCA	ATTON (OF CAPITAL RELATED COSTS		Provider CC		Period: From 07/01/2022 To 06/30/2023	Worksheet B Part II Date/Time Pre 1/25/2024 11:	pared:
		Cost Center Description	I NTERNS & R SERVI CES-SALARSI Y & FRI NGES APPRV		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	31 dill
	OFNED	AL CERVI OF COCT OFNITERS	21. 00	22. 00	24. 00	25. 00	26. 00	
1. 00 2. 00 4. 00 5. 00 6. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 21. 00	00100 00200 00400 00500 00600 00800 01000 01100 01300 01400 01500 01600	AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY I&R SERVICES-SALARY & FRINGES APPRV	2, 153					1. 00 2. 00 4. 00 5. 00 6. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 21. 00
22. 00		I &R SERVICES-OTHER PRGM COSTS APPRV		108, 046				22. 00
30. 00 31. 00 40. 00 41. 00 43. 00 44. 00	03000 03100 04000 04100 04300 04400	I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - I PF SUBPROVIDER - I RF NURSERY SKI LLED NURSI NG FACILITY			697, 72 321, 27 240, 77 127, 19 83, 40 151, 81	2 0 5 0 0 0 3 0	697, 728 321, 272 240, 775 127, 190 83, 403 151, 816	31. 00 40. 00 41. 00 43. 00
50. 00 52. 00 53. 00 54. 00 56. 00 60. 00 65. 00 66. 00 69. 00 69. 01 69. 02	05000 05200 05300 05400 05600 06600 06600 06900 06901	LARY SERVICE COST CENTERS OPERATING ROOM DELIVERY ROOM & LABOR ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE LABORATORY RESPI RATORY THERAPY PHYSI CAL THERAPY PLLECTROCARDI OLOGY PULMONARY CARDI OPULMONARY			34, 72	0 0 0 0 8 0 9 0 0 6 0 0 7 0 0 2 0 0 4 0 0	912, 804 157, 860 5, 283 314, 068 21, 759 169, 766 60, 256 137, 717 290, 812 0	52. 00 53. 00 54. 00 56. 00 60. 00 65. 00 66. 00 69. 00 69. 01 69. 02
69. 03 70. 00 71. 00 72. 00 73. 00 74. 00 77. 00	07000 07100 07200 07300 07400 07700	SLEEP LAB ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS RENAL DIALYSIS ALLOGENEIC HSCT ACQUISITION TIENT SERVICE COST CENTERS			7, 11 8, 83 116, 18	0 9 0 8	40, 594 0 7, 119 8, 838 116, 188 0	70. 00 71. 00 72. 00 73. 00
88. 00 88. 01 89. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 91. 00 92. 00	08800 08801 08900 09000 09001 09002 09003 09004 09005 09100	RURAL HEALTH CLINIC RURAL HEALTH CLINIC II FEDERALLY QUALIFIED HEALTH CENTER CLINIC			42, 17 95, 21 121, 71 269, 50 116, 99 11, 82 253, 46	1 0 0 0 6 0 0 0 4 0 0 0 7 0 6 0	42, 174 95, 211 0 121, 716 0 269, 504 0 116, 997 11, 826 253, 460	88. 01 89. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05
96. 00 101. 00 102. 00	09500 09600 10100 10200 SPECI	AMBULANCE SERVICES DURABLE MEDICAL EQUIP-RENTED HOME HEALTH AGENCY OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS			57, 91 62, 44	0 0 8 0 0 0	0	96. 00 101. 00 102. 00
118.00	NONRE	HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	0	0	4, 931, 22		4, 931, 227	
192. 00 192. 01 194. 00 194. 01	19200 19201 07950 07951	GIFT FLOWER COFFEE SHOP & CANTEEN PHYSICIANS PRIVATE OFFICES PSYCHIATRIC/PSYCHOLOGICAL SERVICES LODGE OTHER NRCC MEMORIAL HOSPITAL FOUNDATION			20, 87 2, 247, 99 55, 11 605, 55 32, 44	6 0 2 0 1 0 0	2, 247, 996 55, 112 605, 551 0	192. 01

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0115

		INTERNS &	RESI DENTS				
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		Intern & Residents Cost & Post Stepdown	Total	
		21.00	22.00	24. 00	Adjustments 25.00	26. 00	
194. 03 07953	MKT/PHY SERVICES	21.00	22.00	8, 590			194. 03
	COMMUNITY EDUCATION			105, 731		105, 731	•
194. 05 07955	VOLUNTEER			993	0	993	194. 05
194. 06 07956	MAB			0	0	0	194. 06
194. 07 07957	OFFSITE COVID SCREENING			849	0	849	194. 07
194. 08 07958	PUBLIC RELATIONS			0	0	0	194. 08
194. 09 07959	UNUSED SPACE			0	0	0	194. 09
194. 10 07960	EMERGENCY PREPAREDNESS			568	0	568	194. 10
194. 11 07961	HOME OFFICE			4, 679, 508	0	4, 679, 508	194. 11
200.00	Cross Foot Adjustments	2, 153	108, 046	110, 199	0	110, 199	200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	2, 153	108, 046	12, 799, 641	0	12, 799, 641	202. 00

Provider CCN: 15-0115

					To 06/30/2023		
		CAPITAL REI	L LATED COSTS			1/25/2024 11:	51 am
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	
		(SQUARE TELT)	(SQUARL TELT)	DEPARTMENT		(ACCUM. COST)	
				(GROSS		(
		4.00	0.00	SALARI ES)	5.4	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2. 00	4.00	5A	5. 00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT	916, 352					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		916, 352	2			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	_	1,			4. 00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	24, 010 870		1		202, 204, 997 5, 311, 595	5. 00 6. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	2, 899	l .			503, 298	8.00
9. 00	00900 HOUSEKEEPI NG	0	0			1, 668, 838	9. 00
10.00	01000 DI ETARY	2, 872		1		467, 882	10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	9, 282 2, 016		1		1, 277, 845 1, 434, 605	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 681	1, 681	1		614, 566	14. 00
15. 00	01500 PHARMACY	5, 286		1		333, 895	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0		٥	1, 535, 525	16.00
21. 00 22. 00	02100 1&R SERVICES-SALARY & FRINGES APPRV 02200 1&R SERVICES-OTHER PRGM COSTS APPRV	0 7, 453	7, 453) 3 1, 358, 320	0		21. 00 22. 00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	7,455	7,455	1, 330, 32	<u> </u>	1, 760, 033	22.00
30.00	03000 ADULTS & PEDIATRICS	45, 292	45, 292	5, 766, 05	4 O	9, 381, 170	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	20, 795	· ·	1		4, 165, 373	31.00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	16, 428 8, 571	16, 428 8, 571	1		2, 051, 298 979, 056	40. 00 41. 00
43. 00	04300 NURSERY	5, 378		1			43.00
44. 00	04400 SKILLED NURSING FACILITY	9, 321		1			44. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	61, 562 10, 756				16, 784, 241 1, 990, 948	50. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	10, 730				1, 498, 413	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	20, 766	20, 766			6, 926, 243	•
56. 00	05600 RADI OI SOTOPE	1, 411	1, 411			1, 009, 975	56. 00
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	10, 022 3, 678		1		9, 940, 134 2, 690, 024	60. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	8, 856		1		3, 998, 845	66.00
69. 00	06900 ELECTROCARDI OLOGY	19, 567	19, 567			5, 275, 282	69. 00
69. 01	06901 PULMONARY	0	0)	۷	0	69. 01
69. 02	06902 CARDI OPULMONARY 06903 SLEEP LAB	2, 432		1		242, 450 382, 728	69. 02
69. 03 70. 00	07000 ELECTROENCEPHALOGRAPHY	2, 794		253, 07	0	302, 720	69. 03 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö		0		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	_		0	5, 285, 095	72. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	_	1, 738, 220	0	22, 761, 641 0	73. 00 74. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION					0	77.00
	OUTPATIENT SERVICE COST CENTERS	_	-		-		
88. 00	08800 RURAL HEALTH CLINIC	2, 873				713, 670	1
88. 01 89. 00	08801 RURAL HEALTH CLINIC II 08900 FEDERALLY QUALIFIED HEALTH CENTER	6, 628			3 0	943, 416 0	88. 01 89. 00
90. 00	09000 CLINIC	8, 512				863, 462	90.00
90. 01	09001 I MED	0	0		0	0	90. 01
90. 02	09002 ONCOLOGY	18, 156	18, 156	2, 782, 12	0	4, 895, 272	90. 02
90. 03 90. 04	09003 OUTPATIENT CENTER 09004 HBURG URGENT CARE CLINIC	7, 984	0 7, 984) 1, 293, 360	0	0 1, 755, 620	90. 03 90. 04
90.04	09005 DI ABETES MGMT CLINIC	824				98, 912	90.04
91. 00	09100 EMERGENCY	16, 074		1		8, 230, 142	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	2 224	2 224	2 945 90		2 745 040	05 00
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	3, 236				3, 745, 960 0	95. 00 96. 00
	10100 HOME HEALTH AGENCY	3, 758	_		-	3, 255, 141	
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0)	0	0	102. 00
11/ 00	SPECIAL PURPOSE COST CENTERS			\	0	1 0	116. 00
118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0 372, 043			-		
110.00	NONREI MBURSABLE COST CENTERS	072,010	072,010	71,217,70	20,000,070	111,011,271	1110.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	1, 489			0	,	
	19200 PHYSICIANS PRIVATE OFFICES	152, 335		1		48, 967, 948	
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 07950 LODGE	3, 682 43, 195		1		1, 176, 169 622, 924	
	07951 OTHER NRCC	0			o o	0	194. 01
194. 02	07952 MEMORIAL HOSPITAL FOUNDATION	2, 274	2, 274	138, 27	1 0	222, 571	194. 02
						·	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0115

			1	0 06/30/2023	1/25/2024 11:	
	CAPITAL REL	ATED COSTS			172072021 11.	O T GIII
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
			DEPARTMENT		(ACCUM. COST)	
			(GROSS			
	1.00	2.00	SALARI ES)	ΕΛ.	F 00	
194. 03 07953 MKT/PHY SERVI CES	1.00	2.00	4.00	5A	5. 00	104.00
194. 04 07953 MK1/PHY SERVICES 194. 04 07954 COMMUNITY EDUCATION	120 7, 389	120 7, 389			4, 005, 528 696, 830	
194. 05 07955 VOLUNTEER	7, 389	7, 389	· ·		339, 280	
194. 06 07956 MAB	0	0	240, 025	0		194. 05
194. 07 07957 OFFSITE COVID SCREENING	0	0	157, 393	0	217, 538	
194. 08 07958 PUBLIC RELATIONS	0	0	137, 393	0		194. 07
194. 09 07959 UNUSED SPACE	0	0	0	0		194. 09
194. 10107960 EMERGENCY PREPAREDNESS	0	0	28, 185	0	231, 255	
194. 11 07961 HOME OFFICE	333, 825	333, 825		0	4, 662, 882	
200.00 Cross Foot Adjustments	000,020	000,020	Ĭ	J		200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	7, 260, 339	5, 539, 302	32, 213, 703		28, 668, 895	
Part I)	,,	., ,	, , ,		, , , , , , , , , , , , , , , , , , , ,	
203.00 Unit cost multiplier (Wkst. B, Part I)	7. 923090	6. 044950	0. 309324		0. 141781	203. 00
204.00 Cost to be allocated (per Wkst. B,			0		335, 372	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part			0. 000000		0. 001659	205. 00
11)						
NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						007.00
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)	1				1	I

		MEMORIAL HOSP &			In Lie	u of Form CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provi der CC		eriod: rom 07/01/2022 o 06/30/2023	Worksheet B-1 Date/Time Pre 1/25/2024 11:	pared:
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DA YS)	CAFETERI A (HOURS)	or am
		6. 00	8.00	9.00	10. 00	11. 00	
	GENERAL SERVICE COST CENTERS		1				
1. 00 2. 00 4. 00 5. 00 6. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	891, 472					1. 00 2. 00 4. 00 5. 00 6. 00
8. 00 9. 00 10. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY	2, 899 0 2, 872	0 5, 511	888, 573 2, 872	17, 303		8. 00 9. 00 10. 00
11. 00 13. 00	01100 CAFETERIA 01300 NURSI NG ADMINI STRATI ON	9, 282 2, 016	1	9, 282 2, 016	0	1, 971, 630 23, 534	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 681	1		0	14, 054	1
15. 00	01500 PHARMACY	5, 286	1	5, 286	0	5, 991	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	1	0	0	0	
21.00	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV	7 452	1	7 452	0	11 720	
22.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7, 453	0	7, 453		11, 728	22.00
30.00	03000 ADULTS & PEDIATRICS	45, 292	150, 958	45, 292	6, 779	140, 212	30.00
31. 00	03100 I NTENSI VE CARE UNI T	20, 795	1		3, 105	78, 784	1
40.00	04000 SUBPROVI DER - I PF	16, 428	•		923	27, 783	1
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	8, 571 5, 378	•		987 1, 662	15, 324 14, 854	1
44. 00	04400 SKILLED NURSING FACILITY	9, 321	1		3, 847	40, 396	1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	61, 562	1		0	130, 437	
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	10, 756	1	10, 756 0	0	29, 707 34, 006	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	20, 766	_	_	0	85, 309	1
56.00	05600 RADI OI SOTOPE	1, 411	1	1	0	4, 269	1
60.00	06000 LABORATORY	10, 022	1		0	85, 945	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	3, 678 8, 856	1	-,	0	41, 136 81, 935	1
69. 00	06900 ELECTROCARDI OLOGY	19, 567	1		0	57, 933	1
69. 01	06901 PULMONARY	0	1		Ö	0	1
69. 02	06902 CARDI OPULMONARY	2, 432			0	3, 462	1
69. 03	06903 SLEEP LAB	2, 794	1		0	8, 373	1
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1	0	0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	o o	ő	Ö	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	42, 941	1
74. 00	07400 RENAL DIALYSIS	0		0	0	0	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	77. 00
88. 00	08800 RURAL HEALTH CLINIC	2, 873	0	2, 873	0	11, 167	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	6, 628			0	12, 769	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0 513	1	0 513	0	14.47/	
90. 00 90. 01	09000 CLI NI C 09001 MED	8, 512	1, 781	8, 512	0	14, 476 0	1
90. 02	09002 ONCOLOGY	18, 156	21, 270	18, 156	Ö	86, 640	
90. 03	09003 OUTPATIENT CENTER	0	0	0	0	0	90. 03
	09004 HBURG URGENT CARE CLINIC	7, 984	1		0	30, 449	1
90. 05 91. 00	09005 DIABETES MGMT CLINIC	824 16, 074		824 16, 074	0	1, 852 123, 682	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	10,071	110,000	10,071	Ŭ.	120, 002	92.00
	OTHER REIMBURSABLE COST CENTERS			1			
	09500 AMBULANCE SERVICES	3, 236	4, 665		0	90, 273	
	09600 DURABLE MEDICAL EQUIP-RENTED	3, 758	0	0 3, 758	0	0 65 504	96. 00 101. 00
	10200 OPI OI D TREATMENT PROGRAM	0,700	l .	0,700	Ö		102. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	NONREI MBURSABLE COST CENTERS	347, 163		_			116. 00 118. 00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	1, 489		1, 489	0		190.00
	19200 PHYSI CLANS PRI VATE OFFI CES 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	152, 335 3, 682		152, 335 3, 682	0	492, 591 24, 222	192. 00 192. 01
	07950 LODGE	43, 195	1	43, 195	ol		194. 00
194. 01	07951 OTHER NRCC	0	0	0	o	0	194. 01
	07952 MEMORIAL HOSPITAL FOUNDATION	2, 274		2, 274	0		194. 02
194.03	07953 MKT/PHY SERVICES 07954 COMMUNITY EDUCATION	120 7, 389		120 7, 389	0		194. 03 194. 04
	07955 VOLUNTEER	7, 389	1		0		194. 04
	,	1	1		- 1		

From 07/01/2022 06/30/2023 Date/Time Prepared: 1/25/2024 11:51 am Cost Center Description MAINTENANCE & LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A **REPAI RS** LINEN SERVICE (SQUARE FEET) (PATIENT DA (HOURS) (SQUARE FEET) (POUNDS OF YS) LAUNDRY) 8.00 11.00 6.00 9.00 10.00 194.06 07956 MAB 0 0 0 194. 06 0 0 0 194. 07 07957 OFFSITE COVID SCREENING 0 7, 295 194. 07 0 0 194. 08 07958 PUBLIC RELATIONS 0 0 194. 08 194.09 07959 UNUSED SPACE 0 0 0 194. 09 C 194. 10 07960 EMERGENCY PREPAREDNESS 1, 804 194. 10 194. 11 07961 HOME OFFICE 333, 825 333, 825 0 194. 11 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 6, 064, 678 594, 378 1, 905, 448 563, 975 1, 542, 068 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 6.802993 0.736532 2.144391 32. 594059 0. 782128 203. 00 132, 018 204. 00 204.00 Cost to be allocated (per Wkst. B, 20, 964 41, 396 2, 769 41, 252 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.023516 0.051296 0.003116 2. 384095 0. 066959 205. 00 H) 206.00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2)

207. 00

207.00

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period: From 07/01/2022 To 06/30/2023	Worksheet B-1 Date/Time Pre	nared:
				10 00/30/2023	1/25/2024 11:	51 am
Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (REVENUE)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED	
	HRS) 13.00	REQUI S.) 14. 00	15. 00	16. 00	TIME) 21.00	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT						1 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01600 MEDICAL RECORDS & LIBRARY 21.00 02200 I&R SERVICES-SALARY & FRINGES APPRV 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	317, 353 0 0 0 0 0	12, 007, 827 48, 685 0 0 2, 150	10	0 0 805, 745, 072 0 0 0	1, 350	1. 00 2. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 21. 00 22. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	140, 212	345, 104		0 11, 201, 138	364	30. 00
31. 00 03100 NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - PF	78, 784 27, 783	88, 453 10, 053		0 11, 201, 138 0 7, 831, 258 0 1, 726, 350	0 28	31. 00 40. 00
41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	15, 324 14, 854	5, 325 0		0 1, 541, 337 0 1, 684, 388	0	41. 00 43. 00
44.00 OA400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	40, 396	28, 835		0 1, 474, 312	0	44. 00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	3, 592, 927 0		0 86, 422, 916 0 2, 609, 143	147 0	50. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	Ö	223, 035		5, 872, 879	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 56. 00 05600 RADI OI SOTOPE	0	231, 580 3, 283		0 109, 498, 391 0 15, 043, 157	0	54. 00 56. 00
60. 00 06000 LABORATORY	0	3, 063, 270		78, 004, 560	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	685, 028		0 8, 488, 726 0 15, 596, 619	0	65. 00
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	0	35, 856 698, 017	1	0 15, 596, 619 0 48, 474, 481	42	66. 00 69. 00
69. 01 06901 PULMONARY	0	0		0 0	0	69. 01
69. 02 06902 CARDI OPULMONARY 69. 03 06903 SLEEP LAB	0	6, 070 9, 866		0 1, 580, 774 0 2, 211, 029	42 0	69. 02 69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	1, 810, 928 0		0 12, 499, 226 0 23, 221, 312	0	71. 00 72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	10	0 126, 412, 450	0	73. 00
74.00 07400 RENAL DIALYSIS 77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	74. 00 77. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC 88. 01 08801 RURAL HEALTH CLINIC II	0	14, 150 13, 910		0 1, 165, 084 0 1, 039, 221	0	88. 00 88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	Ö	0		0 0	0	89. 00
90. 00 09000 CLI NI C 90. 01 09001 I MED	0	39, 512		0 4, 163, 278	0	90. 00 90. 01
90. 02 09002 ONCOLOGY	0	136, 697		0 31, 652, 135	4	90. 01
90. 03 09003 OUTPATIENT CENTER 90. 04 09004 HBURG URGENT CARE CLINIC	0	79 457		0 0 6, 516, 128	0 55	90. 03 90. 04
90. 05 09005 DI ABETES MGMT CLINIC	0	78, 657 2, 072		0 6, 516, 128	0	90. 04
91. 00 09100 EMERGENCY	0	192, 203		0 74, 161, 916	55	91.00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00 09500 AMBULANCE SERVICES	0	48, 005	•	0 8, 656, 415	0	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 101. 00 10100 HOME HEALTH AGENCY	0	0 25, 437	•	0 0 4, 495, 701	0	96. 00 101. 00
102. 00 10200 OPLOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	o	0		0 0		102. 00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0 317, 353	0 11, 439, 108		0 0 693, 427, 281		116. 00 118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT FLOWER COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	508, 770		0 110, 053, 725		192.00
192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 194. 00 07950 LODGE		2, 135 251		0 1, 748, 819 0 0		192. 01 194. 00
194. 01 07951 OTHER NRCC	0	0		0 0	0	194. 01
194. 02 07952 MEMORIAL HOSPITAL FOUNDATION	0	687	l	0 0	0	194. 02

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10 Period: Worksheet B-1 From 07/01/2022 To 06/30/2023 Date/Time Prepared: 1/25/2024 11:51 am Provider CCN: 15-0115

						1/25/2024 11:	<u>51 am</u>
						INTERNS &	
						RESI DENTS	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SERVI CES-SALAR	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	Y & FRINGES	
			SUPPLY	REQUIS.)	LI BRARY	APPRV	
		(DIRECT NRSING	(COSTED		(REVENUE)	(ASSI GNED	
		HRS)	REQUI S.)			TIME)	
		13. 00	14. 00	15. 00	16. 00	21. 00	
	953 MKT/PHY SERVICES	0	370	0	515, 247		194. 03
194. 04 07	954 COMMUNITY EDUCATION	0	27, 517	0	0	216	194. 04
194. 05 07	955 VOLUNTEER	O	999	0	0	0	194. 05
194. 06 07	956 MAB	0	0	0	0	0	194. 06
194. 07 07	957 OFFSITE COVID SCREENING	0	0	0	0	0	194. 07
194. 08 07	958 PUBLIC RELATIONS	o	0	0	0	0	194. 08
194. 09 07	959 UNUSED SPACE	o	0	0	0	0	194. 09
194. 10 07	960 EMERGENCY PREPAREDNESS	o	27, 990	0	0	0	194. 10
194. 11 07	961 HOME OFFICE	l ol	0	0	o	23	194. 11
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	1, 674, 450	750, 076	436, 258	1, 753, 233	1, 481, 825	202. 00
	Part I)			·			
203. 00	Unit cost multiplier (Wkst. B, Part I)	5. 276301	0. 062466	4, 362. 580000	0. 002176	1, 097. 648148	203. 00
204.00	Cost to be allocated (per Wkst. B,	32, 169	27, 043	75, 040	2, 547	2, 153	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 101367	0. 002252	750. 400000	0. 000003	1. 594815	205. 00
	11)						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

From 07/01/2022 06/30/2023 Date/Time Prepared: 1/25/2024 11:51 am INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHER PRGM COSTS **APPRV** (ASSI GNED TIME) 22.00 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 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVI CE COST CENTERS 22.00 22.00 1, 350 30.00 03000 ADULTS & PEDIATRICS 30.00 364 31.00 03100 INTENSIVE CARE UNIT 0 31.00 04000 SUBPROVI DER - I PF 40.00 28 40.00 04100 SUBPROVIDER - IRF 41.00 0 41.00 04300 NURSERY 0 43.00 43.00 04400 SKILLED NURSING FACILITY 0 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 147 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 0 53.00 05300 ANESTHESI OLOGY 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 56.00 05600 RADI OI SOTOPE 0 0 0 56,00 60.00 06000 LABORATORY 60.00 06500 RESPIRATORY THERAPY 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 42 0 06900 ELECTROCARDI OLOGY 69.00 69.00 06901 PULMONARY 69.01 69.01 42 0 0 0 0 06902 CARDI OPULMONARY 69.02 69.02 69. 03 06903 SLEEP LAB 69.03 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77 00 77 00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 88. 01 08801 RURAL HEALTH CLINIC II 8 0 0 88.01 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 89 00 90.00 09000 CLI NI C 90.00 09001 I MED 90.01 90.01 4 09002 ONCOLOGY 90.02 90.02 09003 OUTPATIENT CENTER 90 03 90.03 90.04 09004 HBURG URGENT CARE CLINIC 55 90.04 09005 DIABETES MGMT CLINIC 0 90.05 90.05 91 00 09100 EMERGENCY 55 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 0 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 102.00 10200 OPI OID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116 00 SUBTOTALS (SUM OF LINES 1 through 117) 745 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 190.00 192.00 19200 PHYSICIANS PRIVATE OFFICES 366 192.00 192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 192.01 194. 00 07950 LODGE 194.00 194. 01 07951 OTHER NRCC 194. 01 194. 02 07952 MEMORIAL HOSPITAL FOUNDATION 194. 02

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0115	Peri od: Worksheet B-1 From 07/01/2022
		To 06/30/2023 Date/Time Prepared: 1/25/2024 11:51 am

		To 06/30/2023 Date/Time Prepar	
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV (ASSI GNED TI ME) 22.00		
194. 03 07953 MKT/PHY SERVI CES	0	194	4. 03
194. 04 07954 COMMUNITY EDUCATION	216	194	4. 04
194. 05 07955 VOLUNTEER	0	194	4. 05
194. 06 07956 MAB	0	194	4. 06
194.07 07957 OFFSITE COVID SCREENING	0		4. 07
194. 08 07958 PUBLIC RELATIONS	0		4. 08
194. 09 07959 UNUSED SPACE	0		4. 09
194. 10 07960 EMERGENCY PREPAREDNESS	0		4. 10
194. 11 07961 HOME OFFI CE	23		4. 11
200.00 Cross Foot Adjustments			0.00
201.00 Negative Cost Centers	0.400.440		1.00
202.00 Cost to be allocated (per Wkst. B, Part I)	2, 109, 110	202	2. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	1, 562. 303704	201	3. 00
204.00 Cost to be allocated (per Wkst. B,	108, 046		4. 00
Part II)	100,010		1. 00
205.00 Unit cost multiplier (Wkst. B, Part	80. 034074	205	5. 00
206.00 NAHE adjustment amount to be allocated		206	6. 00
(per Wkst. B-2)			
207.00 NAHE unit cost multiplier (Wkst. D,		207	7. 00
Parts III and IV)			

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0115 Peri od: Worksheet C From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/25/2024 11:51 am Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 12, 344, 024 12.344.024 12.344.024 5, 578, 353 03100 INTENSIVE CARE UNIT 5, 578, 353 5, 578, 353 0 31.00 31.00 04000 SUBPROVIDER - IPF 0 40.00 2, 699, 995 2, 699, 995 2, 699, 995 40.00 04100 SUBPROVI DER - I RF 0 41.00 1, 332, 842 1, 332, 842 1, 332, 842 41.00 04300 NURSERY 0 43.00 1, 332, 855 1, 332, 855 1, 332, 855 43.00 2, 931, 792 44.00 04400 SKILLED NURSING FACILITY 2, 931, 792 2, 931, 792 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 50.00 20, 320, 216 20, 320, 216 0 20, 320, 216 52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 427, 569 2, 427, 569 0 2, 427, 569 52.00 53.00 05300 ANESTHESI OLOGY 1, 764, 167 1, 764, 167 0 0 0 1, 764, 167 53.00 05400 RADI OLOGY-DI AGNOSTI C 8, 491, 080 8, 491, 080 8, 491, 080 54.00 54.00 05600 RADI OI SOTOPE 56,00 1, 202, 073 1, 202, 073 1, 202, 073 56,00 60.00 06000 LABORATORY 11, 869, 365 11, 869, 365 11, 869, 365 60.00 06500 RESPIRATORY THERAPY 3, 197, 762 65.00 3, 197, 762 0 0 0 3, 197, 762 65.00 06600 PHYSI CAL THERAPY 4.767.304 4. 767. 304 66 00 4 767 304 66 00 69.00 06900 ELECTROCARDI OLOGY 6, 430, 448 6, 430, 448 6, 430, 448 69.00 06901 PULMONARY 69.01 69.01 C 0 0 69.02 06902 CARDI OPULMONARY 305, 632 305, 632 305, 632 69.02 06903 SLEEP LAB 477, 801 69 03 477, 801 477, 801 69 03 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 208, 002 2, 208, 002 0 2, 208, 002 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 6.084.951 6.084.951 6. 084. 951 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 26, 733, 661 26, 733, 661 26, 733, 661 73.00 74.00 07400 RENAL DIALYSIS 74.00 0 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 852, 714 852, 714 0 852, 714 88.00 08801 RURAL HEALTH CLINIC II 0 1, 149, 594 88.01 88.01 1, 149, 594 1, 149, 594 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 n 90.00 09000 CLI NI C 1, 086, 206 1,086,206 1,086,206 90 00 90.01 09001 I MED 0 0 0 90.01 0 09002 ONCOLOGY 90.02 5, 912, 622 5, 912, 622 5, 912, 622 90.02 90.03 09003 OUTPATIENT CENTER 90.03 0 09004 HBURG URGENT CARE CLINIC 90 04 2, 120, 518 2, 120, 518 2, 120, 518 90 04 0 90.05 09005 DIABETES MGMT CLINIC 122, 285 122, 285 122, 285 90.05 91.00 09100 EMERGENCY 9, 895, 923 9, 895, 923 9, 895, 923 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 4, 424, 249 92.00 4, 424, 249 4, 424, 249 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 4, 401, 895 4, 401, 895 4, 401, 895 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 101.00 10100 HOME HEALTH AGENCY 3, 812, 888 101. 00 3, 812, 888 3, 812, 888 102.00 10200 OPI OID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 116. 00 C 156, 278, 786 200. 00 200.00 Subtotal (see instructions) 156, 278, 786 Ω 156, 278, 786 0 201.00 Less Observation Beds 4, 424, 249 4, 424, 249 4, 424, 249 201. 00 202.00 Total (see instructions) 151, 854, 537 151, 854, 537 151, 854, 537 202. 00

Provider CCN: 15-0115

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/25/2024 11:51 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 11, 201, 138 03000 ADULTS & PEDIATRICS 11, 201, 138 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 7, 831, 258 7, 831, 258 31.00 04000 SUBPROVI DER - I PF 40.00 1, 726, 350 1, 726, 350 40.00 41.00 04100 SUBPROVI DER - I RF 1.541.337 1, 541, 337 41.00 04300 NURSERY 43 00 1,684,388 1, 684, 388 43.00 44.00 04400 SKILLED NURSING FACILITY 1, 474, 312 1, 474, 312 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9.457.539 76, 965, 377 86, 422, 916 0. 235125 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 2, 576, 287 32, 856 2, 609, 143 0 930409 0.000000 52 00 53.00 05300 ANESTHESI OLOGY 1, 408, 558 4, 464, 321 5, 872, 879 0.300392 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 11, 678, 299 97, 820, 092 109, 498, 391 0.077545 0.000000 54.00 05600 RADI OI SOTOPE 313, 780 0.079908 0.000000 56,00 14, 729, 377 15, 043, 157 56,00 60.00 06000 LABORATORY 11, 475, 724 66, 528, 836 78, 004, 560 0.152162 0.000000 60.00 06500 RESPIRATORY THERAPY 1, 992, 103 6, 496, 623 8, 488, 726 0.000000 65.00 0.376707 65.00 66.00 06600 PHYSI CAL THERAPY 6, 610, 688 8, 985, 931 15, 596, 619 0.305663 0.000000 66.00 06900 ELECTROCARDI OLOGY 69 00 14, 909, 951 33, 564, 530 48, 474, 481 0.132656 0.000000 69 00 69.01 06901 PULMONARY 0.000000 0.000000 69.01 06902 CARDI OPULMONARY 1, 577, 032 1, 580, 774 69.02 3,742 0.193343 0.000000 69.02 06903 SLEEP LAB 2, 211, 029 2, 211, 029 0.216099 0.000000 69.03 69.03 0 07000 ELECTROENCEPHALOGRAPHY 70.00 0.000000 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 502, 924 9, 996, 302 12, 499, 226 0.176651 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 6, 985, 327 16, 235, 985 23, 221, 312 0. 262042 0.000000 72.00 22, 901, 146 73 00 07300 DRUGS CHARGED TO PATIENTS 103, 511, 304 126, 412, 450 0 211480 0 000000 73 00 74.00 07400 RENAL DIALYSIS C 0.000000 0.000000 74.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0.000000 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 1, 165, 084 1, 165, 084 88.00 88. 01 08801 RURAL HEALTH CLINIC II 0 1,039,221 1, 039, 221 88.01 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90 00 09000 CLINIC 92 293 4, 070, 985 4, 163, 278 0 260902 0.000000 90 00 90.01 09001 I MED 0.000000 0.000000 90.01 09002 ONCOLOGY 149, 922 31, 502, 213 0.186800 0.000000 90.02 90.02 31, 652, 135 90.03 09003 OUTPATIENT CENTER 0.000000 0.000000 90.03 09004 HBURG URGENT CARE CLINIC 17, 313 6, 498, 815 0. 325426 90 04 6, 516, 128 0.000000 90 04 09005 DIABETES MGMT CLINIC 0.000000 90.05 408 182, 549 182, 957 0.668381 90.05 09100 EMERGENCY 10, 320, 476 74, 161, 916 0.000000 91.00 63, 841, 440 0.133437 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 231, 555 8, 848, 255 10, 079, 810 0.438922 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 8, 651, 421 95.00 09500 AMBULANCE SERVICES 4, 994 8, 656, 415 0.508512 0.000000 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0.000000 0.000000 96.00 101.00 10100 HOME HEALTH AGENCY 4, 495, 701 4, 495, 701 101.00 0 102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 130, 091, 812 573, 415, 279 703, 507, 091 200. 00 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 130, 091, 812 573, 415, 279 703, 507, 091 202.00

			10 06/30/2023	Date/II me Prepared: 1/25/2024 11:51 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient	THE AVIII	1103pi tai	113
oost ochter boschiptron	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
40. 00 04000 SUBPROVI DER - 1 PF				40.00
41. 00 04100 SUBPROVI DER - RF				41.00
43. 00 04300 NURSERY				43. 00
44.00 04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS	<u>'</u>			
50. 00 05000 OPERATING ROOM	0. 235125			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 930409			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 300392			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 077545			54.00
56. 00 05600 RADI 0I SOTOPE	0. 079908			56.00
60. 00 06000 LABORATORY	0. 152162			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 376707			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 305663			66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 132656			69.00
69. 01 06901 PULMONARY	0. 000000			69. 01
69. 02 06902 CARDI OPULMONARY	0. 193343			69. 02
69. 03 06903 SLEEP LAB	0, 216099			69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 176651			71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 262042			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 211480			73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000			74. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC				88. 00
88. 01 08801 RURAL HEALTH CLINIC II				88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90. 00 09000 CLI NI C	0. 260902			90.00
90. 01 09001 I MED	0. 000000			90. 01
90. 02 09002 ONCOLOGY	0. 186800			90. 02
90. 03 09003 OUTPATIENT CENTER	0. 000000			90. 03
90. 04 09004 HBURG URGENT CARE CLINIC	0. 325426			90. 04
90. 05 09005 DIABETES MGMT CLINIC	0. 668381			90. 05
91. 00 09100 EMERGENCY	0. 133437			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 438922			92.00
OTHER REIMBURSABLE COST CENTERS	<u>'</u>			
95. 00 09500 AMBULANCE SERVI CES	0. 508512			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96. 00
101.00 10100 HOME HEALTH AGENCY				101. 00
102.00 10200 OPI OI D TREATMENT PROGRAM				102. 00
SPECIAL PURPOSE COST CENTERS				
116. 00 11600 H0SPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Provider CCN: 15-0115

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/25/2024 11:51 am Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 12, 344, 024 12.344.024 12.344.024 5, 578, 353 03100 INTENSIVE CARE UNIT 5, 578, 353 5, 578, 353 0 31.00 31.00 04000 SUBPROVIDER - IPF 0 40.00 2, 699, 995 2, 699, 995 2, 699, 995 40.00 04100 SUBPROVI DER - I RF 0 41.00 1, 332, 842 1, 332, 842 1, 332, 842 41.00 04300 NURSERY 0 43.00 1, 332, 855 1, 332, 855 1, 332, 855 43.00 44.00 04400 SKILLED NURSING FACILITY 2, 931, 792 2, 931, 792 2, 931, 792 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 50.00 20, 320, 216 20, 320, 216 0 20, 320, 216 52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 427, 569 2, 427, 569 0 2, 427, 569 52.00 53.00 05300 ANESTHESI OLOGY 1, 764, 167 1, 764, 167 0 0 0 1, 764, 167 53.00 05400 RADI OLOGY-DI AGNOSTI C 8, 491, 080 8, 491, 080 8, 491, 080 54.00 54.00 05600 RADI OI SOTOPE 56,00 1, 202, 073 1, 202, 073 1, 202, 073 56,00 60.00 06000 LABORATORY 11, 869, 365 11, 869, 365 11, 869, 365 60.00 06500 RESPIRATORY THERAPY 3, 197, 762 65.00 3, 197, 762 0 0 0 3, 197, 762 65.00 06600 PHYSI CAL THERAPY 4.767.304 4. 767. 304 66 00 4 767 304 66 00 69.00 06900 ELECTROCARDI OLOGY 6, 430, 448 6, 430, 448 6, 430, 448 69.00 06901 PULMONARY 69.01 69.01 C 0 0 69.02 06902 CARDI OPULMONARY 305, 632 305, 632 305, 632 69.02 06903 SLEEP LAB 477, 801 69 03 477, 801 477, 801 69 03 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 208, 002 2, 208, 002 0 2, 208, 002 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 6.084.951 6.084.951 6. 084. 951 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 26, 733, 661 26, 733, 661 26, 733, 661 73.00 74.00 07400 RENAL DIALYSIS 74.00 0 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 852, 714 852, 714 0 852, 714 88.00 08801 RURAL HEALTH CLINIC II 0 1, 149, 594 88.01 88.01 1, 149, 594 1, 149, 594 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 n 09000 CLI NI C 1, 086, 206 90 00 1,086,206 1,086,206 90 00 90.01 09001 I MED 0 0 0 90.01 0 09002 ONCOLOGY 90.02 5, 912, 622 5, 912, 622 5, 912, 622 90.02 90.03 09003 OUTPATIENT CENTER 90.03 0 09004 HBURG URGENT CARE CLINIC 90 04 2, 120, 518 2, 120, 518 2, 120, 518 90 04 0 90.05 09005 DIABETES MGMT CLINIC 122, 285 122, 285 122, 285 90.05 91.00 09100 EMERGENCY 9, 895, 923 9, 895, 923 9, 895, 923 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 4, 424, 249 4, 424, 249 92.00 4, 424, 249 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 4, 401, 895 4, 401, 895 4, 401, 895 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 101.00 10100 HOME HEALTH AGENCY 3, 812, 888 101. 00 3, 812, 888 3, 812, 888 102.00 10200 OPI OID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 116. 00 C 156, 278, 786 200. 00 200.00 Subtotal (see instructions) 156, 278, 786 Ω 156, 278, 786 0 201.00 Less Observation Beds 4, 424, 249 4, 424, 249 4, 424, 249 201. 00 202.00 Total (see instructions) 151, 854, 537 151, 854, 537 151, 854, 537 202. 00

Provider CCN: 15-0115

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/25/2024 11:51 am Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 11, 201, 138 03000 ADULTS & PEDIATRICS 11, 201, 138 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 7, 831, 258 7, 831, 258 31.00 04000 SUBPROVI DER - I PF 40.00 1, 726, 350 1, 726, 350 40.00 41.00 04100 SUBPROVI DER - I RF 1.541.337 1, 541, 337 41.00 04300 NURSERY 43 00 1,684,388 1, 684, 388 43.00 44.00 04400 SKILLED NURSING FACILITY 1, 474, 312 1, 474, 312 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9.457.539 76, 965, 377 86, 422, 916 0. 235125 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 2, 576, 287 32, 856 2, 609, 143 0 930409 0.000000 52 00 53.00 05300 ANESTHESI OLOGY 1, 408, 558 4, 464, 321 5, 872, 879 0.300392 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 11, 678, 299 97, 820, 092 109, 498, 391 0.077545 0.000000 54.00 05600 RADI OI SOTOPE 313, 780 0.079908 0.000000 56,00 14, 729, 377 15, 043, 157 56,00 60.00 06000 LABORATORY 11, 475, 724 66, 528, 836 78, 004, 560 0.152162 0.000000 60.00 06500 RESPIRATORY THERAPY 1, 992, 103 6, 496, 623 8, 488, 726 0.000000 65.00 0.376707 65.00 66.00 06600 PHYSI CAL THERAPY 6, 610, 688 8, 985, 931 15, 596, 619 0.305663 0.000000 66.00 06900 FLECTROCARDI OLOGY 69 00 14, 909, 951 33, 564, 530 48, 474, 481 0.132656 0.000000 69 00 69.01 06901 PULMONARY 0.000000 0.000000 69.01 06902 CARDI OPULMONARY 1, 577, 032 1, 580, 774 0.193343 69.02 3,742 0.000000 69.02 06903 SLEEP LAB 2, 211, 029 2, 211, 029 0.216099 0.000000 69.03 69.03 0 07000 ELECTROENCEPHALOGRAPHY 70.00 0.000000 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 502, 924 9, 996, 302 12, 499, 226 0.176651 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 6, 985, 327 16, 235, 985 23, 221, 312 0. 262042 0.000000 72.00 22, 901, 146 73 00 07300 DRUGS CHARGED TO PATIENTS 103, 511, 304 126, 412, 450 0.000000 73 00 0 211480 74.00 07400 RENAL DIALYSIS C 0.000000 0.000000 74.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0.000000 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 0.000000 88.00 08800 RURAL HEALTH CLINIC 1, 165, 084 1, 165, 084 0.731891 88. 01 08801 RURAL HEALTH CLINIC II 0 1,039,221 1, 039, 221 1.106207 0.000000 88.01 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0.000000 89.00 90 00 09000 CLINIC 92 293 4, 070, 985 4, 163, 278 0 260902 0 000000 90 00 90.01 09001 I MED 0.000000 0.000000 90.01 09002 ONCOLOGY 149, 922 31, 502, 213 0.186800 0.000000 90.02 90.02 31, 652, 135 90.03 09003 OUTPATIENT CENTER 0.000000 0.000000 90.03 09004 HBURG URGENT CARE CLINIC 17, 313 6, 498, 815 0. 325426 90 04 6, 516, 128 0.000000 90 04 09005 DIABETES MGMT CLINIC 90.05 408 182, 549 182, 957 0.668381 0.000000 90.05 09100 EMERGENCY 10, 320, 476 74, 161, 916 91.00 63, 841, 440 0.133437 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 231, 555 8, 848, 255 10, 079, 810 0.438922 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 8, 651, 421 95.00 09500 AMBULANCE SERVICES 4, 994 8, 656, 415 0.508512 0.000000 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0.000000 0.000000 96.00 101.00 10100 HOME HEALTH AGENCY 4, 495, 701 4, 495, 701 101.00 0 102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 130, 091, 812 573, 415, 279 703, 507, 091 200. 00 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 130, 091, 812 573, 415, 279 703, 507, 091 202.00

1/25/2024 11:51 am Title XIX Hospi tal Cost PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 40. 00 | 04000 | SUBPROVI DER - I PF 40.00 41.00 04100 SUBPROVIDER - IRF 41.00 43.00 04300 NURSERY 43.00 44.00 04400 SKILLED NURSING FACILITY 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 53. 00 | 05300 | ANESTHESI OLOGY 0.000000 53 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.000000 54.00 56.00 56.00 05600 RADI OI SOTOPE 0.000000 60.00 06000 LABORATORY 0.000000 60.00 06500 RESPIRATORY THERAPY 65.00 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 06901 PULMONARY 0.000000 69.01 69.01 06902 CARDI OPULMONARY 0.000000 69.02 69 02 69.03 06903 SLEEP LAB 0.000000 69.03 07000 ELECTROENCEPHALOGRAPHY 70.00 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 07400 RENAL DIALYSIS 74.00 0.000000 74.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0.000000 77.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0. 000000 88.00 88.00 08801 RURAL HEALTH CLINIC II 0.000000 88. 01 88.01 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 89.00 90. 00 09000 CLINIC 0.000000 90.00 09001 I MED 0.000000 90. 01 90.01 09002 ONCOLOGY 90 02 0.000000 90 02 09003 OUTPATIENT CENTER 90.03 0.000000 90.03 90.04 09004 HBURG URGENT CARE CLINIC 0.000000 90.04 90.05 09005 DIABETES MGMT CLINIC 0.000000 90.05 09100 EMERGENCY 0.000000 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 96.00 101.00 10100 HOME HEALTH AGENCY 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200. 00

201. 00

202.00

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems MI	EMORIAL HOSP & I	HEALTH CARE CTF	?	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der CO	CN: 15-0115	Peri od: From 07/01/2022 To 06/30/2023		pared: 51 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
· ·	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,	,	Related Cos		·	
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	697, 728	0	697, 72	9, 955	70.09	30. 00
31.00 INTENSIVE CARE UNIT	321, 272		321, 2 ⁻	72 3, 105	103. 47	31.00
40. 00 SUBPROVIDER - IPF	240, 775	0	240, 7	75 923	260.86	40.00
41. 00 SUBPROVI DER - I RF	127, 190	0	127, 19	90 987	128. 87	41.00
43. 00 NURSERY	83, 403		83, 40	1, 662	50. 18	43.00
44.00 SKILLED NURSING FACILITY	151, 816		151, 8°	16 3, 847	39. 46	44.00
200.00 Total (lines 30 through 199)	1, 622, 184		1, 622, 18	34 20, 479		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00 ADULTS & PEDIATRICS	2, 663		•			30. 00
31.00 INTENSIVE CARE UNIT	1, 601					31. 00
40. 00 SUBPROVI DER - I PF	138					40. 00
41.00 SUBPROVI DER - I RF	585	75, 389				41. 00
43. 00 NURSERY	0					43. 00
44.00 SKILLED NURSING FACILITY	3, 221	127, 101				44. 00
200.00 Total (lines 30 through 199)	8, 208	590, 794				200. 00

Health Financial Systems ME	EMORIAL HOSP & I	HEALTH CARE CTF	₹	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 07/01/2022 To 06/30/2023	Worksheet D Part II Date/Time Pre 1/25/2024 11:	pared: 51 am
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col		column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
50. 00 05000 OPERATING ROOM	912, 804	86, 422, 916	0. 01056	2 4, 984, 952	52, 651	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	157, 860				02,001	52.00
53. 00 05300 ANESTHESI OLOGY	5, 283				302	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	314, 068				18, 044	54.00
56. 00 05600 RADI 01 SOTOPE	21, 759				222	56.00
60. 00 06000 LABORATORY	169, 766				10, 547	60.00
65. 00 06500 RESPI RATORY THERAPY	60, 256				6, 292	65.00
66. 00 06600 PHYSI CAL THERAPY	137, 717				12, 847	66.00
69. 00 06900 ELECTROCARDI OLOGY	290, 812				38, 781	
69. 01 06901 PULMONARY	0	_	0. 00000		0	69. 01
69. 02 06902 CARDI OPULMONARY	34, 724				0	69. 02
69. 03 06903 SLEEP LAB	40, 594				0	69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	_	0.0000		0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 119	12, 499, 226	0. 00057	0 1, 281, 422	730	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	8, 838	23, 221, 312	0. 00038	1 4, 234, 579	1, 613	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	116, 188	126, 412, 450	0. 00091	9 9, 267, 440	8, 517	73.00
74.00 07400 RENAL DIALYSIS	0	0	0. 00000	0 0	0	74.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 00000	0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	*					
88. 00 08800 RURAL HEALTH CLINIC	42, 174	1, 165, 084	0. 03619	8 0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	95, 211	1, 039, 221	1		0	88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000		0	89. 00
90. 00 09000 CLI NI C	121, 716	4, 163, 278	1		1, 231	90.00
90. 01 09001 MED	.2.,,,,0	1,100,270	0. 00000		0	90. 01
90. 02 09002 0NCOLOGY	269, 504	31, 652, 135	1		1, 159	90. 02
90. 03 09003 0UTPATI ENT CENTER	207, 304		0.00000	· ·	1, 137	90. 03
90. 04 09004 HBURG URGENT CARE CLINIC	116, 997	ļ			41	90.03
90. 05 09005 DIABETES MGMT CLINIC	11, 826				0	90.04
91. 00 09100 EMERGENCY			l .			91.00
	253, 460		1		18, 062	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	250, 076	10, 079, 810	0. 02481	0 457, 461	11, 350	92.00
OTHER REIMBURSABLE COST CENTERS	T	I	I			05 00
95. 00 09500 AMBULANCE SERVICES					_	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0 420 752	·	0. 00000		102 200	96.00
200.00 Total (lines 50 through 199)	3, 438, 752	664, 896, 192	I	46, 123, 609	182, 389	J200. 00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0115 Peri dd:	Health Financial Systems	MEMORIAL HOSP &	HEALTH CARE CT	?	In Lie	eu of Form CMS-	2552-10
Nursing Program Post-Stepdown Adjustments			TS Provider C	CN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part III Date/Time Pre 1/25/2024 11:	pared:
Program			Ti tl e				
NAME Post - Stepdown Adjustments Adjustment Adjustments Adjustment	Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
NPATI ENT ROUTINE SERVICE COST CENTERS 1A		Program	Program	Post-Stepdowr	Cost	Medi cal	
INPATI ENT ROUTINE SERVICE COST CENTERS 1A		Post-Stepdown	_	Adjustments		Education Cost	
NPATI ENT ROUTINE SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0		Adjustments					
INPATI ENT ROUTINE SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0		1A	1, 00	2A	2, 00	3, 00	
NPATIENT ROUTINE SERVICE COST CENTERS	INPATIENT ROUTINE SERVICE COST CENTERS			•			
NPATIENT ROUTINE SERVICE COST CENTERS		C	0		ol o	0	30.00
40.00 04000 SUBPROVIDER - IPF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				,	0		
1				,	0		
43.00					0		
A4. 00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0						_	
Total (lines 30 through 199)							
Cost Center Description					0		
Adj ustment Amount (see instructions) in through 3, 1 thr		Swing Pod	Total Costs	Total Dation	Dor Diam (col		200.00
Amount (see instructions) minus col. 4) INPATIENT ROUTINE SERVICE COST CENTERS	cost center bescription						
INPATIENT ROUTINE SERVICE COST CENTERS				Days	3 ÷ COI. 6)	Program bays	
NPATIENT ROUTINE SERVICE COST CENTERS							
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 3000 ADULTS & PEDI ATRICS 0 0 0 9,955 0.00 2,663 30.00				4 00	7 00	0.00	
30. 00	INDATIENT DOUTINE SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
31.00			J 0	0.05	0.00	2 442	20 00
40.00							
41.00							
43.00 04300 NURSERY 0 1,662 0.00 0 43.00 44.00 20.00 20,479 20.00 20,479 20.00 20,479 20.00 20.00 20.00 20.00							
44.00 04400 SKILLED NURSING FACILITY 0 3,847 0.00 3,221 44.00 20,479 0.00 3,221 44.00 0 20,479 0.00							
200.00 Total (lines 30 through 199) 0 20,479 8,208 200.00			0				
Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 PSA Adj. All Other Medical Education Cost 13.00			0				
Program Pass-Through Cost (col. 7 x col. 8) 9.00 Other Medical Education Cost 13.00			0	20, 47	9	8, 208	200. 00
Pass-Through Education Cost Cost (col. 7 x col. 8) 9.00 13.00	Cost Center Description						
Cost (col. 7 x col. 8) 9.00 13.00							
col . 8) 9.00 13.00							
9.00 13.00		Cost (col. 7 x					
		9. 00	13. 00				

0 0 0

30.00

31.00

40.00

43. 00 44. 00 200. 00

30. 00 | 03000 | ADULTS & PEDI ATRICS | 03100 | INTENSI VE CARE UNIT | 04000 | SUBPROVI DER - I PF | 04100 | SUBPROVI DER - I RF | 04300 | NURSERY | 04400 | SKILLED NURSI NG FACILITY | Total (lines 30 through 199)

Health Financial Systems MEMORIAL HOSP & HEAR APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0115 THROUGH COSTS

					lo	06/30/2023	Date/lime Pre 1/25/2024 11:	
			Title	XVIII	ŀ	Hospi tal	PPS	<u> </u>
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Al I	lied Health	Allied Health	
		Anesthetist	Program	Program		st-Stepdown		
		Cost	Post-Stepdown		Ad	djustments		
			Adjustments					
	T	1.00	2A	2. 00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS			l	_	_1	_	
50.00	05000 OPERATING ROOM	0	0		0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54. 00
56. 00	05600 RADI OI SOTOPE	0	0		0	0	0	56. 00
60.00	06000 LABORATORY	0	0		0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0		0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69. 00
69. 01	06901 PULMONARY	0	0		0	0	0	69. 01
69. 02	06902 CARDI OPULMONARY	0	0		0	0	0	69. 02
69. 03	06903 SLEEP LAB	0	0		0	0	0	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0	0	0	74.00
77. 00	07700 ALLOGENEI C HSCT ACQUISITION	U U	0		0	0	0	77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0		0	ol	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC		0		0	0	0	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0	0	0	89. 00
90.00	09000 CLINIC	0	0		0	0	0	90.00
90.00	09001 LI MED	0	0		0	0	0	90.00
90. 01	09002 ONCOLOGY	0	0		0	0	0	90.01
90. 02	09003 OUTPATIENT CENTER		0		0	0	0	90. 02
90. 04	09004 HBURG URGENT CARE CLINIC		0		0	0	0	90.03
90. 05	09005 DIABETES MGMT CLINIC		0		0	0	0	90.04
91. 00	09100 EMERGENCY		0		0	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0		0	٩	0	92. 00
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>			O ₁	I	0	72.00
95. 00	09500 AMBULANCE SERVICES					T		95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	ol	0	96. 00
200.00	1		0		0	ő	-	200. 00
200.00	1.222. (١	O	ı	-1	٩	٥١	0.00

Health Financial Systems	MEMORIAL HOSP & HEAL	LTH CARE CTR	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AI	NCILLARY SERVICE OTHER PASS	Provider CCN: 15-0115	Peri od:	Worksheet D

	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	RVICE OTHER PASS	Provider Co	CN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Pre 1/25/2024 11:	pared: 51 am
				XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0 86, 422, 916		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 2, 609, 143	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 5, 872, 879	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 109, 498, 391	0.000000	54.00
56.00	05600 RADI OI SOTOPE	0	0		0 15, 043, 157	0.000000	56. 00
60.00	06000 LABORATORY	0	0		0 78, 004, 560	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0		0 8, 488, 726	0. 000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0 15, 596, 619		
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 48, 474, 481	0. 000000	
69. 01	06901 PULMONARY	0	0		0 10, 17 1, 101	0. 000000	
69. 02	06902 CARDI OPULMONARY	0	0		0 1, 580, 774	0. 000000	
69. 03	06903 SLEEP LAB	0	0		0 2, 211, 029	0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 2,211,029	0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 12, 499, 226	0.000000	
		0	0		,,	l	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 23, 221, 312		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 126, 412, 450	l e	1
74.00	07400 RENAL DIALYSIS	0	0		0	0.000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0. 000000	77. 00
	OUTPATIENT SERVICE COST CENTERS			T		T	1
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 1, 165, 084		
88. 01	08801 RURAL HEALTH CLINIC II	0	0		0 1, 039, 221	0. 000000	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0. 000000	
90.00	09000 CLI NI C	0	0		0 4, 163, 278		
90. 01	09001 I MED	0	0		0	0.000000	90. 01
90. 02	09002 ONCOLOGY	0	0		0 31, 652, 135	0.000000	90. 02
90.03	09003 OUTPATIENT CENTER	0	0		0 0	0.000000	90. 03
90.04	09004 HBURG URGENT CARE CLINIC	0	0		0 6, 516, 128	0.000000	90. 04
90.05	09005 DIABETES MGMT CLINIC	0	0		0 182, 957		90. 05
91.00	09100 EMERGENCY	0	0		0 74, 161, 916	0. 000000	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 10, 079, 810	l .	1
	OTHER REIMBURSABLE COST CENTERS				,,,,	2: 223000	1
95. 00	09500 AMBULANCE SERVICES						95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0. 000000	
200.00		٥	Ö	•	0 664, 896, 192	1	200. 00
200.00	Trotal (Tries so through 177)	1 9	O	1	0 004, 070, 172	I	1200.00

Health Financial Systems	MEMORIAL HOSP & HE	EALTH CARE CTE	R	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCI THROUGH COSTS	LLARY SERVICE OTHER PASS	Provi der Co		Period: From 07/01/2022 To 06/30/2023		pared: 51 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program	
	to Charges (col. 6 ÷ col.	Charges	Pass-Through	Charges	Pass-Through Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12.00	13.00	
ANCLILIARY SERVICE COST CENTERS	·					

	Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	, , , , , , , , , , , , , , , , , , ,	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.	3	Costs (col. 8	3	Costs (col. 9	
		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	4, 984, 952	0	19, 946, 224	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	335, 020	0	1, 368, 034	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	6, 291, 423	0	25, 712, 800	0	54.00
56.00	05600 RADI 0I SOTOPE	0. 000000	153, 733	0	6, 128, 462	0	56.00
60.00	06000 LABORATORY	0. 000000	4, 846, 872	0	10, 906, 127	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	886, 452	0	1, 190, 838	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 454, 952	0	181, 008	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	6, 464, 504	0	13, 729, 988	0	69. 00
69. 01	06901 PULMONARY	0. 000000	0	0	0	0	69. 01
69. 02	06902 CARDI OPULMONARY	0. 000000	0	0	839, 913	0	69. 02
69. 03	06903 SLEEP LAB	0. 000000	0	0	712, 348	0	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 281, 422	0	2, 470, 293	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	4, 234, 579	0	5, 984, 670	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	9, 267, 440		44, 470, 667	0	73. 00
	07400 RENAL DIALYSIS	0. 000000	0	0	0	0	74. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	1		<u>'</u>			
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0. 000000	0	0	0	0	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	0	0	0	89. 00
90.00	09000 CLI NI C	0. 000000	42, 112	0	1, 229, 552	0	90.00
90. 01	09001 I MED	0. 000000	0	0	0	0	90. 01
90. 02	09002 ONCOLOGY	0. 000000	136, 084	0	14, 407, 369	0	90. 02
90. 03	09003 OUTPATIENT CENTER	0. 000000	0	0	0	0	90. 03
90. 04	09004 HBURG URGENT CARE CLINIC	0. 000000	2, 292	0	303, 912	0	90. 04
90. 05	09005 DIABETES MGMT CLINIC	0. 000000	0	0	0	0	90. 05
91.00	09100 EMERGENCY	0. 000000	5, 284, 311	0	14, 168, 071	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	457, 461	0	1, 799, 734	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	0	0	0	96. 00
200.00	Total (lines 50 through 199)		46, 123, 609	О	165, 550, 010	0	200. 00

Title XVIII Hospital PPS
Physician Anesthetist Cost Education Cost Education Cost
Ancillary Service Cost 21.00 24.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 0PERATING ROOM 0 0 52.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 53.00 05300 ANESTHESIOLOGY 0 0 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 54.00
Cost 21.00 24.00
21.00 24.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM 0 0 0 0 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 53. 00 05300 ANESTHESI OLOGY 0 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 55. 00 054. 00 054. 00 054. 00 0 56. 00 054. 00 054. 00 054. 00 0 57. 00 054. 00 054. 00 0 58. 00 054. 00 054. 00 0 59. 00 054. 00 054. 00 59. 00 054. 00 054. 00 59. 00 054. 00 054. 00 59. 00 054. 00 054. 00 59. 00 054. 00 054. 00 59
50. 00 05000 0PERATING ROOM 0 0 50. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 52. 00 53. 00 05300 ANESTHESI OLOGY 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 52. 00 53. 00 05300 ANESTHESI OLOGY 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0
53. 00 05300 ANESTHESI OLOGY 0 0 54. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54. 00
56, UU US 60 UI UI SU UPE UI UI UI UI UI UI UI
60. 00 06000 LABORATORY 0 0 60. 00
65. 00 06500 RESPI RATORY THERAPY 0 0 65. 00
66. 00 06600 PHYSI CAL THERAPY 0 0 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0 69. 00
69. 00 06900 ELECTROCARDI OLOGY 0 69. 00 69. 01 69. 01 06901 PULMONARY 0 0 69. 01
69. 01 06901 PULMONARY 0 09. 01 69. 02 69. 02 69. 02 69. 02 69. 02 69. 02 69. 02 69. 02
69. 03 06903 SLEEP LAB 0 0 69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71. 00
71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 73. 00
74. 00 07400 RENAL DI ALYSI S 0 0 74. 00
77. 00 07700 ALLOGENET C HSCT ACQUISITION 0 0 0 777. 00
OUTPATIENT SERVICE COST CENTERS
88. 00 08800 RURAL HEALTH CLINIC 0 0 88. 00
88. 01 08801 RURAL HEALTH CLINIC II 0 0 88. 01
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00
90. 00 09000 CLINIC 90. 00
90. 01 09001 IMED 90. 01
90. 02 09002 0NCOLOGY 0 0 90. 02
90. 03 09003 0UTPATI ENT CENTER 0 0 90. 03
90. 04 09004 HBURG URGENT CARE CLINIC 0 0 90. 04
90. 05 09005 DI ABETES MGMT CLINIC 0 0 90. 05
91. 00 09100 EMERGENCY 0 0 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 92. 00
OTHER REI MBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES 95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 96. 00
200.00 Total (lines 50 through 199) 0 0 200.00

Heal th	Financial Systems ME	EMORIAL HOSP & F	HEALTH CARE CTF	7	In Lie	u of Form CMS-	2552-10
	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-0115	Peri od:	Worksheet D	
					From 07/01/2022	Part V	
					To 06/30/2023	Date/Time Pre	
						1/25/2024 11:	<u>51 am</u>
			Ti tl e	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge		Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 235125	19, 946, 224		0 0	4, 689, 856	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 930409	0)	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 300392	1, 368, 034		0 0	410, 946	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 077545	25, 712, 800	1	0	1, 993, 899	
56. 00	05600 RADI OI SOTOPE	0. 079908	6, 128, 462	1	o o	489, 713	
60.00	06000 LABORATORY	0. 152162	10, 906, 127	1	0 135	1, 659, 498	1
65. 00	06500 RESPIRATORY THERAPY	0. 132102		1	-		1
			1, 190, 838	1	-	448, 597	1
66. 00	06600 PHYSI CAL THERAPY	0. 305663	181, 008		0	55, 327	1
69. 00	06900 ELECTROCARDI OLOGY	0. 132656	13, 729, 988		0	1, 821, 365	1
69. 01	06901 PULMONARY	0. 000000	0	1	0	0	69. 01
69. 02	06902 CARDI OPULMONARY	0. 193343	839, 913	1	0	162, 391	1
69. 03	06903 SLEEP LAB	0. 216099	712, 348		0	153, 938	
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0)	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 176651	2, 470, 293		0	436, 380	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 262042	5, 984, 670)	0	1, 568, 235	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 211480	44, 470, 667		0 65, 302	9, 404, 657	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	l		0 0	0	1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	,	0 0	0	
	OUTPATIENT SERVICE COST CENTERS				-		
88. 00	08800 RURAL HEALTH CLINIC						88. 00
88. 01	08801 RURAL HEALTH CLINIC II						88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90.00	09000 CLINIC	0. 260902	1, 229, 552		0	320, 793	
90. 00	09001 I MED	0. 200902	1, 229, 332	1	0 0	320, 743	1
90.01	09001 TWED	l .	14 407 240		-	_	
		0. 186800	14, 407, 369	1	-	2, 691, 297	
90. 03	09003 OUTPATIENT CENTER	0.000000	0 000 040	1	0	0	90. 03
90. 04	09004 HBURG URGENT CARE CLINIC	0. 325426	303, 912	1	0	98, 901	1
90. 05	09005 DIABETES MGMT CLINIC	0. 668381	0	1	0	0	90. 05
91. 00	09100 EMERGENCY	0. 133437	14, 168, 071		0 83	1, 890, 545	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 438922	1, 799, 734		0 0	789, 943	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0. 508512			0		95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	0	96.00
200.00	Subtotal (see instructions)		165, 550, 010		0 65, 520	29, 086, 281	200.00
201.00					0		201.00
	Only Charges						
202.00			165, 550, 010		0 65, 520	29, 086, 281	202.00
	,	•	•	•			•

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0115 Period: From 07/01/2022 To 06/30/2023 Part V Date/Time Prepared: 1/25/2024 11: 51 am

Cost Center Description Cost Cost Pointwised Pointwised Pointwised Pointwised

			Title	V\/	Hospi tal	PPS	or am
		0		AVIII	110Spi tai	FF3	
		Cost					
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
			Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7. 00				
ANCI	LLARY SERVICE COST CENTERS						
50.00 0500	OO OPERATING ROOM	0	0				50.00
52.00 0520	DO DELIVERY ROOM & LABOR ROOM	O	o				52.00
	OO ANESTHESI OLOGY	0	0				53.00
	DO RADI OLOGY-DI AGNOSTI C	0	0				54.00
	OO RADI OI SOTOPE		o				56.00
	DO LABORATORY		21				60.00
	DO RESPIRATORY THERAPY		0				65.00
			0				66.00
	OO PHYSI CAL THERAPY		0				
	OO ELECTROCARDI OLOGY	0	0				69.00
	D1 PULMONARY	0	0				69. 01
	02 CARDI OPULMONARY	0	0				69. 02
	03 SLEEP LAB	0	0				69. 03
1	OO ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 0710	DO MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 0720	DO IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	0	13, 810				73. 00
74.00 0740	DO RENAL DIALYSIS	O	o				74. 00
77. 00 0770	OO ALLOGENEIC HSCT ACQUISITION	o	o				77. 00
OUTE	PATIENT SERVICE COST CENTERS	· I	- 1				
88. 00 0880	DO RURAL HEALTH CLINIC						88. 00
	D1 RURAL HEALTH CLINIC II						88. 01
	DO FEDERALLY QUALIFIED HEALTH CENTER						89. 00
	DO CLINIC						90.00
	D1 I MED		0				90.00
			0				
	O2 ONCOLOGY	0	O ₁				90. 02
	O3 OUTPATIENT CENTER	0	0				90. 03
	04 HBURG URGENT CARE CLINIC	0	0				90. 04
	D5 DIABETES MGMT CLINIC	0	0				90. 05
	OO EMERGENCY	0	11				91.00
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART	0	0				92. 00
OTHE	ER REIMBURSABLE COST CENTERS						
95. 00 0950	OO AMBULANCE SERVICES	0					95. 00
96.00 0960	DO DURABLE MEDICAL EQUIP-RENTED	o	o				96.00
200.00	Subtotal (see instructions)	ol	13, 842				200.00
201. 00	Less PBP Clinic Lab. Services-Program		.,				201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)	o	13, 842				202. 00
232.00	1.101 3.13. god (11110 200 11110 201)	١	10, 542				1232.00

Heal th	Financial Systems ME	MORIAL HOSP &	HEALTH CARE CTE	?	In lie	eu of Form CMS-2	2552-10
	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C		Peri od:	Worksheet D	2002 10
711 1 0101	TOTAL OF THE ATTENT ANOTHER WAY SERVINGE SALT IT	L 00010	110vruei o	014: 10 0110	From 07/01/2022		
			· ·	CCN: 15-S115	To 06/30/2023	1/25/2024 11:	
		_		e XVIII	Subprovi der - PPS I PF		
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,			. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	912, 804				0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	157, 860	2, 609, 143			0	52. 00
53.00	05300 ANESTHESI OLOGY	5, 283			0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	314, 068	109, 498, 391	0. 00286	8 20, 159	58	54. 00
56.00	05600 RADI OI SOTOPE	21, 759	15, 043, 157	0.00144	6 0	0	56. 00
60.00	06000 LABORATORY	169, 766	78, 004, 560	0. 00217	6 90, 055	196	60.00
65.00	06500 RESPI RATORY THERAPY	60, 256	8, 488, 726	0. 00709	1, 922	14	65.00
66.00	06600 PHYSI CAL THERAPY	137, 717	15, 596, 619	0. 00883	6, 266	55	66.00
69.00	06900 ELECTROCARDI OLOGY	290, 812	48, 474, 481	0.00599	7, 095	43	69.00
69. 01	06901 PULMONARY	0	0	0. 00000	0 0	0	69. 01
69. 02	06902 CARDI OPULMONARY	34, 724	1, 580, 774	0. 02196	0	0	69. 02
69.03	06903 SLEEP LAB	40, 594	2, 211, 029	0. 01836	0 0	0	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000	0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 119	12, 499, 226	0. 00057	0 12	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 838	23, 221, 312	0. 00038	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	116, 188	126, 412, 450	0. 00091	9 34, 307	32	73. 00
74.00	07400 RENAL DIALYSIS	0		1		0	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	1		0	77. 00
	OUTPATIENT SERVICE COST CENTERS]
88. 00	08800 RURAL HEALTH CLINIC	42, 174	1 ' '				
88. 01	08801 RURAL HEALTH CLINIC II	95, 211	1			0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1	1 0.0000		0	
90. 00	09000 CLI NI C	121, 716	4, 163, 278			0	
90. 01	09001 I MED	0	0	0. 00000		0	
90. 02	09002 ONCOLOGY	269, 504	31, 652, 135			0	
90. 03	09003 OUTPATI ENT CENTER	0	0	1 0.0000		0	
90. 04	09004 HBURG URGENT CARE CLINIC	116, 997			55 0	0	90. 04
90. 05	09005 DIABETES MGMT CLINIC	11, 826	182, 957	0.06463	0 88	0	90. 05
91.00	09100 EMERGENCY	253, 460	74, 161, 916	0. 00341	8 128, 094	438	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	10, 079, 810	0.00000	00 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS		1	1			l
95. 00	09500 AMBULANCE SERVICES						95. 00
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	1 0.0000		0	
200.00	Total (lines 50 through 199)	3, 188, 676	664, 896, 192	I	287, 910	836	200. 00

APPORT	Financial Systems METONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	EMORIAL HOSP & I RVICE OTHER PAS	S Provider C			riod: om 07/01/2022		pared:
-			Title	: XVIII	Sı	ubprovi der - I PF	1/25/2024 11: PPS	51 am_
	Cost Center Description	Non Physician Anesthetist Cost	Program Post-Stepdown Adjustments		P	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	_						
50.00	05000 OPERATI NG ROOM	0	_		0	0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	
53.00	05300 ANESTHESI OLOGY	0	0		0	0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
56. 00	05600 RADI OI SOTOPE	0			0	0	0	56. 00
60.00	06000 LABORATORY	0			0	0	0	
65. 00	06500 RESPI RATORY THERAPY	0			0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0			0	0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0			0	0	0	
69. 01	06901 PULMONARY	0			0	0	0	69. 01
69. 02	06902 CARDI OPULMONARY	0			0	0	0	69. 02
69. 03	06903 SLEEP LAB	0			0	0	0	69. 03
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0	0	0	70. 00 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0			0	0	0	71.00
	07300 DRUGS CHARGED TO PATIENTS				0	0	0	
74.00	07400 RENAL DIALYSIS				0	0	0	
	07700 ALLOGENEI C HSCT ACQUISITION				0	0	0	77. 00
77.00	OUTPATIENT SERVICE COST CENTERS					<u> </u>	0	77.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0			0	0	0	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	0	1
90.00	09000 CLI NI C	0			0	0	0	90.00
90. 01	09001 I MED	0	l d		0	ol	0	90. 01
90. 02	09002 ONCOLOGY	0			0	ol	0	90. 02
90. 03	09003 OUTPATIENT CENTER	0	l o		0	o	0	90. 03
90. 04	09004 HBURG URGENT CARE CLINIC	0	o c		0	o	0	90. 04
90. 05	09005 DI ABETES MGMT CLINIC	0	O		0	O	0	90. 05
91.00	09100 EMERGENCY	0	0		0	o	0	91. 00
92 00	00200 OBSERVATION REDS (NON_DISTINCT DART		J		Ω		0	92 00

0

0

0

92.00 95.00

0 96.00 0 200.00

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 095.00 09500 AMBULANCE SERVICES

96. 00 | 09600 | DURABLE MEDICAL EQUIP-RENTED | 200. 00 | Total (lines 50 through 199)

52.00 05200 DELLVERY ROOM & LABOR ROOM 0 0 0 0 2,609,143 0,00000 52.00 05300 05300 05300 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0,9498,391 0,000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0,000000 054.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0,000000 054.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0,000000 054.00 054.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0,000000 054.00 056.00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0,000000 056.00 056.00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0,000000 0.50.		Financial Systems MI TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	EMORIAL HOSP & F			In Lie	eu of Form CMS-: Worksheet D	<u>2552-10</u>
Title XVIII Subprovider - PPS	THROUG	H COSTS		Component	CCN: 15-S115		Date/Time Pre	pared: 51 am
Medical Education Cost 1, 2, 3, and 4 Cost (sum of cols. Cost (sum of cols. 2, 3, and 4) Cost (sum of cols. 2, 4				Ti tl e	: XVIII			
AMCILLARY SERVICE COST CENTERS 4,00 5.00 6.00 7.00 8.00		Cost Center Description	All Other	Total Cost			Ratio of Cost	
A			Medi cal	(sum of cols.	Outpati ent			
ANCILLARY SERVICE COST CENTERS			Education Cost	1, 2, 3, and		Part I, col.	(col. 5 ÷ col.	
ANCILLARY SERVICE COST CENTERS				4)	col s. 2, 3,	8)		
ANCILLARY SERVICE COST CENTERS					and 4)		(see	
ANCILLARY SERVICE COST CENTERS							instructions)	
SOLO 05000 05000 05000 0 0 0 0			4.00	5. 00	6. 00	7. 00	8. 00	
S2.00 05.200 05.200 05.1 VERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0		ANCILLARY SERVICE COST CENTERS						
S3.00 05300 AMESTHESI OLOGY 0 0 5,872,879 0,000000 53.00	50.00	05000 OPERATI NG ROOM	0	0		0 86, 422, 916	0.000000	50. 00
S4.00 05400 RADI OLOGY-DI AGNOSTIC 0 0 0 109, 498, 391 0.000000 54.00 56.00 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 2, 609, 143	0.000000	52.00
56.00 05600 RABI OI SOTOPE 0 0 0 0 15, 043, 157 0.000000 56.00 60.00 6	53.00		0	0		0 5, 872, 879	0.000000	53.00
56.00 05600 RABI OI SOTOPE 0 0 0 0 15, 043, 157 0.000000 56.00 60.00 6	54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 109, 498, 391	0.000000	54.00
65.00 06500 RESPIRATORY THERAPY 0 0 0 8, 488, 726 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 15,596,619 0.000000 66.00 66.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0.000000 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0.000000 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0.000000 69.00 06900 CARDI OPULMONARY 0 0 0 0 0 0.000000 69.00 06900 CARDI OPULMONARY 0 0 0 0 0 0.000000 69.00 06902 CARDI OPULMONARY 0 0 0 0 0 0.000000 69.00 06903 SLEEP LAB 0 0 0 0 0 0 0.000000 69.00 0.000000 70.	56.00		0	0		0 15, 043, 157	0.000000	56. 00
66. 00 06600 PHYSICAL THERAPY 0 0 0 15, 596, 619 0.000000 66. 00 69. 00 06900 ELECTROCARDIOLOGY 0 0 0 0.000000 69. 00 69. 01 06901 PULMONARY 0 0 0 0.000000 69. 00 69. 02 06902 CARDIOPULMONARY 0 0 0 0.000000 69. 00 69. 03 06903 SLEEP LAB 0 0 0 0.000000 69. 00 0.000000 0.000000 69. 00 0.000000 0.000000 69. 00 0.000000 0.000000 69. 00 0 0.000000 69. 00 0 0 0 0.000000 69. 00 0 0 0 0 69. 00 0 0 0 0 0.000000 69. 00 0 0 0 0 69. 00 0 0 0 0 69. 00 0 0 0 0 69. 00 0 0 0 0 0 69. 00 0 0 0 69. 00 0 0 0 0 69. 00 0	60.00	06000 LABORATORY	0	0		0 78, 004, 560	0.000000	60.00
69. 00 06900 ELECTROCARDIOLOGY 0 0 0 48, 474, 481 0.000000 69. 00 69. 00 0 0.000000 69. 00 0 0.000000 69. 00 0 0.000000 69. 00 0 0.000000 69. 00 0 0.000000 69. 00 0 0.000000 69. 00 0.0000000 69. 00 0.0000000 69. 00 0.0000000 69. 00 0.0000	65.00	06500 RESPIRATORY THERAPY	0	0		0 8, 488, 726	0.000000	65. 00
69. 01 06901 DULMONARY 0 0 0 0 0 0 0 0 0	66.00	06600 PHYSI CAL THERAPY	0	0		0 15, 596, 619	0.000000	66. 00
69. 02 06902 CARDI OPULMONARY 0 0 0 1,580,774 0.00000 69. 07 69. 03 06903 SLEEP LAB 0 0 0 0 2,211,029 0.000000 69. 07 70. 00 7000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0.000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 12,499,226 0.000000 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 23,221,312 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 126,412,450 0.000000 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0.000000 75. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0.000000 76. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0.000000 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0.000000 88. 01 08800 RURAL HEALTH CLI NI C 0 0 0 1,165,084 0.000000 88. 01 08801 RURAL HEALTH CLI NI C 1 0 0 0 0 1,039,221 0.000000 89. 00 09000 CLI NI C 0 0 0 0 0,000000 90. 01 09001 IMED 0 0 0 0 0,000000 90. 02 09002 ONCOLOGY 0 0 0 0 0,000000 90. 03 09003 OUTPATI ENT CENTER 0 0 0 0 0,000000 90. 04 09004 HBURG URGENT CARE CLI NI C 0 0 0 0,000000 90. 05 09005 DI ABETES MOMT CLI NI C 0 0 0 0,000000 90. 05 09005 DI ABETES MOMT CLI NI C 0 0 0 0,000000 90. 07 07 07 07 07 07 07 07	69.00	06900 ELECTROCARDI OLOGY	0	0		0 48, 474, 481	0.000000	69. 00
69. 03	69. 01	06901 PULMONARY	0	0		0 0	0.000000	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0	69. 02	06902 CARDI OPULMONARY	0	0		0 1, 580, 774	0.000000	69. 02
71. 00	69. 03	06903 SLEEP LAB	0	0		0 2, 211, 029	0.000000	69. 03
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 23, 221, 312 0.000000 72. 073. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 126, 412, 450 0.000000 73. 074. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0.000000 74. 00 0.000000	70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	70.00
73. 00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 12, 499, 226	0.000000	71.00
73. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 23, 221, 312	0.000000	72.00
77. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 126, 412, 450	0.000000	73. 00
SERVICE COST CENTERS	74.00	07400 RENAL DI ALYSI S	0	0		0 0	0.000000	74. 00
SECTION SERVICE COST CENTERS SERVICE CO	77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0.000000	77. 00
88. 00			<u>'</u>		•		•	1
88. 01	88. 00		0	0		0 1, 165, 084	0.000000	88.00
90. 00	88. 01	08801 RURAL HEALTH CLINIC II	0	0		0 1, 039, 221	0.000000	88. 01
90. 00	89. 00		0	0			0.000000	89. 00
90. 01			0	0		0 4, 163, 278	l .	
90. 02	90. 01		0	0				1
90. 03	90. 02		0	0		0 31, 652, 135		
90. 04 09004 BURG URGENT CARE CLINIC 0 0 0 6, 516, 128 0.000000 90. 00 09005			0	0		0 0		1
90. 05 09005 DI ABETES MGMT CLINIC 0 0 182, 957 0. 000000 90. 00 1900 09000			0	0		0 6, 516, 128		1
91. 00 09100 EMERGENCY 0 0 0 74, 161, 916 0. 000000 91. 00 0 0 0 0 0 0 0 0 0			0	Ö				1
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 10, 079, 810 0. 000000 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0. 000000 96. 00 00 0. 0000000 96. 00 00 0. 0000000 96. 00 00 0. 0000000 96. 00 00 00 00 00 00 00 00			0	Ö		·	l .	
OTHER REIMBURSABLE COST CENTERS 95. 00 995. 00 09500 AMBULANCE SERVI CES 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0. 000000 96. 00			0					1
95. 00 09500 AMBULANCE SERVI CES 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 0 0			·					1
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 0 0	95.00							95. 00
			0	0		0 0	0.000000	96.00
200.00 Total (Lines 50 through 199) 0 0 664,896,192 200.00	200.00	Total (lines 50 through 199)	0			0 664, 896, 192		200.00

	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS	RVICE OTHER PASS	<u>'</u>	CCN: 15-S115	Period: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Pre 1/25/2024 11:	
			Title	XVIII	Subprovi der – I PF	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col.		Outpatient Program Pass-Through Costs (col. 9	
		7)	10.00	x col. 10) 11.00	12.00	x col . 12) 13.00	
	ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00	05000 OPERATING ROOM	0. 000000	0		0 0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	
53. 00	05300 ANESTHESI OLOGY	0. 000000	0			0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	20, 159			0	
56. 00	05600 RADI 0I SOTOPE	0. 000000	23, .37		ol ol	0	
50. 00	06000 LABORATORY	0. 000000	90, 055		ol ol	0	
55. 00	06500 RESPI RATORY THERAPY	0. 000000	1, 922		ol ol	0	
66. 00	06600 PHYSI CAL THERAPY	0. 000000	6, 266		ol ol	0	
59. 00	06900 ELECTROCARDI OLOGY	0. 000000	7, 095		ol ol	0	69.00
59. 01	06901 PULMONARY	0. 000000	0		ol ol	0	
59. 02	06902 CARDI OPULMONARY	0. 000000	0		o o	0	69. 02
59. 03	06903 SLEEP LAB	0. 000000	0		o o	0	69. 03
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	12		0 0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	34, 307		0 0	0	73.00
74. 00	07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	0.00000		T	ما ما		
38. 00	08800 RURAL HEALTH CLINIC	0.000000	0		0 0	0	
38. 01	08801 RURAL HEALTH CLINIC II	0.000000	0		0 0	0	
39. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0		0 0	0	
90.00	09000 CETNIC	0. 000000 0. 000000	0		0 0	0	
90. 01	09002	0. 000000	0		0 0	0	
90. 02	09003 OUTPATIENT CENTER	0.000000	0			0	
90. 03	09004 HBURG URGENT CARE CLINIC	0. 000000	0			0	
90. 04	09005 DIABETES MGMT CLINIC	0.000000	0		0 0	0	
91. 00	09100 EMERGENCY	0. 000000	128, 094		0 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	120, 094			0	
, <u>2</u> . 00	OTHER REIMBURSABLE COST CENTERS	0.000000		I	0		72.00
95. 00	09500 AMBULANCE SERVICES						95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	
200. 00		1	287, 910		0 0		200.00

Health Financial Systems	MEMORIAL HOSP & HEA	LTH CARE CTR	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0115	Peri od: From 07/01/2022	Worksheet D
THROUGH COSTS		Component CCN: 15-S115		Date/Time Prepared: 1/25/2024 11:51 am
		Title XVIII	Subprovi der -	PPS

			litie	XVIII	Subprovider -	PPS	
	Cost Center Description	Physician 0	PSA Adj. All ther Medical ducation Cost				
	ANCILLARY SERVICE COST CENTERS	21.00	24.00				
50. 00	05000 OPERATING ROOM	O	0				50.00
	05200 DELIVERY ROOM & LABOR ROOM		0				52. 00
	05300 ANESTHESI OLOGY		0				53. 00
	05400 RADI OLOGY-DI AGNOSTI C		0				54.00
56. 00	05600 RADI OI SOTOPE		0				56.00
	06000 LABORATORY		o				60.00
	06500 RESPI RATORY THERAPY	l ol	o				65. 00
66, 00	06600 PHYSI CAL THERAPY	O	o				66.00
69. 00	06900 ELECTROCARDI OLOGY	O	o				69.00
	06901 PULMONARY	O	o				69. 01
69. 02	06902 CARDI OPULMONARY	0	o				69. 02
69. 03	06903 SLEEP LAB	0	o				69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	o				70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	o				71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
	07400 RENAL DIALYSIS	0	0				74. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0				88. 00
	08801 RURAL HEALTH CLINIC II	0	0				88. 01
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
	09000 CLI NI C	0	0				90.00
	09001 I MED	0	0				90. 01
	09002 ONCOLOGY	0	0				90. 02
	09003 OUTPATIENT CENTER	0	0				90. 03
	09004 HBURG URGENT CARE CLINIC	0	0				90. 04
	09005 DI ABETES MGMT CLINIC	0	0				90. 05
91.00	09100 EMERGENCY	0	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92. 00
05 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVI CES						95. 00
	09600 DURABLE MEDI CAL EQUI P-RENTED						96.00
		0	0				
200.00	Total (lines 50 through 199)	0	0				200. 00

Health Financial Systems MF	Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10									
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C		Peri od:	Worksheet D	2002 10				
ALTOKITONIMENT OF THEATTENT ANOTEENIN SERVICE OATTA	1L 00313	110VIGCI C	CIN. 13 0113	From 07/01/2022						
		Component	CCN: 15-T115	To 06/30/2023	Date/Time Pre 1/25/2024 11:					
			e XVIII	Subprovi der - I RF	PPS					
Cost Center Description	Capi tal	Total Charges			Capital Costs					
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x					
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)					
	Part II, col.	8)	2)							
	26)									
	1. 00	2.00	3. 00	4. 00	5. 00					
ANCILLARY SERVICE COST CENTERS										
50. 00 05000 OPERATING ROOM	912, 804	86, 422, 916	0. 01056	5, 509	58	50. 00				
52.00 05200 DELIVERY ROOM & LABOR ROOM	157, 860	2, 609, 143	0.06050	0	0	52.00				
53. 00 05300 ANESTHESI OLOGY	5, 283			00 818	1	53. 00				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	314, 068	109, 498, 391	0. 00286	8 46, 652	134	54.00				
56. 00 05600 RADI OI SOTOPE	21, 759		1		0	56.00				
60. 00 06000 LABORATORY	169, 766		1		153					
65. 00 06500 RESPIRATORY THERAPY	60, 256		1		19	1				
66. 00 06600 PHYSI CAL THERAPY	137, 717		1		7. 875					
69. 00 06900 ELECTROCARDI OLOGY	290, 812		1		63	69. 00				
69. 01 06901 PULMONARY	270,012		1		0					
69. 02 06902 CARDI OPULMONARY	34, 724	_	1		Ö	69. 02				
69. 03 06903 SLEEP LAB	40, 594				0	1				
70. 00 07000 ELECTROENCEPHALOGRAPHY	40, 374		0.00000		0					
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 119		1		0					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	8, 838		1		0	72.00				
73. 00 07300 DRUGS CHARGED TO PATTENTS	1		1							
	116, 188		1		l e					
	0				0					
77. 00 O7700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0			0	77. 00				
88.00 08800 RURAL HEALTH CLINIC	42, 174	1, 165, 084	0. 03619	0 8	0	88. 00				
88.01 08801 RURAL HEALTH CLINIC II	95, 211	1, 039, 221	0. 09161	8 0	0	88. 01				
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	0 0	0	89. 00				
90. 00 09000 CLI NI C	121, 716	4, 163, 278	0. 02923	86 0	0	90.00				
90. 01 09001 I MED	0	0	0. 00000	00	0	90. 01				
90. 02 09002 ONCOLOGY	269, 504	31, 652, 135	0. 00851	5 0	0	90. 02				
90. 03 09003 OUTPATIENT CENTER	0	0	0.00000	00	0	90. 03				
90. 04 09004 HBURG URGENT CARE CLINIC	116, 997	6, 516, 128	0. 01795	55 0	0	90. 04				
90. 05 09005 DIABETES MGMT CLINIC	11, 826				0	90. 05				
91. 00 09100 EMERGENCY	253, 460		1		5	91. 00				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		1		0					
OTHER REIMBURSABLE COST CENTERS					·	1 33				
95. 00 09500 AMBULANCE SERVICES						95. 00				
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 00000	00	0					
200.00 Total (lines 50 through 199)	3, 188, 676	ļ	1	1, 215, 372	1	200. 00				

	Financial Systems ME TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	MORIAL HOSP & I			Peri		u of Form CMS- Worksheet D	2552-10
	TONMENT OF INPATTENT/OUTPATTENT ANCIELARY SER SH COSTS	WICE UTHER PAS	S Provider Co	JN: 15-0115		00:	Part IV	
TTIKOOC	66515		Component (CCN: 15-T115	То	06/30/2023	Date/Time Pre 1/25/2024 11:	pared:
			Title	XVIII	Sub	provi der -	PPS	<u> </u>
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	AI	IRF lied Health	Allied Health	
	,	Anesthetist	Program	Program		st-Stepdown		
		Cost	Post-Stepdown		A	djustments		
			Adjustments					
		1.00	2A	2. 00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0		0	0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
56.00	05600 RADI OI SOTOPE	0	0		0	0	0	56.00
60.00	06000 LABORATORY	0	0		0	0	0	
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	0	65. 00
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0	0		0	0	0	66. 00 69. 00
69. 00	06901 PULMONARY	0	0		0	0	0	
69. 02	06902 CARDI OPULMONARY	0	0		0	0	0	69. 02
69. 03	06903 SLEEP LAB	0	0		0	0	0	69. 03
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		O	Ö	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	O	0	1
74.00	07400 RENAL DI ALYSI S	0	0		0	o	0	74. 00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	О	0	77. 00
	OUTPATIENT SERVICE COST CENTERS							1
88.00	08800 RURAL HEALTH CLINIC	0	0		0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0		0	0	0	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	0	89. 00
90.00	09000 CLI NI C	0	0		0	0	0	
90. 01	09001 I MED	0	0		0	0	0	90. 01
90. 02	09002 ONCOLOGY	0	0		0	0	0	90. 02
90. 03	09003 OUTPATIENT CENTER	0	0		0	0	0	
90.04	09004 HBURG URGENT CARE CLINIC	0	0		0	0	0	90. 04
90.05	09005 DIABETES MGMT CLINIC				O	0	0	90. 05 91. 00
	09100 EMERGENCY				0	٩	0	

0

0

0

92. 0095. 00

0 96.00 0 200.00

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 095.00 09500 AMBULANCE SERVICES

96. 00 | 09600 | DURABLE MEDICAL EQUIP-RENTED | 200. 00 | Total (lines 50 through 199)

	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	6 Provider C		Peri od:	Worksheet D	
THROUG	H COSTS		Component		From 07/01/2022 To 06/30/2023		pared: 51 am
			Ti tl e	: XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 86, 422, 916	l	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 2, 609, 143	0. 000000	
53.00	05300 ANESTHESI OLOGY	0	0		0 5, 872, 879		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 109, 498, 391	0. 000000	
56.00	05600 RADI OI SOTOPE	0	0	1	0 15, 043, 157	0. 000000	
60.00	06000 LABORATORY	0	0	i .	0 78, 004, 560	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0	1	0 8, 488, 726	0. 000000	
66.00	06600 PHYSI CAL THERAPY	0	0		0 15, 596, 619	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 48, 474, 481	0. 000000	
69. 01	06901 PULMONARY	0	0		0	0. 000000	
69. 02	06902 CARDI OPULMONARY	0	0		0 1, 580, 774	0. 000000	
69. 03	06903 SLEEP LAB	0	0		0 2, 211, 029	0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 12, 499, 226	0. 000000	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 23, 221, 312	0.000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 126, 412, 450		
	07400 RENAL DIALYSIS	0	0		0	0. 000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0. 000000	77. 00
	OUTPATIENT SERVICE COST CENTERS			1			
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 1, 165, 084	0.000000	1
88. 01	08801 RURAL HEALTH CLINIC II	0	0		0 1, 039, 221	0.000000	1
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0.000000	
90.00	09000 CLINIC	0	0		0 4, 163, 278	0.000000	
90. 01	09001 I MED	0	0		0 0	0.000000	
90. 02	09002 ONCOLOGY	0	0		0 31, 652, 135	0.000000	
90. 03	09003 OUTPATIENT CENTER	0	0		0 0	0.000000	
90. 04	09004 HBURG URGENT CARE CLINIC	0	0		0 6, 516, 128	l e	
90.05	09005 DIABETES MGMT CLINIC	0	0		0 182, 957	0.000000	
91.00	09100 EMERGENCY		0	1	0 74, 161, 916		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 10, 079, 810	0.000000	92. 00
05 00	OTHER REIMBURSABLE COST CENTERS			1		I	05 00
	09500 AMBULANCE SERVICES		_			0.000000	95.00
96. 00 200. 00	O9600 DURABLE MEDICAL EQUIP-RENTED Total (lines 50 through 199)	0			0 ((4.80(.103	0.000000	
	i itotal (TINES 50 INFOUGN 199)	0	0	I .	0 664, 896, 192	I	200.00

		EMORIAL HOSP & HE				u of Form CMS-	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF SH COSTS	RVICE OTHER PASS	Provider Component (CN: 15-0115 CCN: 15-T115	Peri od: From 07/01/2022 To 06/30/2023	Worksheet D Part IV Date/Time Pre	pared:
			Title XVIII		Subprovi der -	1/25/2024 11: PPS	51 am
			11 (16	AVIII	I RF	113	
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)	10.00	x col . 10)	12.00	x col . 12)	
	ANCILLARY SERVICE COST SENTERS	9. 00	10.00	11. 00	12. 00	13. 00	
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0. 000000	5, 509		0 0	0	50.00
	1 1	1	-		-	-	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		-	0	52.00
53. 00	05300 ANESTHESI OLOGY	0. 000000	818		0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	46, 652		0	0	54.00
56.00	05600 RADI OI SOTOPE	0. 000000	0		0	0	56. 00
60.00	06000 LABORATORY	0. 000000	70, 299		0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	2, 730		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	891, 812		0	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	10, 540		0	0	69. 00
69. 01	06901 PULMONARY	0. 000000	0		0	0	69. 01
69. 02	06902 CARDI OPULMONARY	0. 000000	0		0 0	0	69. 02
69. 03	06903 SLEEP LAB	0. 000000	0		0	0	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	426		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	349		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	184, 719		0	0	73. 00
74.00	07400 RENAL DI ALYSI S	0. 000000	0		0	0	74. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS	0. 000000	0	Ι	0 0	0	88. 00
88. 00	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC I	0. 000000	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	I I	0		0 0		89.00
90.00	09000 CLINIC	0. 000000 0. 000000	0		0		
90.00	09000 CLINIC 09001 I MED		0		0		90.00
		0. 000000	0		0	0	90. 01
90. 02	09002 ONCOLOGY	0. 000000	0		0	-	90. 02
90. 03	09003 OUTPATIENT CENTER	0. 000000	0		0	0	90. 03
90. 04	09004 HBURG URGENT CARE CLINIC	0. 000000	0		0	0	90. 04
90. 05	09005 DIABETES MGMT CLINIC	0. 000000	0		0	0	90. 05
91.00	09100 EMERGENCY	0. 000000	1, 518		0	0	91.00
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	92. 00
95. 00	09500 AMBULANCE SERVICES						95. 00
95. 00 96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	
200.00		0.000000	1, 215, 372				200.00
200.00	Total (Titles 50 till ough 199)	1	1, 210, 3/2	I	o _l 0	ı	₁ 200.00

Health Financial Systems	MEMORIAL HOSP & HEA	LTH CARE CTR	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0115 Component CCN: 15-T115	Peri od: From 07/01/2022 To 06/30/2023	Date/Time Prepared:
				1/25/2024 11:51 am
		Title XVIII	Subprovi der -	PPS

			Title	· XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	PSA Adj. Non			TIM		
		, ,	Other Medical				
			Education Cost				
		Cost 21.00	24. 00	-			
	ANCILLARY SERVICE COST CENTERS	21.00	24.00	<u> </u>			
50. 00	05000 OPERATI NG ROOM	0	0				50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	Ö	0	1			52. 00
53. 00	05300 ANESTHESI OLOGY	o	Ö				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
56. 00	05600 RADI OI SOTOPE	0	0				56.00
60.00	06000 LABORATORY	0	0				60.00
65.00	06500 RESPIRATORY THERAPY	0	0				65. 00
66.00	06600 PHYSI CAL THERAPY	0	0				66. 00
69.00	06900 ELECTROCARDI OLOGY	0	0				69. 00
69. 01	06901 PULMONARY	0	0				69. 01
69. 02	06902 CARDI OPULMONARY	0	0				69. 02
69. 03	06903 SLEEP LAB	0	0				69. 03
	07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
	07400 RENAL DIALYSIS	0	0	1			74. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
	OUTPATIENT SERVICE COST CENTERS	_1		1			
88. 00	08800 RURAL HEALTH CLINIC	0	0	1			88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0				88. 01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90. 00 90. 01	09000 CLI NI C 09001 I MED	0	0				90.00
		0	0				90. 01
90. 02 90. 03	09002 ONCOLOGY 09003 OUTPATI ENT CENTER	0	0				90. 02 90. 03
	09004 HBURG URGENT CARE CLINIC	0	0				90.03
90. 04	09005 DI ABETES MGMT CLINIC						90.04
91.00	09100 EMERGENCY						91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0	•			92.00
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>					12.00
95. 00	09500 AMBULANCE SERVICES						95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	o	0				96. 00
200.00	1 1	o	0	1			200. 00

In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0115 Peri od: Worksheet D From 07/01/2022 Part V Date/Time Prepared: 06/30/2023 1/25/2024 11:51 am Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 235125 584, 596 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 930409 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 05300 ANESTHESI OLOGY 0. 300392 53 00 0 36 022 53 00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.077545 0 1, 132, 919 0 54.00 56.00 05600 RADI OI SOTOPE 0.079908 95, 356 0 56.00 60.00 06000 LABORATORY 0. 152162 888. 991 60.00 0 06500 RESPIRATORY THERAPY 65.00 0.376707 47, 696 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.305663 61, 050 0 66.00 06900 ELECTROCARDI OLOGY 69.00 0.132656 252, 239 0 69.00 06901 PUL MONARY 69 01 69 01 0.000000 C 0 69.02 06902 CARDI OPULMONARY 0. 193343 6, 432 0 69.02 69.03 06903 SLEEP LAB 0. 216099 16, 715 0 69.03 07000 ELECTROENCEPHALOGRAPHY 70.00 0.000000 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0.176651 0 94.838 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 262042 0 29, 098 0 72.00 0. 211480 07300 DRUGS CHARGED TO PATIENTS 1, 359, 605 0 73.00 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0 0 0 74.00 C 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 0.000000 Ω 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II 88. 01 88.01 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89 00 90.00 09000 CLI NI C 0. 260902 0 90.00 125, 662 0 0 0 0 0 09001 I MED 90. 01 0.000000 90.01 09002 ONCOLOGY 0.186800 231, 703 90.02 90.02 0 09003 OUTPATIENT CENTER 90.03 0.000000 0 C 0 90.03 09004 HBURG URGENT CARE CLINIC 0. 325426 78, 930 90.04 90.04 0 0 90.05 09005 DIABETES MGMT CLINIC 0.668381 1, 588 0 90.05 91 00 09100 EMERGENCY 0 91.00 0.133437 1, 624, 752 Λ 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.438922 68, 953 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 0.508512 378, 759 95.00 |09600|DURABLE MEDICAL EQUIP-RENTED 96.00 0.000000 C 0 0 96.00 0 200.00 Subtotal (see instructions) 0 7, 115, 904 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00

0

7, 115, 904

0

0 202. 00

Only Charges

Net Charges (line 200 - line 201)

202.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet D |
| From 07/01/2022 | Part V |
| To 06/30/2023 | Date/Time Prepared: 1/25/2024 | 11:51 am Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCM Provider CCN: 15-0115

						1/25/2024 11:	51 am
			Titl	e XIX	Hospi tal	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				
	CILLARY SERVICE COST CENTERS						
	OOOO OPERATING ROOM	137, 453	0	1			50. 00
	200 DELIVERY ROOM & LABOR ROOM	0	0	1			52. 00
53. 00 05	300 ANESTHESI OLOGY	10, 821	0				53. 00
54. 00 05	6400 RADI OLOGY-DI AGNOSTI C	87, 852	0				54. 00
56.00 05	6600 RADI OI SOTOPE	7, 620	0				56. 00
60.00 06	0000 LABORATORY	135, 271	0				60.00
65. 00 06	500 RESPI RATORY THERAPY	17, 967	0				65. 00
66. 00 06	6600 PHYSI CAL THERAPY	18, 661	0				66. 00
69. 00 06	900 ELECTROCARDI OLOGY	33, 461	0				69. 00
69. 01 06	901 PULMONARY	o	0				69. 01
69. 02 06	902 CARDI OPULMONARY	1, 244	0				69. 02
69. 03 06	903 SLEEP LAB	3, 612	0				69. 03
1	OOO ELECTROENCEPHALOGRAPHY	0	0				70. 00
1	100 MEDICAL SUPPLIES CHARGED TO PATIENT	16, 753	0				71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	7, 625	0				72. 00
	300 DRUGS CHARGED TO PATIENTS	287, 529	0				73. 00
	7400 RENAL DIALYSIS	0	0	1			74. 00
	7700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
	ITPATIENT SERVICE COST CENTERS	<u> </u>					,,,,
	8800 RURAL HEALTH CLINIC						88. 00
	8801 RURAL HEALTH CLINIC II						88. 01
	3900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
	2000 CLINIC	32, 785	0				90.00
	2001 MED	027,700	0	ł			90. 01
	2002 ONCOLOGY	43, 282	0	1			90. 02
	2003 OUTPATIENT CENTER	10, 202	0				90. 03
	2004 HBURG URGENT CARE CLINIC	25, 686	0				90. 04
	2005 DIABETES MGMT CLINIC	1, 061	0	1			90.05
	2100 EMERGENCY	216, 802	0	•			91.00
	2200 OBSERVATION BEDS (NON-DISTINCT PART	30, 265	0	1			92.00
	·	30, 203					92.00
	HER REIMBURSABLE COST CENTERS DESCO AMBULANCE SERVICES	102 402					95. 00
	2600 DURABLE MEDICAL EQUIP-RENTED	192, 603	0				96.00
200.00		1 200 252	0	•			
	Subtotal (see instructions)	1, 308, 353	0				200. 00
201. 00	Less PBP Clinic Lab. Services-Program						201. 00
202 00	Only Charges (Line 200 Line 201)	1 200 252	^				202. 00
202. 00	Net Charges (line 200 - line 201)	1, 308, 353	0	T			12U2. UU

Health Financial Systems	MEMORIAL HOSP & HEAL	LTH CARE CTR	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0115	Peri od: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prep 1/25/2024 11:5	
		Title XVIII	Hospi tal	PPS	
Cost Center Description					

		Title XVIII	Hospi tal	1/25/2024 11: PPS	<u>51 am</u>	
	Cost Center Description	THE AVIII	позрі саі			
	DADT I ALL DROW DED COMPONENTS			1. 00		
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		9, 955	1.00	
2.00	Inpatient days (including private room days, excluding swing-			9, 955	2. 00	
3. 00						
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		6, 387	4.00	
5. 00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost		5. 00	
	reporting period					
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) after December :	31 of the cost	0	6. 00	
7. 00	Total swing-bed NF type inpatient days (including private room	m davs) through December	31 of the cost	0	7. 00	
	reporting period					
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00	
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	n the Program (excluding	swing_bod_and	2, 663	9. 00	
7. 00	newborn days) (see instructions)	o the rrogram (excruding	swifig-bed and	2, 003	7.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days)	0	10. 00	
11 00	through December 31 of the cost reporting period (see instructions and CNT)				11 00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		oom days) arter	0	11. 00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00	
	through December 31 of the cost reporting period					
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13. 00	
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Progra			o	14. 00	
15. 00	Total nursery days (title V or XIX only)	am (one during oming boar)	aayo,	Ö	15. 00	
16. 00	Nursery days (title V or XIX only)			0	16. 00	
17.00	SWING BED ADJUSTMENT	+b	6 414	0.00	17.00	
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	r the cost		17. 00	
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00	
	reporting period					
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0. 00	19. 00	
20. 00	Medicald rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20.00	
	reporting period					
21.00	Total general inpatient routine service cost (see instructions			12, 344, 024		
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost report	ing period (line	0	22. 00	
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00	
	x line 18)	•	•			
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	r 31 of the cost reporti	ng period (line	0	24. 00	
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00	
	x line 20)	3				
26.00	Total swing-bed cost (see instructions)	(1) 04 1 11 0()		0	26.00	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		12, 344, 024	27.00	
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00	
29. 00	Private room charges (excluding swing-bed charges)		J ,	0		
30.00	Semi -private room charges (excluding swing-bed charges)			0		
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	÷ line 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)		tions)	0.00	ı	
35. 00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	1	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35)	and private room cost di-	fforential (line	12 344 024	36.00	
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost dr	ilelential (IINe	12, 344, 024	37. 00	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1	
0.5	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU					
38. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 239. 98	1	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		3, 302, 067	39. 00 40. 00	
	Total Program general inpatient routine service cost (line 39			3, 302, 067		
		· · · · · · · · · · · · · · · · · · ·				

Cost Center Description			NORIAL HOSP & HE	_			u of Form CMS-2	<u> 2552-10</u>
Title Moragan Title Moragan Program Desprisor Cost	COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CC	CN: 15-0115		Date/Time Pre	pared:
Impatient Cost Inpatient Duysili en (Cot. 1 + Cot. 3 x cot. 4.00 Sept. 4.00 S				Title	XVIII	Hospi tal		51 am
Col.							9	
Misself (Title V & XIX only)			·		col . 2)		4)	
Internative Care Type Inpatrient Rospital Units 1,000 INTERNITY CARE UNIT 2,876,309 43,00 44,00 INTERNITY CARE UNIT 46,00 2,876,309 44,00 2,876,309 44,00 2,876,309 44,00 2,876,309 44,00 2,876,309 44,00 2,876,309 44,00 2,876,309 44,00 2,876,309 44,00 2,876,309 44,00 2,876,309 44,00 2,876,309 44,00 2,876,309 44,00 2,876,309 47,00	42 00	NURSERY (title V & XIX only)						42.00
44.00	42.00		0		0. 0	0	0	42.00
45.00 SURCI INTERSIVE CARE UNIT 46.00		l l	5, 578, 353	3, 105	1, 796. 5	1, 601	2, 876, 309	•
46.00								
Cost Center Poscription 1.00		1						•
1.00	47.00							47.00
48.01 Program inpartient cellular therapy acquisition cost (Worksheet 0-6, Part III, line 10, column 1)								
1. Trail Program Inpattent costs (suin of lines 41 through 48.01)(see instructions) 14, 563, 921 49, 00 PASS THROUGH COST ADJUSTMENTS 1. Pass through costs applicable to Program inpattent routine services (from West. D. sum of Parts I and 352, 305 50, 00 Pass through costs applicable to Program inpattent program inpattent program inpattent program inpattent program inpattent program (suit in through costs) 1. Pass 1. Pas					III line 10	column 1)		1
10.00 Pass through costs applicable to Program inpatient routine services (from Wisst. D. sum of Parts and 352,305 51.00 11.01 1		Total Program inpatient costs (sum of lines 4					_	
111 182,389 51.00 Pass through costs applicable to Program Inpatient and Illary services (from West. D. sum of Parts II 182,389 51.00 Pass through costs applicable to Program Inpatient and III 182,389 51.00 Pass through costs applicable to Program Inpatient operating cost cord and 51 52,00 52.00 Target Anolina Mol Illar Corpulation of the 40 minus Illar 52) 74,00 74	50 00		tient routine so	arvices (from	Wket D sum	of Darts L and	352 305	50 00
and IV) 1014 Program excludable cost (sum of lines 50 and 51) 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 14,029,227 53.00 14,029,227 54.00				`	•			
52.00 Total Program excludable cost (sum of Lines 50 and 51) 53.40 74 52.00 75.00	51. 00	1	tient ancillary	services (fro	om Wkst. D, s	um of Parts II	182, 389	51.00
medical education costs (line 49 minus line 52) Macro Ma	52.00	Total Program excludable cost (sum of lines 5					534, 694	
TARCET MOUNT AND LIMIT COMPUTATION 54.00 Forgame discharge 0.0 54.00 Forgame discharge 0.0 54.00 55.01 Perment discharge 0.0 55.01 Perment adjustment amount per discharge 0.00 55.01 Perment adjustment amount per discharge (contractor use only) 0.00 55.01 Perment adjustment amount per discharge (contractor use only) 0.00 55.00 0.00 0.0	53. 00			ated, non-phys	sician anesth	etist, and	14, 029, 227	53. 00
55.00 Target amount per discharge 0.00 55.01 St. 00 St. 01 St			2)					
Permanent adjustment amount per discharge 0.00 55.02 Adjustment amount per discharge 0.00 55.02 Adjustment amount per discharge 0.00 55.02 56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 0.05 56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 0.56.00 57.00 0.57.00 0.57.00 0.57.00 0.57.00 0.57.00 0.57.00 0.0		, ,						
56.00 Target amount (line 54 x sum of lines 55, 5.01, and 55.02) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56) 58.00 Douglated and compounded by the market basket) 60.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 61.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 50, 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 Relicefi payment (see instructions) 63.00 Allowable inpatient cost plus incertive paymont (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (line XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for 64.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for 65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for 66.00 Medicare swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only): for 67.00 Medicare swing-bed NF inpatient routine costs (line 67 + line 68) 67.00 Total Medicare swing-bed NF inpatient routine costs (line 67 + line 68) 67.00 Total Head costs (line 9 x line 11 yr. (line 11 yr. (
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 58.00 58.00 58.00 59.00 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 0.00 69.00								
58.00 Bonus payment (see Instructions) 59.00 Trended costs (Icsser of Iline 54 + Iline 54, or Iline 55 from the cost reporting period ending 1996. 60.00 Expected costs (Icsser of Iline 53 + Iline 54, or Iline 55 from prior year cost report, updated by the market basket) 61.00 Continuous improvement bonus payment (If Iline 53 + Iline 54 is Iess than the lowest of Ilines 55 plus 55.01, or Iline 59, or Iline 60, enter the Iesser of 50% of the amount by which operating costs (Iline 53) are less than expected costs (Ilines 54 x 60), or 1 % of the target amount (Iline 56), otherwise enter zero. (see Instructions) 62.00 Relicefi payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (Iline XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (III XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (Iline 64 plus Iline 65) (Itile XVIII only): for 10 total Medicare swing-bed SNF inpatient routine costs (Iline 64 plus Iline 65) (Itile XVIII only): for 10 total Medicare swing-bed SNF inpatient routine costs (Iline 64 plus Iline 65) (Itile XVIII only): for 10 total Medicare swing-bed SNF inpatient routine costs (Iline 64 plus Iline 65) (Itile XVIII only): for 10 total Medicare swing-bed SNF inpatient routine costs (Iline 64 plus Iline 65) (Itile XVIII only): for 10 total medicare swing-bed SNF inpatient routine costs (Iline 64 plus Iline 65) (Itile XVIII only): for 10 total medicare swing-bed SNF inpatient routine costs (Iline 64 plus Iline 65) (Itile XVIII only): for 10 total medicare swing-bed SNF inpatient routine costs (Iline 64 plus Iline 65) (Itile XVIII only): for 10 total medicare swing-bed NF inpatient routine costs (Iline 64 plus Iline 65) (Itile XVIII only): for 10 total medicare swing-bed NF inpatient routine service costs (Iline 64 plus Iline 65)				get amount (Li	ine 56 minus	line 53)	-	•
updated and compounded by the market basket) 6.0.00 Expected costs (clesser of II ine 54 or II ine 55 from prior year cost report, updated by the market basket) 6.1.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 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 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) 6.2.00 Relider payment (see Instructions) 6.3.00 Allowable Inpatient cost plus Incentive payment (see Instructions) 6.4.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (tilt a WIII only) 6.5.00 Medicare swing-bed SNF inpatient routine costs of the cost reporting period (See Instructions) (tilt a WIII only) 6.6.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions 6.7.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 6.8.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 6.9.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 6.9.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 6.9.00 Total title V or XIX swing-bed NF inpatient routine costs (line 70 + line 2) 7.0.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 7.0.00 Pogram routine service cost (line 9 x line 71) 7.0.00 Program facility/other nursing fac	58. 00	Bonus payment (see instructions)		,		,		58. 00
60.00 Expected costs (tesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 61.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 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) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for 66.00 Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total rogram general inpatient routine service costs (line 70 + line 2) 70.00 Skilled orusing facility/often runsing facility/often runsing facility/often vortine service cost (line 37) 71.00 Adjusted general inpatient routine service costs (line 72 + line 73) 72.00 Porgam routine service cost (line 9 x line 74) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 2) 74.00 Total P							0.00	59. 00
61.00 Continuous improvement bonus payment (if line 53 * line 54 is less than the lowest of lines 55 plus 5.01, 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) 0.62.00 62.00 Relief payment (see instructions) 0.63.00 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0.63.00 63.00 Allowable Inpatient put incentive payment (see instructions) 0.63.00 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVII only) 0.65.00 65.00 Instructions) (title XVII only) 0.65.00 66.00 Instructions) (title XVII only) 0.66.00 66.00 Instructions (title XVII only) 0.66.00 67.00 Otal Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for call, see instructions 0.67.00 67.00 Otal Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period 0.67.00 67.00 Otal Little VOI XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period 0.68.00 67.00 Otal Little VOI XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0.69.00 67.00 Otal Little VOI XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0.69.00 67.00 Otal Little VOI XIX swing-bed NF inpatient routine service costs (line 67 + line 68) 0.69.00 67.00 Otal Little VOI XIX swing-bed NF inpatient routine service costs (line 67 + line 68) 0.69.00 67.00 Otal Little VOI XIX swing-bed NF inpatient routine service costs (line 67 + line 68) 0.69.00 67.00 Otal Little VOI XIX swing-bed NF inpatient routine service costs (line 67 + line 68) 0.69.00 67.00 Otal Little VOI XIX swing-bed NF inpatient routine service costs (line 67 + line 68) 0.69.00 67.00 Otal Little VOI XIX swing-bed NF inpatient routine s	60.00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	prior year co	ost report, u	pdated by the	0. 00	60. 00
enter zero. (see instructions)	61. 00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less	er of 50% of the	e amount by wh	hich operatin	g costs (İine	0	61. 00
62.00 Relief payment (see instructions) 0 62.00			60), or 1 % of 1	the target am	ount (line 56), otherwise		
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			iem (line 27 ÷ l	ine 2)				
	89. 00			*				

Health Financial Systems ME	MORIAL HOSP & F	HEALTH CARE CTR	2	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 07/01/2022 To 06/30/2023		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	697, 728	12, 344, 024	0. 05652	4, 424, 249	250, 076	90. 00
91.00 Nursing Program cost	o	12, 344, 024	0.00000	4, 424, 249	0	91. 00
92.00 Allied health cost	o	12, 344, 024	0.00000	4, 424, 249	0	92. 00
93.00 All other Medical Education	o	12, 344, 024	0.00000	4, 424, 249	0	93. 00

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0115	Peri od: From 07/01/2022	Worksheet D-1
	Component CCN: 15-S11		
	Title XVIII	Subprovi der -	PPS

Description 1.000 Description 1.00 Descri			II the Aviii	I PF	FF3	
NAME		Cost Center Description				
Imparitiest DMS Input In		DADT I ALL DDOWLDED COMPONIENTS			1. 00	
private room days (excluding swing-bed and observation bed days). If you have only private room days. do not complete this time. 5.00 Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). Total swing-bed WF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). Total swing-bed WF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). Total swing-bed WF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) and the private room days) after leads of the cost reporting period (if calendar year, enter 0 on this line). Swing-bed SWF type inpatient days applicable to the Ite XVIII only (including private room days) after leads of the cost reporting period (if calendar year, enter 0 on this line). Swing-bed SWF type inpatient days applicable to tale XVIII only (including private room days) after leads of the cost reporting period (if calendar year, enter 0 on this line). We have been been 31 of the cost reporting period (if calendar year, enter 0 on this line). We have been been 31 of the cost reporting period (if calendar year, enter 0 on this line). We have been been 31 of the cost reporting period (if calendar year, enter 0 on this line). We have been been 31 of the cost reporting period (if calendar year, enter 0 on this line). We have been been 31 of the cost reporting period (if calendar year, enter 0 on this line). We have been been 31 of the cost reporting period (if calendar year, enter 0 on this line). We have been been 31 of the cost reporting period (in a line of year). We have been been swing-bed SWF services applica	1.00	Inpatient days (including private room days and swing-bed days			923	1.00
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24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average perion private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 3 x line 35) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 699, 995) 37.00 PRATI II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 403.603 Average general inpatient routine service cost per diem (see instructions) 403.604 Ond Medically necessary private room cost applicable to the Program (line 14 x line 35) 400.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23. 00		31 of the cost reporting	g period (line 6	0	23.00
7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 20) 26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ± line 28) 32.00 Average private room per diem charge (line 29 ± line 3) 33.00 Average semi-private room per diem charge (line 30 ± line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 699, 995) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 699, 995) 38.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Private room cost differential adjustment (line 3 x line 35) 40.00 General inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24.00		a 21 of the cost reporting	na pariod (line	0	24.00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 699, 995) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 699, 995) 38.00 Agiusted general inpatient routine service cost per diem (see Instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 403.683 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	24.00	, , , , , , , , , , , , , , , , , , , ,	31 of the cost reportin	ig perrod (Trile	U	24.00
Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Frovate room cost differential adjustment (line 3 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 699, 995) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	25. 00		31 of the cost reporting	period (line 8	0	25.00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30. 00 Average private room per diem charge (line 29 + line 3) 30. 00 Average semi-private room per diem charge (line 30 + line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30. 00 Average per diem private room cost differential (line 34 x line 31) 30. 00 Average per diem private room cost differential (line 34 x line 31) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 36) 30. 00 Average per diem private room cost differential (line 3 x line 36) 30. 00 Average per diem private room cost differential (line 3 x line 36) 30. 00 Average per diem private r	01.00					04.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 32. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 699, 995) 37. 00 General inpatient routine service cost per diem (see instructions) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost per diem (see instructions) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 20. 00 20. 00 30.		, ,	(line 21 minus line 26)		-	
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 27 + line 28) 30.00 Average private room per diem charge (line 29 + line 3) 31.00 Average semi-private room per diem charge (line 30 + line 4) 32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 33.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 699, 995) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	27.00		(Trice 21 millias Trice 20)		2,077,773	27.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 699, 995) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 30.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			and observation bed cha	arges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average semi-private room per diem charge (line 30 ÷ line 4) 35.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 36.00 Private room cost differential (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 699, 995) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 000 32.00 0.00 32.00 0.00 33.00 0.00 35.00 0.0						
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33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 699, 995) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		,	1111e 20)			
35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 699, 995) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 403, 683 403, 683 9. 00 40. 00 40. 00	33.00	, , , , , , , , , , , , , , , , , , , ,				
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 699, 995 and 100 per line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 403,683 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		9 '	, ,	tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2,699,995 and part II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2,925.24 and 2		, , ,	ne 31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 925. 24 38.00 Program general inpatient routine service cost (line 9 x line 38) 403, 683 40, 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			and private room cost dif	ferential (line		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 925. 24 38.00 Program general inpatient routine service cost (line 9 x line 38) 403, 683 403, 683 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		27 minus line 36)			, 211, 170	
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 925. 24 38.00 Program general inpatient routine service cost (line 9 x line 38) 403, 683 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			ICTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 403,683 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38 VV			I	2 025 24	38 UU
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 403,683 41.00						
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		403, 683	41. 00

MPUT	ATION OF INPATIENT OPERATING COST		Component	CCN: 15-0115 CCN: 15-S115 e XVIII	Peri od: From 07/01/2022 To 06/30/2023 Subprovi der - I PF	Worksheet D-1 Date/Time Pre 1/25/2024 11: PPS	pared:
	Cost Center Description	Total Inpatient Cost		Average Pers Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4) 5.00	
2. 00	NURSERY (title V & XIX only)	1.00	2. 00	0 0.0			42. 0
8. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O		0. (00 0	0	43.0
. 00	CORONARY CARE UNIT					1	44.0
6. 00 6. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT					ı	45. 0 46. 0
. 00 '. 00	OTHER SPECIAL CARE (SPECIFY)						47. 0
	Cost Center Description					1. 00	
3. 00	Program inpatient ancillary service cost (Wk:	st. D-3, col. 3,	line 200)			43, 195	48. 0
	Program inpatient cellular therapy acquisition	on cost (Worksh	et D-6, Part		, column 1)	0	48. 0
0. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48.0°)(see instru	ctions)		446, 878	49.0
0. 00	Pass through costs applicable to Program inpa	atient routine s	services (fro	m Wkst. D, su	m of Parts I and	35, 999	50.0
. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	/ services (f	rom Wkst. D, s	sum of Parts II	836	51.0
2. 00	Total Program excludable cost (sum of lines	50 and 51)				36, 835	52. 0
3. 00	Total Program inpatient operating cost exclu		ated, non-ph	ysician anestl	hetist, and	410, 043	53. 0
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	
	Target amount per discharge					0.00	1
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				0. 00 0. 00	1
. 00	Target amount (line $54 \times sum$ of lines 55 , 55	. 01, and 55. 02)				0	1
. 00							
3. 00 9. 00							58. C
	updated and compounded by the market basket)						
). 00	00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						60.0
. 00	· ·					0	61.0
2. 00	Relief payment (see instructions)					0	62.0
3. 00	Allowable Inpatient cost plus incentive payments	ent (see instru	ctions)			0	63. C
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decer	nber 31 of th	e cost report	ing period (See	0	64. 0
	instructions)(title XVIII only)						,,,
5. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after becembe	er 31 or the	cost reporting	g period (See	0	65. 0
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line d	64 plus line	65)(title XVI	<pre>II only); for</pre>	0	66. 0
. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost r	eporting period	0	67. 0
	(line 12 x line 19)	· ·					
3. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after De	ecember 31 of	the cost repo	orting period	0	68. 0
0.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 0
0. 00	Skilled nursing facility/other nursing facility)		70.0
. 00	Adjusted general inpatient routine service co		ne 70 ÷ line	2)		ı	71. 0
	Program routine service cost (line 9 x line Medically necessary private room cost applications)		(line 14 v l	ino 25)		ı	72. C
. 00	Total Program general inpatient routine serv	•	•			ı	74. C
6. 00	Capital -related cost allocated to inpatient	routine service	costs (from	Worksheet B, I	Part II, column	1	75. C
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)				1	76. 0
. 00	Program capital-related costs (line 9 x line	76)				1	77.0
3. 00 9. 00	Inpatient routine service cost (line 74 minus		rovi don rocca	de)		ı	78. C
	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				nus line 79)	1	80.0
. 00	Inpatient routine service cost per diem limi	tati on			/	1	81.0
2. 00	Inpatient routine service cost limitation (I					ı	82.0
3. 00 4. 00	Reasonable inpatient routine service costs (: Program inpatient ancillary services (see in:)			ı	83. 0 84. 0
. 00	Utilization review - physician compensation	(see instruction				1	85. 0
. 00	Total Program inpatient operating costs (sum		ough 85)				86. 0
	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 0
. 00		diem (line 27 ÷			ŀ		88. 0

Health Financial Systems ME	MORIAL HOSP & F	HEALTH CARE CTR	2	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0115 Peri od:			Worksheet D-1	
		Component (From 07/01/2022 To 06/30/2023		
		Title	XVIII	Subprovi der – I PF	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	240, 775	2, 699, 995	0. 08917	6 0	0	90. 00
91.00 Nursing Program cost	0	2, 699, 995	0.00000	0 0	0	91.00
92.00 Allied health cost	0	2, 699, 995	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 699, 995	0.00000	0 0	0	93. 00
				•		-

Health Financial Systems	MEMORIAL HOSP & HEAD	LTH CARE CTR	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0115	Peri od: From 07/01/2022	Worksheet D-1
		Component CCN: 15-T115	To 06/30/2023	Date/Time Prepared: 1/25/2024 11:51 am
		Title XVIII	Subprovi der -	PPS

		II the Aviii	I RF	FF3				
	Cost Center Description							
	PART I - ALL PROVIDER COMPONENTS							
	INPATIENT DAYS							
1.00	Inpatient days (including private room days and swing-bed days			987	1. 00			
2. 00	Inpatient days (including private room days, excluding swing-			987	2. 00 3. 00			
3.00								
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days)				4. 00			
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost				5. 00			
	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost							
6. 00	reporting period (if calendar year, enter 0 on this line)	0	6. 00					
7. 00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00			
	reporting period							
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December 31	I of the cost	0	8. 00			
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	585	9. 00			
	newborn days) (see instructions)	0 .						
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10.00			
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		nom days) after	0	11. 00			
11.00	December 31 of the cost reporting period (if calendar year, en	nter 0 on this line)	Join days) arter	G	11.00			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00			
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	(only (including private	room days)	0	13. 00			
13.00	after December 31 of the cost reporting period (if calendar ve			U	13.00			
14. 00	Medically necessary private room days applicable to the Progra	*	, I	0	14. 00			
15. 00	Total nursery days (title V or XIX only)			0	15. 00			
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00			
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00			
	reporting period	, and the second						
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of 1	the cost	0. 00	18. 00			
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00			
. ,	reporting period	o tili dagi. December di di		0.00	. ,			
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00			
21. 00	reporting period Total general inpatient routine service cost (see instructions)				21. 00			
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	1, 332, 842 0	22. 00			
	5 x line 17)							
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00			
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reportir	na period (line	0	24. 00			
	7 x line 19)		.9					
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00			
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00			
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		1, 332, 842				
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)		28. 00			
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00			
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000				
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00				
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 22) (:+	.:>	0.00				
34. 00 35. 00	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin	, ,	(I ons)	0. 00 0. 00				
36. 00	Private room cost differential adjustment (line 3 x line 35)	01)		0.00	36. 00			
37. 00	General inpatient routine service cost net of swing-bed cost a	1, 332, 842	37. 00					
	27 minus line 36)							
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS							
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 350. 40	38. 00			
39. 00	Program general inpatient routine service cost (line 9 x line			789, 984				
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		0 789, 984	40.00			
41.00	Trotal Trogram general impatrent routine service cost (ITHE 39	T IIIIC 40)	I	107, 784	41.00			

COMPUT	ATION OF INPATIENT OPERATING COST			CCN: 15-0115 CCN: 15-T115	Fro	ri od: om 07/01/2022	w of Form CMS- Worksheet D-1 Date/Time Pre 1/25/2024 11:	epared:
			Ti tl	e XVIII	Sı	ubprovi der -	PPS	or alli
	Cost Center Description	Total Inpatient Cost	Total Inpatient Day	Average Pes Diem (col. col. 2)		IRF Program Days	Program Cost (col. 3 x col. 4)	
40.00	NUDGEDY (1) II - V o VIV - I -)	1.00	2. 00	3.00		4. 00	5. 00	10.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0 0	0. 00	0	0	42. 00
43.00	INTENSIVE CARE UNIT	0		0 0	0.00	0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT							44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT							46.00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description							47. 00
48. 00	Program inpatient ancillary service cost (Wk	st D 2 col 2	lino 200)				1. 00 330, 309	48. 00
48. 01	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)						330, 309	1
49. 00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)							49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp.	atient routine	servi ces (fro	m Wkst. D, s	um of	Parts I and	75, 389	50. 00
51. 00	Dass through costs applicable to Dragram in	ationt ancillar	v sorvisos (f	rom Wkat D	CLIM	of Dorts II	8. 478	51.00
	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non-ph	vsician anes	theti	st and	83, 867 1, 036, 426	
JJ. 00	medical education costs (line 49 minus line		. ατοα, ποπ-μπ	Jaroran anes	LI IC LI	Ji, and	1, 030, 420	33.00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						0	54.00
55. 00	Target amount per discharge							55. 00
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor use only)							55. 01 55. 02
56. 00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)							56. 00
57. 00 58. 00								57. 00 58. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996,							
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54	0.00	60.00					
	market basket)							
61. 00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 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)							61. 00
62. 00	Relief payment (see instructions)							62. 00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST							63. 00
64. 00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See							
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See							65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for							66.00
00.00	CAH, see instructions	0	00.00					
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period						0	68. 00
69. 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
70. 00	Skilled nursing facility/other nursing facil				7)			70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	2)				71. 00 72. 00
73. 00	Medically necessary private room cost applications		(line 14 x l	ine 35)				73. 00
74. 00 75. 00	Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column							74. 00 75. 00
	26, line 45)		Costs (110III	WOI KSHEEL D,	гаг	t ii, coruiiii		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	,						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus line 77)						78. 00	
79. 00 80. 00	Aggregate charges to beneficiaries for excess costs (from provider records)							79. 00 80. 00
81. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation							81.00
82. 00 83. 00	Inpatient routine service cost limitation (line 9 x line 81)							82. 00 83. 00
84. 00	Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions)							
85.00	Utilization review - physician compensation	(see instructio						85.00
86. 00	Total Program inpatient operating costs (sum		i ougii 85)					86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST						

Health Financial Systems ME	MORIAL HOSP & H	HEALTH CARE CTR	2	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (From 07/01/2022 To 06/30/2023		
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	127, 190	1, 332, 842	0. 09542	8 0	0	90. 00
91.00 Nursing Program cost	O	1, 332, 842	0.00000	0 0	0	91. 00
92.00 Allied health cost	o	1, 332, 842	0.00000	0 0	0	92. 00
93.00 All other Medical Education	o	1, 332, 842	0.00000	0 0	0	93. 00

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0115	Peri od: From 07/01/2022	Worksheet D-1
	Component CCN: 15-530	To 06/30/2023	Date/Time Prepared: 1/25/2024 11:51 am
	Title XVIII	Skilled Nursing	PPS

		litle XVIII	Facility	PPS	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 847	1. 00
2.00	Inpatient days (including private room days, excluding swing-			3, 847	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		3, 847	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	5. 00
	reporting period	3 .			
6.00	Total swing-bed SNF type inpatient days (including private room	om days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
7.00	reporting period	" days) trii dagii becember	or the cost	O	7.00
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	5		0.004	
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	o the Program (excluding	swing-bed and	3, 221	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private r	oom days)	0	10. 00
	through December 31 of the cost reporting period (see instruc-	tions)	,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		o room days)	0	12. 00
12.00	through December 31 of the cost reporting period	A only (frictualing privat	e room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including privat	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
.,. 00	reporting period	e in eag. Becomes of e.		0.00	. , , , ,
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00
21 00	reporting period	-)		2 021 702	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ing period (line	2, 931, 792 0	21. 00 22. 00
22.00	5 x line 17)	or or the cost report	ing period (inic	· ·	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00
24.00	x line 18)	- 21 -6 +1+	(1:	0	24.00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 line 19)	r 31 or the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)	. 0			
	Total swing-bed cost (see instructions)	(line 21 minus line 24)		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		2, 931, 792	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00			J ,	0	29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	32. 00 33. 00
34. 00	Average per diem private room charge differential (line 32 mi)	nus line 33)(see instruc	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li	, ,		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 a 27 minus line 36)	and private room cost di	fferential (line	2, 931, 792	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	i nstructi ons)			38. 00
39.00	Program general inpatient routine service cost (line 9 x line				39. 00
40.00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,			40. 00 41. 00
41.00	Trotal Trogram general impatrent routine service cost (IIIIe 39	11116 40)	ı		41.00

		MORIAL HOSP &				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST			CN: 15-0115 CCN: 15-5305	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Pre	
			'			1/25/2024 11:	
			Titl∈	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42. 00
43. 00	INTENSIVE CARE UNIT						43.00
	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
+7.00	Cost Center Description						47.00
10.00						1. 00	10.00
	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			III line 10	column 1)		48. 00 48. 01
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS				COI UIIIII 1)		49. 00
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sum	n of Parts I and		50. 00
51. 00	Pass through costs applicable to Program inp and IV)	atient ancilla	y services (fr	om Wkst. D, s	sum of Parts II		51. 00
52. 00	Total Program excludable cost (sum of lines						52. 00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, non-phy	sician anesth	netist, and		53. 00
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						54.00
55. 00	Target amount per discharge						55.00
5. 01	Permanent adjustment amount per discharge						55. 01
55. 02 56. 00	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55						55. 02 56. 00
	Difference between adjusted inpatient operat			ine 56 minus	line 53)		57.00
58. 00	Bonus payment (see instructions)	3	3		,		58. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	n the cost repo	orting period	endi ng 1996,		59. 00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fro	om prior year o	cost report, ι	updated by the		60. 00
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of	the amount by w	which operatir	ng costs (line		61. 00
	enter zero. (see instructions) Relief payment (see instructions)						62. 00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)				63.00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of the	cost reporti	ng period (See		64. 00
55. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 of the c	cost reportino	g period (See		65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line 6	55)(title XVII	I only); for		66. 00
57. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	n December 31 c	of the cost re	eporting period		67. 00
58. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [December 31 of	the cost repo	orting period		68. 00
59. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N		•				69. 00
	Skilled nursing facility/other nursing facil	ity/ICF/IID row	utine service d	cost (line 37)		2, 931, 792	1
1.00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	•	n (line 14 x li	ne 35)		2, 454, 724 0	1
74. 00	Total Program general inpatient routine serv					2, 454, 724	1
75. 00	Capital-related cost allocated to inpatient 26, line 45)	•			Part II, column	0	1
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)				0.00	76. 00

Health Financial Systems ME	MORIAL HOSP & H	HEALTH CARE CTR	2	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (CCN: 15-5305	From 07/01/2022 To 06/30/2023		
		Title	XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	0	0	0.00000	0	0	90. 00
91.00 Nursing Program cost	0	0	0.00000	0	0	91.00
92.00 Allied health cost	0	0	0.00000	0	0	92.00
93.00 All other Medical Education	0	0	0. 00000	0 0	0	93. 00

Health Financial Systems	MEMORIAL HOSP & HEA	LTH CARE CTR	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0115	Peri od: From 07/01/2022	Worksheet D-1	
				Date/Time Prep 1/25/2024 11:	
		Title XIX	Hospi tal	Cost	
Cost Center Description					
				1. 00	

Part ALL PROVIDER COMPONENTS 1.00			Title XIX	Hospi tal	Cost	<u> </u>
PART I		Cost Center Description				
Impatient days (including private room days, and swing-bed days, excluding newborn) 9,955 1.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 9,955 2.00 2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 9,955 2.00 2.00 3.00 Private room days (sculding swing-bed and observation bed days) 7.00 2.00		DADT I ALL DDOVIDED COMPONENTS			1. 00	
Inpatient days (including private room days, and swing-bed days, excluding newborn days) 9,955 1.00						
Inpatient days (Including private room days, excluding swing-bed and newborn days) 9,955 2.00			s, excluding newborn)		9, 955	1. 00
do not complete this line. OS emiliprivate room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost O	2.00	Inpatient days (including private room days, excluding swing-b	ped and newborn days)		9, 955	2. 00
Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNT type inpatient days (including private room days) after December 31 of the cost reporting period (1 realendar year, enter 0 on this line) 7.00 Total swing-bed NT type inpatient days (including private room days) through December 31 of the cost reporting period (1 realendar year, enter 0 on this line) 7.00 Total swing-bed NT type inpatient days (including private room days) through December 31 of the cost reporting period (1 realendar year, enter 0 on this line) 7.00 Total swing-bed NT type inpatient days (including private room days) after December 31 of the cost reporting period (1 realendar year, enter 0 on this line) 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (1 real endar year, enter 0 on this line) 7.00 Swing-bed SNT type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed SNT type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed SNT type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed SNT type inpatient days applicable to title XV or XIX only (including private room days) 7.01 December 31 of the cost reporting period (including private room days) 7.02 December 31 of the cost reporting period (including private room days) 7.03 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days) 7.01 December 31 of the cost reporting period (including type type type type type type type type	3.00		/s). If you have only pri	vate room days,	0	3. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Room of the cost reporting period (if calendar year, enter 0 on this line) Room of the cost reporting period (if calendar year, enter 0 on this line) Room of the cost reporting period (if calendar year, enter 0 on this line) Room of the cost reporting period (if calendar year, enter 0 on this line) Room of the cost reporting period (see instructions) Room of the cost reporting period (see instru	4 00		ad daya)		/ 207	4 00
reporting period 6. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period 8. 00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost on this line) 7. 00 Total sing steef of type impatient days (including private room days) after December 31 of the cost on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 13. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 14. 00 Medically December 31 of the cost reporting period (if calendar year, enter 0 on this line) 15. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 16. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 17. 00 Medically December 31 of the cost reporting period (if calendar year, enter 0 on this line) 18. 00 Swing-bed SNF services applicable to the Program (excluding swing-bed days) 18. 00 Swing-bed SNF services applicable to the Program (excluding swing-bed days) 18. 00 Swing-bed SNF services applicable to services through December 31 of the cost (a cost of the cost reporting period (a cost applicable to services after December 31 of the cost (a cost of the cost reporting period (a cost applicable to SNF services applicable to services after December 31 of the cost (a cost of the cost (a cost of the cost (a cost of the				31 of the cost		
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27 minus line 36)						
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			ISTMENTS			
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,239.98 38.00	38. 00				1, 239. 98	38. 00
39.00 Program general inpatient routine service cost (line 9 x line 38) 128,958 39.00	39. 00	Program general inpatient routine service cost (line 9 x line	38)			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		3 31 11	,			
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 128,958 41.00	41.00	liotal Program general inpatient routine service cost (line 39	+ IINE 4U)	l	128, 958	41.00

Cost Center Description Cost Center Description Total Inpatient Cost Inpatient Description Total Inpatient Descr		Financial Systems ME ATION OF INPATIENT OPERATING COST	EMORIAL HOSP & H	Provider C		Peri od:	wof Form CMS-2 Worksheet D-1	
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				Ti tl	e XIX	Hospi tal		
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Mitted We CARE WINT				1, 662	801. 9	96 85	68, 167	42.0
44.00 CROMARY CARE UNIT 45.00 BURN INTERSIVE CARE UNIT 46.00 SIRRICAL INTERSIVE CARE UNIT 46.00 SIRRICAL INTERSIVE CARE UNIT 46.00 SIRRICAL INTERSIVE CARE UNIT 46.00 Program inpatient negatient and illary service cost (Wisst. D-3. col. 3. Iline 200) 48.00 Program inpatient cellular therapy acquisition cost (Worksheet D-6. Pert IIII, line 10. column 1) 48.00 Program inpatient costs (Gund illness) 48.01 Program inpatient costs (Gund illness) 49.01 Intersive Care Unit Costs (Gund illness) 49.01 Intersive Care Unit Costs (Gund illness) 49.01 Intersive Care Unit Costs (Gund illness) 49.02 Intersive Device Device Unit Costs (Gund illness) 49.02 Intersive Device Unit Costs (Gund illness) 49.02 Intersive Device Unit Costs (Gund illness) 49.02 Intersive Device Unit Costs (Gund illness) 49.02 Inte				2 105	1 704 5	7 20	E2 101	43. 0
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### Cast Center Description Cast Center Description 1.00								45.0
Record Content Description	00	SURGICAL INTENSIVE CARE UNIT						46.0
18. 00 Program inpatient ancillary service cost (Wast. D-3, col. 3, line 200) 16.5.376 18. 01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part IIII, line 10, column 1) 16.5.376 18. 01 Program inpatient costs (sum of lines 41 through 48.01)(see instructions) 19. 02 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions) 19. 03 Through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts II and on 1) 19. 04 Total Program excludable cost (sum of lines 41 through 48.01)(see instructions) 19. 05 Total Program excludable cost (sum of lines 50 and 51) 19. 06 Total Program excludable cost (sum of lines 50 and 51) 19. 07 Total Program excludable cost (sum of lines 50 and 51) 19. 08 Total Program excludable cost (sum of lines 50 and 51) 19. 08 Total Program excludable cost (sum of lines 52) 19. 08 Total Program excludable cost (sum of lines 52) 19. 08 Total Program excludable cost (sum of lines 52) 19. 08 Total Program excludable cost (sum of lines 52) 19. 09 Total Program excludable cost (sum of lines 52) 19. 00 Total Program excludable cost (sum of lines 52) 19. 00 Total Program excludable cost (sum of lines 52) 19. 00 Total Program excludable cost (sum of lines 52) 19. 00 Total Program excludable cost (sum of lines 52) 19. 00 Total Program excludable cost (sum of lines 52) 19. 00 Total Program excludable cost (sum of lines 52) 19. 00 Total Program excludable cost (sum of lines 55) 19. 00 Total Program inpatient amount per discharge (contractor use only) 19. 00 Total Model cost (sum of lines 54) 19. 00 Total Program excludable cost (sum of lines 55) 19. 00 Total Model cost (seser of line 53) 19. 00 Total Program excludable cost (seser of lines 54) 19. 00 Expected cost (seser of line 54) 19. 00 Expected cost (seser of line 54) 19. 00 Total Model cost (see lines tructions) 19. 00 Model cost os wing-bed SM inpatient routine costs (fine 64 plus line 65) (title XVIII only): for cost (see linstructions) 19. 00 Model cost os wing-bed SM inpatient ro	00							47.0
18.00 in Program inpatient ancillary service cost (Wisst. D-3, col. 3, line 200) 18.01 in Program inpatient collular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 18.01 in Program inpatient costs (sum of lines 41 through 48,01) (see instructions) 18.02 in Pass through costs applicable to Program inpatient routine services (from Wisst. D, sum of Parts I and 10) 18.03 in Program excludable cost (sum of lines 50 and 51) 18.04 in Program excludable cost (sum of lines 50 and 51) 18.05 in Interpretation of the program inpatient ancillary services (from Wisst. D, sum of Parts II and 10) 18.05 in Interpretation of the program inpatient ancillary services (from Wisst. D, sum of Parts II and 10) 18.06 in Interpretation of the program inpatient ancillary services (from Wisst. D, sum of Parts II and 10) 18.07 in Interpretation of the program inpatient ancillary services (from Wisst. D, sum of Parts II and 10) 18.07 in Interpretation of the program inpatient ancillary services (from Wisst. D, sum of Parts II and 10) 18.08 in Interpretation of the program inpatient ancillary services (from Wisst. D, sum of Parts II and 10) 18.09 in Interpretation of the program inpatient of the program inpatient ancillary services (from Wisst. D, sum of Parts II and III an		Cost Center Description					1 00	
19.00 Total Program inpatient costs (sum of lines 41 through 48.01) (see Instructions) 414,601	00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			165, 375	48. 0
ASS THROUGH COST ADJUSTMENTS						column 1)	0	48.0
Pass through costs applicable to Program inpatient routine services (from West. D. sum of Parts I and III) 110 Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II and III) 101			41 through 48.0	1)(see instruc	tions)		414, 601	49.0
111 111			ationt routing	sorvices (from	Wkst D sum	of Dorte L and		50. c
2 2 2 2 2 2 2 2 2 2			attent routine :	services (IIIIII	WKSt. D, Suii	I OI PAILS I AIIU	0	30.0
Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION Program discharges O.00 Program discharges O.00 Program discharges O.00 O.00 O.00 O.00 O.00 O.00 O.00 O.0		,	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	0	51.0
Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (Ine 49 minus line 52) ARRECT AMOUNT AND LIMIT COMPUTATION AND Program discharges Target amount per discharge O. 0. 00 Target amount per discharge (contractor use only) O. 0. 01 Difference amount per discharge (contractor use only) O. 0. 07 O. 00 Difference between adjusted inpatient operating cost and target amount (Ilne 56 minus Ilne 53) O. 00 O. 0	- 1		F0 1 513					
medical education costs (line 49 minus line 52) TARRET AMOUNT AND LIMIT COMPUTATION 14.00 Program discharges 5.00 Target amount per discharge 5.01 Permanent adjustment amount per discharge 5.01 Permanent adjustment amount per discharge 6.00 0.00 6.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 6.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6.00 Difference costs (lesses of line 53 + line 54, or line 55 from the cost reporting period ending 1996, output dated and compounded by the market basket) 6.00 Difference costs (lines 53 + line 54, or line 55 from prior year cost report, updated by the carket basket) 6.00 Difference between a cost of lines 53 + line 54, or line 55 from prior year cost report, updated by the carket basket) 6.01 Difference between a cost of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 55) or line 60, or line 69, or line 60, or line 69, or line 60, or l				ated non shi	cician anac+h	notict and	0	
ARREET AMOUNT AND LIMIT COMPUTATION AND Program discharge				ateu, non-pny	orcian anestr	ictist, dilu		33.0
Target amount per discharge 0.00		TARGET AMOUNT AND LIMIT COMPUTATION	,					
Second Permanent adjustment amount per discharge 0.00							-	54.0
Adjustment amount per discharge (contractor use only) 0.00								
16.00 Target amount (line 54 xsum of lines 55, 55.01, and 55.02) 0.00			use onl v)					55.0
8.00 Bonus payment (see instructions) 9.00 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, 0.00 updated and compounded by the market basket) 9.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 9.10 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 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) 9.00 Relief payment (see instructions) 9.01 All owable Inpatient cost plus incentive payment (see instructions) 9.00 Relief payment (see instructions) 9.01 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (trict XVIII only) 9.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (trict XVIII only) 9.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions 9.00 Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 9.00 Total Medicare swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 9.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9.00 Total title V or XIX swing-bed NF inpatient routine costs (line 70 + line 2) 9.00 Papart III - SKILLED NUSSING FACULITY, AMD INCE/IID MILY 9.00 Adjusted general inpatient routine service costs (line 70 + line 2) 9.01 Program general inpatient routine service costs (line 70 + line 2) 9.00 Total trided costs (line 9 x line 71) 9.00 Adjusted general inpatient routine service costs (line 77 + line 2) 9.00 Program routine se							0	1
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Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		·						76. (77. (
Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		•						78. 0
1.00 Inpatient routine service cost per diem limitation 2.00 Inpatient routine service cost limitation (line 9 x line 81) 3.00 Reasonable inpatient routine service costs (see instructions) 4.00 Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	- 1	•	,	rovi der record	s)			79.
2.00 Inpatient routine service cost limitation (line 9 x line 81) 3.00 Reasonable inpatient routine service costs (see instructions) 4.00 Program inpatient ancillary services (see instructions) 5.00 Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	- 1			ost limitation	(line 78 mir	nus line 79)		80.
3.00 Reasonable inpatient routine service costs (see instructions) 4.00 Program inpatient ancillary services (see instructions) 5.00 Utilization review - physician compensation (see instructions) 6.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	- 1	·						81.
4.00 Program inpatient ancillary services (see instructions) 5.00 Utilization review - physician compensation (see instructions) 6.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	- 1	•						82. 83.
5.00 Utilization review - physician compensation (see instructions) 6.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		•		,				84.
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	00	Utilization review - physician compensation	(see instruction					85.
	-			rough 85)				86.
							3 568	87. (
		, ·	•	line 2)			1, 239. 98	

Health Financial Systems ME	MORIAL HOSP &	HEALTH CARE CTR	2	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 07/01/2022 To 06/30/2023	Date/Time Pre 1/25/2024 11:	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	697, 728	12, 344, 024	0. 05652	4, 424, 249	250, 076	90.00
91.00 Nursing Program cost	C	12, 344, 024	0.00000	0 4, 424, 249	0	91.00
92.00 Allied health cost	C	12, 344, 024	0.00000	4, 424, 249	0	92.00
93.00 All other Medical Education	(12, 344, 024	0. 000000	4, 424, 249	0	93. 00

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lie	eu of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-011	5 Peri od: From 07/01/2022	Worksheet D-1
	Component CCN: 15-S1	15 To 06/30/2023	Date/Time Prepared: 1/25/2024 11:51 am
	Title XIX	Subprovi der -	Cost

		TI LIE XIX	I PF	Cost	
	Cost Center Description			4.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			923	1.00
2.00	Inpatient days (including private room days, excluding swing-bervate room days (excluding swing-bed and observation bed day			923	2.00
3. 00	do not complete this line.	(S). IT you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		923	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December (R1 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becember t	or the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	days) after December 2	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) at tel becember 3	i or the cost	O	0.00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	375	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	oly (including private re	nom dave)	0	10.00
10.00	through December 31 of the cost reporting period (see instruct	ing (frictualing private it	Joili days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	t only (including private	e room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye			0	14. 00
15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	dii (excidding swing-bed t	lays)		15. 00
16. 00	Nursery days (title V or XIX only)			85	
47.00	SWING BED ADJUSTMENT		c	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	r the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
10.00	reporting period	- +h	*	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through becember 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	:)		2, 699, 995	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	2,077,773	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	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	ng period (line	0	24. 00
	7 x line 19)			_	
25. 00	Swing-bed cost applicable to NF type services after December (x, y)	of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		2, 699, 995	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation hed cha	arnes)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	and observation bed en	11 900)	0	
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 mir	ous line 33)(see instruct	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line	, ,	5/15/	0.00	1
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 a	and private room cost di	fferential (line	2, 699, 995	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			2, 925. 24	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		1, 096, 965	
40.00	Medically necessary private room cost applicable to the Progra			1 00/ 0/5	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ ITHE 40)	l	1, 096, 965	41.00

COMPUI	ATION OF INPATIENT OPERATING COST		Component	CCN: 15-0115 CCN: 15-S115 Le XLX	Peri od: From 07/01/2022 To 06/30/2023 Subprovi der - I PF	Worksheet D-1 Date/Time Pre 1/25/2024 11: Cost	pared:
	Cost Center Description	Total Inpatient Cost		col . 2)	÷	Program Cost (col. 3 x col. 4)	
12. 00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00 00 0	5. 00	42. 00
13. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	l ol		0.	00 0	0	43.00
14. 00 15. 00 16. 00 17. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						44. 00 45. 00 46. 00 47. 00
	Cost Center Description					1. 00	
18. 00	Program inpatient ancillary service cost (Wk					0	48. 00
18. 01 19. 00	Program inpatient cellular therapy acquisition total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS				, column 1)	0 1, 096, 965	
50. 00	Pass through costs applicable to Program inp.	atient routine	services (fro	m Wkst. D, su	m of Parts I and	0	50.00
51.00	Pass through costs applicable to Program inpand IV)		y services (f	rom Wkst. D,	sum of Parts II	0	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu- medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	ding capital re	lated, non-ph	ysician anest	hetist, and	0	1
4. 00	Program di scharges					0	54.00
	Target amount per discharge					0.00	
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				0. 00 0. 00	1
6. 00	Target amount (line 54 x sum of lines 55, 55	.01, and 55.02)				0	1
7.00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (line 56 minus	line 53)	0	1
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost ren	orting period	ending 1996	0 0. 00	
50. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,			0 .	<u> </u>	0. 00	
51. 00	market basket) Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of t	he amount by	which operati	ng costs (line	0	61.00
52. 00 53. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos			e cost report	ina period (See	0	
	instructions)(title XVIII only)						
55. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)			•		0	65.00
6. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line	65)(title XVI	II only); for	0	66. 00
57. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost r	eporting period	0	67. 00
8. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
59. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY	AND ICF/IID	ONLY	×	0	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	,)		70.00
	Program routine service cost (line 9 x line		ine 70 ÷ ime	2)			72. 00
73. 00	Medically necessary private room cost applic	able to Program	•	,			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			Dart II column		74. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li		COSTS (TIOIII	worksneet b,	Part II, Corumni		76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
	Inpatient routine service cost (line 74 minu		rovi dor rocor	de)			78. 0
79. 00 30. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 79)		79. 0
31. 00	Inpatient routine service cost per diem limi			(70 m)	. = ,		81. 00
32. 00	Inpatient routine service cost limitation (I	ne 9 x line 81	•				82. 00
33.00	Reasonable inpatient routine service costs (s)				83. 00
34. 00 35. 00	Program inpatient ancillary services (see in		ne)				84. 00 85. 00
	Utilization review - physician compensation Total Program inpatient operating costs (sum						86.00
			/ ي				1
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					1

Heal th	Financial Systems ME	MORIAL HOSP & F	HEALTH CARE CTR	!	In Lie	u of Form CMS-2	2552-10
COMPUTA	ATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
			Component (From 07/01/2022 To 06/30/2023	Date/Time Pre 1/25/2024 11:	
			Ti tl	e XIX	Subprovi der – I PF	Cost	
	Cost Center Description						
						1.00	
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00
	Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
			(from line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
		1. 00	2.00	3.00	4. 00	5. 00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					l
90.00	Capital-related cost	240, 775	2, 699, 995	0. 08917	6 0	0	90.00
91.00	Nursing Program cost	0	2, 699, 995	0.00000	0 0	0	91.00
92.00	Allied health cost	0	2, 699, 995	0.00000	0	0	92.00
93.00	All other Medical Education	0	2, 699, 995	0.00000	0	0	93. 00

Health Financial Systems	MEMORIAL HOSP & HEA	LTH CARE CTF	}	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der Co		Peri od: From 07/01/2022	Worksheet D-3	
				To 06/30/2023	Date/Time Prep 1/25/2024 11:5	pared: 51 am
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos To Charges		Inpatient Program Costs	
					(col . 1 x col . 2)	
			1, 00	2, 00	3, 00	

	II tre xviii	ноѕрі таі	PP5	
Cost Center Description	Ratio of Cost	Inpati ent	I npati ent	
	To Charges	Program	Program Costs	
			(col. 1 x col.	
		onal goo	2)	
	1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1.00	2.00	3.00	
		4, 347, 550		20.00
				30.00
31. 00 03100 I NTENSI VE CARE UNI T		3, 706, 530		31. 00
40. 00 04000 SUBPROVI DER - 1 PF		0		40. 00
41. 00 04100 SUBPROVI DER - I RF		326		41. 00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 235125	4, 984, 952	1, 172, 087	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 930409	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 300392	335, 020	100, 637	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 077545	6, 291, 423	487, 868	54.00
56. 00 05600 RADI 0I SOTOPE	0. 079908	153, 733	12, 284	56.00
60. 00 06000 LABORATORY	0. 152162	4, 846, 872	737, 510	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 376707	886, 452	333, 933	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 305663	1, 454, 952	444, 725	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 132656	6, 464, 504	857, 555	69.00
69. 01 06901 PULMONARY	0. 000000	0	0	69. 01
69. 02 06902 CARDI OPULMONARY	0. 193343	0	0	69. 02
69. 03 06903 SLEEP LAB	0. 216099	0	0	69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 176651	1, 281, 422	226, 364	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 262042	4, 234, 579	1, 109, 638	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 211480	9, 267, 440		73. 00
74. 00 07400 RENAL DI ALYSI S	0.000000	0	0	74. 00
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0. 000000	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	0.00000		Ü	77.00
88. 00 08800 RURAL HEALTH CLINIC	0.000000		0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	0.00000		0	88. 01
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.00000		0	89. 00
		40 110		
90. 00 09000 CLI NI C	0. 260902	42, 112	10, 987	90.00
90. 01 09001 I MED	0.000000	0	0	90. 01
90. 02 09002 0NC0L0GY	0. 186800	136, 084	25, 420	90. 02
90. 03 09003 OUTPATI ENT CENTER	0.000000	0	0	90. 03
90. 04 09004 HBURG URGENT CARE CLINIC	0. 325426	2, 292	746	90. 04
90.05 09005 DIABETES MGMT CLINIC	0. 668381	0	0	90. 05
91. 00 09100 EMERGENCY	0. 133437	5, 284, 311	705, 123	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 438922	457, 461	200, 790	92.00
OTHER REIMBURSABLE COST CENTERS	<u>'</u>			
95. 00 O9500 AMBULANCE SERVI CES				95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	n	0	96. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)	0.00000	46, 123, 609		
201. 00 Less PBP Clinic Laboratory Services-Program only charg	es (line 61)	40, 123, 009		200.00
202.00 Net charges (line 200 minus line 201)	es (The OI)	46, 123, 609		201.00
202. 00 Net Charges (Title 200 IIII has Title 201)	I	40, 123, 009		202.00

PATI ENT	ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0115	Peri		Worksheet D-3	
		Component	CCN: 15-S115	To	07/01/2022 06/30/2023	Date/Time Pre 1/25/2024 11:	
		Title	× XVIII	Suk	oprovi der - I PF	PPS	
	Cost Center Description		Ratio of Cos	st	I npati ent	I npati ent	
			To Charges		Program	Program Costs	
					Charges	(col. 1 x col.	
			1.00		2.00	2)	-
I NP	ATIENT ROUTINE SERVICE COST CENTERS		1.00		2. 00	3. 00	-
	00 ADULTS & PEDIATRICS						30
	OO INTENSIVE CARE UNIT						3
	00 SUBPROVI DER – I PF				244, 485		40
00 041	00 SUBPROVI DER - I RF				·		4
00 043	00 NURSERY						43
	ILLARY SERVICE COST CENTERS						
	OO OPERATING ROOM		0. 2351		0	0	1
	OO DELIVERY ROOM & LABOR ROOM		0. 9304		0	0	
	OO ANESTHESI OLOGY		0. 3003		0	0	
	00 RADI OLOGY-DI AGNOSTI C		0. 0775		20, 159	1, 563	
	00 RADI OI SOTOPE		0.0799		00.055	12.702	1 .
	00 LABORATORY 00 RESPI RATORY THERAPY		0. 1521 0. 3767		90, 055 1, 922	13, 703 724	
	00 PHYSI CAL THERAPY		0.3767		6, 266	1, 915	
	00 ELECTROCARDI OLOGY		0. 3030		7, 095	941	6
	01 PULMONARY		0.0000		7, 075	0	
	02 CARDI OPULMONARY		0. 1933		o	0	
	03 SLEEP LAB		0. 2160		o	0	
00 070	00 ELECTROENCEPHALOGRAPHY		0.0000	00	0	0	70
00 071	OO MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1766	51	12	2	7
	00 IMPL. DEV. CHARGED TO PATIENTS		0. 2620	42	0	0	7
	00 DRUGS CHARGED TO PATIENTS		0. 2114		34, 307	7, 255	
	00 RENAL DIALYSIS		0.0000		0	0	
	OO ALLOGENEIC HSCT ACQUISITION		0.0000	00	0	0	7
	PATIENT SERVICE COST CENTERS OO RURAL HEALTH CLINIC		0.0000	00	1	0	8
	01 RURAL HEALTH CLINIC II		0.0000			0	
	00 FEDERALLY QUALIFIED HEALTH CENTER		0.0000			0	
	OO CLI NI C		0. 2609		0	0	
	O1 I MED		0.0000		0	0	9
	O2 ONCOLOGY		0. 1868		0	0	
03 090	03 OUTPATIENT CENTER		0.0000	00	0	0	9
	04 HBURG URGENT CARE CLINIC		0. 3254	26	0	0	91
	05 DIABETES MGMT CLINIC		0. 6683		0	0	
	00 EMERGENCY		0. 1334		128, 094	17, 092	
	OO OBSERVATION BEDS (NON-DISTINCT PART		0. 4389	22	0	0	9
	ER REIMBURSABLE COST CENTERS		1				1
	00 AMBULANCE SERVICES 00 DURABLE MEDICAL EQUIP-RENTED		0.0000	00	0	0	9
00 096). 00	Total (sum of lines 50 through 94 and 96 through 98)		0.0000	00	287, 910	43, 195	
1. 00	Less PBP Clinic Laboratory Services-Program only charges	(Line 61)			207, 710 N	43, 193	20
2. 00	Net charges (line 200 minus line 201)	(11110 01)	1		287, 910		20

I NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0115	Peri od:	Worksheet D-3	
		Component	CCN: 15-T115	From 07/01/2022 To 06/30/2023	Date/Time Pre 1/25/2024 11:	
		Ti tl e	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	-	Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	ATLENT ROUTINE SERVICE COST CENTERS					1
	OO ADULTS & PEDIATRICS					30.0
	DO INTENSIVE CARE UNIT DO SUBPROVIDER - IPF					31. 0 40. 0
	OO SUBPROVIDER - I RF			862, 875		41. 00
	OO NURSERY			002, 073		43. 0
	LLARY SERVICE COST CENTERS		1			1 43.0
50.00 0500	OO OPERATING ROOM		0. 2351	25 5, 509	1, 295	50.0
	DO DELIVERY ROOM & LABOR ROOM		0. 9304	· ·	0	1
	OO ANESTHESI OLOGY		0. 3003		246	
	DO RADI OLOGY-DI AGNOSTI C		0. 0775		3, 618	
	DO RADI OI SOTOPE		0.0799		0	56.0
0600	DO LABORATORY		0. 1521	62 70, 299	10, 697	60.0
55. 00 0650	00 RESPI RATORY THERAPY		0. 3767	07 2, 730	1, 028	65.0
	DO PHYSI CAL THERAPY		0. 3056	63 891, 812	272, 594	66.0
	DO ELECTROCARDI OLOGY		0. 1326		1, 398	
	D1 PULMONARY		0.0000		0	
	O2 CARDI OPULMONARY		0. 1933		0	
	O3 SLEEP LAB		0. 2160		0	
	OO ELECTROENCEPHALOGRAPHY		0.0000		0	
	00 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1766		75	
	DO IMPL. DEV. CHARGED TO PATIENTS DO DRUGS CHARGED TO PATIENTS		0. 2620 0. 2114		91 39, 064	
	DO RENAL DIALYSIS		0.2114		39,004	1
	OO ALLOGENEIC HSCT ACQUISITION		0.0000		0	
	PATIENT SERVICE COST CENTERS		0.0000	00	0	1 //. 0
	OO RURAL HEALTH CLINIC		0.0000	00	0	88. 0
	D1 RURAL HEALTH CLINIC II		0.0000		0	
	DO FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	89.0
	DO CLI NI C		0. 2609	02 0	0	90. C
0. 01 0900	D1 I MED		0.0000	00	0	90.0
	O2 ONCOLOGY		0. 1868	00	0	90.0
0.03 0900	O3 OUTPATIENT CENTER		0.0000	00	0	90.0
	04 HBURG URGENT CARE CLINIC		0. 3254	26 0	0	90.0
	D5 DIABETES MGMT CLINIC		0. 6683		0	
	DO EMERGENCY		0. 1334		203	1
	OO OBSERVATION BEDS (NON-DISTINCT PART		0. 4389	22 0	0	92.0
	R REIMBURSABLE COST CENTERS					1 05 0
	OO AMBULANCE SERVICES		0.0000		_	95.0
	DO DURABLE MEDICAL EQUIP-RENTED		0.0000			96. 0
200. 00 201. 00	Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only char	ane (lina 41)		1, 215, 372	330, 309	200. 0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Period: From 07/01/2022 To 06/30/2023	Worksheet D-3 Date/Time Pre 1/25/2024 11:	pare
	Ti tl e	e XVIII	Skilled Nursing Facility	PPS	31 a
Cost Center Description		Ratio of Cost		Inpati ent	
·		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00 03000 ADULTS & PEDI ATRI CS					30.
1.00 03100 INTENSIVE CARE UNIT					31.
0. 00 04000 SUBPROVI DER - 1 PF					40.
1. 00 04100 SUBPROVI DER - I RF					41.
3. 00 04300 NURSERY					43
ANCILLARY SERVICE COST CENTERS		0.00540	-		
O. OO O5000 OPERATING ROOM		0. 23512		0	
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 93040		-	
3. 00 05300 ANESTHESI OLOGY		0. 30039		0	53
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 07754	· ·	1	
6. 00 05600 RADI 0I SOTOPE		0. 07990		0 702	56
0. 00 06000 LABORATORY 5. 00 06500 RESPI RATORY THERAPY		0. 15216 0. 37670			1
6.00 06600 PHYSI CAL THERAPY		0.37670	· ·	19, 825 639, 610	
9. 00 06900 ELECTROCARDI OLOGY		1			
9. 01 06900 ELECTROCARDI OLOGI 9. 01 06901 PULMONARY		0. 13265 0. 00000		2,410	1
9. 02 06902 CARDI OPULMONARY		0. 19334		0	69
9. 03 06903 SLEEP LAB		0. 17334		0	69
0. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	70
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 17665		2, 290	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 26204		2,2,0	72.
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 21148		252, 628	
4. 00 07400 RENAL DIALYSIS		0.00000		0	1
7. 00 07700 ALLOGENEIC HSCT ACQUISITION		0. 00000			
OUTPATIENT SERVICE COST CENTERS		0.00000	<u> </u>		1
8. 00 08800 RURAL HEALTH CLINIC		0.00000	0	0	88.
8. 01 08801 RURAL HEALTH CLINIC II		0. 00000		Ō	88
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	1
D. 00 09000 CLI NI C		0. 26090		0	
D. 01 09001 I MED		0.00000		0	90
0. 02 09002 ONCOLOGY		0. 18680	0 252	47	90
O. O3 09003 OUTPATIENT CENTER		0.00000		0	90.
00. 04 09004 HBURG URGENT CARE CLINIC		0. 32542	6 0	0	90
0.05 09005 DIABETES MGMT CLINIC		0. 66838		0	90
1. 00 09100 EMERGENCY		0. 13343	7 370	49	91
22 OO 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.43892	2 0	0	92

4, 070, 519

4, 070, 519

0. 438922

0.000000

0 92.00 95. 00

0

1, 014, 611 200. 00

96. 00

201. 00 202. 00

92.00

95.00

200.00

201.00

202.00

09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

Health Financial Systems	MEMORIAL HOSP & HEALTI	TH CARE CTR	In Lie	ı of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	P	Provider CCN: 15-0115	Peri od:	Worksheet D-3

		CILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0115	Peri od:	Worksheet D-3	
					From 07/01/2022 To 06/30/2023	Doto/Timo Dro	narodi
					10 00/30/2023	Date/Time Pre 1/25/2024 11:	51 am
			Ti tl	e XIX	Hospi tal	Cost	
		Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
				To Charges	Program	Program Costs	
					Charges	(col. 1 x col.	
						2)	
	LNDATI	ENT DOUTINE CEDVICE COCT CENTEDS		1.00	2. 00	3. 00	
30. 00		ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS		1	220 745		30.00
31. 00		INTENSIVE CARE UNIT			320, 745 73, 364	l .	31.00
40. 00		SUBPROVI DER - I PF			63, 740		40.00
41. 00		SUBPROVIDER - IRF			03, 740	l	41.00
43. 00		NURSERY			119, 060		43. 00
10.00		LARY SERVICE COST CENTERS			117,000		10.00
50.00		OPERATING ROOM		0. 23512	7, 959	1, 871	50. 00
52. 00		DELIVERY ROOM & LABOR ROOM		0. 93040			1
53.00	05300	ANESTHESI OLOGY		0. 30039	18, 773	5, 639	53. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C		0. 07754	108, 181	8, 389	54.00
56.00	05600	RADI OI SOTOPE		0. 07990			56.00
60.00	06000	LABORATORY		0. 1521	181, 659	27, 642	60.00
65.00		RESPI RATORY THERAPY		0. 37670)7 47, 712		
66. 00	06600	PHYSI CAL THERAPY		0. 30566	12, 829	3, 921	66. 00
69. 00		ELECTROCARDI OLOGY		0. 1326		18, 577	
69. 01		PULMONARY		0. 00000		_	
69. 02		CARDI OPULMONARY		0. 19334			
69. 03		SLEEP LAB		0. 21609		_	
70. 00		ELECTROENCEPHALOGRAPHY		0.00000		_	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1766			1
72. 00		IMPL. DEV. CHARGED TO PATIENTS		0. 26204			1
73.00		DRUGS CHARGED TO PATIENTS		0. 21148			
74.00	1 1	RENAL DI ALYSI S		0.00000		_	
77. 00		ALLOGENEIC HSCT ACQUISITION		0.00000	00 0	0	77. 00
88. 00		FIENT SERVICE COST CENTERS RURAL HEALTH CLINIC		0. 73189	0	0	88. 00
88. 01		RURAL HEALTH CLINIC		1. 10620			
89. 00		FEDERALLY QUALIFIED HEALTH CENTER		0. 00000			89. 00
90.00		CLINIC		0. 26090		_	
90. 01	09001			0. 00000			
90. 02	1 1	ONCOLOGY		0. 18680		_	1
90. 03		OUTPATIENT CENTER		0. 00000		_	90. 03
90. 04		HBURG URGENT CARE CLINIC		0. 32542			1
90. 05		DIABETES MGMT CLINIC		0. 66838		273	90. 05
91.00		EMERGENCY		0. 13343		l .	
92.00		OBSERVATION BEDS (NON-DISTINCT PART		0. 43892			1
	OTHER	REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95. 00
96.00		DURABLE MEDICAL EQUIP-RENTED		0.00000	00	·	
200.00	o	Total (sum of lines 50 through 94 and 96 through 98)			962, 605	165, 375	200. 00
201.00		Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201. 00
202.00)	Net charges (line 200 minus line 201)			962, 605		202. 00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0115	Peri od:	Worksheet D-3	\$
	Component	CCN: 15-S115	From 07/01/2022 To 06/30/2023	Date/Time Pre	
	Ti tl	e XIX	Subprovi der - I PF	Cost	
Cost Center Description	,	Ratio of Cos To Charges	t Inpatient	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 0. 00 03000 ADULTS & PEDI ATRI CS				I	30.0
0.00			64, 937		30. 0 31. 0 40. 0 41. 0 43. 0
ANCILLARY SERVICE COST CENTERS					
D. 00 05000 OPERATING ROOM 2. 00 05200 DELIVERY ROOM & LABOR ROOM 3. 00 05300 ANESTHESI OLOGY 4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2351 0. 9304 0. 3003 0. 0775	09 92 0	0	52. 0 53. 0
6. 00 05600 RADI 0 I SOTOPE 0. 00 06000 LABORATORY 5. 00 06500 RESPI RATORY THERAPY		0. 0799 0. 1521 0. 3767	62 07 0	0	60. C
6. 00 06600 PHYSI CAL THERAPY 9. 00 06900 ELECTROCARDI OLOGY 9. 01 06901 PULMONARY 9. 02 06902 CARDI OPULMONARY		0. 3056 0. 1326 0. 0000 0. 1933	56 00 0	0	69.0
9.03 06903 SLEEP LAB 0.00 07000 ELECTROENCEPHALOGRAPHY 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2160 0. 0000 0. 1766	99 0 00 0	0	69. (
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 3. 00 07300 DRUGS CHARGED TO PATIENTS 4. 00 07400 RENAL DIALYSIS		0. 2620 0. 2114 0. 0000	80 00 0	0	73. (
7. 00 O7700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS		0.0000	00 0	0	77. (
B. 00		0. 7318 1. 1062 0. 0000 0. 2609	07 0 00 0 02 0	0 0	88. C 89. C 90. C
D. 02 09002 ONCOLOGY D. 03 09003 OUTPATIENT CENTER D. 04 09004 HBURG URGENT CARE CLINIC		0. 0000 0. 1868 0. 0000 0. 3254	00 0 00 0 26 0	0 0 0	90. 0 90. 0 90. 0
0. 05 09005 DI ABETES MGMT CLI NI C 1. 00 09100 EMERGENCY 2. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS		0. 6683 0. 1334 0. 4389	37 0	0	91. (
5.00 O9500 AMBULANCE SERVICES 6.00 DURABLE MEDICAL EQUIP-RENTED 70.00 Total (sum of lines 50 through 94 and 96 through 1.00 Less PBP Clinic Laboratory Services-Program onlines)		0.0000	00 0	0	95. () 96. () 200. (201. (

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0115	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Prepared: 1/25/2024 11:51 am

	Title XVIII Hospital	1/25/2024 11: PPS	51 am
		1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see	6, 986, 846	1. 00 1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	6, 892, 251	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to Octob 1 (see instructions)	per 0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount	0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2. 02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	6, 688	2. 03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2. 04
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporting period (see instructions)	4, 256, 542 86. 17	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending	on 0.00	5. 00
5. 01	or before 12/31/1996.(see instructions) FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5. 01
6. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap f new programs in accordance with 42 CFR 413.79(e)	l .	•
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 c the CAA 2021 (see instructions)	of 0.00	6. 26
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cap are specified under 42 CFR §412.105(f)(1)(iv)(B)(1)(1)(iv)(B)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	0. 00 ne 0. 00	7. 00 7. 01
7. 02	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural		7. 02
	track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,	0.00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the co	ost 0.00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital	0.00	8. 02
8. 21	under § 5506 of ACA. (see instructions) The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see	0.00	8. 21
9. 00	instructions) Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or	0.00	9. 00
10. 00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10. 00
11. 00	FTE count for residents in dental and podiatric programs.	0.00	•
12.00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.	0.00	12. 00 13. 00
13. 00 14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year ended on or after September 30, 199	l	•
1 1. 00	otherwise enter zero.	0.00	11.00
15. 00	Sum of lines 12 through 14 divided by 3.		15. 00
	Adjustment for residents in initial years of the program (see instructions)	l e	16.00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count	l e	17. 00 18. 00
	Current year resident to bed ratio (line 18 divided by line 4).	0. 167924	1
	Prior year resident to bed ratio (see instructions)	0. 167148	1
21. 00	Enter the lesser of lines 19 or 20 (see instructions)	0. 167148	21. 00
	IME payment adjustment (see instructions)	1, 210, 382	
22. 01	IME payment adjustment - Managed Care (see instructions)	371, 209	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23. 00
24. 00 25. 00	INCLIVATION IN THE STATE IN THE STATE INSTRUCTION IN THE STATE IN THE	0.00	1
	instructions)	0.00	
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)	0. 000000 0. 000000	•
	IME add-on adjustment amount (see instructions)	0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)	0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)	1, 210, 382	1
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	371, 209	29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1. 53	30.00
31. 00	Percentage of Medicaid patient days (see instructions)	19. 09	
32. 00	Sum of lines 30 and 31	20. 62	32. 00
33. 00	Allowable disproportionate share percentage (see instructions)	l e	33.00
34. 00	Disproportionate share adjustment (see instructions)	230, 046	34.00

CALCIII	<u> </u>	HEALTH CARE CTR		u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0115	Peri od: From 07/01/2022 To 06/30/2023	Worksheet E Part A Date/Time Pre 1/25/2024 11:	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
			1. 00	2. 00	
35. 00	Uncompensated Care Payment Adjustment Total uncompensated care amount (see instructions)		7 102 009 710	6, 874, 403, 459	35. 00
35. 00	Factor 3 (see instructions)		0. 000101243	0. 000107121	
35. 02	Hospital UCP, including supplemental UCP (If line 34 is zer	ro. enter zero on this lin		736, 393	
	(see instructions)	,			
	Pro rata share of the hospital UCP, including supplemental		183, 532	550, 781	1
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		734, 313		36. 00
40. 00	Additional payment for high percentage of ESRD beneficiary Total Medicare discharges (see instructions)	discharges (lines 40 thro	ugn 46)		40. 00
40.00	Total medicale discharges (see Histi detrolis)		Before 1/1	On/After 1/1	40.00
			1. 00	1. 01	
41. 00	Total ESRD Medicare discharges (see instructions)		0	0	41. 00
41.01	Total ESRD Medicare covered and paid discharges (see instru	uctions)	0	0	41. 01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qua	alify for adjustment)	0.00		42. 00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44. 00	Ratio of average length of stay to one week (line 43 divide days)	ed by line 41 divided by /	0. 000000		44. 00
45. 00	Average weekly cost for dialysis treatments (see instruction	ons)	0.00	0.00	45. 00
46. 00	Total additional payment (line 45 times line 44 times line	•	0		46. 00
47.00	Subtotal (see instructions)	ŕ	16, 060, 526		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH,	, small rural hospitals	0		48. 00
	only. (see instructions)				
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instruction	ons)		16, 431, 735	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I)	1, 194, 882	
51.00	Exception payment for inpatient program capital (Wkst. L, F			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4,	line 49 see instructions)		343, 885	
53.00	Nursing and Allied Health Managed Care payment			0	
54.00	Special add-on payments for new technologies			15, 837	1
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	2 69)		0	
55. 01	Cellular therapy acquisition cost (see instructions)	<i>c</i> 07)		Ö	1
56. 00	Cost of physicians' services in a teaching hospital (see in	ntructions)		Ō	
57.00	Routine service other pass through costs (from Wkst. D, Pt.	. III, column 9, lines 30	through 35).	0	57. 00
58.00	Ancillary service other pass through costs from Wkst. D, P	t. IV, col. 11 line 200)		0	
59. 00	Total (sum of amounts on lines 49 through 58)			17, 986, 339	1
60.00	Primary payer payments	nua lina (O)		4, 130 17, 982, 209	
61. 00 62. 00	Total amount payable for program beneficiaries (line 59 min Deductibles billed to program beneficiaries	nus i i ne 60)		1, 933, 116	1
63. 00	Coinsurance billed to program beneficiaries			1, 933, 110	1
64. 00	Allowable bad debts (see instructions)			67, 263	1
65.00				43, 721	1
66.00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		0	
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			16, 091, 614	1
68. 00	Credits received from manufacturers for replaced devices for			0	1
69. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and 90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	b). (FOR SCH See INSTRUCTIO	ns)	0	1
70. 50	Rural Community Hospital Demonstration Project (§410A Demon	nstration) adjustment (see	instructions)	0	1
70. 75	N95 respirator payment adjustment amount (see instructions)	, ,	This true true ons)	Ö	1
70. 87	Demonstration payment adjustment amount before sequestration			0	1
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	1
70. 89	Pioneer ACO demonstration payment adjustment amount (see in				70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions))		0	1
	HSP bonus payment HRR adjustment amount (see instructions)			0	1
70. 91				0	70. 92
70. 92	Bundled Model 1 discount amount (see instructions)			-	
	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			0 -1, 989	70. 93

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0115	Peri od:	Worksheet E

To 06/30/2023 Date/Time Prepared: 1/25/2024 11:51 am Title XVIII Hospi tal PPS FFY (yyyy) Amount 1.00 70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 2022 329, 437 70.96 the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 2023 70.97 70.97 the corresponding federal year for the period ending on or after 10/1) 70.98 0 Low Volume Payment-3 70.98 0 70 99 HAC adjustment amount (see instructions) 40,888 70 99 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 16, 378, 174 71.00 71.00 71. 01 Sequestration adjustment (see instructions) 327, 563 71.01 Demonstration payment adjustment amount after sequestration 71.0271. 02 71. 03 Sequestration adjustment-PARHM pass-throughs 71.03 72.00 Interim payments 15, 200, 079 72.00 72. 01 Interim payments-PARHM 72.01 73.00 Tentative settlement (for contractor use only) Ω 73.00 73.01 Tentative settlement-PARHM (for contractor use only) 73.01 74.00 Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 850, 532 74.00 73) Balance due provider/program-PARHM (see instructions) 74 01 74 01 75.00 Protested amounts (nonallowable cost report items) in accordance with 309, 041 75.00 CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 90.00 6, 688 90.00 plus 2.04 (see instructions) Capital outlier from Wkst. L, Pt. I, line 2 91.00 91.00 164 92.00 Operating outlier reconciliation adjustment amount (see instructions) 0 92.00 93.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 94 00 The rate used to calculate the time value of money (see instructions) 0 00 94 00 95.00 Time value of money for operating expenses (see instructions) 0 95.00 96.00 Time value of money for capital related expenses (see instructions) 96.00 0 Prior to 10/1 On/After 10/1 2 00 1 00 HSP Bonus Payment Amount 0 100. 00 100.00 HSP bonus amount (see instructions) 0 HVBP Adjustment for HSP Bonus Payment 0.0000000000 101.00 0.0000000000 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 0 102.00 HRR Adjustment for HSP Bonus Payment 0.0000 103.00 103.00 HRR adjustment factor (see instructions) 0.0000 104.00 HRR adjustment amount for HSP bonus payment (see instructions) 0 104.00 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. 200.00 Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 201.00 202.00 Medicare discharges (see instructions) 202. 00 203.00 Case-mix adjustment factor (see instructions) 203.00 Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration peri od) 204.00 Medicare target amount 204.00 205.00 Case-mix adjusted target amount (line 203 times line 204) 205. 00 206.00 Medicare inpatient routine cost cap (line 202 times line 205) 206. 00 Adjustment to Medicare Part A Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) 207.00 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 208. 00 209.00 Adjustment to Medicare IPPS payments (see instructions) 209. 00 210.00 Reserved for future use 210. 00 211.00 Total adjustment to Medicare IPPS payments (see instructions) 211. 00 Comparision of PPS versus Cost Reimbursement 212.00 Total adjustment to Medicare Part A IPPS payments (from line 211) 212.00 213. 00 218. 00 213.00 Low-volume adjustment (see instructions) 218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)

Health Financial Systems In Lieu of Form CMS-2552-10 CALCULATION OF DSH PAYMENT PERCENTAGE Provider CCN: 15-0115 Peri od: Worksheet DSH From 07/01/2022 06/30/2023 Date/Time Prepared: 1/25/2024 11:51 am Title XVIII Hospi tal PPS Original mcrxAdjusted mcax HFS Look Up Overri de Value Revi sed Value Val ues Val ues 3.00 4 00 5 00 1 00 2 00 CALCULATION OF THE DSH PAYMENT PERCENTAGE 1.00 Percentage of SSI patient days to Medicare 1. 53 0.00 0.00 0.00 1.00 0.00 Part A days (Previous from E, Part A, line 30 - Revised from CMS) 2.00 Percentage of Medicaid patient days to total 19.09 19.09 0.00 2.00 days (From line 27) 3.00 Sum of lines 1 and 2, if less than 15% DSH 20.62 0.00 19.09 3.00 Payment Percentage = 0 4.00 Provider Type * (urban, rural, SCH, RRC, RRC RRC 4.00 pickle - If pickle worksheet NA) Bed days available divided by number of days 5.00 86.17 0.00 86.17 5.00 in the cost reporting period (Worksheet E, Part A, Line 4) Disproportionate Share Payment Percentage 0.00 0.00 6.00 6.63 6.00 (transferred from Worksheet E, Part A, line 33) 7 00 Qualify for Operating DSH Eligibility (DPP Yes 7 00 Yes 15% or more)? 8.00 S-2, Line 22 Yes 8.00 Yes Qualify for Capital DSH Eligibility (Urban 9.00 No No 9.00 with 100 or more beds)? 10.00 S-2. Line 45 10.00 No No Is the provider reimbursed under the fully 11.00 Yes Yes 11.00 prospective method? (Worksheet L, Part I, line 1 geater than -0-) Percentage of SSI patient days to Medicare 12 00 0 00 0 00 0.00 0 00 0.00 12.00 Part A days (Previous from L, Part I, line 7 - Revised from CMS) Is this an IRF provider or a provider with 13.00 Yes Yes 13.00 an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y") 14.00 Medicare SSI ratio (Previous from E-3, Part 0.00 0.00 0.00 0.00 0.00 14.00 line 2 - Revised from CMS) CALCULATION OF THE PERCENTAGE OF MEDICALD DAYS TO TOTAL DAYS 15.00 In-State Medicaid paid days (Worksheet S-2, \cap 218 15.00 line 24, column 1) In-State Medicaid eligible unpaid paid days 16.00 167 167 16.00 (Worksheet S-2, line 24, column 2) Out-of-State Medicaid paid days (Worksheet 17.00 0 17.00 0 0 S-2, line 24, column 3) 18.00 Out-of-State Medicaid eligible unpaid days 5 C 18.00 (Worksheet S-2, line 24, column 4) 18.01 N/A 18.01 Medicaid HMO days (Worksheet S-2, line 24, 1.700 1,700 19.00 19.00 column 5) 20.00 Other Medicaid days (Worksheet S-2, line 24, 167 167 20.00 column 6) Total Medicaid patient days for the DSH 2, 257 21.00 21.00 2.257 calculation (sum of lines 15-20) Total patient days (Worksheet S-3, Part I, 22.00 11, 154 11, 154 22.00 Column 8, Line 14) 23.00 Plus total labor room days (Worksheet S-3, 672 672 23.00 Part I, Column 8, Line 32) Plus total employee discount days (Worksheet 24.00 0 0 24.00 S-3, Part I, Column 8, Line 30) Less total Swing-bed SNF and NF patient days 0 25.00 0 25.00 (Worksheet S-3, Part I, Column 8, Lines 5 and 6) Total Medicaid patient days for the DSH 11,826 11, 826 26.00 calculation (sum of lines 22-24, less line

19.09

0.00

19.09

27.00

Percentage of Medicaid patient days to total

days (Line 21 divided by line 26)

27.00

Heal th	Financial Systems MEI	MORIAL HOSP & F	HEALTH CARE CTF	}	In Lie	eu of Form CMS-	2552-10
CALCUL	ATION OF DSH PAYMENT PERCENTAGE		Provider Co		Peri od: From 07/01/2022 To 06/30/2023	1/25/2024 11:	pared:
			Title	XVIII	Hospi tal	PPS	
		Original .m	ncrx Values	Adj usted	. mcax Values	Revi sed	
		Condi ti on	Percentage	Condi ti on	Percentage	Condi ti on	
		1.00	2. 00	3.00	4. 00	5. 00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28. 00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	6. 23		0.00	Fal se	28. 00
29. 00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	Fal se	0. 00		0.00	True	29. 00
30.00	Line 28 or 29 as applicable		6. 23		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and		6. 23		0.00		31. 00
	fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200,						
	if RRC, MDH or otherwise enter line 30.						
		Original .mcrx	Adjusted .mcax	HFS Look Up	Overri de Value	Revi sed Value	
		Val ues	Val ues				
		1.00	2.00	3. 00	4. 00	5. 00	
	DETERMINATION OF PROVIDER TYPE						
32. 00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	Fal se				Fal se	32. 00
33. 00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	True				True	33. 00
34. 00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	Fal se				Fal se	34. 00
35. 00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	Fal se				Fal se	35. 00
36. 00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36. 00

Health Financial Systems	MEMORIAL HOSP & HEA	ALTH CARE CTR	In Lie	u of Form CMS-2	2552-10
CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 15-0115	Peri od: From 07/01/2022	Worksheet DSH	
			To 06/30/2023	Date/Time Pre 1/25/2024 11:	
		Title XVIII	Hospi tal	PPS	
	Revi sed				

			Title XVIII	Hospi tal	PPS	
		Revi sed				
		Percentage				
		6.00				
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE					
28. 00	If line 3 is greater than 20.2% - 5.88% plus	0. 00				28. 00
	82.5% of the difference between 20.2% and					
	line 3					
29. 00	If line 3 is less than 20.2% - 2.5% plus 65%	5. 16				29. 00
	of the difference between 15% and line 3					
30.00	Line 28 or 29 as applicable	5. 16				30. 00
31.00	If Urban and fewer than 100 beds, Rural and	0. 00				31. 00
	fewer than 500 beds, or an SCH with less					
	than 100 beds the lower of line 30 or .1200,					
	if RRC, MDH or otherwise enter line 30.					

Health Financial Systems	MEMORIAL HOSP & HEA	LTH CARE CTR	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0115	Peri od: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Prepared: 1/25/2024 11:51 am
		T1 11 10 11		DDO

More Service More		Title XVIII Hospi	tal	PPS	<u> </u>
Martine Mart				4.00	
		PART B - MEDICAL AND OTHER HEALTH SERVICES		1.00	
200 Description 200 See Instructions 200 200	1.00			13, 842	1.00
According Acco				1	•
Outlier reconcilitation amount (see Instructions)				1	1
Inter-the hospital specific payment to cast ratio (see instructions)				1	•
		· · · · · · · · · · · · · · · · · · ·			•
Translitional corridor payment (see instructions)		Line 2 times line 5			1
Ancil lary service other pass through costs from Wist. D. Pt. IV, col. 13, line 200 0, 0 0, 0 0, 0 11 10 10				l .	1
10,00 Organ acquisitions 13,842 11.00					1
1.0 Total cost (sum of lines 1 and 10) (see instructions) 1.0					1
Reasonable Charges				13, 842	1
12.00 Ancil lary service charges 65,520 12.00 12.00 13.00 Organ acquist it on charges (From Wist. D-4, Pt. III. col. 4, line 69) 65,520 14.00 15.0					
13.00 Organ acquisition charges (From Mist. D-4, Pt. 111, col. 4, line 69) 0.13.00	12 00			45 520	12.00
14.00				1	1
15.00 Aggregate amount actually collected from patients 16.00					•
16.00 Amounts that would have been real ized from patients iable for payment for services on a chargebasis 0 16.00 Natio of line 15 to line 16 (not to exceed 1.000000)					
had such payment been made in accordance with 42 CFR \$413.13(e)*					1
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.0000000 17.00 0.0000000 17.00 0.0000000 17.00 0.0000000 17.00 0.0000000 17.00 0.0000000 17.00 0.0000000 17.00 0.0000000 17.00 0.0000000 17.00 0.00000000 17.00 0.0000000 17.00 0.0000000 17.00 0.0000000 17.00 0.000000000 17.00 0.000000000 17.00 0.0000000000000000000000000000000	16.00	1	ebasi s	0	16.00
18.00 Total customery charges (see instructions) 65,520 18.00 Excess of customery charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 10,678 19.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0.00 13,678 19.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0.00 20.00	17. 00			0. 000000	17. 00
Instructions	18. 00			65, 520	18. 00
20.00 Excess of reasonable cost over customary charges (complete only If line 11 exceeds line 18) (see 0.20.00 instructions) 13,842 21.00 clesser of cost or charges (see instructions) 0.22.00 clesser of cost or charges (see instructions) 0.22.00 clesser of cost or charges (see instructions) 0.23.00 cost of physicians' services in a teaching hospital (see instructions) 29,631,418 24.00 cost of physicians' services in a teaching hospital (see instructions) 0.25.00 computation (or REIMBURSEWENT SETTLEMENT 0.26.00 beductible sand coinsurance amounts (for CAH, see instructions) 0.25.00 beductible sand coinsurance amounts (for CAH, see instructions) 0.25.00 clear (clear through the color of the	19. 00		е	51, 678	19. 00
Instructions	20.00		20	0	20.00
22.00 Interns and residents	20.00		<i>,</i> C		20.00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 29,631,418 24.00 Computation for Retineurs (see instructions) 29,631,418 24.00 25	21. 00			13, 842	21. 00
24. 00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 29, 631, 418 24. 00		,			1
COMPUTATION OF RELIBEDISSEMENT SETTLEMENT COMPUTATION OF RELIBEDISSEMENT SETTLEMENT Computer state Computer Computer state Compute					•
25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 0 25.00	24.00			27, 031, 410	24.00
27. 00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 24, 429, 471 27. 00	25. 00			0	25. 00
Instructions					1
28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 496, 383 28. 00 29. 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 0 29. 00 30. 00 Subtotal (sum of lines 27, 28, 28. 28. 50 and 29) 24, 925, 854 30. 00 30. 00 Subtotal (sum of lines 27, 28, 28. 28. 50 and 29) 24, 919, 656 31. 00 30. 00 Primary payer payments 6, 198 31. 00 30. 00 Subtotal (line 30 minus lines 31) 30. 00 30. 00 Composite rate ESRD (from Wkst. I5, line 11) 0 33. 00 30. 00 Adjusted relimbursable bad debts (see instructions) 83, 942 34. 00 30. 00 Aljusted relimbursable bad debts (see instructions) 9, 0 0 5, 562 35. 00 30. 00 Minowalbe bad debts for equal eligible beneficiaries (see instructions) 24, 974, 218 37. 00 37. 00 Subtotal (see instructions) 24, 974, 218 37. 00 39. 00 TOTHER ADJUSTIRMITS (SEE IIISTRUCTIONS) (SPECIFY) 24, 974, 235 39. 50 39. 75 Poneer ACD demonstration payment adjustment amount (see	27. 00		see	24, 429, 471	27. 00
REH Facility payment amount	28 00			496 383	28 00
24, 925, 854 30, 00				170,000	1
1.00 Subtotal (line 30 minus line 31) 24,919,656 32.00					
Subtotal (fine 30 minus line 31)				1	1
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 0 0 33 30 0 0 0 0 0					
34. 00	02.00			21,717,000	02.00
35.00					
36. 00				•	1
37.00 Subtotal (see instructions) 24,974,218 37.00 38.00 MSP-LCC reconciliation amount from PS&R -141 38.00 39.00 39.50 39.50 70 70 70 70 70 70 70		, ,		•	
38.00 MSP-LCC reconciliation amount from PS&R -141 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 39.00 39				1	•
39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.75 39.75 39.75 39.75 39.75 39.75 39.97 39.97 39.97 39.97 39.97 39.97 39.97 39.98 39.98 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0.39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0.39.99 3					1
39.75 N95 respirator payment adjustment amount (see instructions) 0 39.75 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 24,974,359 40.00 40.01 Sequestration adjustment (see instructions) 499,487 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 24,430,039 41.00 1 1 1 1 1 1 1 1 1				0	1
39. 97 Demonstration payment adjustment amount before sequestration 39. 97 39. 98 39. 87 39. 98 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 98 39. 99 39. 80 39. 99 39. 80 39. 99 39. 80 39. 99 39. 80 39. 99 39. 80 39. 99 39. 80 39. 99 39. 80 39. 99 39. 80 39. 99 39. 99 39. 80 39. 99 39. 99 39. 99 39. 99 39. 99 39. 39. 39. 39. 39. 39. 39. 39. 39. 39.					•
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) 24, 974, 359 40. 01 40. 01 Sequestration adjustment (see instructions) 499, 487 40. 01 40. 02 Sequestration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 01 Interim payments 24, 430, 039 41. 00 41. 01 Interim payments-PARHM 41. 01 42. 01 Tentative settlement (for contractors use only) 0 42. 00 43. 00 Bal ance due provider/program (see instructions) 44, 833 43. 00 43. 01 Bal ance due provider/program (see instructions) 44, 83 43. 01 44. 00 \$115. 2 44. 00 70				1	•
40.00 Subtotal (see instructions) 24, 974, 359 40.00 40.01 Sequestration adjustment (see instructions) 499, 487 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 40.03 Sequestration adjustment-PARHM pass-throughs 24, 430, 039 41.00 41.00 Interim payments 24, 430, 039 41.00 41.01 Interim payments-PARHM 41.01 42.00 Tentative settlement (for contractors use only) 0 42.00 43.00 Bal ance due provider/program (see instructions) 44, 833 43.00 43.01 Bal ance due provider/program-PARHM (see instructions) 44, 833 43.00 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 44.00 90.00 To BE COMPLETED BY CONTRACTOR 7, 636 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00		, , , , , , , , , , , , , , , , , , , ,			1
40. 01 Sequestration adjustment (see instructions) 499, 487 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 Interim payments 24, 430, 039 41. 00 41. 01 Interim payments-PARHM 41. 00 42. 01 Tentative settlement (for contractors use only) 0 42. 00 42. 01 Tentative settlement-PARHM (for contractor use only) 42. 01 43. 00 Bal ance due provider/program (see instructions) 44, 833 43. 00 43. 01 Bal ance due provider/program-PARHM (see instructions) 44, 833 43. 01 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 90. 00 Original outlier amount (see instructions) 7, 636 90. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 0 91. 00 92. 00 The rate used to calculate the Time Value of Money 0. 00 92. 00 93. 00 Time Value of Money (see instructions) 0 93. 00	39. 99	RECOVERY OF ACCELERATED DEPRECIATION		0	39. 99
40. 02 Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments Interim payments-PARHM Interim payments-PARHM 1 Interim payments-PARHM Interim payments Inte				1	1
40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 1 1 1 1 1 1 1 1 1				1	1
41. 00 Interim payments 24, 430, 039 41. 00 41. 01 Interim payments-PARHM 41. 01 42. 00 Tentative settlement (for contractor use only) 0 42. 00 42. 01 Tentative settlement (procontractor use only) 0 42. 01 43. 00 Balance due provider/program (see instructions) 44, 833 43. 01 Balance due provider/program-PARHM (see instructions) 43. 01 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 §115. 2 TO BE COMPLETED BY CONTRACTOR 7, 636 90. 00 Original outlier amount (see instructions) 7, 636 90. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 0 91. 00 92. 00 The rate used to calculate the Time Value of Money (see instructions) 0 93. 00					•
42.00 Tentative settlement (for contractors use only) 0 42.00 42.01 Tentative settlement-PARHM (for contractor use only) 42.01 43.00 Balance due provider/program (see instructions) 44,833 43.00 43.01 Balance due provider/program-PARHM (see instructions) 43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00				24, 430, 039	1
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 44.00 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 7,636 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00					1
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, 0 44.00 \$\text{\$\frac{\text{\$\				0	
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{\text{\$115.2}}{\text{\$10.80}}\$ COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		44 833	1
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,				74,000	
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)		Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		0	1
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 90.00 Original outlier amount (see instructions) 91.00 Original outlier amount (see instructions) 90.00 Original outlier amount (see instructions) 91.00 Original outlier amount (see instructions) 92.00 Original outlier amount (see instructions) 92.00 Original outlier amount (see instructions) 93.00 Original outlier amount (see instructions) 93.00 Original outlier amount (see instructions) 94.00 Original outlier amount (see instructions) 95.00 Original outlier amount (see instructions) 97.00 Original outlier amount (see instructions) 97.00 Original outlier amount (see instructions)					
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00 Time Value of Money (see instructions)	90 00			7 626	90 00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 0.00 93.00				1	1
				•	1
94. UU lotal (sum of lines 91 and 93) 0 94. 00				•	1
	94. 00	Iotal (sum of lines 91 and 93)		1 0	94.00

Health Financial Systems	MEMORIAL HOSP & HEA	LTH CARE CTR	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0115	Peri od: From 07/01/2022 To 06/30/2023		pared: 51 am
		Title XVIII	Hospi tal	PPS	
				Overri des	
				1. 00	
WORKSHEET OVERRIDE VALUES					
112.00 Override of Ancillary service charges (I	ine 12)			0	112. 00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

Health Financial Systems

MEMORIAL HOSP & HEALTH CARE CTR

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0115

Period:
From 07/01/2022
To 06/30/2023

Title XVIII Hospital

Part B

In Lieu of Form CMS-2552-10

Worksheet E-1
Part I
Date/Time Prepared:
1/25/2024 11: 51 am
PPS

Inpatient Part A

Part B

		Title	XVIII	Hospi tal	PPS	JI alli
			t Part A		t B	
		ripatron		Tai		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		15, 135, 479		24, 430, 039	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	02/15/2023	64, 600		0	3. 01
3. 02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		64, 600		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		15, 200, 079		24, 430, 039	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	1				
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)					
F 01	Program to Provider	T			0	F 01
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Dravi dan ta Draggam		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM	T	0		0	5. 50
5. 50	TENTATIVE TO PROGRAM) 0		0	5. 50
			0		0	
5. 52 5. 99	Subtatal (sum of lines E O1 E 40 minus sum of lines		_		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		U U	5. 99
	5. 50-5. 98)					/ 00
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		850, 532		44, 833	6. 01
					44, 833	
6. 02	SETTLEMENT TO PROGRAM		14 050 411		ı	6. 02
7. 00	Total Medicare program liability (see instructions)		16, 050, 611	Contracts	24, 474, 872	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
)	1. 00	2. 00	
8. 00	Name of Contractor		ICIAN SERVICES	08001	2.00	8. 00
0.00	maile of softer deter	III 2001/211/1 11112	I OLINIA DEIMALOED	00001	ı	5. 00

| Peri od: | Worksheet E-1 | From 07/01/2022 | Part | Date/Time Prepared: 1/25/2024 11:51 am | Prepared: 1/25/2024 11:51 mm | Prepared: 1/25/2024 | Prepared: 1/25/2024 | Prepared: 1/25/2 Component CCN: 15-S115

Inpatient Part A			Ti tl e	XVIII	Subprovi der - I PF	PPS	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			I npati en	t Part A	Par	t B	
Total interim payments paid to provider 105, 276			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
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				105, 27			
Services rendered in the cost reporting period. If none, write "NoNE" or enter a zero unp sum adjustment	2.00				0	0	2. 00
write "NONE" or enter a zero 3.00 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) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 0 3.02 3.03 3.04 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 3.50 Provider to Program 3.51 3.52 0 0 0 0 3.50 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 3.50 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 3.50 Separately and the separately each separ							
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) Program to Provider		1 91					
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)	3.00						3. 00
payment, If none, write "NONE" or enter a zero. (1)		amount based on subsequent revision of the interim rate					
Program to Provi der							
ADJUSTMENTS TO PROVIDER							
3.02 0	2 01						2 01
3.03 0 0 0 3.03 3.04 3.05		ADJUSTIMENTS TO PROVIDER			-		
3.05							
Provider to Program	3.04				0	0	3. 04
3. 50 ADJUSTMENTS TO PROGRAM	3.05				0	0	3. 05
3.51						1	
3.52 3.53 3.54 3.54 3.59 3.50 3.53 3.50 3.50 3.53 3.50		ADJUSTMENTS TO PROGRAM					
3.53 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.59 3.50-3.98 3.50-3.99 3.50							
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 105,276 0 4.00 (transfer to Wist. E or Wist. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
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) TO BE COMPLETED BY CONTRACTOR					-	1 - 1	
105,276 0 4.00 105,276 0 4.00	3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
Contractor Con							
appropriate 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	4. 00			105, 27	6	0	4. 00
To BE COMPLÉTED BY CONTRACTOR							
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NDNE" or enter a zero. (1) Program to Provider							
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5. 00
Program to Provider							
TENTATI VE TO PROVI DER							
Contractor Number	F 01						E 01
Solution September Solution		TENTATIVE TO PROVIDER				1 - 1	
Provider to Program							
TENTATI VE TO PROGRAM 0 0 5.50		Provider to Program					
5.52 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 4,954 0 6.02 7.00 Total Medicare program liability (see instructions) 110,230 Contractor Number (Mo/Day/Yr) 0 1.00 2.00		TENTATI VE TO PROGRAM			0		
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 4, 954 0 6. 01 6. 02 SETTLEMENT TO PROGRAM 0 0 0 6. 02 7. 00 Total Medicare program liability (see instructions) 110, 230 0 7. 00 Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00							
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) Contractor Number (Mo/Day/Yr) 0 1.00 2.00		Cubtatal (aum af lines F 01 F 40 minus aum af lines					
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) Contractor NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr) 0 1.00 2.00	5. 99				U	ا	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr) 0 1.00 2.00	6. 00						6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00		, ,					
7.00 Total Medicare program Liability (see instructions) 110,230 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				4, 95	4	1 - 1	
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00					-		
Number (Mo/Day/Yr) 0 1.00 2.00	7. 00	lotal Medicare program liability (see instructions)		110, 23			7. 00
0 1.00 2.00							
			()			
	8.00	Name of Contractor					8. 00

Title XVIII Subprovider - PPS

		litle	XVIII	Subprovi der - I RF	PPS	
		Innatien	t Part A		rt B	
		rnpatron	t rait n	T di		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 100, 990		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,					
0.00	write "NONE" or enter a zero					0.00
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	ABSOLIMENTS TO TROVIDER		Ö		o o	3. 02
3. 03			0		0	3. 03
3. 04			Ö		Ö	3. 04
3. 05			Ö		Ö	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 100, 990		0	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
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
, 00	5. 50-5. 98)					, 00
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		5, 770		0	6. 01
6. 01	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		3,770			6. 02
7. 00	Total Medicare program liability (see instructions)		1, 106, 760			
7.00	Total mode out o program Trability (300 Thisti detroits)		1, 100, 700	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor	WISCONSIN PHYS	ICIAN SERVICES	08001		8. 00
	•			•		•

Peri od: Worksheet E-1
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared: 1/25/2024 11:51 am Provider CCN: 15-0115 Component CCN: 15-5305 Title XVIII Skilled Nursing PPS

Inpatient Part A			litle	XVIII	Facility	PPS	
1.00			I npati en	t Part A		t B	
1.00			/ - - /	A +		A +	
Total interin payments paid to provider 1,687,454 0 1.00 0 2.00 1.00 0 2.00 1.00 0 2.00 0 2.00 0 0 2.00 2.00 0 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 neter a zero.	1 00	Total interim navments naid to provider	1.00				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							
Services rendered in the cost reporting period. If none, write "NONE" or neter a zero.	2.00					Ü	2.00
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)							
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 3.02 3.03 3.04 3.05 Provider to Program 3.50 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 3.03 3.55 3.51 3.52 0 0 0 3.55 3.53 3.54 0 0 0 3.55 3.53 3.54 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR write "NONE" or enter a zero. (1) Program to Provider ENTATIVE TO PROGRAM 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 ENTATIVE TO PROGRAM 5.01 ENTATIVE TO PROGRAM 0 0 5.50 Provider to Program ENTATIVE TO PROGRAM 0 0 0 5.50 5.50 Provider to Program ENTATIVE TO PROGRAM 0 0 0 5.50 5.50 Provider to Program ENTATIVE TO PROGRAM 0 0 0 5.50 5.50 5.50 Frow ider to Program 1 ENTATIVE TO PROGRAM 0 0 0 5.50 5.50 5.50 5.50 5.50 6.00 Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROGRAM 0 0 0.00 Contractor Ners are (Mo/Day/Yrr) Contractor Ners are contractor Ners are (Mo/Day/Yrr)		write "NONE" or enter a zero					
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	List separately each retroactive lump sum adjustment					3. 00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02			Г	T = ==================================	T	_	
3.03 3.04 3.05 Provider to Program 3.50 3.51 3.52 3.53 3.54 3.99 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) (transfer to Wist. E or Wist. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR write "NONE" or enter a zero. (1) Program to Provider 5.00 5.01 5.01 5.02 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7		ADJUSIMENTS TO PROVIDER		_			
3.04							
ADJUSTMENTS TO PROGRAM				_			
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 3.52 0 0 0 3.51 3.52 0 0 0 3.51 3.52 3.53 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.59 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,657,454 0 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR							
ADJUSTMENTS TO PROGRAM	3.00	Provider to Program				U	3.03
3.51 0	3 50			0	1	0	3 50
3.52		ADDUST WENTS TO TROOKAWI					
3.53 0							
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,657,454 0 4.00 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR				0			
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.09) 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,657,454 0 4.00 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR				Ö)		
A.00 Total inferim payments (sum of lines 1, 2, and 3.99) 1,657,454 0 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0)	0	
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		3. 50-3. 98)					
appropriate TO BE COMPLETED BY CONTRACTOR	4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 657, 454		0	4. 00
TO BE COMPLETED BY CONTRACTOR S. 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 S. 01 TENTATIVE TO PROVIDER S. 00 S. 02 S. 03 S. 00 S. 0							
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONDE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 5.02 0 0 0 5.02 5.03 Provider to Program 5.50 TENTATIVE TO PROGRAM 5.50 TENTATIVE TO PROGRAM 5.50 0 0 0 0 5.51 5.51 0 0 0 0 0 5.55 5.52 0 0 0 0 0 5.55 5.52 0 0 0 0 0 5.55 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETILEMENT TO PROGRAM 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 6.00 NPR Date (Mo/Day/Yr) 7.00 NPR Date (Mo/Day/Yr) 8.00 0 0 0.00 0 0.00 0.00 0.00 0.00 0.							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider			1				
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5.00
Program to Provider							
TENTATI VE TO PROVI DER							
Solition Settlement amount (balance due) based on the cost report. (1) Settlement To PROGRAM S	5 01			0		0	5 01
Solidar to Program Solidar		TENTITIVE TO TROVIDER					
Provider to Program							
TENTATI VE TO PROGRAM 0		Provider to Program			"		
5.52 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 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5.50	TENTATI VE TO PROGRAM		0)	0	5. 50
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 0 0 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 0 6.02 7.00 Total Medicare program liability (see instructions) 1,657,454 0 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5.51			0)	0	5. 51
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) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00	5. 52			0)	0	5. 52
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) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 99			0)	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) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6. 00	,					6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 0 0 0 6.02 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	. 01			_			, 00
7.00 Total Medicare program liability (see instructions) 1,657,454 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00				_			
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	Trotal medicale program frability (see Instructions)		1,007,454			7.00
0 1.00 2.00							
			()			
	8. 00	Name of Contractor					8. 00

Heal th	Financial Systems MEMORIAL HOSP & HEA	ALTH CARE CTR	In Lie	u of Form CMS-:	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0115	Peri od:	Worksheet E-1	
			From 07/01/2022 To 06/30/2023	Part II Date/Time Pre	narod:
			10 00/30/2023	1/25/2024 11:	
-		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	: 14		1. 00
2.00	Medicare days (see instructions)				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE 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
				Overri des	
	CONTRACTOR OVERROUND			1. 00	

108. 00

CONTRACTOR OVERRIDES

108.00 Override of HIT payment

CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-0115 From 07/01/2022 To 06/30/2023 Part II Date/Time Prepared: 1/25/2024 11: 51 am Provider CCN: 15-0115 Subprovider - IPF	Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lie	u of Form CMS-2552-10
Component CCN: 15-S115 To O6/30/2023 Date/Time Prepared: 1/25/2024 11:51 am Title XVIII Subprovider - PPS	CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115		
		Component CCN: 15-S115		
I I PF		Title XVIII		PPS
			IPF	

	I PF		
		1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS	1.00	
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	152, 178	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	l ol	3.00
4. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0.00	4.00
1. 00	15, 2004. (see instructions)	0.00	1. 00
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	4. 01
1.01	program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0.00	1.01
	CFR \$412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		1
5. 00	New Teaching program adjustment. (see instructions)	0.00	5.00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	6.00
0.00	teaching program" (see instuctions)	0.00	0.00
7. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0. 27	7.00
,, 00	teaching program" (see instuctions)	0,27	1.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0. 27	8.00
9. 00	Average Daily Census (see instructions)	2. 528767	9. 00
10. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0. 053635	
11. 00	Teaching Adjustment (line 1 multiplied by line 10).	8, 162	
12. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	160, 340	
13. 00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14. 00	Organ acquisition (DO NOT USE THIS LINE)	١	14.00
15. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16. 00	Subtotal (see instructions)	160, 340	
17. 00	Primary payer payments	100, 340	17.00
18. 00	Subtotal (line 16 less line 17).	160, 340	18.00
19. 00	Deductibles	50, 408	ı
20.00	Subtotal (line 18 minus line 19)	109, 932	
21. 00	Coinsurance	109, 932	21.00
22. 00		109, 932	
23. 00	Subtotal (line 20 minus line 21)		
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	3, 920	
25. 00	Adjusted reimbursable bad debts (see instructions)	2, 548	25.00
	Allowable bad debts for dual eligible beneficiaries (see instructions)	-	
26. 00	Subtotal (sum of lines 22 and 24)	112, 480	
27. 00	Direct graduate medical education payments (see instructions)	0	
28. 00	Other pass through costs (see instructions)	0	28. 00
29. 00	Outlier payments reconciliation	0	
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	
30. 98	Recovery of accelerated depreciation.	0	30. 98
30. 99	Demonstration payment adjustment amount before sequestration	0	30. 99
31.00	Total amount payable to the provider (see instructions)	112, 480	
31. 01	Sequestration adjustment (see instructions)	2, 250	
31. 02	Demonstration payment adjustment amount after sequestration	0	31. 02
32. 00	Interim payments	105, 276	
33. 00	Tentative settlement (for contractor use only)	0	33. 00
34. 00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	4, 954	
35. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	35. 00
	§115. 2		1
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51. 00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52. 00	The rate used to calculate the Time Value of Money	0.00	52. 00
53. 00	Time Value of Money (see instructions)	0	53. 00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THI	E END OF	
	THE COVID-19 PHE)		
99. 00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0. 053635	
99. 01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 053634	99. 01

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Peri od: From 07/01/2022	Worksheet E-3
	Component CCN: 15-T115		
	Title XVIII	Subprovi der -	PPS

	IRF	110	
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	1, 083, 460	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	26, 870	3. 00
4.00	Outlier Payments	22, 173	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5. 01
6. 00	New Teaching program adjustment. (see instructions)	0.00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0. 00	7. 00
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8. 00
9. 00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00
10.00	Average Daily Census (see instructions)	2. 704110	
11. 00	Teaching Adjustment Factor (see instructions)	0.000000	11. 00
12. 00	Teaching Adjustment (see instructions)	0	12.00
13. 00	Total PPS Payment (see instructions)	1, 132, 503	13.00
14. 00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15. 00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17. 00	Subtotal (see instructions)	1, 132, 503	17.00
18. 00	Primary payer payments	0	18.00
19. 00	Subtotal (line 17 less line 18).	1, 132, 503	19.00
20. 00	Deducti bl es	3, 156	20.00
21. 00	Subtotal (line 19 minus line 20)	1, 129, 347	21. 00
22. 00	Coi nsurance	0	22. 00
23. 00	Subtotal (line 21 minus line 22)	1, 129, 347	23. 00
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25. 00	Adjusted reimbursable bad debts (see instructions)	0	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26. 00
27. 00	Subtotal (sum of lines 23 and 25)	1, 129, 347	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29. 00	Other pass through costs (see instructions)	0	29. 00
30.00	Outlier payments reconciliation	0	30.00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31. 50
31. 98	Recovery of accelerated depreciation.	0	31. 98
31. 99	Demonstration payment adjustment amount before sequestration	1 120 247	31. 99
32. 00	Total amount payable to the provider (see instructions)	1, 129, 347	32. 00 32. 01
32. 01 32. 02	Sequestration adjustment (see instructions)	22, 587	
	Demonstration payment adjustment amount after sequestration	1 100 000	32. 02
33. 00 34. 00	Interim payments Tentative settlement (for contractor use only)	1, 100, 990 0	33. 00 34. 00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	5, 770	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	5, 770	36. 00
30. 00	§115. 2	0	30.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	22, 173	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	ı	52.00
53. 00	Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE	END OF	53. 00
20.00	THE COVID-19 PHE) Trackling Adjustment Factor for the cost reporting period immediately preceding February 20, 2020	0.00000	00.00
99. 00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0. 000000	
	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000	00 01

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lie	u of Form CMS-2	<u>2552-10</u>
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0115	Peri od:	Worksheet E-3	
		From 07/01/2022		
	Component CCN: 15-5305	To 06/30/2023	Date/Time Prep	oared:
			1/25/2024 11: 5	51 am
	Title XVIII	Skilled Nursing	PPS	
		Facility		
			1. 00	
PART VI - CALCULATION OF REIMBURSEME	NT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR T	ITLE XVIII PART A	PPS SNF	
SERVI CES				
PROSPECTIVE PAYMENT AMOUNT (SEE INST	RUCTIONS)			
1 00 Resource Utilization Group Payment	,		1 823 081	1 00

		1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART	A PPS SNF	
	SERVI CES		-
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)	1 000 001	
1.00	Resource Utilization Group Payment (RUGS)	1, 823, 081	
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3. 00
4.00	Subtotal (sum of lines 1 through 3)	1, 823, 081	4. 00
F 00	COMPUTATION OF NET COST OF COVERED SERVICES	ı	- 00
5. 00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E,		5. 00
6. 00	Part B. This line is now shaded.) Deductible	0	6. 00
	Coi nsurance	_	1
7.00		131, 801	1
8. 00 9. 00	Allowable bad debts (see instructions)	0	
10.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions) Adjusted reimbursable bad debts (see instructions)		1
11. 00	Utilization review		11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		
12.00	Inpatient primary payer payments	1, 691, 280 0	
14. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		
14. 50	Pioneer ACO demonstration payment adjustment (see instructions)		
14. 98	Recovery of accelerated depreciation.		
14. 90	Demonstration payment adjustment amount before sequestration		
15. 00	Subtotal (see instructions	1, 691, 280	
15. 00	Sequestration adjustment (see instructions)	33, 826	
15. 01	Demonstration payment adjustment amount after sequestration	33, 820	1
15. 75	Sequestration for non-claims based amounts (see instructions)		
16. 00	Interim payments	1, 657, 454	
17. 00		1, 037, 434	1
18. 00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)		
19. 00			
17.00	\$115. 2		1 7. 00
	15	1	1

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE (CTR	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 15-0115	From 07/01/2022	Worksheet E-3 Part VII Date/Time Prepared:

		7	To 06/30/2023	Date/Time Pre 1/25/2024 11:	pared: 51 am
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XIX			
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		414, 601		1.00
2. 00	Medical and other services		,	1, 308, 353	
3.00	Organ acquisition (certified transplant programs only)		0	.,,	3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		414, 601	1, 308, 353	1
5. 00	Inpatient primary payer payments		0	.,,	5. 00
6. 00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		414, 601	1, 308, 353	1
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		111,001	1,000,000	7.00
	Reasonable Charges				
8.00	Routine service charges		0		8. 00
9. 00	Ancillary service charges		962, 605	7, 115, 904	9. 00
10. 00	Organ acquisition charges, net of revenue		0	7, 1.0, 701	10.00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		962, 605	7, 115, 904	1
12.00	CUSTOMARY CHARGES		702,000	7,110,701	12.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
10.00	basis	services on a enarge		Ŭ	10.00
14. 00	Amounts that would have been realized from patients liable for	payment for services on	0	0	14. 00
11.00	a charge basis had such payment been made in accordance with 4			Ŭ	11.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	2 0.11 3.10. 10(0)	0.000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		962, 605	7, 115, 904	
17. 00	Excess of customary charges over reasonable cost (complete onl	v if line 16 exceeds	548, 004	5, 807, 551	
	line 4) (see instructions)	j i i iii i i eneceue	0.0,00.	0,007,007	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	vifline 4 exceeds line	0	0	18. 00
	16) (see instructions)	,			
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instr	uctions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		414, 601	1, 308, 353	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	•		.,,,	
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	
24. 00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	1
27. 00	Subtotal (sum of lines 22 through 26)		0	0	1
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		414, 601	1, 308, 353	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		,	.,,,	
30.00	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)		414, 601	1, 308, 353	
32. 00	Deductibles		0	0	32. 00
33. 00	Coinsurance		0	0	33. 00
34. 00	Allowable bad debts (see instructions)		0	0	34. 00
35. 00	,		0	Ŭ	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	414, 601	1, 308, 353	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	33)	-414, 601	-1, 308, 353	
38. 00	Subtotal (line 36 ± line 37)		0	0	
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0	Ü	39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	1
41. 00	Interim payments		0	0	1
41.00	Balance due provider/program (line 40 minus line 41)		0	0	1
43. 00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub 15-2	0	0	1
43.00	chapter 1, §115.2	WE WE THE GIVE FUD 19-2,			45.00
	OVERRI DES		1		1
109 00	Override Ancillary service charges (line 9)		0	Λ	109. 00
. 57. 00	1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-		,	·	1.07.00

Health Financial Systems	MEMORIAL HOSP & HEALTH CAR	E CTR	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi d	der CCN: 15-0115	Peri od: From 07/01/2022	Worksheet E-3
	Compon			Date/Time Prepared: 1/25/2024 11:51 am
		Title XIX	Subprovi der -	Cost

		II tie xix	I PF	COST	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIC	ES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		1, 096, 965		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1, 096, 965	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1, 096, 965	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		0		8. 00
9.00	Ancillary service charges		0	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
	CUSTOMARY CHARGES				4
13. 00	Amount actually collected from patients liable for payment for se	ervices on a charge	0	0	13. 00
44.00	basi s			0	14.00
14. 00	Amounts that would have been realized from patients liable for pa		0	0	14. 00
15. 00	a charge basis had such payment been made in accordance with 42 (FR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Ratio of line 13 to line 14 (not to exceed 1.000000) Total customary charges (see instructions)		0.000000	0.000000	1
17. 00	Excess of customary charges over reasonable cost (complete only i	fline 16 exceeds	0	0	1
17.00	line 4) (see instructions)	Title to exceeds	٥	Ü	17.00
18. 00	Excess of reasonable cost over customary charges (complete only i	fline 4 exceeds line	1, 096, 965	0	18. 00
10.00	16) (see instructions)	Time Texaccus Time	1,070,700	· ·	10.00
19.00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instruct	i ons)	O	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	,	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	pleted for PPS provide	rs.		1
22.00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24. 00
25.00	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		1 00/ 0/5		4
30.00	Excess of reasonable cost (from line 18)		1, 096, 965	0	1
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	
32.00	Deducti bl es Coi nsurance		0	0	
				0	
34. 00 35. 00	Allowable bad debts (see instructions)			Ü	34. 00 35. 00
36. 00	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33		0	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	·)		0	
	Subtotal (line 36 ± line 37)			0	
	Direct graduate medical education payments (from Wkst. E-4)			O	39.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)			0	
41. 00	Interim payments		0	0	
42. 00	Balance due provider/program (line 40 minus line 41)		0	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2.	o	0	
	chapter 1, §115.2	· · · · · · · · · · · · · · · · · · ·		Ü	
	OVERRI DES		. '		I
109.00	Override Ancillary service charges (line 9)		0	0	109. 00

Health Financial Systems	MEMORIAL HOSP & HEA	LTH CARE CTR	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0115	Peri od: From 07/01/2022	Worksheet E-3
		Component CCN: 15-T115		
		Title XIX	Subprovi der - I RF	Cost

		IRF		
		I npati ent	Outpati ent	
		1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR	XIX SERVICES		1
	COMPUTATION OF NET COST OF COVERED SERVICES		-T	
1.00	Inpatient hospital/SNF/NF services	(1.00
2.00	Medical and other services		0	
3.00	Organ acquisition (certified transplant programs only)			3.0
4.00	Subtotal (sum of lines 1, 2 and 3)		0	
5.00	Inpatient primary payer payments	(5.0
6.00	Outpatient primary payer payments		0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		0	7.0
	COMPUTATION OF LESSER OF COST OR CHARGES			+
0.00	Reasonable Charges			١.,
8.00	Routine service charges)))	8.0
9.00	Ancillary service charges		-1	
10.00	Organ acquisition charges, net of revenue			10.0
11.00	Incentive from target amount computation			11.0
12. 00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		0	12.0
13. 00			o lc	12 0
13.00	Amount actually collected from patients liable for payment for services on a charge basis	'	٥	13. 0
14. 00	Amounts that would have been realized from patients liable for payment for services	on	ol o	14.0
14.00	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	OII	٦	14.0
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 00000	0. 000000	15. 0
16. 00	Total customary charges (see instructions)		0.000000	1
17. 00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds			
17.00	line 4) (see instructions)	· ·		17.0
18. 00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds li	ne	ol o	18. 0
	16) (see instructions)		1	
19.00			ol o	19.0
20.00	Cost of physicians' services in a teaching hospital (see instructions)		ol o	20.0
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		o o	21.0
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS prov	i ders.		
22.00	Other than outlier payments		0	22.0
23.00	Outlier payments	(0	23.0
24.00	Program capital payments	(O O	24. 0
25.00	Capital exception payments (see instructions)	(O	25. 0
26.00	Routine and Ancillary service other pass through costs	(0	26. 0
27.00	Subtotal (sum of lines 22 through 26)		0 0	27. 0
28. 00	Customary charges (title V or XIX PPS covered services only)		0 0	28. 0
29. 00	Titles V or XIX (sum of lines 21 and 27)	(0	29. 0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)		0 0	
31. 00			0 0	
32.00	Deducti bl es		0 0	
33.00	Coinsurance		0 0	33.0
34.00	Allowable bad debts (see instructions)		0 0	34.0
35.00	Utilization review		0	35.0
36.00			0 (0	
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0 (0	1
	Subtotal (line 36 ± line 37)		0 (0	1
	Direct graduate medical education payments (from Wkst. E-4)		0	39.0
	Total amount payable to the provider (sum of lines 38 and 39)		0 0	
41.00	Interim payments		0	41.0
42.00	Balance due provider/program (line 40 minus line 41)		0 0	42.0
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	(0 0	43. C
	chapter 1, §115.2]
	OVERRI DES			
109.00	Override Ancillary service charges (line 9)		0 0	109. 0

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0115	Peri od: From 07/01/2022	Worksheet E-3
	Component CCN: 15-5305		
	Title XIX	Skilled Nursing	Cost
		Facility	

			Facility		
			I npati ent	Outpati ent	
	T		1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES	V OR XIX	SERVI CES		1
1 00	COMPUTATION OF NET COST OF COVERED SERVICES				1 00
1. 00 2. 00	Inpatient hospital/SNF/NF services Medical and other services		0	0	1.0
3.00	Organ acquisition (certified transplant programs only)		0	U	3.0
4. 00	Subtotal (sum of lines 1, 2 and 3)		0	0	
5. 00	Inpatient primary payer payments		0	0	5.0
6. 00	Outpatient primary payer payments			0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		0		8.0
9.00	Ancillary service charges		0	0	9.0
10.00	Organ acquisition charges, net of revenue		0		10.0
11.00	Incentive from target amount computation		0		11.0
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12. 0
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a ch	arge	0	0	13. 0
14 00	basis			0	140
14. 00	Amounts that would have been realized from patients liable for payment for serva charge basis had such payment been made in accordance with 42 CFR §413.13(e)	rces on	0	0	14. 0
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	15.0
16. 00	Total customary charges (see instructions)		0.000000	0.000000	1
17. 00	Excess of customary charges over reasonable cost (complete only if line 16 exce	ade	0	0	
17.00	line 4) (see instructions)	cus		0	17.0
18. 00	Excess of reasonable cost over customary charges (complete only if line 4 excee	ds line	0	0	18. 0
	16) (see instructions)			_	
19.00	Interns and Residents (see instructions)		0	0	19. 0
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.0
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.0
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS	provi de			
22. 00	1		0	0	
23. 00	1		0	0	
24. 00	1 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4		0		24. 0
25. 00			0		25. 0
26. 00			0	0	
27. 00			0	0	
28. 00 29. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	0	29.0
30. 00	Excess of reasonable cost (from line 18)		0	0	30.0
31. 00			0	0	
32. 00	Deductibles		0	0	1
	Coinsurance		0	0	
34. 00			0	0	
35. 00			0	Ŭ	35. 0
36. 00			0	0	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.0
	Subtotal (line 36 ± line 37)		0	0	
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.0
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40. C
41.00	Interim payments		0	0	41.0
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.0
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 1	5-2,	0	0	43.0
	chapter 1, §115.2]
	OVERRI DES		-		4
109.00	Override Ancillary service charges (line 9)		0	0	109. 0

	Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10									
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CC	CN: 15-0115	Peri od: From 07/01/2022	Worksheet E-4					
WEDT OF	LE EDUSTITION COSTS			To 06/30/2023	Date/Time Prep 1/25/2024 11:					
		Title	XVIII	Hospi tal	PPS	<u> </u>				
					1. 00					
4 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT				0.00	1 00				
1. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost reporti	ng perioas	0.00	1. 00				
1. 01	FTE cap adjustment under §131 of the CAA 2021 (see instruction		1) (:+-		0.00	1. 01				
2. 00 2. 26	Unweighted FTE resident cap add-on for new programs per 42 CFI Rural track program FTE cap limitation adjustment after the ca				0. 00 0. 00	2. 00 2. 26				
2 00	the CAA 2021 (see instructions)	Λ			0.00	2 00				
3. 00 3. 01	Amount of reduction to Direct GME cap under section 422 of MM. Direct GME cap reduction amount under ACA §5503 in accordance		§413.79 (m).	(see	0. 00 0. 00	3. 00 3. 01				
3. 02	instructions for cost reporting periods straddling 7/1/2011) Adjustment (increase or decrease) to the hospital's rural tra-	ok ETE limi+	ation(s) for	rural track	0. 00	3. 02				
3.02	programs with a rural track Medicare GME affiliation agreemen		0.00	3. 02						
4. 00	49075 (August 10, 2022) (see instructions) Adjustment (plus or minus) to the FTE cap for allopathic and	to a Modicaro	0. 00	4. 00						
4.00	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)	to a medicale	0.00	4.00						
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instacted ling 7/1/2011)	ng periods	0. 00	4. 01						
4. 02	ACA Section 5506 number of additional direct GME FTE cap slots	cost reporting	0. 00	4. 02						
4. 21	periods straddling 7/1/2011) The amount of increase if the hospital was awarded FTE cap slo	nts under 81	26 of the CAA	2021 (see	0.00	4. 21				
	instructions)	•								
5. 00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus line 3.01, plus or minus line 3.02, plus or minus line 4, plus line	us lines 3 and	0. 00	5. 00						
6. 00	Unweighted resident FTE count for allopathic and osteopathic	year from your	0. 00	6. 00						
7. 00	records (see instructions) Enter the lesser of line 5 or line 6		0.00	7. 00						
			Primary Care		Total					
8. 00	Weighted FTE count for physicians in an allopathic and osteop	athi c	1.00	2.00	3. 00	8. 00				
	program for the current year.									
9. 00	If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8.		0.0	0.00	0. 00	9. 00				
	6. For cost reporting periods beginning on or after October 1									
10. 00	if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curre	ent year		0.00		10. 00				
10. 01	Unweighted dental and podiatric resident FTE count for the cu			0.00		10. 01				
11. 00 12. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting	g year (see	0. 0 0. 0			11. 00 12. 00				
40.00	instructions)					40.00				
13. 00	Total weighted resident FTE count for the penultimate cost relyear (see instructions)	porting	0.0	0.00		13. 00				
14.00		by 3).	0.0			14.00				
15. 00 15. 01	Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p	rograms	14. 2 14. 2			15. 00 15. 01				
	Adjustment for residents displaced by program or hospital clos	sure	0.0			16. 00				
16. 01	Unweighted adjustment for residents displaced by program or held osure	ospi tal	0.0	0.00		16. 01				
17. 00	Adjusted rolling average FTE count		14. 2			17. 00				
18. 00 18. 01			105, 000. 0 0. 0	· ·		18. 00 18. 01				
19. 00	Approved amount for resident costs		1, 495, 20		1, 547, 700					
					1. 00					
20. 00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots rec	eived under 42		20. 00				
21. 00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instru	ctions)			0.00	21. 00				
22. 00	Allowable additional direct GME FTE Resident Count (see instru	uctions)			0. 00	22. 00				
23. 00 24. 00	Enter the locality adjustment national average per resident as Multiply line 22 time line 23	πουητ (see i	nstructions)		0.00	23. 00 24. 00				
	Total direct GME amount (sum of lines 19 and 24)				1, 547, 700					

	HEALTH CARE CTE		In Lie	u of Form CMS-2	2552-10			
DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider C		Period: From 07/01/2022 To 06/30/2023	Worksheet E-4 Date/Time Pre				
	Ti +l c	xVIII	Hospi tal	1/25/2024 11: PPS	51 am			
	Inpatient Part			Total				
	A	Prior to 1/1		,				
	1.00	2.00	2. 01	3. 00				
COMPUTATION OF PROGRAM PATIENT LOAD								
26.00 Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	4, 987	81	0 811		26. 00			
27.00 Total Inpatient Days (see instructions)	12, 074	12, 07	4 12, 074		27. 00			
28.00 Ratio of inpatient days to total inpatient days	0. 413036				28. 00			
29.00 Program direct GME amount	639, 256	103, 82	9 103, 957	847, 042				
29.01 Percent reduction for MA DGME		3. 2			29. 01			
30.00 Reduction for direct GME payments for Medicare Advantage		3, 38	5 3, 389	6, 774				
31.00 Net Program direct GME amount				840, 268	31. 00			
				1. 00				
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE -	TITIE XVIII ONLY	(NURSING PRO	GRAM AND PARAMET					
EDUCATION COSTS)	TITLE XVIII ONE	(NOROTHO TRO	OTO WILL THE TANK WILL	, r one				
32.00 Renal dialysis direct medical education costs (from Wkst. and 94)	23, lines 74	0	32. 00					
34.00 Ratio of direct medical education costs to total charges			,	0.000000	34.00			
35.00 Medicare outpatient ESRD charges (see instructions)	•	ŕ		0	35. 00			
36.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 3	5)		0	36.00			
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE X	/III ONLY							
Part A Reasonable Cost								
37.00 Reasonable cost (see instructions)				20, 408, 897				
38.00 Organ acquisition and HSCT acquisition costs (see instruc				0				
39.00 Cost of physicians' services in a teaching hospital (see	instructions)			0				
40.00 Primary payer payments (see instructions) 41.00 Total Part A reasonable cost (sum of lines 37 through 39	minus lina 40)			4, 130 20, 404, 767				
41.00 Total Part A reasonable cost (sum of lines 37 through 39 Part B Reasonable Cost	iii nus Trne 40)			20, 404, 767	41.00			
42. 00 Reasonable cost (see instructions)				29, 459, 582	42 00			
43.00 Primary payer payments (see instructions)				6, 198				
44. 00 Total Part B reasonable cost (line 42 minus line 43)				29, 453, 384				
45. 00 Total reasonable cost (sum of lines 41 and 44)				49, 858, 151				
46.00 Ratio of Part A reasonable cost to total reasonable cost	(line 41 ÷ line	45)		0. 409256				
47.00 Ratio of Part B reasonable cost to total reasonable cost	•	,		0. 590744				
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AN								
48.00 Total program GME payment (line 31)	<u> </u>			840, 268	48. 00			
49.00 Part A Medicare GME payment (line 46 x 48) (title XVIII o				343, 885	49. 00			
50.00 Part B Medicare GME payment (line 47 x 48) (title XVIII o	nly) (see instru	ıctions)		496, 383	50.00			

Heal th	Financial Systems MEMORIAL HOSP	MEMORIAL HOSP & HEALTH CARE CTR			552-10			
OUTLIE	R RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0115	Peri od:	Worksheet E-5				
			From 07/01/2022 To 06/30/2023	Date/Time Prep 1/25/2024 11:5				
	Title XVIII							
				1. 00				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or	sum of 2.03 plus 2.04 (see i	nstructions)	6, 688	1.00			
2.00	Capital outlier from Wkst. L, Pt. I, line 2			164	2.00			
3.00	Operating outlier reconciliation adjustment amount (see	instructions)		0	3.00			
4.00	Capital outlier reconciliation adjustment amount (see in	structions)		0	4.00			
5.00 The rate used to calculate the time value of money (see instructions)					5.00			
6.00	O	6.00						
7.00	Time value of money for capital related expenses (see in	nstructions)		0	7.00			

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

Provi der CCN: 15-0115

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

onl y)				0 06/30/2023	1/25/2024 11:	
		General Fund	Speci fi c	Endowment Fund	r'	J I dill
		1. 00	Purpose Fund 2.00	3. 00	4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	32, 056, 290) (0	0	1. 00
2.00	Temporary investments	72, 868, 952				
3.00	Notes recei vable	24 240 470		0	l ~	
4. 00 5. 00	Accounts recei vable Other recei vable	24, 368, 679			0	
6. 00	Allowances for uncollectible notes and accounts receivable	Ċ	ól ö	o o	l ő	
7. 00	Inventory	C		0	0	
8.00	Prepai d expenses	C		0	0	
9.00	Other current assets	8, 390, 588	1	0	0	
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	137, 684, 509			0	
11.00	FIXED ASSETS	137, 004, 309	'1) 0	0	11.00
12.00	Land	11, 208, 673	3	0	0	12. 00
13. 00	Land improvements	C		0		1
14.00	Accumulated depreciation	C			0	
15. 00 16. 00	Buildings Accumulated depreciation	124, 027, 093 -89, 067, 496	1	0	0	
17. 00	Leasehold improvements	-09,007,490			0	
18. 00	Accumulated depreciation	C		o o	Ö	
19. 00	Fi xed equipment	166, 968, 190) (0	0	
20. 00	Accumulated depreciation	-107, 056, 796		0	0	
21. 00 22. 00	Automobiles and trucks Accumulated depreciation			0	0	
23. 00	Major movable equipment					
24. 00	Accumul ated depreciation	Ċ		o o	Ö	
25. 00	Mi nor equi pment depreci abl e	C		0	0	25. 00
26. 00	Accumulated depreciation	C		0	0	
27. 00	HIT designated Assets	C		0	0	
28. 00 29. 00	Accumulated depreciation Minor equipment-nondepreciable			0	0	
30. 00	Total fixed assets (sum of lines 12-29)	106, 079, 664			l	
	OTHER ASSETS					
31.00	Investments	69, 294, 839		-		
32. 00 33. 00	Deposits on Leases Due from owners/officers			-	0	
34. 00	Other assets	11, 855, 190	1		0	
35. 00	Total other assets (sum of lines 31-34)	81, 150, 029		o o	Ö	
36. 00	Total assets (sum of lines 11, 30, and 35)	324, 914, 202	2 (0	0	36. 00
07.00	CURRENT LI ABI LI TI ES	4 700 040			_	07.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	4, 720, 342 25, 680, 522	1		1	
39. 00	Payroll taxes payable	23, 000, 322			0	
40. 00	Notes and Loans payable (short term)	3, 917, 375	5	0	0	
41. 00	Deferred income	C		0	0	
42. 00	Accel erated payments	846, 523	3			42.00
43. 00 44. 00	Due to other funds Other current liabilities	1, 269, 376			0	
45. 00		36, 434, 138		Ó	1	
	LONG TERM LIABILITIES					1
46. 00	Mortgage payable	C	(0	0	
47. 00	Notes payable	62, 791, 776	I .	-	1	1
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	1		-	0	1
50. 00	Total long term liabilities (sum of lines 46 thru 49)	62, 791, 776			l	
51.00	Total liabilities (sum of lines 45 and 50)	99, 225, 914	1	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	225, 688, 288	1			52.00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted			<u>'</u>		53. 00 54. 00
55. 00	Donor created - endowment fund balance - unrestricted			O		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	225, 688, 288	3		0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	324, 914, 202	1	ol ol	ő	
	59)					

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10 STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-0115 Peri od: Worksheet G-1 From 07/01/2022 To 06/30/2023 Date/Time Prepared: 1/25/2024 11: 51 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 Fund balances at beginning of period 1.00 223, 113, 355 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 94, 115, 410 2.00 Total (sum of line 1 and line 2) 317, 228, 765 3.00 0 3.00 4.00 IDENTIFIED ON TRIAL BALANCE 1, 044, 027 4.00 0 5.00 0 5.00 0 0 0 0 6.00 6.00 7.00 0 0 0 0 7.00 8.00 0 8.00 9.00 0 9. 00 10.00 Total additions (sum of line 4-9) 1,044,027 10.00 Subtotal (line 3 plus line 10) 318, 272, 792 11.00 11.00 0 FREESTANDING RHC DEPARTMENTS 266, 844 12.00 0 12.00 13.00 HOME OFFICE DEPARTMENTS 92, 317, 660 13.00 14.00 0 0 14.00 15.00 0 15.00 0 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 92, 584, 504 18.00 Fund balance at end of period per balance 225, 688, 288 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund

		6. 00	7. 00	8. 00	
1.00	Fund balances at beginning of period	0		0	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	IDENTIFIED ON TRIAL BALANCE		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9. 00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11. 00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	FREESTANDING RHC DEPARTMENTS		0		12.00
13.00	HOME OFFICE DEPARTMENTS		0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance	0		0	19.00

sheet (line 11 minus line 18)

24.00

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0115 Peri od: Worksheet G-2 From 07/01/2022 Parts I & II Date/Time Prepared: 06/30/2023 1/25/2024 11:51 am Cost Center Description Outpati ent Inpati ent Total 1.00 2. 00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 25, 242, 735 25, 242, 735 1.00 SUBPROVIDER - IPF 2.00 1, 780, 691 1, 780, 691 2.00 3.00 SUBPROVIDER - IRF 1, 541, 391 1, 541, 391 3.00 4.00 SUBPROVI DER 4.00 Swing bed - SNF Swing bed - NF 5.00 5.00 6.00 6.00 0 0 SKILLED NURSING FACILITY 7.00 1, 520, 004 1, 520, 004 7.00 8.00 NURSING FACILITY 8.00 OTHER LONG TERM CARE 9.00 9.00 10.00 Total general inpatient care services (sum of lines 1-9) 30, 084, 821 30, 084, 821 10 00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 9, 809, 898 9, 809, 898 11.00 12.00 CORONARY CARE UNIT 12.00 BURN INTENSIVE CARE UNIT 13 00 13.00 14.00 SURGICAL INTENSIVE CARE UNIT 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 Total intensive care type inpatient hospital services (sum of lines 16, 00 9, 809, 898 9, 809, 898 16, 00 11 - 15) 39, 894, 719 17.00 Total inpatient routine care services (sum of lines 10 and 16) 39, 894, 719 17.00 18.00 Ancillary services 99, 572, 007 548, 470, 501 648, 042, 508 18.00 Outpatient services 19.00 19.00 RURAL HEALTH CLINIC 1, 165, 084 1, 165, 084 20.00 0 20.00 20.01 RURAL HEALTH CLINIC II 0 1, 039, 221 1, 039, 221 20.01 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 21.00 HOME HEALTH AGENCY 4, 709, 671 22.00 4, 709, 671 22.00 AMBULANCE SERVICES 4, 994 23.00 8, 651, 421 8, 656, 415 23.00

00	6.11.10			,	00
25.00	AMBULATORY SURGICAL CENTER (D. P.)			l	25. 00
26.00	HOSPI CE	0	0	0	26. 00
27.00	PHYSI CI ANS	0	112, 317, 791	112, 317, 791	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	139, 471, 720	676, 353, 689	815, 825, 409	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		184, 802, 337		29. 00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38. 00		0			38. 00
39. 00		0			39. 00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		184, 802, 337		43. 00
	10 MGC. 0 0, 1116 4)	1	ı	ı	1

24.00 CMHC

	Financial Systems MEMORIAL HOSP & HE MENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0115	Peri od:	Worksheet G-3	
			From 07/01/2022 To 06/30/2023	Date/Time Pre	narad:
			10 06/30/2023	1/25/2024 11:	pareu: 51 am
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, Ii			815, 825, 409	1. 00
2.00	Less contractual allowances and discounts on patients' accou	nts		556, 736, 561	2. 00
3.00	Net patient revenues (line 1 minus line 2)		259, 088, 848	3. 00	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line		184, 802, 337	4. 00	
5.00	Net income from service to patients (line 3 minus line 4)		74, 286, 511	5. 00	
	OTHER I NCOME				
6. 00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			8, 000, 766	
8.00	Revenues from telephone and other miscellaneous communicatio	n servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10. 00	Purchase di scounts			0	10. 00
11. 00	Rebates and refunds of expenses			0	11. 00
12. 00	Parking lot receipts			0	12. 00
13. 00	Revenue from Laundry and Linen service			0	13. 00
14. 00	Revenue from meals sold to employees and guests			634, 251	
15. 00	Revenue from rental of living quarters			0	15. 00
		than patients		0	16. 00
	1			473, 546	
	Revenue from sale of medical records and abstracts			0	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	
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	MI SCELLANEOUS			10, 720, 336	24. 00
24. 50	COVI D-19 PHE Funding			0	24. 50
25. 00				19, 828, 899	25. 00
26. 00	Total (line 5 plus line 25)			94, 115, 410	26. 00
27. 00	OTHER EXPENSES (SPECIFY)			0	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29.00	Net income (or loss) for the period (line 26 minus line 28)			94, 115, 410	29. 00

1.00	Capital Related - Bldg. &	0	0	0	0		1. 00
	Fi xtures						1
2.00	Capital Related - Movable	0	0	0	0		2. 00
	Equi pment						1
3. 00	Plant Operation & Maintenance	0	0	0	0		3. 00
4.00	Transportati on	0	0	0	0		4. 00
5.00	Administrative and General	-2, 017, 030	490, 443	0	490, 443		5. 00
	HHA REIMBURSABLE SERVICES						ı
6.00	Skilled Nursing Care	964, 104	964, 104	0	964, 104		6.00
7.00	Physical Therapy	555, 692	555, 692	0	555, 692		7. 00
8.00	Occupational Therapy	343, 703	343, 703	0	343, 703		8. 00
9.00	Speech Pathology	20, 454	20, 454	0	20, 454		9.00
10.00	Medical Social Services	9, 828	9, 828	O	9, 828		10.00
11. 00	Home Health Aide	123, 249	123, 249	O	123, 249		11. 00
12.00	Supplies (see instructions)	0	50, 540	-50, 540	0		12.00
13.00	Drugs	0	25, 291	-25, 291	0		13.00
14.00	DME	О	O	0	0		14.00
	HHA NONREI MBURSABLE SERVI CES	,					ı
15.00	Home Dialysis Aide Services	0	0	0	0		15. 00
16.00	Respiratory Therapy	o	o	o	0		16.00
17. 00	Private Duty Nursing	o	o	o	0		17. 00
18. 00	Clinic	o	o	o	0		18. 00
19. 00	Health Promotion Activities	o	o	o	0		19. 00
20. 00	Day Care Program	o	ol	o	0		20.00
21. 00	Home Delivered Meals Program	o	ol	o	0		21. 00
22. 00	Homemaker Service	0	ol	o	0		22. 00
	All Others (specify)	o o	ol	ol	n		23. 00
23. 50		٥	ő	Ö	0		23. 50
24. 00		o o	2, 583, 304	-75, 831	2, 507, 473		24. 00
21.00	1.5ta. (5am 61 111165 1 25)	١	2,000,004	70,001	2,007, 170	l	_ 1. 00

8. 00 9. 00	Occupational Therapy Speech Pathology	343, 703 20, 454	0	0 0	0	0	343, 703 20, 454	
10.00	Medical Social Services	9, 828	0	0	0	0	9, 828	
11. 00	Home Health Aide	123, 249	0	0	0	0	123, 249	
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13. 00	Drugs	0	0	0	0	_	0	13. 00
14. 00	DME	0	0	0	0	0	0	14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	ol	ol	0	ol	0	15. 00
16. 00	Respiratory Therapy	0	ol Ol	ol Ol	0	o	0	16. 00
17. 00	Private Duty Nursing		0	0	0	0	0	17. 00
18. 00	Clinic		0	o	0	0	0	18. 00
19. 00	Health Promotion Activities		o	o	Ö	ő	o	19. 00
20. 00	Day Care Program	o	o	o	0	o	Ö	20. 00
21. 00	Home Delivered Meals Program	O	O	o	0	o	O	21. 00
22. 00	Homemaker Service	o	O	o	0	o	0	22. 00
23. 00	All Others (specify)	o	O	0	0	o	0	23. 00
23. 50	Tel emedi ci ne	0	0	0	0	0	0	23. 50
24. 00	Total (sum of lines 1-23)	2, 507, 473	0	0	0	0	2, 507, 473	24. 00
		Admi ni strati ve						
		& General	4A + 5)					
	GENERAL SERVICE COST CENTERS	5. 00	6. 00		<u> </u>			
1. 00	Capital Related - Bldg. &							1. 00
1.00	Fixtures							1.00
2.00	Capital Related - Movable							2. 00
	Equipment							
3.00	Plant Operation & Maintenance							3. 00
4.00	Transportation							4.00
5.00	Administrative and General	490, 443						5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	234, 423	1, 198, 527					6. 00
7.00	Physical Therapy	135, 117	690, 809					7. 00
8.00	Occupational Therapy	83, 572	427, 275					8. 00
9.00	Speech Pathology	4, 973	25, 427					9. 00
10.00	Medical Social Services	2, 390	12, 218					10. 00 11. 00
11.00	Home Heal th Ai de	29, 968 0	153, 217 0					11.00
12. 00 13. 00	Supplies (see instructions) Drugs	0	0					12.00
14. 00	DME		ol ol					14. 00
14.00	HHA NONREIMBURSABLE SERVICES	<u> </u>	U _I					14.00
15. 00	Home Dialysis Aide Services	0	0					15. 00
16. 00	Respiratory Therapy		o					16. 00
17. 00	Private Duty Nursing	l ol	o					17. 00
18. 00	Clinic	o	o					18. 00
19. 00	Health Promotion Activities	o	o					19. 00
20.00	Day Care Program	0	o					20. 00
21.00	Home Delivered Meals Program	O	o					21. 00
22.00	Homemaker Servi ce	0	o					22. 00
23.00	All Others (specify)	0	0					23.00
23. 50	Tel emedi ci ne	0	0					23. 50
24. 00	Total (sum of lines 1-23)		2, 507, 473					24. 00

Health Financial Systems	ME	MORIAL HOSP & F	HEALTH CARE CTI	R	In Li€	eu of Form CMS-	2552-10
COST ALLOCATION - HHA STATISTICAL BA	ISI S		Provi der C	CN: 15-0115	Period: From 07/01/2022	Worksheet H-1	
					To 06/30/2023		
				Home Health Agency I	PPS		
	Capital Re	ated Costs					
	BI dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	PI ant Operation & Maintenance (SQUARE FEET)	Transportation (MI LEAGE)	on Reconciliation	Admi ni strati ve & General (ACCUM. COST)	
	1 00	2.00	2 00	4.00	EA 00	F 00	

		Capital Rel	ated Costs					
		Bl dgs &	Movabl e	PI ant	Transportation	Reconciliation	Administrative	
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
			(DOLLAR VALUE)	Mai ntenance	(===)		(ACCUM. COST)	
			, , ,	(SQUARE FEET)			,	
		1.00	2.00	3.00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS		1					
1.00	Capital Related - Bldg. &	0				0		1. 00
2.00	Fixtures							2 00
2.00	Capital Related - Movable		0			0		2. 00
3.00	Equipment Plant Operation & Maintenance	_	0	0		0		3. 00
4.00	Transportation (see	0	0	0				4.00
4.00	instructions)	0	U		,			4.00
5.00	Administrative and General	0	0	Ō		-490, 443	2, 017, 030	5. 00
	HHA REIMBURSABLE SERVICES			_		11.57.115		
6.00	Skilled Nursing Care	0	0	C	0	0	964, 104	6.00
7.00	Physical Therapy	0	0	0	0	0	555, 692	7. 00
8.00	Occupational Therapy	0	0	0	0	0	343, 703	8. 00
9.00	Speech Pathology	0	0	0	0	0	20, 454	9. 00
10.00	Medical Social Services	0	0	0	0	0	9, 828	10.00
11.00	Home Health Aide	0	0	0	0	0	123, 249	11. 00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12. 00
13.00	Drugs	0	0	0)	0	0	13. 00
14.00	DME	0	0	0	0	0	0	14. 00
	HHA NONREIMBURSABLE SERVICES							
15. 00	Home Dialysis Aide Services	0	0	0	0	· ·	0	
16. 00	Respiratory Therapy	0	0	0	0	0	0	16. 00
17. 00	Private Duty Nursing	0	0	0	0	0	0	17. 00
18. 00	Clinic	0	0	0	0	0	0	18. 00
19. 00	Health Promotion Activities	0	0	0		0	0	19. 00
20. 00	Day Care Program	0	0	0	0	0	0	20.00
21. 00	Home Delivered Meals Program	0	0	0	0	0	0	21. 00
22. 00	Homemaker Servi ce	0	0	0	0	0	0	22. 00
23. 00	All Others (specify)	0	0	0	0	0	0	23. 00
23. 50	Tel emedi ci ne	0	0	0		0	0	23. 50
24. 00	Total (sum of lines 1-23)	0	0	0		-490, 443	, , , , , , , , , , , , , , , , , , , ,	
25. 00	Cost To Be Allocated (per	0	0	0	y C	'	490, 443	25. 00
26 00	Worksheet H-1, Part I) Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.000000		0. 243151	26.00
20.00	Tour Cost Martipire	J 0. 000000	0. 000000	0.00000	, U. UUUUUU	1	0. 243131	20.00

Health Financial Systems MEMORIA ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 1/25/2024 11:51 am Provi der CCN: 15-0115 Peri od: From 07/01/2022 To 06/30/2023 HHA CCN: 15-7222 Home Health PPS

						Agency I		
			CAPITAL REL	ATED COSTS				
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1. 00	2. 00	4. 00	4A	5. 00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.50 20.00 21.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	0 1, 198, 527 690, 809 427, 275 25, 427 12, 218 153, 217 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00 29,775 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22, 717 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4. 00 131, 869 273, 105 154, 953 97, 092 5, 901 2, 924 29, 332 0 0 0 0 0 0 0 0 0 0 0 0 0	4A 184, 361 1, 471, 632 845, 762 524, 367 31, 328 15, 142 182, 549 0 0 0 0 0 0 0 0 0 0 0 0 0	26, 139 208, 649 119, 913 74, 345 4, 442 2, 147	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 50 20. 00 21. 00
	26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description	MAI NTENANCE & REPAI RS 6.00	LAUNDRY & LI NEN SERVI CE	HOUSEKEEPI NG 9.00	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	
1.00	Administrative and General	25, 566	8. 00	8, 059	10.00	9, 566	13.00	1. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	25, 566 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		8, 059 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		9, 566 20, 782 10, 395 6, 034 274 3, 828 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00

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

Date/Time Prepared:

Part I

1/25/2024 11:51 am Home Health PPS Agency I INTERNS & RESIDENTS CENTRAL MEDI CAL SERVI CES-SALAR SERVI CES-OTHER PHARMACY Cost Center Description Subtotal SERVICES & RECORDS & Y & FRINGES PRGM COSTS **SUPPLY** LI BRARY **APPRV APPRV** 14. 00 15.00 22. 00 24. 00 16.00 21.00 1.00 Administrative and General 1, 589 0 0 255, 280 1.00 0 0 4, 053 0 o 1, 705, 116 2 00 2 00 Skilled Nursing Care 3.00 Physical Therapy 0 0 2, 734 0 0 978, 804 3.00 4.00 Occupational Therapy 0 00000000000000000 1, 489 0 0 606, 235 4.00 Speech Pathology 0 0 36, 193 5 00 5 00 69 0 6.00 Medical Social Services 19 17, 582 6.00 0 7.00 Home Health Aide 1, 419 213, 678 7.00 0 0 8.00 Supplies (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 8.00 0 0 9.00 9 00 Drugs Ω 0 10.00 DMF 0 0 10.00 0 11.00 Home Dialysis Aide Services 0 11.00 Respiratory Therapy 0 12.00 12.00 0 0 0 13.00 Private Duty Nursing 0 13.00 14.00 Clinic 0 0 0 14.00 Health Promotion Activities 15.00 15.00 Day Care Program 0 0 0 16, 00 16.00 17.00 Home Delivered Meals Program C 0 17 00 18.00 Homemaker Service 0 18.00 19.00 All Others (specify) 0 Ω 0 19.00 0 19.50 Tel emedi ci ne 0 0 19.50 3, 812, 888 20.00 Total (sum of lines 1-19) (2) 1.589 9, 783 20.00 Unit Cost Multiplier: column 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description Intern & Subtotal Allocated HHA Total HHA Residents Cost A&G (see Part Costs & Post II) Stepdown Adjustments 27.00 28.00 25.00 26.00 1.00 Administrative and General 255, 280 1.00 2.00 Skilled Nursing Care 0 1, 705, 116 122, 352 1, 827, 468 2.00 0 Physical Therapy 978, 804 70, 235 1,049,039 3.00 3.00 4.00 Occupational Therapy 0 606, 235 43, 501 649, 736 4.00 5.00 Speech Pathology 0 36, 193 2, 597 38, 790 5.00 0 Medical Social Services 17, 582 1, 262 18, 844 6.00 6.00 0 7. 00 7.00 Home Health Aide 213, 678 15, 333 229, 011 8.00 Supplies (see instructions) 0 8.00 9.00 Drugs 0 9.00 0 0 0 0 0 10.00 10.00 DME Home Dialysis Aide Services 0 0 11.00 C 11.00 12.00 Respiratory Therapy 12.00 0 13.00 Private Duty Nursing 0 0 0 13.00 0 Clinic 0 14.00 14.00 15.00 Health Promotion Activities 15.00 Day Care Program 0 0 16.00 0 0 16.00 Home Delivered Meals Program 0 17.00 0 0 17.00 0 0 Homemaker Service 0 18.00 18.00 19.00 All Others (specify) 0 0 C 0 19.00 Tel emedi ci ne 19.50 0 19.50 20 00 Total (sum of lines 1-19) (2) 3, 812, 888 255, 280 3, 812, 888 20.00 21.00 Unit Cost Multiplier: column 0.071756 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

Provider CCN: 15-0115

HHA CCN:

15-7222

Peri od:

То

From 07/01/2022

06/30/2023

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.

⁽²⁾ Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems MEMORIAL HOSP & HEAL	_TH CARE CTR	u of Form CMS-2552-10	
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 15-0115	Peri od: From 07/01/2022	Worksheet H-2 Part II
	HHA CCN: 15-7222	To 06/30/2023	Date/Time Prepared:

1/25/2024 11:51 am Home Health PPS Agency I CAPITAL RELATED COSTS **EMPLOYEE** ReconciliationADMINISTRATIVE MAINTENANCE & BLDG & FIXT MVBLE EQUIP Cost Center Description (SQUARE FEET) (SQUARE FEET) **BENEFITS** & GENERAL REPAIRS **DEPARTMENT** (ACCUM. COST) (SQUARE FEET) (GROSS SALARI ES) 6.00 1.00 2.00 5A 5.00 4.00 1.00 Administrative and General 3,758 3, 758 426.314 0 184.361 3,758 1.00 2.00 Skilled Nursing Care 882, 910 0 1, 471, 632 2.00 3.00 Physical Therapy 0 0 500, 941 0 845, 762 3.00 Occupational Therapy 0 0 313, 883 0 524, 367 4.00 4.00 0 0 5.00 Speech Pathology 19,078 31, 328 5.00 6.00 Medical Social Services 0 9, 453 0 15, 142 6.00 0000000 0 7.00 Home Health Aide 94, 826 0 182, 549 7.00 0 0 8.00 8.00 Supplies (see instructions) C 0 0 9.00 Drugs C 0 0 9.00 10.00 DMF 0 0 10.00 0 0 11.00 Home Dialysis Aide Services 0 0 11.00 0 0 12.00 Respiratory Therapy C 12.00 13.00 Private Duty Nursing 13.00 0 0 0 14.00 Clinic 0 0 14.00 0 0 15.00 Health Promotion Activities C 15.00 16.00 Day Care Program 16.00 0 17.00 Home Delivered Meals Program 0 0 0 0 17.00 0 0 Homemaker Service 18.00 18.00 0 0 0 19.00 All Others (specify) 19.00 19.50 Tel emedi ci ne 0 0 0 0 19.50 20.00 Total (sum of lines 1-19) 3,758 3, 758 2, 247, 405 3, 255, 141 3, 758 20.00 21.00 Total cost to be allocated 29.775 22.717 695, 176 461, 517 25. 566 21.00 7. 923097 6.044971 0.309324 6.803087 22.00 Unit cost multiplier 0.141781 22.00 Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL LINEN SERVICE (SQUARE FEET) (PATIENT DA (HOURS) ADMINI STRATION SERVICES & (POUNDS OF YS) **SUPPLY** (COSTED LAUNDRY) (DIRECT NRSING REQUIS.) HRS) 8.00 9.00 10.00 11.00 13.00 14.00 1.00 Administrative and General 3, 758 12, 230 0 25, 437 1. 00 0 2.00 Skilled Nursing Care 0 0 26, 572 0 0 0 0 0 0 2.00 0 0 13, 291 0 3 00 Physical Therapy 3 00 O 0 4.00 Occupational Therapy 0 7, 715 0 4.00 5.00 Speech Pathology 0 452 5.00 6 00 Medical Social Services 0 00000000000 0 350 6 00 O 7.00 Home Heal th Aide C 4,894 7.00 8.00 Supplies (see instructions) 8.00 Drugs 0 9.00 0 0 0 9.00 0 0 10.00 DMF Ω 10 00 11.00 Home Dialysis Aide Services 0 0 11.00 Respiratory Therapy 0 0 0 0 0 0 0 0 0 12.00 12.00 13.00 Private Duty Nursing 0 0 0 0 0 13.00 0 14.00 0 Clinic 14.00 15.00 Health Promotion Activities 0 0 15.00 Day Care Program 16.00 16.00 0 0 0 0 17.00 Home Delivered Meals Program 17.00 0 18.00 Homemaker Service C 18.00 0 19.00 All Others (specify) 0 0 0 0 19.00 19.50 Tel emedi ci ne 0 0 C 0 0 19.50 Total (sum of lines 1-19) 0 65, 504 20.00 20.00 3.758 0 25, 437 C 21.00 Total cost to be allocated 0 8.059 51, 233 1, 589 21.00 Unit cost multiplier 0. 000000 2. 144492 0.000000 0.782135 0.000000 0.062468 22.00

22.00

15-0115 | Peri od: From 07/01/2022 | From 07/01/2022 | Part II |
15-7222 | To 06/30/2023 | Date/Time Prepared: 1/25/2024 11:51 am BASIS HHA CCN:

							1/25/2024 11:	51 am_
						Home Health	PPS	
						Agency I		
				INTERNS &	RESI DENTS			
	Cost Center Description	PHARMACY	MEDI CAL	SERVI CES-SALAR	SERVI CES-OTHER	3		
		(COSTED	RECORDS &	Y & FRINGES	PRGM COSTS			
		REQUIS.)	LI BRARY	APPRV	APPRV			
			(REVENUE)	(ASSI GNED	(ASSI GNED			
				TIME)	TIME)			
		15. 00	16. 00	21. 00	22. 00			
1.00	Administrative and General	0	0	0	(1.00
2.00	Skilled Nursing Care	0	1, 862, 946	0	(2. 00
3.00	Physical Therapy	0	1, 256, 233	0	(3. 00
4.00	Occupational Therapy	0	684, 196	0	(4. 00
5.00	Speech Pathology	0	31, 567	0	(5. 00
6.00	Medical Social Services	0	8, 609		(6. 00
7.00	Home Health Aide	0	652, 150	0	(7. 00
8.00	Supplies (see instructions)	0	0	0	(8. 00
9.00	Drugs	0	0	0	(9. 00
10.00	DME	0	0	0	(10.00
11. 00	Home Dialysis Aide Services	0	0	0	(11. 00
12.00	Respiratory Therapy	0	0	0	(12.00
13.00	Private Duty Nursing	0	0	0	(13.00
14.00	Clinic	0	0	0	(14.00
15.00	Health Promotion Activities	0	0	0	(15. 00
16.00	Day Care Program	0	0	0	(16.00
17.00	Home Delivered Meals Program	0	0	0	(17. 00
18. 00	Homemaker Service	0	0	0	(18. 00
19.00	All Others (specify)	0	0	0	(19. 00
19. 50	Tel emedi ci ne	0	0	0	(19. 50
20.00	Total (sum of lines 1-19)	0	4, 495, 701	0	(20.00
21. 00	Total cost to be allocated	0	9, 783	0	(21. 00
22.00	Unit cost multiplier	0. 000000	0. 002176	0. 000000	0. 000000			22. 00

	<u>Financial Systems</u> TIONMENT OF PATLENT SERVICE COST		MORIAL HOSP & F	Provi der C		Peri od:	eu of Form CMS-2 Worksheet H-3	
				HHA CCN:	15-7222	From 07/01/2022 To 06/30/2023		pared: 51 am
				Titl∈	e XVIII	Home Health Agency I	PPS	
	Cost Center Description		Facility Costs		Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from Part II)	+ 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F						
	BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation	1 000	1 007 110		1 207 4			
1. 00 2. 00	Skilled Nursing Care Physical Therapy	2. 00 3. 00			1, 827, 4 1, 049, 0			
3.00	Occupati onal Therapy	4.00		l e	1		l .	
4. 00	Speech Pathology	5. 00		l e	38, 7		1	
5. 00	Medical Social Services	6. 00			18, 8		l .	
6.00	Home Health Aide	7. 00	229, 011		229, 0	11 2, 727	83. 98	6. 00
7. 00	Total (sum of lines 1-6)		3, 812, 888	0	0,0.2,0)	7. 00
			I		Program Visi			
	Cost Contar Doscription	Cost Limits	CBSA No. (1)	Part A	Not Subject	art B to Subject to		
	Cost Center Description	COST LIMITES	CBSA NO. (1)	Part A	Deductibles			
					Coi nsurance			
		0	1.00	2.00	3.00	4. 00	5. 00	
	Limitation Cost Computation	ı	T					
8.00	Skilled Nursing Care		99915	0				8. 00
9. 00 10. 00	Physical Therapy Occupational Therapy		99915 99915		1			9.00
11. 00	Speech Pathology		99915			74		11. 00
12. 00	Medical Social Services		99915		1	21		12. 00
13.00	Home Health Aide		99915	0	1, 4	89		13. 00
14.00	Total (sum of lines 8-13)			0				14. 00
	Cost Center Description		Facility Costs		Total HHA		Ratio (col. 3	
		Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (cols.		÷ col. 4)	
		20, 11116	п-2, Pait I)	Part II)	+ 2)	Records)		
		0	1.00	2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Comput							
15. 00		8. 00		l .	1	0 39, 108	1	
16. 00	Cost of Drugs	9. 00			Cost of	0 0	0. 000000	16. 00
			Program Visits		Servi ces			
			Par	t B	901 11 003	Part B		
	Cost Center Description	Part A	Not Subject to	Subject to	Part A	Not Subject to		
			Deductibles &			Deductibles &		
		/ 00	Coi nsurance	Coi nsurance	0.00	Coi nsurance	Coi nsurance	
	PART I - COMPUTATION OF LESSER	6.00	7.00	8.00	9.00	10.00	11.00	
	BENEFICIARY COST LIMITATION	OF AGUNEUATE I	ROGINAW COST, A	SONEONIE UI III	IL TROUKAW ET	IATTON 6031, U		
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	4, 201			0 985, 513		1. 00
2.00	Physi cal Therapy	0				0 649, 225	1	2. 00
3.00	Occupational Therapy	0	1, 797			0 408, 099	1	3.00
4. 00 5. 00	Speech Pathology Medical Social Services	0	74 21			0 21, 746 0 10, 992		4. 00 5. 00
6. 00	Home Heal th Aide		1, 489			0 125, 046		6. 00
7. 00	Total (sum of lines 1-6)	l o		l e		0 2, 200, 621	1	7. 00
	Cost Center Description							
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
0 00	Limitation Cost Computation	I			I			0 00
8. 00 9. 00	Skilled Nursing Care Physical Therapy							8. 00 9. 00
10.00	Occupati onal Therapy							10.00
	Speech Pathology							11. 00
11.00		1	1	İ	1	1	1	12. 00
12. 00	Medical Social Services							12.00
12. 00 13. 00	Medical Social Services Home Health Aide Total (sum of lines 8-13)							13.00

Heal th	Financial Systems	ME	MORIAL HOSP & I	HEALTH CARE CTF	2	In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF PATIENT SERVICE COST	S		Provider CO	CN: 15-0115 15-7222	Peri od: From 07/01/2022 To 06/30/2023	Worksheet H-3 Part I Date/Time Pre 1/25/2024 11:	pared:
				Ti tl e	XVIII	Home Health Agency I	PPS	or am
		Prog	ram Covered Cha	arges	Cost of Services			
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Tanana and a same and a same a same a same a same a same a same a same a same a same a same a same a same a sa	6.00	7.00	8. 00	9. 00	10.00	11. 00	
45.00	Supplies and Drugs Cost Computa						0	45.00
15.00	Cost of Medical Supplies Cost of Drugs	0	0			0 0	0	
16. 00	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00		,		0	0	10.00
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE I	PROGRAM COST, A	AGGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	
1. 00	Cost Per Visit Computation Skilled Nursing Care	985, 513						1.00
2. 00	Physical Therapy	649, 225						2.00
3.00	Occupational Therapy	408, 099						3.00
4.00	Speech Pathology	21, 746						4. 00
5.00	Medical Social Services	10, 992						5. 00
6.00	Home Health Aide	125, 046	,					6. 00
7.00	Total (sum of lines 1-6)	2, 200, 621						7. 00
	Cost Center Description							
	To a constant of the constant	12. 00						
	Limitation Cost Computation	1						
8.00	Skilled Nursing Care							8. 00 9. 00
9. 00 10. 00	Physical Therapy Occupational Therapy							10.00
11. 00	Speech Pathology							11.00
12. 00	Medical Social Services							12.00
13. 00	Home Heal th Aide							13.00
	Total (sum of lines 8-13)							14. 00
50	1.11.1. (00 0. 1.1.00 0 10)	I	1					

Heal th	Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-1							
APPORT	TIONMENT OF PATIENT SERVICE COST	S		Provider C		Peri od:	Worksheet H-3	
				HHA CCN:	15-7222	From 07/01/2022 To 06/30/2023		
							1/25/2024 11:	<u>51 am</u>
						Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		1
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2. 00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	CES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00	Physi cal Therapy	66. 00	0. 305663	0		Ocol. 2, line 2	. 00	1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3. 00
4.00	Cost of Medical Supplies	71. 00	0. 176651	0)	0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 211480	0)	0 col. 2, line 1	6. 00	5. 00

	Financial Systems MEMORIAL HOSP & HEARTION OF HHA REIMBURSEMENT SETTLEMENT	Provider CC	N: 15-0115	Peri	od:	Worksheet H-4	2552
		HHA CCN:	15-7222	From To	07/01/2022 06/30/2023	Part I-II Date/Time Prep 1/25/2024 11:	
		Title	XVIII		ome Health Agency I	PPS	51 6
				<u> </u>	Par	t B	
			Part A		t Subject to	Subject to Deductibles &	
					oi nsurance	Coi nsurance	
	DADT A COMPUTATION OF THE A FOOD OF DEACONARIES COOT OF CHARLES		1.00		2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO Reasonable Cost of Part A & Part B Services	JWARY CHARGES	>				1
00	Reasonable cost of services (see instructions)			0	0	0	1
00	Total charges			0	o	0] 2
00	Customary Charges Amount actually collected from patients liable for payment for	s corvi cos		0	ol	0	:
00	on a charge basis (from your records)	services		U	٩	U	`
00	Amount that would have been realized from patients liable for			0	0	0	4
	for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)	accordance					
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	000	0. 000000	0. 000000	
00	Total customary charges (see instructions)			0	o	0	
00	Excess of total customary charges over total reasonable cost (only if line 6 exceeds line 1)	(complete		0	0	0	
00	Excess of reasonable cost over customary charges (complete onl	yifline		0	О	0	;
00	1 exceeds line 6)			0	0	0	١.
00	Primary payer amounts			U	Part A	Part B	
					Servi ces	Servi ces	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				1. 00	2. 00	
. 00	Total reasonable cost (see instructions)				ol	0	10
. 00	Total PPS Reimbursement - Full Episodes without Outliers				o	1, 087, 396	
00	Total PPS Reimbursement - Full Episodes with Outliers				0	463, 674	
. 00	Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes				0	23, 695 4, 960	
00	Total PPS Outlier Reimbursement - Full Episodes with Outliers				ő	154, 132	
00	Total PPS Outlier Reimbursement - PEP Episodes				o	6, 428	
00	Total Other Payments				0	0	
00	DME Payments Oxygen Payments				0	0	
00	Prosthetic and Orthotic Payments				Ö	Ö	
00	Part B deductibles billed to Medicare patients (exclude coinsu	urance)				2, 822	
00	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)				0	1, 737, 463	2
	Subtotal (line 22 minus line 23)				ol	1, 737, 463	
00	Coinsurance billed to program patients (from your records)					0	
	Net cost (line 24 minus line 25)				0	1, 737, 463	
	Allowable bad debts (from your records) Adjusted reimbursable bad debts (see instructions)					0	
	Allowable bad debts for dual eligible (see instructions)					0	ł
00	Total costs - current cost reporting period (see instructions))			o	1, 737, 463	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	0	
50 99	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration	5)			0	0	30
00	Subtotal (see instructions)				ol	1, 737, 463	1
. 01	Sequestration adjustment (see instructions)				o	34, 749	3
. 02	Demonstration payment adjustment amount after sequestration				0	0	
. 75 . 00	Sequestration adjustment for non-claims based amounts (see instructions)	structions)			0	0 1, 702, 713	
. 00	Tentative settlement (for contractor use only)				0	1, 702, 713	
. 00	Balance due provider/program (line 31 minus lines 31.01, 31.02	2, 31.75, 32,	and 33)		ő	1	
	Protested amounts (nonallowable cost report items) in accordan		,	11	_	0	35

Provider CCN: 15-0115 TO PROGRAM BENEFICIARIES HHA CCN:

Peri od: From 07/01/2022 To 06/30/2023 Date/Ti me Prepared: 1/25/2024 11:51 am PPS 15-7222

				Home Health Agency I	PPS	
		I npati en	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	1, 702, 713 0	1. 00 2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01				0	0	3. 01
3. 02				0	0	3. 02
3.03				0	0	3. 03
3. 04 3. 05				0	0	3. 04 3. 05
3.05	Provider to Program			U	0	3. 03
3. 50	11 ovi dei 10 11 ogi aiii			0	0	3. 50
3. 51				0	0	3. 51
3.52				0	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)			0	1, 702, 713	4. 00
4.00	(transfer to Wkst. H-4, Part II, column as appropriate,			O .	1, 702, 713	4.00
	line 32)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					- 04
5. 01				0	0	5. 01
5. 02 5. 03				0	0	5. 02 5. 03
5.05	Provider to Program			0		5. 05
5. 50	Troving to Trogram			0	0	5. 50
5. 51				0	0	5. 51
5.52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6.01	SETTLEMENT TO PROVIDER			0	1	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0 1 702 714	6. 02
7. 00	Total Medicare program liability (see instructions)			0 Contractor	1, 702, 714 NPR Date	7. 00
				Number	(Mo/Day/Yr)	
)	1. 00	2. 00	
8. 00	Name of Contractor	WISCONSIN PHYS	ICIAN SERVICE	S 08001		8. 00

CALCUI	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0115	Peri od: From 07/01/2022 To 06/30/2023		
		Title XVIII	Hospi tal	PPS	
	DART I FILLY PROCEEDING METHOD			1. 00	
	PART I - FULLY PROSPECTIVE METHOD				1
. 00	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier			1, 031, 797	1.
. 00	Model 4 BPCI Capital DRG other than outlier			1,031,747	1
. 00	Capital DRG outlier payments			164	
. 01	Model 4 BPCI Capital DRG outlier payments			0	1
. 00	Total inpatient days divided by number of days in the cost	reporting period (see ins	tructions)	27. 85	
. 00	Number of interns & residents (see instructions)		,	14. 47	4.
. 00	Indirect medical education percentage (see instructions)			15. 79	5.
. 00	Indirect medical education adjustment (multiply line 5 by tl 1.01) (see instructions)	162, 921	6.		
00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (Worksheet I	E, part A line	0.00	7.
00	Percentage of Medicaid patient days to total days (see insti	ructions)		0.00	8.
00	Sum of lines 7 and 8	4011 0113)		0.00	
0. 00	Allowable disproportionate share percentage (see instruction	0.00			
1. 00	Disproportionate share adjustment (see instructions)	0			
2. 00	Total prospective capital payments (see instructions)			1, 194, 882	12
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
00	Program inpatient routine capital cost (see instructions)			0	
00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2)			0	
. 00	Capital cost payment factor (see instructions)			0	
	Total inpatient program capital cost (line 3 x line 4)			0	
00	Total Tripatrent program capital cost (Trie 3 x Trie 4)			0	3
00				1. 00	5.
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)	oces (see instructions)		1.00	1.
00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstal	nces (see instructions)		1.00	1 2
00 00 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2)	nces (see instructions)		1.00	1 2 3
00 00 00 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstal	nces (see instructions)		1.00	1 2 3 4
00 00 00 00 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)			1.00 0 0 0 0.00	1 2 3 4 5
00 00 00 00 00 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinary	nstructions)	ιine 6)	1.00 0 0 0.00 0.00 0.00	1. 2. 3. 4. 5. 6.
00 00 00 00 00 00 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinal Capital minimum payment level (line 5 plus line 7)	nstructions) ry circumstances (line 2 :	(line 6)	1.00 0 0 0.00 0.00 0.00	1. 2. 3. 4. 5. 6. 7. 8.
.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinal Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable)	nstructions) ry circumstances (line 2 :	,	0 0 0 0.00 0 0.00 0	1. 2. 3. 4. 5. 6. 7. 8.
. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstant Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see adjustment to capital minimum payment level for extraordinary capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to	nstructions) ry circumstances (line 2 : icable) capital payments (line 8	less line 9)	1.00 0 0 0.00 0.00 0.00 0	1. 2. 3. 4. 5. 6. 7. 8. 9.
.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstant Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinant capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	nstructions) ry circumstances (line 2 : icable) capital payments (line 8 capital payment (from pri	less line 9) or year	1.00 0 0 0.00 0.00 0.00 0 0	1 2 3 4 5 6 7 8 9 10
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstant Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see individual adjustment to capital minimum payment level for extraordinary capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurent year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital	nstructions) ry circumstances (line 2 : icable) capital payments (line 8 capital payment (from pri	less line 9) or year ne 11)	0 0 0 0.00 0.00 0.00 0 0 0	1 2 3 4 5 6 7 8 9 10 11
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinal Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, entering the comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, entering the comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, entering the comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, entering the capital minimum payment level to capital current year exception payment (if line 12 is positive)	nstructions) ry circumstances (line 2 : icable) capital payments (line 8 capital payment (from pri	less line 9) or year ne 11)	0 0 0 0.00 0.00 0 0.00 0 0 0	1 2 3 4 5 6 7 8 9 10 11 12 13
00 00 00 00 00 00 00 00 00 0. 00 1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstant of the program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appled current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, enterprover of accumulated capital minimum payment level over	nstructions) ry circumstances (line 2 : icable) capital payments (line 8 capital payment (from pri	less line 9) or year ne 11)	0 0 0 0.00 0.00 0.00 0 0 0	1 2 3 4 5 6 7 8 9 10 11 12 13
000 000 000 000 000 000 000 000 000 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinal Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicurrent year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, entering the comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, entering the comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, entering the comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, entering the capital minimum payment level to capital current year exception payment (if line 12 is positive)	nstructions) ry circumstances (line 2 dicable) capital payments (line 8 capital payment (from prior the amount on this line capital payment for the second	less line 9) or year ne 11)	1.00 0 0 0.00 0.00 0 0.00 0 0 0	11 22 33 44 55 66 77 18 86 99 110 111

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)

15.00 0 16.00 0 17.00

Heal th	Financial Systems	MEMORIAL HOSP & I	HEALTH CARE CTF	?	In Lie	eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
			Component		From 07/01/2022 To 06/30/2023		
					RHC I	Cost	
		Compensation	Other Costs	Total (col.	Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	418, 977	0	418, 97	7 -410, 565	8, 412	1.00
2.00	Physician Assistant	0	0		0 11, 583	11, 583	2.00
3.00	Nurse Practitioner	0	0		0 247, 051	247, 051	3. 00

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-01	15
	Component CCN: 15-8	507 To 06/30/2023 Date/Time Prepared:

			Component	JCIN. 13-0307	10	00/ 30/ 2023	1/25/2024 11:	
						RHC I	Cost	
	·	Adjustments	Net Expenses					
			for Allocation					
			(col. 5 + col.					
			6)					
		6.00	7.00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	8, 412					1.00
2.00	Physician Assistant	0	11, 583	•				2. 00
3.00	Nurse Practitioner	0	247, 051					3. 00
4.00	Visiting Nurse	0	0					4. 00
5.00	Other Nurse	0	0					5. 00
6.00	Clinical Psychologist	0	0					6. 00
7.00	Clinical Social Worker	0	0	i .				7. 00
8.00	Laboratory Techni ci an	0	0	1				8. 00
9.00	Other Facility Health Care Staff Costs	0	101, 067					9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	368, 113					10.00
11. 00	Physician Services Under Agreement	0	0					11. 00
12.00	Physician Supervision Under Agreement	0	0	l .				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	1, 252					15. 00
16. 00	Transportation (Health Care Staff)	0	0					16. 00
17. 00	Depreciation-Medical Equipment	0	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	1, 252					21. 00
22. 00	Total Cost of Health Care Services (sum of	0	369, 365					22. 00
	lines 10, 14, and 21)							1
00.00	COSTS OTHER THAN RHC/FQHC SERVICES	٥	40.004	I				
23. 00	Pharmacy	0	12, 304	1				23. 00
24. 00	Dental	0	0					24. 00
25. 00	Optometry	0	0	1				25. 00
25. 01	Tel eheal th	0	0					25. 01
25. 02	Chronic Care Management	0	0					25. 02
26. 00	All other nonreimbursable costs	0	0					26. 00
27. 00	Nonallowable GME costs		40.004					27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	12, 304					28. 00
	through 27)							_
20.00	FACILITY OVERHEAD	O	// 040					29. 00
29. 00	Facility Costs	٥	66, 842					
30.00	Administrative Costs	-640	95, 429					30.00
31. 00	Total Facility Overhead (sum of lines 29 and 30)	-640	162, 271					31.00
32. 00	Total facility costs (sum of lines 22, 28	-640	543, 940					32. 00
32.00	and 31)	-040	545, 940					32.00
	lana ori	ı		ı				1

	Financial Systems ME SIS OF HOSPITAL-BASED RHC/FQHC COSTS	MORIAL HOSP & F			In Lie Period:	eu of Form CMS-2 Worksheet M-1	
ANALTS	SIS OF HUSPITAL-BASED KHC/FUHC CUSTS		Provider C		From 07/01/2022		
			Component		To 06/30/2023	Date/Time Pre	
						1/25/2024 11:	<u>51 am</u>
				1=	RHC II	Cost	
		Compensation	Other Costs		Reclassi fi cati	Reclassified	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
		1.00	2. 00	3.00	4. 00	4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	3.00	
1.00	Physi ci an	583, 911		583, 91	1 -334, 401	249, 510	1.00
2.00	Physician Assistant	000,711	Č	303, 71	0 0	247, 310	2. 00
3.00	Nurse Practitioner	0	Č		0 119, 664	_	
4.00	Visiting Nurse	0	Č		0 117,001	0	
5. 00	Other Nurse	0	Č		0 0	0	5. 00
6.00	Clinical Psychologist	0	Ċ		0	0	6.00
7. 00	Clinical Social Worker	o	Ċ		o o	ĺ	7. 00
8.00	Laboratory Techni ci an	o	Ċ		o o	0	
9.00	Other Facility Health Care Staff Costs	0	C		0 134, 827	134, 827	9. 00
10.00	Subtotal (sum of lines 1 through 9)	583, 911	C	583, 91	1 -79, 910	504, 001	10.00
11.00	Physician Services Under Agreement	0	C		0 0	0	
12.00	Physician Supervision Under Agreement	0	C		0	0	12. 00
13.00	Other Costs Under Agreement	0	C		0 0	0	13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	C		0 0	0	14. 00
15.00	Medical Supplies	0	1, 302	1, 30	2 0	1, 302	15. 00
16. 00	Transportation (Health Care Staff)	0	C)	0	0	16. 00
17. 00	Depreciation-Medical Equipment	0	C)	0	0	1
18. 00	Professional Liability Insurance	0	C)	0	0	18. 00
19. 00	Other Health Care Costs	0	C)	0	0	
20. 00	Allowable GME Costs						20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	1, 302			1, 302	
22. 00	Total Cost of Health Care Services (sum of	583, 911	1, 302	585, 21	3 -79, 910	505, 303	22. 00
	lines 10, 14, and 21)					1	
23. 00	COSTS OTHER THAN RHC/FQHC SERVICES		15, 387	15, 38	7 0	15, 387	23. 00
24. 00	Pharmacy Dental	0	15, 387	15, 38	0 0		
25. 00	Optometry	0			0 0	1	
25. 00	Tel eheal th	0			0	0	
25. 01	Chronic Care Management		,		0		25. 01
26. 00	All other nonreimbursable costs				0	0	1
27. 00	Nonal Lowable GME costs			1		I	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	15, 387	15, 38	7 0	15, 387	
_0.00	through 27)			.5, 66		1 .5, 557	-0.00

0

583, 911

2, 655 67, 397

70, 052

86, 741

2, 655 67, 397

70, 052

670, 652

2, 655 147, 307 149, 962

670, 652

79, 910 79, 910

29.00

30.00

31.00

32.00

through 27)
FACILITY OVERHEAD
29.00 Facility Costs
30.00 Administrative Costs

and 31)

31.00 Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28

Health Financial Systems	MEMORIAL HOSP & HEALTH C	ARE CTR	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Prov	ider CCN: 15-0115	Peri od: From 07/01/2022	Worksheet M-1
	Comp	onent CCN: 15-8508		Date/Time Prepared:

						1/25/2024 11:	51 am_
					RHC I I	Cost	
		Adjustments	Net Expenses	5			
			for Allocatio	on			
			(col. 5 + col				
			6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	249, 51	0			1.00
2.00	Physician Assistant	0		0			2. 00
3.00	Nurse Practitioner	0	119, 66	4			3. 00
4.00	Visiting Nurse	0		0			4. 00
5.00	Other Nurse	0		o			5. 00
6.00	Clinical Psychologist	0		o			6. 00
7.00	Clinical Social Worker	0		o			7. 00
8.00	Laboratory Techni ci an	0		o			8. 00
9.00	Other Facility Health Care Staff Costs	0	134, 82	27			9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	504, 00	1			10.00
11.00	Physician Services Under Agreement	0	•	ol			11.00
12.00	Physician Supervision Under Agreement	0		o			12. 00
13.00	Other Costs Under Agreement	0		o			13. 00
14.00	Subtotal (sum of lines 11 through 13)	0		0			14. 00
15. 00	Medical Supplies	0	1, 30)2			15. 00
16. 00	Transportation (Health Care Staff)	0	.,	o			16. 00
17. 00	Depreciation-Medical Equipment	0		0			17. 00
18. 00	Professional Liability Insurance	0		o			18. 00
19. 00	Other Health Care Costs	0		0			19. 00
20. 00	Allowable GME Costs	Ţ.					20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	1, 30	12			21. 00
22. 00	Total Cost of Health Care Services (sum of	0	505, 30				22. 00
22.00	lines 10, 14, and 21)	0	303, 30	,3			22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						†
23. 00	Pharmacy	0	15, 38	87			23. 00
24. 00	Dental	0	.0,00	0			24. 00
25. 00	Optometry	0		0			25. 00
25. 01	Tel eheal th	0		0			25. 01
25. 02	Chronic Care Management	0		0			25. 02
26. 00	All other nonreimbursable costs	0		0			26. 00
27. 00	Nonallowable GME costs	J		Ĭ			27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	15, 38	27			28. 00
20.00	through 27)	0	13, 30	′′			20.00
	FACILITY OVERHEAD						1
29. 00	Facility Costs	0	2, 65	55			29. 00
30.00	Admi ni strati ve Costs	-119	147, 18				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-119	149, 84	1			31. 00
51.00	30)	-117	147,04				31.00
32. 00	Total facility costs (sum of lines 22, 28	-119	670, 53	13			32. 00
JZ. 00	and 31)	-117	070, 50	, 5			32.00
	1	l		1			1

Heal th	Financial Systems ME	EMORIAL HOSP & F	HEALTH CARE CTE	?	In lie	u of Form CMS-2	2552-10
	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S		Provi der CO	CN: 15-0115	Peri od:	Worksheet M-2	
			Component (From 07/01/2022 To 06/30/2023	Date/Time Pre	narad:
			Component	JCN. 15-6507	10 00/30/2023	1/25/2024 11:	
					RHC I	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col. 3)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY		2.00	0.00	1.00	0.00	
	Posi ti ons						
1.00	Physi ci an	0.00	0	., =-			1. 00
2.00	Physi ci an Assi stant	0. 10	0	_,			2. 00
3.00	Nurse Practitioner	1. 62	4, 522				3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 72	4, 522		3, 612	4, 522	
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. 02	Diabetes Self Management Training (FQHC only)	0. 00	0			0	7. 02
8. 00	Total FTEs and Visits (sum of lines 4	1. 72	4, 522			4, 522	8. 00
0.00	through 7)	1. 72	4, 322			4, 322	0.00
9. 00	Physician Services Under Agreements		0			0	9. 00
7.00	Trigor or arr oor vi ood onder rigi comerico						71.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O HOSPI TAL-BASE	D RHC/FQHC SER	VI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col. 7	, line 22)			369, 365	10.00
11. 00						12, 304	11. 00
12.00	Cost of all services (excluding overhead) (s					381, 669	
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 967763	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		162, 271	14. 00
15. 00	Parent provider overhead allocated to facili	ty (see instruc	tions)			308, 774	
16. 00	Total overhead (sum of lines 14 and 15)					471, 045	
17. 00	,					0	
	Enter the amount from line 16					471, 045	
	Overhead applicable to hospital-based RHC/FQ	•		,		455, 860	
20.00	Total allowable cost of hospital-based RHC/F	UHC Services (S	sum of lines 10	and 19)		825, 225	20.00

Heal th	Financial Systems ME	EMORIAL HOSP & F	HEALTH CARE CTF	?	In Lie	u of Form CMS-2	2552-10
	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der Co		Peri od: From 07/01/2022	Worksheet M-2	
			Component	CCN: 15-8508	To 06/30/2023	Date/Time Pre 1/25/2024 11:	
					RHC II	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col. 3)	4	
		1.00	2. 00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	1. 07	1				1. 00
2.00	Physician Assistant	0. 00		, , ,			2. 00
3.00	Nurse Practitioner	0. 92					3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 99			6, 426		4. 00
5.00	Visiting Nurse	0.00				0	5.00
6. 00 7. 00	Clinical Psychologist Clinical Social Worker	0. 00 0. 00	l e			0	6. 00 7. 00
7. 00 7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l e			0	7.00
7. 01	Diabetes Self Management Training (FQHC	0.00				0	7. 01
7.02	only)	0.00	٥			U	7.02
8.00	Total FTEs and Visits (sum of lines 4	1. 99	3, 971			6, 426	8. 00
	through 7)						
9.00	Physician Services Under Agreements		0			0	9. 00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			VI CES			
	Total costs of health care services (from Wk					505, 303	
11. 00						15, 387	
12.00	Cost of all services (excluding overhead) (s					520, 690	
13.00	Ratio of hospital -based RHC/FQHC services (I			21)		0. 970449	
14. 00 15. 00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		149, 843	
16. 00	Parent provider overhead allocated to facili Total overhead (sum of lines 14 and 15)	ty (see Instruc	ctions)			479, 061 628, 904	
17. 00						020, 904	
	Enter the amount from line 16					628, 904	
	Overhead applicable to hospital-based RHC/FQ	HC services (Li	ne 13 x line 1	8)		610, 319	
	Total allowable cost of hospital based RHC/F					1, 115, 622	
20.00	1.112. 2.11.dat o cost of mospital based 10071	(.,, 022	

Health Financial Systems	MEMORIAL HOSP & HEA			u of Form CMS-2	
CALCULATION OF REIMBURSEMENT SETTLEMENT SERVICES	FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0115	Peri od: From 07/01/2022	Worksheet M-3	
ERVI CES		Component CCN: 15-8507	To 06/30/2023	Date/Time Pre	pared
		71.11.100111	Buo I	1/25/2024 11:	51 ar
		Title XVIII	RHC I	Cost	
				1. 00	
DETERMINATION OF RATE FOR HOSPITAL	BASED RHC/FQHC SERVICES				
00 Total Allowable Cost of hospital -	based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		825, 225	1.
00 Cost of injections/infusions and	•			8, 244	1
OO Total allowable cost excluding in		inus line 2)		816, 981	1
Total Visits (from Wkst. M-2, col		line ()		4, 522	1
.00 Physicians visits under agreement .00 Total adjusted visits (line 4 plu	•	Title 9)		0 4, 522	
.00 Adjusted cost per visit (line 3 d	•			180. 67	7.
i oo i maj datad aaat par vi ar t (i i ma a a	. v. ded by Time by		Cal cul ati on		,
			Rate Period 1		
			(07/01/2022	(01/01/2023	
			through 12/31/2022)	through 06/30/2023)	
			1. 00	2. 00	
.00 Per visit payment limit (from CMS	Pub. 100-04, chapter 9, §20	.6 or your contractor)	113. 00	126.00	8.
.00 Rate for Program covered visits (see instructions)		113. 00	126. 00	9.
CALCULATION OF SETTLEMENT					
0.00 Program covered visits excluding	•	*	671	653 82, 278	
1.00 Program cost excluding costs for 2.00 Program covered visits for mental			75, 823 0	82, 278	1
3.00 Program covered cost from mental			0	0	1
4.00 Limit adjustment for mental healt	•	,	0	0	
5.00 Graduate Medical Education Pass T					15.
6.00 Total Program cost (sum of lines	11, 14, and 15, columns 1, 2	and 3) *	0	158, 101	16.
6.01 Total program charges (see instru		•		295, 605	1
6.02 Total program preventive charges		-		5, 366	1
6.03 Total program preventive costs ((6.04 Total Program non-preventive cost				2, 870 94, 114	1
(Titles V and XIX see instruction		3 and 10) trilles .00)		74, 114	10.
6.05 Total program cost (see instruct			0	96, 984	16.
7.00 Primary payer amounts				0	17.
8.00 Less: Beneficiary deductible for	RHC only (see instructions)	(from contractor		37, 588	18.
records) 9.00 Beneficiary coinsurance for RHC/F	OUC corvices (see instruction	ns) (from contractor		EO E20	19.
records)	unc services (see ilistructio	iis) (ITOIII COITTI actor		50, 530	19.
0.00 Net Medicare cost excluding vacci	nes (see instructions)			96, 984	20.
1.00 Program cost of vaccines and their	r administration (from Wkst.	M-4, line 16)		5, 211	21.
2.00 Total reimbursable Program cost (. ,			102, 195	
3.00 Allowable bad debts (see instruct				0	1
3.01 Adjusted reimbursable bad debts (•	rusti ons)		0	
4.00 Allowable bad debts for dual elig 5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIO	,	ructions)		0	
5.50 Pioneer ACO demonstration payment		s)		0	
5. 99 Demonstration payment adjustment		-,		0	
5.00 Net reimbursable amount (see inst	ructions)			102, 195	
6.01 Sequestration adjustment (see ins	*			2, 044	1
6.02 Demonstration payment adjustment	amount after sequestration			0	
7.00 Interim payments	ton use only)			92, 473	
8.00 Tentative settlement (for contrac 9.00 Balance due component/program (li	3,	02 27 and 20)		0 7, 678	28. 29.
30.00 Protested amounts (nonallowable c				7,678	1
chapter I, §115.2	opo. c . como, 111 docor da			O	1

AL OUT		LTH CARE CTR		u of Form CMS-2	
ERVI C	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0115	Peri od: From 07/01/2022	Worksheet M-3	
LKVIC	L3	Component CCN: 15-8508	To 06/30/2023	Date/Time Pre	
		T: 11	DIIO III	1/25/2024 11:	51 ar
	<u> </u>	Title XVIII	RHC I I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			1, 115, 622	1.
00	Cost of injections/infusions and their administration (from WI			11, 764	2.
00 00	Total allowable cost excluding injections/infusions (line 1 mi Total Visits (from Wkst. M-2, column 5, line 8)	inus line 2)		1, 103, 858 6, 426	1
00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0, 420	
00	Total adjusted visits (line 4 plus line 5)	7)		6. 426	
00	Adjusted cost per visit (line 3 divided by line 6)			171. 78	
			Cal cul ati on	of Limit (1)	
			D . D . 141	D . D . L O	
			Rate Period 1		
			(07/01/2022 through	(01/01/2023 through	
			12/31/2022)	06/30/2023)	
			1. 00	2. 00	
00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	.6 or your contractor)	113.00	126. 00	1
00	Rate for Program covered visits (see instructions)		113. 00	126. 00	9
. 00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from	contractor records)	794	886	10
00	Program cost excluding costs for mental health services (line	•	89, 722	111, 636	
. 00	Program covered visits for mental health services (from contra		0	0	1
. 00	Program covered cost from mental health services (line 9 x li	ne 12)	0	0	13
. 00	Limit adjustment for mental health services (see instructions)		0	0	
. 00	Graduate Medical Education Pass Through Cost (see instructions				15
. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	201, 358	
. 01	Total program charges (see instructions)(from contractor's real Total program preventive charges (see instructions)(from provi	*		318, 462 22, 873	
. 03	Total program preventive charges (see First actions) (From proof	•		14, 462	
. 04	Total Program non-preventive costs ((line 16 minus lines 16.03			119, 498	1
	(Titles V and XIX see instructions.)	,		•	
. 05	Total program cost (see instructions)		0	133, 960	
. 00	Primary payer amounts			0	
. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(Trom contractor		37, 524	18
9. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		51, 613	19
	records)	, (2., 2	
. 00	Net Medicare cost excluding vaccines (see instructions)			133, 960	1
. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		7, 198	
. 00	Total reimbursable Program cost (line 20 plus line 21)			141, 158	1
. 00 . 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			28 18	1
	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. 401. 0.10)		0	
	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	25
. 99	Demonstration payment adjustment amount before sequestration				25
. 00	Net reimbursable amount (see instructions)			141, 176	
. 01	Sequestration adjustment (see instructions)			2, 824	
0. 02	Demonstration payment adjustment amount after sequestration Interim payments			0 128, 226	
3. 00	Tentative settlement (for contractor use only)			128, 226	
9. 00	,	02. 27. and 28)		10, 126	
		nce with CMS Pub. 15-II,			30

Heal th	Financial Systems MEMORIAL HOSP & I	HEALTH CARE CTR		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC	N: 15-0115	Peri od:	Worksheet M-4	
		Component C	CCN: 15-8507	From 07/01/2022 To 06/30/2023	Date/Time Prep 1/25/2024 11:	
		Title	XVIII	RHC I	Cost	
		PNEUMOCOCCAL	I NFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	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)	368, 113	368, 1			1. 00
2. 00	Ratio of injection/infusion staff time to total health	0. 000066	0. 0021	0. 000000	0. 000000	2. 00
2 00	care staff time	2.4	0.	20		2 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	24	81	00 0	0	3. 00
4.00	Injections/infusions and related medical supplies costs	547	2, 3	19	0	4. 00
4.00	(from your records)	347	2, 3	0	O	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	571	3, 1	19 0	o	5. 00
6.00	Total direct cost of the hospital-based RHC/FQHC (from	369, 365	369, 3		369, 365	6. 00
	Worksheet M-1, col. 7, line 22)	·	•			
7.00	Total overhead (from Wkst. M-2, line 19)	455, 860	455, 8	455, 860	455, 860	7.00
8.00	Ratio of injection/infusion direct cost to total direct	0. 001546	0.0084	0. 000000	0.000000	8.00
	cost (line 5 divided by line 6)					
9.00	Overhead cost - injection/infusion (line 7 x line 8)	705	3, 8		0	9. 00
10. 00	Total injection/infusion costs and their administration	1, 276	6, 9	68 0	0	10. 00
44 00	costs (sum of lines 5 and 9)			20		44.00
	Total number of injections/infusions (from your records)	3		99 0	0	11.00
	Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	425. 33	70.			12. 00 13. 00
13.00	beneficiaries	l l	,	68 0	0	13.00
13. 01	Number of COVID-19 vaccine injections/infusions			0	0	13. 01
10.01	administered to MA enrollees				o o	10.01
14.00	Program cost of injections/infusions and their	425	4, 7	36 0	0	14.00
	administration costs (line 12 times the sum of lines 13					
	and 13.01, as applicable)					
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
				1.00	ADMI NI STRATI ON	
15 00	Total cost of injections/infusions and their administration	a seets (sum of	aalumna 1	1. 00	2. 00 8, 244	15. 00
15.00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		COLUMNIS I,		8, 244	15.00
16 00	Total Program cost of injections/infusions and their admini		(sum of		5 211	16. 00
10.00	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amour				5, 211	10.00
	121. 2 1, 2, 2, 0, 1, d. d. 2, 02, 1, 1, 0, 1, 1, (c. d. 1, 1) dilloui			ı	!	

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC		Peri od:	Worksheet M-4	
		Component (From 07/01/2022 To 06/30/2023	Date/Time Prep 1/25/2024 11:	
			XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	504, 001	504, 00		504, 001	1. 00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000226				
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	114	98	0	0	3. 00
. 00	Injections/infusions and related medical supplies costs (from your records)	2, 005	2, 22	0	0	4. 00
. 00	Direct cost of injections/infusions (line 3 plus line 4)	2, 119	3, 20	0	0	
. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	505, 303			·	
. 00	Total overhead (from Wkst. M-2, line 19)	610, 319	610, 31	9 610, 319	610, 319	7.00
. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 004194			0.000000	8.00
. 00	Overhead cost - injection/infusion (line 7 x line 8)	2, 560			0	9.00
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	4, 679	7, 08	0	0	
1.00	Total number of injections/infusions (from your records)	11		05	0	
2.00	Cost per injection/infusion (line 10/line 11)	425. 36	74. 5	0.00	0.00	12.0
3. 00	Number of injection/infusion administered to Program beneficiaries	5	ϵ	0 8	0	13.00
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2, 127	5, 07	71 0	0	14.00
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI ON	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		columns 1,		11, 764	15. 00
4 00	Total Program cost of injections/infusions and their admini	stration costs	(sum of		l 7 100	16.00

Health Financial Systems	MEMORIAL HOSP & HEA	LTH CARE CTR	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FO SERVICES RENDERED TO PROGRAM BENEFICIARIES	OHC PROVIDER FOR	Provider CCN: 15-0115 Component CCN: 15-8507	Peri od: From 07/01/2022 To 06/30/2023	Worksheet M-5 Date/Time Prepared:
		'		1/25/2024 11:51 am_

				1/25/2024 11: 5	51 a
			RHC I	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
.00 Tota	al interim payments paid to hospital-based RHC/FQHC			92, 473	1.
	erim payments payable on individual bills, either submit			0	2.
	contractor for services rendered in the cost reporting	period. If none, write			
	NE" or enter a zero				
	t separately each retroactive lump sum adjustment amount				3.
	sion of the interim rate for the cost reporting period.	Also show date of each			
	ment. If none, write "NONE" or enter a zero. (1)				
	ram to Provider		1		
01				0	3.
02				0	3.
03				0	3.
04				0	3.
05				0	3.
	rider to Program		1		
50				0	3.
51				0	3
52				0	3
53				0	3
54				0	3
	total (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3
	al interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		92, 473	4.
27)	E COMPLETED BY CONTRACTOR				
	E COMPLETED BY CONTRACTOR				_
	t separately each tentative settlement payment after des	sk review. Also show date of			5.
	n payment. If none, write "NONE" or enter a zero. (1)				
	ram to Provider		T		_
01				0	5
02				0	5
03	:			0	5
	ider to Program				-
50 51				0	5
				0	5
52	total (our of lines E O1 E 40 minus our of lines E E0 E	00)			5
	total (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			ا	5
	ermined net settlement amount (balance due) based on the	e cost report. (1)		7 /70	6
	FLEMENT TO PROVIDER			7, 678	6
	FLEMENT TO PROGRAM			100 151	6
00 Tota	al Medicare program liability (see instructions)		0	100, 151	7
			Contractor	NPR Date	
		0	Number	(Mo/Day/Yr)	
00 11-	of Contractor	0	1. 00	2. 00	_
00 Name	e of Contractor	WISCONSIN PHYSICIAN SERVICES	08001		8.

Health Financial Systems	MEMORIAL HOSP & HEALTH	I CARE CTR	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R SERVICES RENDERED TO PROGRAM BENEFICIARI	ES .	rovider CCN: 15-0115 omponent CCN: 15-8508	From 07/01/2022	Worksheet M-5 Date/Time Prepared: 1/25/2024 11:51 am

				1/25/2024 11: 5	51 aı
			RHC II	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			128, 226	1.
. 00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.
-	the contractor for services rendered in the cost reporting	period. If none, write			
] '	"NONE" or enter a zero				
	List separately each retroactive lump sum adjustment amount				3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	3.
02				0	3.
03				0	3
04				0	3
05				0	3
F	Provider to Program				
50				0	3
51				0	3
52				0	3
53				0	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		128, 226	4
	27)				
Т	TO BE COMPLETED BY CONTRACTOR				
	List separately each tentative settlement payment after des	k review. Also show date of			5
	each payment. If none, write "NONE" or enter a zero. (1)				
F	Program to Provider				
01				0	5
02				0	5
03				0	5
	Provider to Program				
50				0	5
51				0	5
52				0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5
00	Determined net settlement amount (balance due) based on the	cost report. (1)			6
01 :	SETTLEMENT TO PROVIDER	•		10, 126	6
02	SETTLEMENT TO PROGRAM			0	6
00	Total Medicare program liability (see instructions)			138, 352	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
		0	1.00	2.00	