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: 15-1334 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/31/2024 6:51 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/31/2024 6: 51 am Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SCOTT MEMORIAL HOSPITAL (15-1334) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Ada	am Kempf	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Adam Kempf			2
3	Signatory Title	SENIOR VP & CHIEF FINANCIAL OFFIC			3
4	Date	(Dated when report is electronica			4

			Title	Y\/			
		Title V	Part A	Part B	HLT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	300, 925	238, 265	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	398, 634	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		20		0	10.00
200.00	TOTAL	0	699, 559	238, 285	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 SCOTT MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1334 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 6:51 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1451 NORTH GARDNER 1.00 PO Box: 1.00 State: IN Zi p Code: 47170-2.00 Ci ty: SCOTTSBURG County: SCOTT 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 SCOTT MEMORIAL HOSPITAL 151334 99915 07/01/1966 Ν 0 0 3.00 Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 Subprovi der - (Other) 6.00 6.00 7 00 Swing Beds - SNF SCOTT MEMORIAL SWING 15Z334 99915 03/21/2013 N 0 N 7.00 BFDS 8.00 Swing Beds - NF 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospital -Based NF 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital -Based Health Clinic - RHC SCOTTSBURG FAMILY 158523 99915 l08/09/2017 0 0 15.00 N 15.00 PRACTI CE Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 2 00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for Ν 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 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 N 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 N 22 03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost

22.04

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

22.04 Did this hospital receive a geographic reclassification from urban to

yes or "N" for no.

"N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

Health Financial Systems SCOTT MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1334 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 6: 51 am 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Qualification Y/N Line # Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 N instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. IME Direct GME IME Direct GME 1. 00 2.00 3. 00 4. 00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61 02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	SCOTT I	MEMORIAL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: com 01/01/2023	Worksheet S-2 Part I	
			To		Date/Time Pre 5/31/2024 6:5	
			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovi der	Hospi tal	col. 2))	
			Si te 1.00	2. 00	3. 00	
Section 5504 of the ACA Base Yea						
period that begins on or after of the following seriod that begins on or after of the following seriod that the base year period, the number of the following seriod that the following seriod the following seriod that the follo	s yes, or your facili <sup>.</sup> nber of unweighted nom otations occurring in	ty trained residents n-primary care all nonprovider	0.00	0. 00	0. 000000	64.00
settings. Enter in column 2 the resident FTEs that trained in yo						
of (column 1 divided by (column	1 + column 2)). (see Program Name	instructions) Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
	11 Ogi alli Nallie	Trogram code	FTEs	FTEs in	3/ (col. 3 +	
			Nonprovi der Si te	Hospi tal	col. 4))	
	1. 00	2. 00	3.00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal		65. 00
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting				
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)	unweighted non-priman occurring in all nonpo unweighted non-priman cal. Enter in column ( column 2)). (see ins	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
(7.00   5.1   1.1   1.1   1.1	1. 00	2.00	3.00	4. 00	5. 00	(7.00
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00	0. 000000	67.00

Health Financial Systems SCOTT MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1334 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 6:51 am 1.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 68.00 68.00 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)? 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. 71.00 | If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for O 76.00 no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. N 80.00 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 "Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87.00 N 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Adiustment Permanent (Y/N)Adjustments 1.00 2.00 88. 00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target Ν amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments Effecti ve Wkst. A Line Approved No. Date Permanent Adjustment Amount Per Di scharge 3. 00 2.00 1.00 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0 00 0 89 00 on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per di scharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90.00 Υ Υ yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 91.00 91.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92.00 Υ 92.00 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. Ν Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν Ν applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 96.00 Ν Ν 96.00 applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 97.00 0.00 0.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	DATA	Provi der C	CN: 15-1334	Peri od:	u of Form CMS Worksheet S-	
	DATA.	Trovider of		From 01/01/2023 To 12/31/2023		epared
				V	XIX	
				1. 00	2. 00	
Does title V or XIX follow Medicare (title XVIII) for stepdown adjustments on Wkst. B, Pt. I, col. 25? En column 1 for title VIX	nter "Y" f			Y	Y	98.0
column 1 for title V, and in column 2 for title XIX 18.01 Does title V or XIX follow Medicare (title XVIII) for C, Pt. I? Enter "Y" for yes or "N" for no in column title XIX.	or the re				Y	98.0
28.02 Does title V or XIX follow Medicare (title XVIII) for bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for title V, and in column 2 for title XIX.	for the ca	lculation of r "N" for no	observation in column 1	Y	Y	98.0
Does title V or XIX follow Medicare (title XVIII) for reimbursed 101% of inpatient services cost? Enter " for title V, and in column 2 for title XIX.					N	98. (
18.04 Does title V or XIX follow Medicare (title XVIII) for outpatient services cost? Enter "Y" for yes or "N" in column 2 for title XIX.				N	N	98.0
18.05 Does title V or XIX follow Medicare (title XVIII) at Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" fo column 2 for title XIX.	nnd add ba or no in d	ck the RCE di column 1 for t	sallowance or itle V, and i	n Y	Y	98.0
P8.06 Does title V or XIX follow Medicare (title XVIII) with Pts. I through IV? Enter "Y" for yes or "N" for no column 2 for title XIX.				Y	Y	98. (
Rural Providers						
O5.00 Does this hospital qualify as a CAH? O6.00 If this facility qualifies as a CAH, has it elected for outpatient services? (see instructions)	the all-	inclusive met	hod of paymer	nt Y N		105. 106.
07.00 Column 1: If line 105 is Y, is this facility eligib training programs? Enter "Y" for yes or "N" for no Column 2: If column 1 is Y and line 70 or line 75	in column	1. (see ins	structions)	N		107.
approved medical education program in the CAH's exc Enter "Y" for yes or "N" for no in column 2. (see 07.01 If this facility is a REH (line 3, column 4, is "12	instructi ?"), is it	ons) eligible for	cost			107.
reimbursement for I&R training programs? Enter "Y" instructions)  08.00 s this a rural hospital qualifying for an exception	,		•	2 N		108.
CFR Section §412.113(c). Enter "Y" for yes or "N" for						
	_	Physi cal	Occupati ona		Respiratory	_
09.00  f this hospital qualifies as a CAH or a cost provi   therapy services provided by outside supplier? Ente		1. 00 Y	2. 00 N	3. 00 N	4. 00 N	109.
	i i					
for yes or "N" for no for each therapy.	:1 1					
	7				1. 00	
for yes or "N" for no for each therapy.	ry Hospita 1? Enter "	Y" for yes or	"N" for no.	If yes,	1. 00 N	110.
for yes or "N" for no for each therapy.  10.00 Did this hospital participate in the Rural Community Demonstration) for the current cost reporting period complete Worksheet E, Part A, lines 200 through 218	ry Hospita 1? Enter "	Y" for yes or	"N" for no.	If yes, ough 215, as	N	110.
for yes or "N" for no for each therapy.  10.00 Did this hospital participate in the Rural Community Demonstration) for the current cost reporting period complete Worksheet E, Part A, lines 200 through 218 applicable.	ry Hospi ta 1? Enter " 3, and Wor	Y" for yes or ksheet E-2, I	"N" for no. ines 200 thro	1.00		
for yes or "N" for no for each therapy.  10.00 Did this hospital participate in the Rural Community Demonstration) for the current cost reporting period complete Worksheet E, Part A, lines 200 through 218 applicable.  11.00 If this facility qualifies as a CAH, did it participate Health Integration Project (FCHIP) demonstration for "Y" for yes or "N" for no in column 1. If the responsintegration prong of the FCHIP demo in which this CEnter all that apply: "A" for Ambulance services; "Integration prong of the FCHIP demo in which this CENTER and The Position Professional Communication Profession Profe	pate in torthis counse to co	Y" for yes or ksheet E-2, I he Frontier (st reporting Jumn 1 is Y, ticipating ir	community period? Enter the column 2.	If yes, bugh 215, as	N	110.
for yes or "N" for no for each therapy.  10.00 Did this hospital participate in the Rural Community Demonstration) for the current cost reporting period complete Worksheet E, Part A, lines 200 through 218 applicable.  11.00 If this facility qualifies as a CAH, did it particily Health Integration Project (FCHIP) demonstration for "Y" for yes or "N" for no in column 1. If the respondintegration prong of the FCHIP demo in which this C.	pate in torthis counse to co	Y" for yes or ksheet E-2, I he Frontier (st reporting Jumn 1 is Y, ticipating ir	Community period? Enter enter the column 2. s; and/or "C"	If yes, bugh 215, as	N 2. 00	
for yes or "N" for no for each therapy.  10.00 Did this hospital participate in the Rural Community Demonstration) for the current cost reporting period complete Worksheet E, Part A, lines 200 through 218 applicable.  11.00 If this facility qualifies as a CAH, did it participate Health Integration Project (FCHIP) demonstration foor "Y" for yes or "N" for no in column 1. If the responsintegration prong of the FCHIP demo in which this Caute all that apply: "A" for Ambulance services; "I for tele-health services.	pate in to conserve to conserve according to	Y" for yes or ksheet E-2, I he Frontier (est reporting of umn 1 is Y, ticipating ir ditional beds	Community period? Enter enter the column 2. g; and/or "C"	If yes, bugh 215, as	N	111.
for yes or "N" for no for each therapy.  0.00 Did this hospital participate in the Rural Community Demonstration) for the current cost reporting period complete Worksheet E, Part A, lines 200 through 218 applicable.  1.00 If this facility qualifies as a CAH, did it participate the latter that the line of the responsion of the responsion of the FCHIP) demonstration for "Y" for yes or "N" for no in column 1. If the responsion tegration prong of the FCHIP demo in which this C. Enter all that apply: "A" for Ambulance services; "I for tele-health services.  2.00 Did this hospital participate in the Pennsylvania R (PARHM) demonstration for any portion of the curren period? Enter "Y" for yes or "N" for no in column "Y", enter in column 2, the date the hospital began	pate in to conserve account of the conserve account of	Y" for yes or ksheet E-2, I he Frontier (st reporting ulumn 1 is Y, ticipating ir ditional beds th Model porting ulumn 1 is pating in the	Community period? Enter enter the column 2. s; and/or "C"	If yes, bugh 215, as	N 2. 00	111.
for yes or "N" for no for each therapy.  0.00 Did this hospital participate in the Rural Community Demonstration) for the current cost reporting period complete Worksheet E, Part A, lines 200 through 218 applicable.  1.00 If this facility qualifies as a CAH, did it participate the line of the least the	pate in to conserve account of the conserve account of	Y" for yes or ksheet E-2, I he Frontier (st reporting ulumn 1 is Y, ticipating ir ditional beds th Model porting ulumn 1 is pating in the	Community period? Enter enter the column 2. g; and/or "C"	If yes, bugh 215, as	N 2. 00	1111.
for yes or "N" for no for each therapy.  0.00 Did this hospital participate in the Rural Community Demonstration) for the current cost reporting period complete Worksheet E, Part A, lines 200 through 218 applicable.  1.00 If this facility qualifies as a CAH, did it participed Health Integration Project (FCHIP) demonstration foour "Y" for yes or "N" for no in column 1. If the responsintegration prong of the FCHIP demoin which this Canter all that apply: "A" for Ambulance services; "I for tele-health services.  2.00 Did this hospital participate in the Pennsylvania R (PARHM) demonstration for any portion of the current period? Enter "Y" for yes or "N" for no in column "Y", enter in column 2, the date the hospital began demonstration. In column 3, enter the date the hospital began demonstration in the demonstration, if applicable. Miscellaneous Cost Reporting Information	pate in to this conse to conse	Y" for yes or ksheet E-2, I he Frontier (st reporting of the st reporting of the st reporting of the st reporting of the st reporting of the state o	Community period? Enter enter the column 2. g; and/or "C"	If yes, bugh 215, as	2. 00 3. 00	111.
for yes or "N" for no for each therapy.  10.00 Did this hospital participate in the Rural Community Demonstration) for the current cost reporting period complete Worksheet E, Part A, lines 200 through 218 applicable.  11.00 If this facility qualifies as a CAH, did it participe Health Integration Project (FCHIP) demonstration for "Y" for yes or "N" for no in column 1. If the responsintegration prong of the FCHIP demoin which this Content all that apply: "A" for Ambulance services; "Infortele-health services.  12.00 Did this hospital participate in the Pennsylvania Responsive tele-health services.  12.00 Did this hospital participate in the Pennsylvania Responsive tele-health services.  13.00 Did this hospital participate in the Pennsylvania Responsive tele-health services.  14.00 Did this hospital participate in the Pennsylvania Responsive tele-health services.  15.00 Did this hospital participate in the Pennsylvania Responsive tele-health services.  16.00 Did this hospital participate in the Pennsylvania Responsive tele-health services.  16.00 Did this hospital participate in the Pennsylvania Responsive tele-health services.  17.00 Did this hospital participate in the Pennsylvania Responsive tele-health services.  18.00 Did this hospital participate in the Pennsylvania Responsive tele-health services; "Interview teleponsylvania Responsive teleponsive t	pate in to this counse to compare in the counse of the c	Y" for yes or ksheet E-2, I he Frontier (st reporting of the state of	community period? Enter enter the column 2. grand/or "C"	If yes, bugh 215, as	2. 00 3. 00	1111.
for yes or "N" for no for each therapy.  10.00 Did this hospital participate in the Rural Community Demonstration) for the current cost reporting period complete Worksheet E, Part A, lines 200 through 218 applicable.  11.00 If this facility qualifies as a CAH, did it participed Health Integration Project (FCHIP) demonstration foour "Y" for yes or "N" for no in column 1. If the responsintegration prong of the FCHIP demoin which this Content all that apply: "A" for Ambulance services; "I for tele-health services.  12.00 Did this hospital participate in the Pennsylvania Responsive to the current period? Enter "Y" for yes or "N" for no in column "Y", enter in column 2, the date the hospital begand demonstration. In column 3, enter the date the hospital participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information  15.00 Is this an all-inclusive rate provider? Enter "Y" for in column 1. If column 1 is yes, enter the method us in column 2. If column 2 is "E", enter in column 3 for short term hospital or "98" percent for long te psychiatric, rehabilitation and long term hospitals	pate in to this conse to conse	Y" for yes or ksheet E-2, I he Frontier (st reporting of the standard provided the stand	Community period? Enter enter the column 2. grand/or "C"  1.00  N	If yes, bugh 215, as	2. 00 3. 00	

Health Financial Systems	SCOTT MEMORIAL	HOSPI TAL		In Lieu	ı of Form CM	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	NTIFICATION DATA	Provider CCM		Peri od: From 01/01/2023 To 12/31/2023	Worksheet S Part I Date/Time F	6-2 Prepared:
			Premi ums	Losses	5/31/2024 6 Insurance	
110 011	d ==: d   =====		1. 00	2.00	3. 00	0110 01
118.01 List amounts of malpractice premiums an	u paru rosses:		83, 44	¥7 U		0118.01
110 00 Are melaration promisms and said League	a ranantad in a coat o	onton othon t	bon the	1. 00 N	2. 00	110.00
118.02 Are mal practice premiums and paid losse Administrative and General? If yes, su and amounts contained therein.				N		118. 02
119.00D0 NOT USE THIS LINE 120.00	nstructions) Enter in th < 100 beds that qua d applicable amendment	column 1, "Y" lifies for th	for yes or ne Outpatient		N	119. 00 120. 00
121.00 Did this facility incur and report cost patients? Enter "Y" for yes or "N" for		table devices	charged to	Y		121. 00
122.00 Does the cost report contain healthcare Act?Enter "Y" for yes or "N" for no in	related taxes as defi column 1. If column 1					122. 00
the Worksheet A line number where these 123.00 Did the facility and/or its subprovider services, e.g., legal, accounting, tax management/consulting services, from an for yes or "N" for no.	s (if applicable) purc preparation, bookkeepi	ng, payroll,	and/or	N		123. 00
If column 1 is "Y", were the majority o professional services expenses, for ser located in a CBSA outside of the main h "N" for no.	vices purchased from u	nrelated orga	ıni zati ons			
Certified Transplant Center Information 125.00 Does this facility operate a Medicare-c		ntor2 Entor "	V" for yes	N		125. 00
and "N" for no. If yes, enter certifica	tion date(s) (mm/dd/yy	yy) below.	,			
126.00  f this is a Medicare-certified kidney in column 1 and termination date, if ap		ter the certi	fication dat	:e		126. 00
127.00 If this is a Medicare-certified heart t	ransplant program, ent	er the certif	ication date			127. 00
in column 1 and termination date, if ap 128.00  f this is a Medicare-certified liver t		er the certif	ication date	,		128. 00
in column 1 and termination date, if ap	plicable, in column 2.					
129.00 If this is a Medicare-certified lung tr in column 1 and termination date, if ap		r the certifi	cation date			129. 00
130.00 If this is a Medicare-certified pancrea	s transplant program,		ti fi cati on			130. 00
date in column 1 and termination date, 131.00 If this is a Medicare-certified intesti			erti fi cati or	1		131. 00
date in column 1 and termination date,	if applicable, in colu	mn 2.				122.00
132.00  f this is a Medicare-certified islet t in column 1 and termination date, if ap		er the certifi	ication date	;		132.00
133.00 Removed and reserved 134.00 If this is a hospital-based organ procu	romont organization (O	PO) optor th	o OPO numbor			133. 00 134. 00
in column 1 and termination date, if ap			ie or o riumber			134.00
All Providers  140.00 Are there any related organization or h	oma offica costs as de	fined in CMS	Dub 15_1	Υ	HB0616	140. 00
chapter 10? Enter "Y" for yes or "N" fo are claimed, enter in column 2 the home	r no in column 1. If y office chain number.	es, and home	office costs	5	TIBOOTO	140.00
1.00  If this facility is part of a chain org	2.00 anization, enter on li	nes 141 throu	ugh 143 the r	3.00 name and address	of the home	
office and enter the home office contra	ctor name and contract Contractor's Name: CGS	or number.	Contracto	or's Number: 1510	1	141. 00
	PO Box:		Contracto	or 3 Number, 1310	1	142.00
143. 00 Ci ty: LOUI SVI LLE	State: KY		Zi p Code:	4020	2	143. 00
					1. 00	
144.00 Are provider based physicians' costs in	cluded in Worksheet A?				Υ	144. 00
				1.00	2. 00	
145.00 If costs for renal services are claimed inpatient services only? Enter "Y" for no, does the dialysis facility include	yes or "N" for no in c Medicare utilization f	olumn 1. If c	olumn 1 is			145. 00
period? Enter "Y" for yes or "N" for n 146.00Has the cost allocation methodology cha Enter "Y" for yes or "N" for no in colu yes, enter the approval date (mm/dd/yyy	nged from the previous mn 1. (See CMS Pub. 15			N		146. 00

Health Financial Systems	SCOTT MEMOR	RLAL HOSPLTAL		In	_ieu of Form CMS	5-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DATA	Provi der CC	CN: 15-1334	Period: From 01/01/20 To 12/31/20		repared:
					1. 00	_
147.00 Was there a change in the statist	ical basis? Enter "Y" fo	or ves or "N" for	no		1.00 N	147. 00
148.00Was there a change in the order o					N	148. 00
149.00 Was there a change to the simplif				or no.	N	149.00
-	-	Part A	Part B	Title V	Title XIX	
		1. 00	2. 00	3. 00	4.00	
Does this facility contain a provor charges? Enter "Y" for yes or						
155. 00 Hospi tal		Y	Y	N	N	155. 00
156.00 Subprovi der - IPF		N	N N	N	N	156. 00
157.00 Subprovi der - IRF		N	N N	N	N	157. 00
158. 00 SUBPROVI DER						158. 00
159. 00 SNF		N	N N	N	N	159.00
160.00 HOME HEALTH AGENCY 161.00 CMHC		N	N N	N	N	160.00
181. OUJCMING			<u>N</u>	N	N	161. 00
I					1. 00	
Mul ti campus						
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has	one or more camp	uses in dif	Terent CBSAs?	N	165. 00
Enter 4 for yes of N for no.	Name	County	State 2	Zip Code   CBS	A FTE/Campus	
	0	1. 00	2.00	3.00 4.0		
166.00 If line 165 is yes, for each		11.00	2.00	0.00		00 166. 00
campus enter the name in column						
0, county in column 1, state in						
column 2, zip code in column 3,						
CBSA in column 4, FTE/Campus in						
column 5 (see instructions)						
					1.00	_
Health Information Technology (HI	T) incentive in the Amer	ri can Recovery ar	nd Reinvestm	ment Act	1.00	
167.00 Is this provider a meaningful use					Υ	167. 00
168.00 If this provider is a CAH (line 1	05 is "Y") and is a mear	ningful user (lin	e 167 is "Y	"), enter the		168.00
reasonable cost incurred for the						
168.01 If this provider is a CAH and is	not a meaningful user, c	does this provide	r qualify f	or a hardship		168. 01
exception under §413.70(a)(6)(ii)						001/0 00
169.00 If this provider is a meaningful transition factor. (see instructi		and is not a CAH	(Tine 105 I	s N), enter	tne U.	00169.00
transition ractor. (see instructi	ons)			Begi nni n	g Ending	
				1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR	beginning date and endir	ng date for the r	eporti ng		2.00	170. 00
period respectively (mm/dd/yyyy)						
				1.00	2. 00	
171.00 If line 167 is "Y", does this pro	vider have any days for	individuals enro	lledin	N		0 171.00
section 1876 Medicare cost plans						
"Y" for yes and "N" for no in col		es, enter the num	ber of sect	ion		
1876 Medicare days in column 2. (	see mstructions)			I	I	I

Health Financial Systems SCOTT MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1334 Peri od: Worksheet S-2 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/31/2024 6:51 am Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 N 2 00 yes, enter in column 2 the date of termination and in column  $\hat{\textbf{3}},$  "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Α 12/31/2022 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5.00 Ν those on the filed financial statements? If yes, submit reconciliation Legal Oper. Y/N 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 N 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? Υ 04/16/2024 Υ 04/16/2024 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for 17.00 N N 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 18.00 Ν N Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE  Provider CCN: 15-1334   Period: From 01/01/2023 To 12/31/2023   Description		-2552-10
0 1.00		epared:
	Y/N	
20 00 H.S. Line 1/ am 17 in the mile of the DCCD	3.00	20.00
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N	20.00
Y/N Date Y/N	Date	
1.00 2.00 3.00	4. 00	
21.00 Was the cost report prepared only using the provider's N N records? If yes, see instructions.		21. 00
	1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)	1.00	
Capital Related Cost		
22.00 Have assets been relifed for Medicare purposes? If yes, see instructions	N	22. 00
23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost	N	23. 00
reporting period? If yes, see instructions.		1
24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period?	N	24.00
25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see	N	25. 00
instructions.	1	
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see	N	26. 00
instructions.		07.00
27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27. 00
Interest Expense		
28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting	N	28. 00
period? If yes, see instructions.		
29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)	N	29. 00
treated as a funded depreciation account? If yes, see instructions	, N	20.00
30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
Purchased Services		
32.00 Have changes or new agreements occurred in patient care services furnished through contractual	N	32.00
arrangements with suppliers of services? If yes, see instructions.		
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? I	T .	33.00
no, see instructions. Provider-Based Physicians		
34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians	57 Y	34.00
If yes, see instructions.		
2E 00 If line 24 is yes, were there now agreements or availed suitiful agreements with the continuous	N	35. 00
	D-+-	
physicians during the cost reporting period? If yes, see instructions.	Date 2.00	
physicians during the cost reporting period? If yes, see instructions.  Y/N	2.00	
physicians during the cost reporting period? If yes, see instructions.  Y/N  1.00	T	36.00
physicians during the cost reporting period? If yes, see instructions.  Y/N  1.00  Home Office Costs		36. 00 37. 00
physicians during the cost reporting period? If yes, see instructions.  Y/N  1.00  Home Office Costs  36.00 Were home office costs claimed on the cost report?  37.00 If line 36 is yes, has a home office cost statement been prepared by the home office?  If yes, see instructions.	40 (05 (222	37.00
physicians during the cost reporting period? If yes, see instructions.  Y/N  1.00  Home Office Costs  36.00 Were home office costs claimed on the cost report?  Y  Y  If line 36 is yes, has a home office cost statement been prepared by the home office?  If yes, see instructions.  Were home office costs claimed on the cost report?  Y  If line 36 is yes, was the fiscal year end of the home office different from that of N	12/31/2022	1
physicians during the cost reporting period? If yes, see instructions.  Y/N  1.00  Home Office Costs  36.00 Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been prepared by the home office?  If yes, see instructions.  38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	12/31/2022	37. 00 38. 00
physicians during the cost reporting period? If yes, see instructions.  Y/N  1.00  Home Office Costs  36.00 Were home office costs claimed on the cost report?  Y  Y  Y  If line 36 is yes, has a home office cost statement been prepared by the home office?  If yes, see instructions.  W  If line 36 is yes, was the fiscal year end of the home office different from that of N	12/31/2022	37.00
physicians during the cost reporting period? If yes, see instructions.  Y/N  1.00  Home Office Costs  Were home office costs claimed on the cost report?  Y If line 36 is yes, has a home office cost statement been prepared by the home office?  If yes, see instructions.  38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.  39.00 If line 36 is yes, did the provider render services to other chain components? If yes,	12/31/2022	37. 00 38. 00
physicians during the cost reporting period? If yes, see instructions.  Y/N  1.00  Home Office Costs  Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been prepared by the home office?  If yes, see instructions.  38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.  39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	12/31/2022	37. 00 38. 00 39. 00
physicians during the cost reporting period? If yes, see instructions.  Y/N  1.00  Home Office Costs  36.00 Were home office costs claimed on the cost report?  17 If line 36 is yes, has a home office cost statement been prepared by the home office?  18 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.  19 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  10 If line 36 is yes, did the provider render services to the home office? If yes, see Instructions.		37. 00 38. 00 39. 00
physicians during the cost reporting period? If yes, see instructions.  Y/N  1.00  Home Office Costs  36.00 Were home office costs claimed on the cost report?  Y If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.  38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.  39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N instructions.	12/31/2022	37. 00 38. 00 39. 00
physicians during the cost reporting period? If yes, see instructions.  Y/N  1.00  Home Office Costs  36.00 Were home office costs claimed on the cost report?  17.00 If line 36 is yes, has a home office cost statement been prepared by the home office?  18.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.  18.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  40.00 If line 36 is yes, did the provider render services to the home office? If yes, see instructions.  18.00 If line 36 is yes, did the provider render services to the home office? If yes, see Instructions.		37. 00 38. 00 39. 00 40. 00
physicians during the cost reporting period? If yes, see instructions.  Y/N  1.00  Home Office Costs  36.00 Were home office costs claimed on the cost report?  Y If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.  38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.  39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.  40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N instructions.		37. 00 38. 00 39. 00
physicians during the cost reporting period? If yes, see instructions.    Y/N   1.00		37. 00 38. 00 39. 00 40. 00
physicians during the cost reporting period? If yes, see instructions.    Y/N   1.00		37. 00 38. 00 39. 00 40. 00
physicians during the cost reporting period? If yes, see instructions.    Y/N   1.00	.00	37. 00 38. 00 39. 00 40. 00

Heal th	Financial Systems SCOTT MEN	10RI	AL HOSPITAL	In Lieu	of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1334	riod: om 01/01/2023 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/31/2024 6:5	pared:
			3.00			
	Cost Report Preparer Contact Information					
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3 respectively.		SENI OR MANAGER			41.00
42. 00	Enter the employer/company name of the cost report preparer.					42.00
43. 00	Enter the telephone number and email address of the cospeport preparer in columns 1 and 2, respectively.	st				43. 00

| Period: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: 
 Health Financial
 Systems
 SCOTT N

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 15-1334

Component   Worksheet A   No. of Beds   Bed Days   CAH/REH Hours   Title V   Trips					Т	o 12/31/2023	Date/Time Pre 5/31/2024 6:5	
Component   Worksheet A   No. of Beds   Bed Days Available   CAH/REH Hours   Trips								ı aiii
Component   Worksheet A   No. of Bods   Bod Days Available   CAH/REH Hours   Title V								
Component								
Description   Line No.   Available   Record   Line No.   Line No		Component	Worksheet A	No. of Beds	Bed Davs	CAH/REH Hours		
PART I - STATISTICAL DATA   1.00   1.00   8 exclude Swing Bed, Observation Bed and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)   2.00   1.00		'	Li ne No.					
1.00   Hospital Adults & Peds. (columns 5, 6, 7 and 8   8 exclude Swing Bed. Observation Bed and Hospice days) (see instructions for col. 2   7, 665   19,536.00   0   1,00			1. 00	2.00	3.00	4. 00	5. 00	
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		PART I - STATISTICAL DATA						
Hospice days) (see instructions for col. 2	1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	21	7, 665	19, 536. 00	0	1.00
For the portion of LDP room available beds) 3.00 HM0 IPF Subprovi der 4.00 H0.0 HM0 IPF Subprovi der 5.00 H0.00 H0.01 IPF Subprovi der 5.00 H0.00 H0.01 IPF Subprovi der 6.00 H0.01 IPF Subprovi der 7.00 H0.00 H0.01 IPF Subprovi der 7.00 H0.00 H0.01 IPF Subprovi der 8.00 Total Adult sa Peds. Swing Bed SNF 9.00 Total Adult sa Peds. Swing Bed SNF 9.00 HTERSI VE CARE UNIT 10.00 H0.00 H0		8 exclude Swing Bed, Observation Bed and						
2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 4.00 HM0 IRF Subprovider 6.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Hds) (see instructions) 8.00 INTERNIVE CARE UNIT 9.00 CORNARY CARE UNIT 11.00 SUBROVIDER SUBSECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 Color of the subsection		Hospice days)(see instructions for col. 2						
3.00 HM0 IPF Subprovider 4.00 HM0 IPF Subprovider 5.00 Hospi tal Adult is & Peds. Swing Bed SNF 6.00 Hospi tal Adult is & Peds. Swing Bed NF 7.00 Total Adult sand Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 COROMARY CARE UNIT 11.00 SURRICAL INTENSIVE CARE UNIT 11.00 SURRICAL INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 43.00 15.00 CAH visits 0 CAH visits 0 0.00 CAH visits 0 0.00 CAH visits 0 0.00 ONDERPOVIDER - IPF 18.00 SUBPROVIDER - IPF 19.00 SKILLED NURSING FACILITY 19.00 SKILLED NURSING FACILITY 19.00 SWILLED NURSING FACILITY 20.00 ONDER LEATH AGENCY 20.00 HOSPICE 20.00 HOME HEALTH AGENCY 21.00 OFFICE 22.00 HOME HEALTH AGENCY 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SWIGICAL CENTER (D.P.) 24.00 CAHC - CUHC 25.00 CAHC - CUHC 26.00 REAL HEALTH CLINIC 27.00 CONSPICE 28.00 ONDER - IPF 29.00 SWILLED NURSING FACILITY 29.00 SWILLED NURSING FACILITY 29.00 ONDER LEATH AGENCY 29.00 HOSPICE 20.00 HOME HEALTH AGENCY 20.00 HOSPICE 20.00 HOME HEALTH AGENCY 20.00 AMBULATORY SWIGICAL CENTER (D.P.) 24.00 CAHC - CUHC 25.00 CAHC - CUHC 26.00 RURAL HEALTH CLINIC 27.00 CAHC - CUHC 28.00 ONDER - IPF 29.00 SWILLED NURSING FACILITY 30.00 SWIGH CANDER - IPF 30.00 SWILLED NURSING FACILITY 30.00 SWILLED NURS		for the portion of LDP room available beds)						
4.00   HMD I RF Subprovider   5.00   Hospit tal Adult s & Peds. Swing Bed NF   0   6.00   Hospit tal Adult s & Peds. Swing Bed NF   0   6.00   6.00   Hospit tal Adult s & Peds. Swing Bed NF   0   6.00   6.00   7.00   Total Adult s and Peds. (exclude observation beds) (see Instructions)   17,976.00   17,								
5.00		•						
6.00   Hospital Adults & Peds. Swing Bed NF   Total Adults and Peds. (exclude observation beds) (see instructions)   21   7, 665   19,536.00   7.00		•						
Total Adults and Peds. (exclude observation beds) (see instructions)								
beds  (see instructions)							_	
8. 00   INTENSIVE CARE UNIT   31. 00   4   1,460   17,976. 00   0   8. 00   CORONARY CARE UNIT   9.00   10. 00   50RN INTENSIVE CARE UNIT   11. 00   11. 00   SURRI CAL INTENSIVE CARE UNIT   11. 00   11. 00   11. 00   SURRI CAL INTENSIVE CARE UNIT   12. 00   11. 00   11. 00   11. 00   12. 00   11. 00   11. 00   12. 00   12. 00   13. 00   14. 00   14. 00   14. 00   15. 00   14. 00   15. 00	7. 00	`		21	7, 665	19, 536. 00	0	7. 00
9.00   CORONARY CARE UNIT   9.00   BURN INTENSIVE CARE UNIT   11.00   BURN INTENSIVE CARE UNIT   11.00   11.00   SURGICAL INTENSIVE CARE UNIT   12.00   11.00		1 ' '						
10.00   BURN INTENSIVE CARE UNIT     10.00   11.00   12.00   13.00   13.00   13.00   14.00   15.00		I I	31. 00	4	1, 460	17, 976. 00	0	
11.00   SURGICAL INTENSIVE CARE UNIT   12.00   OTHER SPECIAL CARE (SPECIFY)   12.00   OTHER SPECIAL CARE (SPECIFY)   12.00   13.00   NURSERY   43.00   14.00   Total (see instructions)   25   9,125   37,512.00   0   14.00   15.00								
12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 43.00 15.00 CAH visits 0 CAH visits 0 0.00 SUBPROVIDER - IPF 15.10 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 20.00 HOME HEALTH AGENCY 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.10 HOSPICE 24.00 HOSPICE (non-distinct part) 25.00 CMRC - CMHC 26.00 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee discount days (see instructions) 32.01 Total ancillary labors & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 30.01 LTCH site neutral days and discharges		· ·						
13. 00 NURSERY 14.00 Total (see instructions) 15. 00 CAH visits 15. 00 CAH visits 15. 00 CAH visits 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMRC - CMHC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instructions) 32. 01 Employee discount days (see instructions) 33. 00 LTCH non-covered days 33. 00 LTCH site neutral days and discharges		· ·						
14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 9, 125 27. 00 TOTAL (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 20. 00 Labor & delivery days (see instruction) 31. 00 Employee di scount days - IRF 32. 01 LTCH non-covered days 33. 00 LTCH site neutral days and discharges							_	
15. 00 CAH visits		· ·	43. 00				_	
15. 10 REH hours and visits 10. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPICE 24. 10 HOSPICE 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 31. 00 Empl oyee discount days - IRF 32. 00 Labor & delivery days (see instruction) 31. 00 Empl oyee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 30. 00 31. 01 LTCH non-covered days and discharges		,		25	9, 125	37, 512. 00		
16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPICE (non-distinct part) 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Observation Bed Days 28. 00 Observation Bed Days 29. 00 Ambul ancer Trips 29. 00 Ambul ancer Trips 29. 00 Simple oped discount days (see instruction) 30. 00 Simple oped discount days - IRF 30. 00 Simple oped discount days (see instructions) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH site neutral days and discharges								
17. 00   SUBPROVIDER - IRF   17. 00   18. 00   SUBPROVIDER     18. 00   18. 00   SUBPROVIDER   19. 00   SKILLED NURSING FACILITY   20. 00   NURSING FACILITY   20. 00   20. 00   21. 00   21. 00   21. 00   22. 00   22. 00   40. MBULATORY SURGICAL CENTER (D.P.)   23. 00   24. 00   40. MBULATORY SURGICAL CENTER (D.P.)   24. 00   24. 10   40. MBULATORY SURGICAL CENTER (D.P.)   24. 10   25. 00   26. 25   27. 00   28. 00		l e				0.00	0	
18. 00   SUBPROVI DER   18. 00   19. 00   SVILLED NURSI NG FACILITY   19. 00   20. 00   19. 00   20. 0								
19. 00								
20.00   NURSING FACILITY   20.00   21.00   OTHER LONG TERM CARE   21.00   22.00   AMBULATORY SURGICAL CENTER (D.P.)   23.00   24.00   HOSPICE   24.10   25.00   24.10   HOSPICE   25.00   24.10   25.00   26.25   EDERALLY QUALIFIED HEALTH CENTER   89.00   26.25   EDERALLY QUALIFIED HEALTH CENTER   89.00   25.00   28.00   29.00		l e						
21.00 OTHER LONG TERM CARE  22.00 HOME HEALTH AGENCY  23.00 AMBULATORY SURGICAL CENTER (D.P.)  24.00 HOSPICE  24.10 HOSPICE (non-distinct part)  25.00 CMHC - CMHC  26.00 RURAL HEALTH CLINIC  26.25 FEDERALLY QUALIFIED HEALTH CENTER  27.00 Total (sum of lines 14-26)  28.00 Observation Bed Days  29.00 Ambulance Trips  30.00 Employee discount days (see instruction)  31.00 Employee discount days (see instructions)  32.00 Labor & delivery days (see instructions)  33.00 LTCH non-covered days  33.00 LTCH non-covered days and discharges  21.00  22.00  22.00  23.00  24.10  25.00  26.00  27.00  28.00  29.00  20.00		I I						
22.00 23.00		l e						
23. 00								
24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 Total (sum of lines 14-26) 27.00 Observation Bed Days 29.00 Ambulance Trips 30.00 26.25 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges								
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 00 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 33. 01  24. 10 25. 00 26. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 30. 00								
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges			20.00					
26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 00 33. 01 LTCH site neutral days and discharges			30.00					
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89.00  27. 00 Total (sum of lines 14-26)  28. 00 Observation Bed Days  29. 00 Ambul ance Trips  30. 00 Employee discount days (see instruction)  31. 00 Employee discount days - IRF  32. 00 Labor & delivery days (see instructions)  32. 01 Total ancillary labor & delivery room outpatient days (see instructions)  33. 00 LTCH non-covered days  33. 00 LTCH site neutral days and discharges		I I	88 00				0	
27.00   Total (sum of lines 14-26)   25   27.00   28.00   28.00   29.00   Ambulance Trips   29.00   29		· ·						
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 30.00 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges		i i	07.00	25			Ŭ	
29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 30.00 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges		1 '		20			0	
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges							Ŭ	
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges		•						
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges								
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges  32.01 33.01				n	0			
outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 33.01		, , , , , , , , , , , , , , , , , , ,						
33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 33.01								
33.01 LTCH site neutral days and discharges 33.01	33.00			•				33.00
		3						
	34.00		30.00	0	0		0	34.00

Health Financial SystemsSCOTT MHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1334 Period: Worksheet S-3 From 01/01/2023 Part I

					o 12/31/2023	Date/Time Pre	
						5/31/2024 6: 5	1 am
		I/P Days	/ O/P Visits	/ Tri ps	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	Component	II the Aviii	II LIE 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	334	14	814			1.00
	8 exclude Swing Bed, Observation Bed and			0			
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	273	259				2.00
3.00	HMO IPF Subprovider	o	o				3.00
4.00	HMO IRF Subprovider	o	o				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	420	o	893			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		o	194			6.00
7.00	Total Adults and Peds. (exclude observation	754	14	1, 901			7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	5	1	749			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		0	0			13.00
14.00	Total (see instructions)	759	15	2, 650	0. 00	163. 11	14.00
15. 00	CAH visits	0	0	0			15. 00
15. 10	REH hours and visits	0	0	0			15. 10
16. 00	SUBPROVI DER - I PF						16.00
17. 00							17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24. 00
24. 10				0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	419	156	2, 084	0. 00	5. 08	1
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0. 00	0.00	1
27. 00	, ,				0. 00	168. 19	
28. 00	Observation Bed Days		30	431			28. 00
29. 00		0		_			29.00
30.00	Employee discount days (see instruction)			0			30.00
31. 00				0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 01				0			32. 01
	outpatient days (see instructions)	1				l	1

33.00 33.01

34.00

outpatient days (see instructions) 33.00 LTCH non-covered days
33.01 LTCH site neutral days and discharges

34.00 Temporary Expansi on COVID-19 PHE Acute Care

 
 Health Financial
 Systems
 SCOTT N

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provi der CCN: 15-1334

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared:

				10	) 12/31/2023	Date/IIMe Pre   5/31/2024 6:5	
		Full Time		Di sch	arges	7 0 7 0 17 202 1 0 1 0	
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	T	11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	141	6	317	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)			91	E4		2.00
2. 00 3. 00	HMO and other (see instructions)			91	54 0		3.00
4. 00	HMO I PF Subprovi der				0		4.00
5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				٩		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8.00
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	141	6	317	
15. 00	CAH visits		_		]		15. 00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0.00					26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions)			0			33.00
33. 00	LTCH non-covered days LTCH site neutral days and discharges			0			33.00
34. 00	, ,			U			34.00
34.00	Tremporary Expansion Covid-19 PRE Acute Care						J 34. 00

Health Financial Systems SCOTT MEMOR		ON 15 1004		eu of Form CMS	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provi der C	CN: 15-1334	Peri od: From 01/01/2023	Worksheet S-	8
	Component	CCN: 15-8523	To 12/31/2023	B Date/Time Pr	
			RHC I	5/31/2024 6: Cost	51 am
			KHC I	Lost	
			1	. 00	
Clinic Address and Identification					
1.00   Street	7 6:		1465 NORTH GAI	1	1.0
		00	State 2.00	ZIP Code 3.00	
2.00 City, State, ZIP Code, County	SCOTTSBURG	00		47170	2.0
	•				
				1.00	
3.00   HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for ru	ral or "U" for		nt Award	Date	3.0
		Gi ai	1. 00	2.00	
Source of Federal Funds				1 2:00	
4.00 Community Health Center (Section 330(d), PHS Act)					4.0
5.00 Migrant Health Center (Section 329(d), PHS Act)					5.0
6.00   Health Services for the Homeless (Section 340(d), PHS Act 7.00   Appalachian Regional Commission	)				6. 0 7. 0
8.00 Look-Alikes					8.0
9.00 OTHER (SPECIFY)					9. 0
10.00 Does this facility operate as other than a hospital-based	DUC on FOUCA F	nton "V" for	1. 00 N	2.00	10.0
10.00 Does this facility operate as other than a hospital-based yes or "N" for no in column 1. If yes, indicate number of				,	10.0
2. (Enter in subscripts of line 11 the type of other opera					
hours.)					
	nday		londay	Tuesday	
from 1.00	2. 00	from 3.00	4. 00	from 5.00	
Facility hours of operations (1)	2.00	3.00	4.00	J 5. 00	
11. 00 CLINIC		08: 30	17: 00	08: 30	11.0
			1.00		
12 00 Have you received an approval for an evention to the pro	duativi tv atand			2. 00	12.0
12.00 Have you received an approval for an exception to the pro			N		
12.00 Have you received an approval for an exception to the pro 13.00 Is this a consolidated cost report as defined in CMS Pub. 30.8? Enter "Y" for yes or "N" for no in column 1. If yes	100-04, chapte	r 9, section	N		
13.00 Is this a consolidated cost report as defined in CMS Pub. 30.8? Enter "Y" for yes or "N" for no in column 1. If yes number of providers included in this report. List the nam	100-04, chapte , enter in colu	r 9, section mn 2 the	N		
13.00 Is this a consolidated cost report as defined in CMS Pub. 30.8? Enter "Y" for yes or "N" for no in column 1. If yes number of providers included in this report. List the nam numbers below.	100-04, chapte , enter in colu es of all provi	r 9, section mn 2 the ders and	N N		
<ul> <li>13.00 Is this a consolidated cost report as defined in CMS Pub.</li> <li>30.8? Enter "Y" for yes or "N" for no in column 1. If yes number of providers included in this report. List the nam numbers below.</li> <li>13.01 If line 13, column 1, is "Y", are you reporting multiple</li> </ul>	100-04, chapte, enter in colu es of all provi	r 9, section mn 2 the ders and Cs (as defin	N N		
13.00 Is this a consolidated cost report as defined in CMS Pub. 30.8? Enter "Y" for yes or "N" for no in column 1. If yes number of providers included in this report. List the nam numbers below.	100-04, chapte, enter in colues of all proviconsolidated RH for yes or "N"	r 9, section mn 2 the ders and Cs (as defin for no. If	N N		13.0
<ul> <li>13.00 Is this a consolidated cost report as defined in CMS Pub. 30.8? Enter "Y" for yes or "N" for no in column 1. If yes number of providers included in this report. List the nam numbers below.</li> <li>13.01 If line 13, column 1, is "Y", are you reporting multiple in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" yes, enter in column 2 the number of consolidated RHC groseparate Worksheet S-8 for each consolidated RHC grouping</li> </ul>	100-04, chapte, enter in colues of all proviconsolidated RH for yes or "N" upings and comp. Consolidated	r 9, section mn 2 the ders and Cs (as defina for no. If lete a RHC groupina	N N		13.0
<ul> <li>13.00 Is this a consolidated cost report as defined in CMS Pub. 30.8? Enter "Y" for yes or "N" for no in column 1. If yes number of providers included in this report. List the nam numbers below.</li> <li>13.01 If line 13, column 1, is "Y", are you reporting multiple in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" yes, enter in column 2 the number of consolidated RHC grouping are comprised exclusively of grandfathered consolidated R</li> </ul>	100-04, chapte, enter in colues of all proviconsolidated RH for yes or "N" upings and comp. Consolidated HCs in the grou	r 9, section mn 2 the ders and Cs (as defina for no. If lete a RHC groupina	N N		13.0
<ul> <li>13.00 Is this a consolidated cost report as defined in CMS Pub. 30.8? Enter "Y" for yes or "N" for no in column 1. If yes number of providers included in this report. List the nam numbers below.</li> <li>13.01 If line 13, column 1, is "Y", are you reporting multiple in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" yes, enter in column 2 the number of consolidated RHC groseparate Worksheet S-8 for each consolidated RHC grouping</li> </ul>	100-04, chapte, enter in colues of all proviconsolidated RH for yes or "N" upings and comp. Consolidated HCs in the grou	r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or	N N N	(	13.0
<ul> <li>13.00 Is this a consolidated cost report as defined in CMS Pub. 30.8? Enter "Y" for yes or "N" for no in column 1. If yes number of providers included in this report. List the nam numbers below.</li> <li>13.01 If line 13, column 1, is "Y", are you reporting multiple in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" yes, enter in column 2 the number of consolidated RHC grouping are comprised exclusively of grandfathered consolidated R</li> </ul>	100-04, chapte, enter in colues of all proviconsolidated RH for yes or "N" upings and comp. Consolidated HCs in the grou	r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or	N N		13.0
<ul> <li>13.00 Is this a consolidated cost report as defined in CMS Pub. 30.8? Enter "Y" for yes or "N" for no in column 1. If yes number of providers included in this report. List the nam numbers below.</li> <li>13.01 If line 13, column 1, is "Y", are you reporting multiple in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" yes, enter in column 2 the number of consolidated RHC groseparate Worksheet S-8 for each consolidated RHC grouping are comprised exclusively of grandfathered consolidated R comprised exclusively of new consolidated RHCs in the group in the comprised exclusively of new consolidated RHCs in the group in the comprised exclusively of new consolidated RHCs in the group in the comprised exclusively of new consolidated RHCs in the group in the comprised exclusively of new consolidated RHCs in the group in the group in the consolidated RHCs in the group in the grou</li></ul>	100-04, chapte, enter in colues of all proviconsolidated RH for yes or "N" upings and comp. Consolidated HCs in the grouuping.	r 9, section mn 2 the ders and  Cs (as definition for no. If lete a RHC grouping ping or  Prov	N N N Sps der name	CCN 2. 00	13.00
13.00 Is this a consolidated cost report as defined in CMS Pub. 30.8? Enter "Y" for yes or "N" for no in column 1. If yes number of providers included in this report. List the nam numbers below.  13.01 If line 13, column 1, is "Y", are you reporting multiple in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" yes, enter in column 2 the number of consolidated RHC groseparate Worksheet S-8 for each consolidated RHC grouping are comprised exclusively of grandfathered consolidated R comprised exclusively of new consolidated RHCs in the group in the comprised exclusively of new consolidated RHCs in the group in the comprised exclusively of new consolidated RHCs in the group in the comprised exclusively of new consolidated RHCs in the group in the comprised exclusively of new consolidated RHCs in the group in the comprised exclusively of new consolidated RHCs in the group in the comprised exclusively of new consolidated RHCs in the group in the group in the consolidated RHCs in the group in the g	100-04, chapte, enter in colues of all proviconsolidated RH for yes or "N" upings and comp. Consolidated HCs in the grouuping.	r 9, section mn 2 the ders and  Cs (as define for no. If lete a RHC grouping ping or  Prov	N N N Sps ider name 1.00	CCN 2.00  Total Visits	13.0
13.00 Is this a consolidated cost report as defined in CMS Pub. 30.8? Enter "Y" for yes or "N" for no in column 1. If yes number of providers included in this report. List the nam numbers below.  13.01 If line 13, column 1, is "Y", are you reporting multiple in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" yes, enter in column 2 the number of consolidated RHC groseparate Worksheet S-8 for each consolidated RHC grouping are comprised exclusively of grandfathered consolidated R comprised exclusively of new consolidated RHCs in the group RHC/FQHC name, CCN    Y/N   1.00	100-04, chapte, enter in colues of all proviconsolidated RH for yes or "N" upings and comp. Consolidated HCs in the grouuping.	r 9, section mn 2 the ders and  Cs (as definition for no. If lete a RHC grouping ping or  Prov	N N N Sps der name	CCN 2. 00	13.0
13.00 Is this a consolidated cost report as defined in CMS Pub. 30.8? Enter "Y" for yes or "N" for no in column 1. If yes number of providers included in this report. List the nam numbers below.  13.01 If line 13, column 1, is "Y", are you reporting multiple in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" yes, enter in column 2 the number of consolidated RHC groseparate Worksheet S-8 for each consolidated RHC grouping are comprised exclusively of grandfathered consolidated RC comprised exclusively of new consolidated RHCs in the group RHC/FOHC name, CCN    Y/N     1.00	100-04, chapte, enter in colues of all proviconsolidated RH for yes or "N" upings and comp. Consolidated HCs in the grouuping.	r 9, section mn 2 the ders and  Cs (as define for no. If lete a RHC grouping ping or  Prov	N N N Sps ider name 1.00	CCN 2.00  Total Visits	13.0
13.00 Is this a consolidated cost report as defined in CMS Pub. 30.8? Enter "Y" for yes or "N" for no in column 1. If yes number of providers included in this report. List the nam numbers below.  13.01 If line 13, column 1, is "Y", are you reporting multiple in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" yes, enter in column 2 the number of consolidated RHC groseparate Worksheet S-8 for each consolidated RHC grouping are comprised exclusively of grandfathered consolidated R comprised exclusively of new consolidated RHCs in the group RHC/FQHC name, CCN    Y/N   1.00	100-04, chapte, enter in colues of all proviconsolidated RH for yes or "N" upings and comp. Consolidated HCs in the grouuping.	r 9, section mn 2 the ders and  Cs (as define for no. If lete a RHC grouping ping or  Prov	N N N Sps ider name 1.00	CCN 2.00  Total Visits	13.0
13.00 Is this a consolidated cost report as defined in CMS Pub. 30.8? Enter "Y" for yes or "N" for no in column 1. If yes number of providers included in this report. List the nam numbers below.  13.01 If line 13, column 1, is "Y", are you reporting multiple in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" yes, enter in column 2 the number of consolidated RHC groseparate Worksheet S-8 for each consolidated RHC grouping are comprised exclusively of grandfathered consolidated R comprised exclusively of new consolidated RHCs in the group in the group of the group of the group of the group in	100-04, chapte, enter in colues of all proviconsolidated RH for yes or "N" upings and comp. Consolidated HCs in the grouuping.	r 9, section mn 2 the ders and  Cs (as define for no. If lete a RHC grouping ping or  Prov	N N N Sps ider name 1.00	CCN 2.00  Total Visits	13.00
13.00 Is this a consolidated cost report as defined in CMS Pub. 30.8? Enter "Y" for yes or "N" for no in column 1. If yes number of providers included in this report. List the nam numbers below.  13.01 If line 13, column 1, is "Y", are you reporting multiple in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" yes, enter in column 2 the number of consolidated RHC grouping are comprised exclusively of grandfathered consolidated R comprised exclusively of new consolidated RHCs in the group in the column 2 the number of consolidated RHCs in the group in the comprised exclusively of new consolidated RHCs in the group in the column in the	100-04, chapte, enter in colues of all proviconsolidated RH for yes or "N" upings and comp. Consolidated HCs in the grouuping.	r 9, section mn 2 the ders and  Cs (as define for no. If lete a RHC grouping ping or  Prov	N N N Sps ider name 1.00	CCN 2.00  Total Visits	13.00
13.00 Is this a consolidated cost report as defined in CMS Pub. 30.8? Enter "Y" for yes or "N" for no in column 1. If yes number of providers included in this report. List the nam numbers below.  13.01 If line 13, column 1, is "Y", are you reporting multiple in CMS Pub. 100-02, chapter 13, section 80.2)? Enter "Y" yes, enter in column 2 the number of consolidated RHC groseparate Worksheet S-8 for each consolidated RHC grouping are comprised exclusively of grandfathered consolidated R comprised exclusively of new consolidated RHCs in the group in the group of the group of the group of the group in	100-04, chapte, enter in colues of all proviconsolidated RH for yes or "N" upings and comp. Consolidated HCs in the grouuping.	r 9, section mn 2 the ders and  Cs (as define for no. If lete a RHC grouping ping or  Prov	N N N Sps ider name 1.00	CCN 2.00  Total Visits	13.0

Health Financial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 15-1334			Peri od:	Worksheet S-8	3
		Component	CCN: 15-8523	From 01/01/2023 To 12/31/2023		narod:
		Component	CCN. 15-6525	10 12/31/2023	5/31/2024 6: 5	ipareu. 11 am
				RHC I	Cost	
		Cou	inty			
		4.	00			
2.00 City, State, ZIP Code, County		SCOTT				2.00
	Tuesday	Wednesday		Thur	sday	
	to	from	to	from	to	
	6. 00	7.00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	16: 30	08: 30	16: 30	08: 30	16: 30	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 30	16: 30				11. 00

	Financial Systems SCOTT MEMORIAL HO				u of Form CMS-2			
HOSPI I	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-		Period: From 01/01/2023	Worksheet S-1 Parts I & II	0		
				o 12/31/2023	Date/Time Pre			
					5/31/2024 6: 5	1 am		
					1. 00			
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA							
	Uncompensated and Indigent Care Cost-to-Charge Ratio							
1. 00	Cost to charge ratio (see instructions)				0. 273524	1.00		
2. 00	Medicaid (see instructions for each line) Net revenue from Medicaid				1, 267, 314	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?				1, 207, 314 N	3.00		
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplement	tal navments fro	m Medica	i d?	N	4.00		
5. 00	If line 4 is no, then enter DSH and/or supplemental payments fi		0	5.00				
6. 00	Medicaid charges				1, 725, 286	1		
7.00	Medicaid cost (line 1 times line 6)				471, 907	7.00		
8.00	Difference between net revenue and costs for Medicaid program	(see instruction	ıs)		0	8.00		
	Children's Health Insurance Program (CHIP) (see instructions for	or each line)						
9. 00	Net revenue from stand-alone CHIP		0					
10.00	Stand-alone CHIP charges		0					
11.00	Stand-alone CHIP cost (line 1 times line 10)	/ ! <b>++</b> !	- \		0	11. 00 12. 00		
12. 00	Difference between net revenue and costs for stand-alone CHIP (see instructions)  Other state or local government indigent care program (see instructions for each line)							
13. 00	Net revenue from state or local indigent care program (Not inc			)	0	13.00		
14. 00	Charges for patients covered under state or local indigent care		0					
11.00	10)	s program (Not 1	nor adea	111 111103 0 01	0	11.00		
15.00								
16.00	00 Difference between net revenue and costs for state or local indigent care program (see instructions)							
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state/loc	al indig	ent care progra	ıms (see			
47.00	instructions for each line)							
17.00	Private grants, donations, or endowment income restricted to for				0			
18. 00 19. 00	Government grants, appropriations or transfers for support of I Total unreimbursed cost for Medicaid, CHIP and state and Loca			(sum of lines	0			
17.00	8, 12 and 16)	Thur gent care	pi ogi allis	(Suiii OI TITIES	U	19.00		
		Uni	nsured	Insured	Total (col. 1			
			tients	pati ents	+ col . 2)			
	Uncompensated care cost (see instructions for each line)		1. 00	2. 00	3. 00			
20. 00	Charity care charges and uninsured discounts (see instructions		C	0	0	20.00		
21. 00	Cost of patients approved for charity care and uninsured discou		(		0			
	instructions)				_			
22.00	Payments received from patients for amounts previously written	off as	C	0	0	22. 00		
	charity care							
23. 00	Cost of charity care (see instructions)			0	0	23. 00		
					1. 00			
24. 00	Does the amount on line 20 col. 2, include charges for patient	days beyond a I	ength of	stay limit	N 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 t	ne indigent care	program	's length of	0	25. 00		
0= -	stay limit				_	05		
25. 01	Charges for insured patients' liability (see instructions)				0			
	Bad debt amount (see instructions)				925, 000			
27. 00 27. 01					104, 940 161, 446			
	01 Medicare allowable bad debts (see instructions) 161,446 2							

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

763, 554 28. 00 265, 356 29. 00 265, 356 30. 00 265, 356 31. 00

PART II Uncompe Cost to Medicai Net rev Di d you If line Hedicai Medicai	4 is no, then enter DSH and/or supp d charges d cost (line 1 times line 6) nce between net revenue and costs fo	arge Ratio  ts from Medicaid?  DSH and/or supplementa		F	eri od: rom 01/01/2023 o 12/31/2023		epare				
Uncompe Cost to Medicai Net rev Did you OO Ifline OO Ifline OO Medicai	sated and Indigent Care Cost-to-Charge ratio (see instructions)  I (see instructions for each line) enue from Medicaid receive DSH or supplemental payment 3 is yes, does line 2 include all E 4 is no, then enter DSH and/or supplemental d charges d cost (line 1 times line 6) nce between net revenue and costs for	ts from Medicaid? DSH and/or supplementa		Medi ca		1.00					
Uncompe Cost to Medicai Net rev Did you OO Ifline OO Ifline OO Medicai	sated and Indigent Care Cost-to-Charge ratio (see instructions)  I (see instructions for each line) enue from Medicaid receive DSH or supplemental payment 3 is yes, does line 2 include all E 4 is no, then enter DSH and/or supplemental d charges d cost (line 1 times line 6) nce between net revenue and costs for	ts from Medicaid? DSH and/or supplementa		Medi ca		1.00					
Uncompe Cost to Medicai Net rev Did you OO Ifline OO Ifline OO Medicai	sated and Indigent Care Cost-to-Charge ratio (see instructions)  I (see instructions for each line) enue from Medicaid receive DSH or supplemental payment 3 is yes, does line 2 include all E 4 is no, then enter DSH and/or supplemental d charges d cost (line 1 times line 6) nce between net revenue and costs for	ts from Medicaid? DSH and/or supplementa		Medi ca							
Cost to Medicai Net rev Did you If line Medicai Medicai Medicai Medicai	charge ratio (see instructions) I (see instructions for each line) enue from Medicaid receive DSH or supplemental payment 3 is yes, does line 2 include all E 4 is no, then enter DSH and/or supplemental d charges d cost (line 1 times line 6) nce between net revenue and costs for	ts from Medicaid? DSH and/or supplementa		Medi ca							
Medicai Net rev Did you If line If line Medicai Medicai	(see instructions for each line) enue from Medicaid receive DSH or supplemental payment 3 is yes, does line 2 include all E 4 is no, then enter DSH and/or supple charges d cost (line 1 times line 6) nce between net revenue and costs for	DSH and/or supplementa		Medi ca			1,				
Did you If line If line If line Medicai Medicai	receive DSH or supplemental payment 3 is yes, does line 2 include all E 4 is no, then enter DSH and/or supp d charges d cost (line 1 times line 6) nce between net revenue and costs for	DSH and/or supplementa		Medi ca	. 10		7 -				
00   If line 00   If line 00   Medicai 00   Medicai	3 is yes, does line 2 include all E 4 is no, then enter DSH and/or supp d charges d cost (line 1 times line 6) nce between net revenue and costs fo	DSH and/or supplementa		Medi ca	. 10		1 4				
00   If line 00   If line 00   Medicai 00   Medicai	3 is yes, does line 2 include all E 4 is no, then enter DSH and/or supp d charges d cost (line 1 times line 6) nce between net revenue and costs fo	DSH and/or supplementa		Medi ca	. 10		3				
Medicai Medicai	d charges d cost (line 1 times line 6) nce between net revenue and costs fo	plemental payments fro	om Medicaid								
00 Medicai	d cost (line 1 times line 6) nce between net revenue and costs fo										
	nce between net revenue and costs fo						1				
							-				
				)			] [				
	's Health Insurance Program (CHIP)	(see instructions for	each line)			T	(				
	one CHIP charges	->					10				
	one CHIP cost (line 1 times line 10						1				
	nce between net revenue and costs for						12				
	ate or local government indigent ca enue from state or local indigent ca				\	T	13				
	for patients covered under state or						12				
10)	Tor patrents covered under state or	rocar margent care	program (Not 111	i uueu	ili ililes o oi		'-				
	r local indigent care program cost (	(line 1 times line 14)					15				
	nce between net revenue and costs for			am (see	instructions)		16				
Grants,	donations and total unreimbursed co ions for each line)					ams (see					
	grants, donations, or endowment inc	come restricted to fur	nding charity ca				1:				
	ent grants, appropriations or transf						1 18				
	nreimbursed cost for Medicaid , CHIF	• • •			(sum of lines		10				
8, 12 a	· · · · · · · · · · · · · · · · · · ·		3	3	(						
			Uni ns	sured	Insured	Total (col. 1					
				ents	pati ents	+ col . 2)					
			1.	00	2. 00	3. 00					
	sated care cost (see instructions f				T		4.				
,	care charges and uninsured discount	,					20				
	patients approved for charity care	and uninsured discour	its (see				2				
instruction on Payment	tions) s received from patients for amounts	e proviouely weitten a	off ac				22				
chari ty	•	s previousiy written c	) I dS				24				
	charity care (see instructions)						23				
00 10031 01	onarrty care (see mistructions)		1				+				
						1. 00					

25.00

25.01

26. 00 27. 00

27.01

28. 00 29. 00

30.00

31.00

25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

27.00 Medicare reimbursable bad debts (see instructions)27.01 Medicare allowable bad debts (see instructions)

stay limit

26.00 Bad debt amount (see instructions)

	Financial Systems	SCOTT MEMORIAL	_ HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provi der C		Period: From 01/01/2023 Fo 12/31/2023	Worksheet A  Date/Time Pre 5/31/2024 6:5	
	Cost Center Description	Sal ari es	0ther	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	T dill
		1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	GENERAL SERVICE COST CENTERS		000 074	000.07	4 000 (05	405 (70	1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		233, 074 364, 890				1
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	82, 083	763, 163				1
5. 01	00550 DATA PROCESSING	193, 725	1, 063, 051			1, 256, 776	1
5. 02	00570 ADMI TTI NG	515, 298	156, 591			666, 881	1
5.03	00560 PURCHASING RECEIVING AND STORES	0	59, 370		o o	59, 370	
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	240	336, 912	1	1	337, 152	
5. 05	00590 OTHER ADMIN AND GENERAL	774, 908	3, 146, 926				
7. 00 9. 00	00700 OPERATION OF PLANT 00900 HOUSEKEEPING	227, 616 271, 323	682, 218 143, 177	1		905, 427 414, 500	1
10.00	01000 DI ETARY	204, 424	182, 648	1	1		1
11. 00	01100 CAFETERI A	0	0	1	266, 973	266, 973	1
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0		53, 759	53, 759	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	68, 429	34, 181			70, 923	1
15.00	01500 PHARMACY	206, 130	523, 313	1			1
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	434, 170	204, 756	638, 92	5 -5, 755	633, 171	16. 00
30.00	03000 ADULTS & PEDI ATRI CS	1, 326, 812	1, 081, 227	2, 408, 039	-12, 331	2, 395, 708	30.00
31. 00	03100   NTENSI VE CARE UNI T	4, 792	1, 207				
43.00		0	0	(	0	0	43.00
FO 00	ANCILLARY SERVICE COST CENTERS	121 5/5	71/ 002	040 444	75 070	770 105	 
50. 00 52. 00	O5000   OPERATING ROOM   O5200   DELIVERY ROOM & LABOR ROOM	131, 565	716, 903	848, 46	-75, 273 0	773, 195 0	50. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	948, 518	884, 862	1, 833, 380		_	1
60.00	06000 LABORATORY	664, 380	705, 274				
63.00	06300 BLOOD STORING PROCESSING & TRANS.	0	32, 450	32, 450	0		63.00
65.00	06500 RESPI RATORY THERAPY	524, 956	135, 396			408, 590	1
66.00	06600 PHYSI CAL THERAPY	76, 560	742, 676	819, 23			
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0	0	67. 00 68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		203, 725	_	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o o	0		134, 666	134, 666	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	11, 346	11, 34	4, 440		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		332, 849		1
76.00	03610 SLEEP LAB	117 501	1, 159	1	1	1, 159	1
76. 97 77. 00	O7697   CARDI AC REHABILITATION   O7700   ALLOGENEIC   HSCT   ACQUISITION	117, 591	15, 514	1	0 0	133, 105 0	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY		0	1			1
	OUTPATIENT SERVICE COST CENTERS	·		'	- 1		
	08800 RURAL HEALTH CLINIC	340, 753	248, 298	1			
	09100 EMERGENCY	1, 264, 514	1, 223, 043	2, 487, 55	1, 012	2, 488, 569	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		o o	0	102.00
	SPECIAL PURPOSE COST CENTERS						]
	11300 I NTEREST EXPENSE		116, 218				
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	8, 378, 787	13, 809, 843	22, 188, 630	0	22, 188, 630	1118. 00
190 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		o lo	0	190. 00
	19001 MARKETI NG	32, 019	27, 750	59, 76			190.01
	19200 PHYSICIANS PRIVATE OFFICES	148, 818	62, 180			210, 998	
	19201 SCOTT PHYSICIAN GROUP	0	0		0		192. 01
	07950 BUHSE CAMPUS	0	0	1	0		194.00
	07951   MEDICAL SPECIALTY   07952   MEDICAL OFFICE	42, 738	124, 605	167, 34	1		194.01
	07952 MEDICAL OFFICE		0				194. 02
	07954 ALREFAI CAMPUS	o o	0		o o		194. 04
194. 05	07955 ORTHO CAMPUS	0	0		o  o	0	194. 05
	07956 DR. CRAIG CLINIC	0	0		0		194.06
	07957 DR. OLABIGE CLINIC	0	0	9			194.07
	07958 URGENT CARE CLINIC 07959 DR. PACE	0	0				194. 08 194. 09
	07960 SCOTTSBURG FAMILY PRACTICE (RHC)		0				194. 10
200.00		8, 602, 362	14, 024, 378	22, 626, 740			
		·					

 Health Financial
 Systems
 SCOTT MEMORE

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-1334 Peri od:

Peri od: Worksheet A From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/31/2024 6:51 am

			5/31/2024	
Cost Center Description	Adjustments	Net Expenses	3, 3, 3, 3, 3	
·	(See A-8)	For		
		Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 CAP REL COSTS-BLDG & FLXT	-114, 562	321, 117		1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP	166, 632	650, 251		2.00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT	0	831, 836		4. 00
5. 01   00550   DATA PROCESSI NG	0	1, 256, 776		5. 01
5. 02   00570   ADMI TTI NG	0	666, 881		5. 02
5.03 00560 PURCHASING RECEIVING AND STORES	0	59, 370		5. 03
5. 04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	337, 152		5.04
5. 05 00590 OTHER ADMIN AND GENERAL	-1, 724, 703	1, 995, 743		5.05
7.00 00700 OPERATION OF PLANT	0	905, 427		7.00
9. 00 00900 HOUSEKEEPI NG	0	414, 500		9.00
10. 00   01000 DI ETARY	0	119, 523		10.00
11. 00 01100 CAFETERI A	-76, 154	190, 819		11.00
13. 00 01300 NURSING ADMINISTRATION	0	53, 759		13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	-7, 100	63, 823		14. 00
15. 00   01500   PHARMACY	-7, 100	366, 213		15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	-3	633, 168		16.00
INPATIENT ROUTINE SERVICE COST CENTERS	-3	033, 100		10.00
	221 476	2 074 222		20.00
30.00   03000   ADULTS & PEDIATRICS 31.00   03100   INTENSIVE CARE UNIT	-321, 476 0	2, 074, 232 5, 999		30. 00 31. 00
	0			
43. 00 04300 NURSERY	U	0		43. 00
ANCILLARY SERVICE COST CENTERS	257, 050	F17 14F		
50. 00   05000   OPERATI NG ROOM	-256, 050	517, 145		50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0	0		52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	-257, 188			54.00
60. 00   06000   LABORATORY	-24, 700	1, 351, 613		60.00
63.00 06300 BLOOD STORING PROCESSING & TRANS.	0	32, 450		63.00
65. 00   06500   RESPI RATORY THERAPY	-4, 860			65.00
66. 00  06600 PHYSI CAL THERAPY	-6, 992	809, 875		66.00
67. 00  06700 OCCUPATI ONAL THERAPY	0	0		67.00
68.00   06800   SPEECH PATHOLOGY	0	0		68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	203, 725		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	134, 666		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	15, 786		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	332, 849		73.00
76.00 03610 SLEEP LAB	0	1, 159		76.00
76. 97 07697 CARDIAC REHABILITATION	0	133, 105		76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	o		77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	o		78.00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0	537, 188		88. 00
91. 00 09100 EMERGENCY	74	2, 488, 643		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
OTHER REIMBURSABLE COST CENTERS				
102.00 10200 OPIOID TREATMENT PROGRAM	0	0		102.00
SPECIAL PURPOSE COST CENTERS		-		
113. 00 11300   NTEREST EXPENSE	-114, 399	0		113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-2, 741, 481			118.00
NONREI MBURSABLE COST CENTERS	, ,	., ,		
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	O	Ω		190. 00
190. 01 19001 MARKETI NG	0	59, 769		190. 01
192.00 19200 PHYSICIANS PRIVATE OFFICES	-3, 009			192.00
192. 01 19201 SCOTT PHYSICIAN GROUP	0	0		192. 01
194. 00 07950 BUHSE CAMPUS	0	0		194. 00
194. 01 07951 MEDI CAL SPECI ALTY	0	167, 343		194. 01
194. 02 07952 MEDICAL OFFICE	0	107, 343		194.01
194. 03 07953  VA PROPERTY	0	٥		194.02
194. 04 07954 ALREFAI CAMPUS	0	0		194.03
· · · · · · · · · · · · · · · · · · ·	0	0		194.04
194. 05 07955 ORTHO CAMPUS	0	-		
194. 06 07956 DR. CRAIG CLINIC	0	0		194.06
194. 07 07957 DR. OLABIGE CLINIC	0	0		194. 07
194. 08 07958 URGENT CARE CLINIC	0	0		194. 08
194. 09 07959 DR. PACE	0	0		194. 09
194. 10 07960 SCOTTSBURG FAMILY PRACTICE (RHC)	0	0		194. 10
200.00   TOTAL (SUM OF LINES 118 through 199)	-2, 744, 490	19, 882, 250		200. 00

	Financial Systems		SCOTT MEMORI.	AL HOSPITAL		In Lieu of Form C	MS-2552-10
RECLAS	SI FI CATI ONS			Provi der CCN	l: 15-1334	Peri od: Worksheet From 01/01/2023	A-6
						To 12/31/2023 Date/Time 5/31/2024	Prepared:
		Increases				3/31/2024	0. 51 aiii
	Cost Center	Li ne #	Sal ary	Other 5 00			
	2.00 A - LEASES	3. 00	4. 00	5. 00			
1.00	CAP REL COSTS-BLDG & FLXT	1. 00	0	50, 632			1.00
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP	2. 00 0. 00	0	118, 562 0			2.00
4. 00		0.00	0	0			3. 00 4. 00
5. 00		0. 00	Ö	Ö			5. 00
6. 00		0.00	0	0			6. 00
7. 00 8. 00		0. 00 0. 00	0	0			7. 00 8. 00
9. 00		0.00	0	0			9.00
10.00		0.00	O	0			10.00
11.00		0. 00	0	0			11.00
12. 00 13. 00		0. 00 0. 00	0	0			12. 00 13. 00
14. 00		0.00	o	Ö			14. 00
15. 00		0. 00	O	0			15. 00
16. 00			0	0 169, 194			16. 00
	B - CNO		O <sub>I</sub>	107, 174			
1. 00	NURSING ADMINISTRATION	1300	39, 085	3, 584			1.00
	O C - CORPORATE PAID BENEFITS		39, 085	3, 584			
1. 00	NURSING ADMINISTRATION	13. 00	0	11, 090			1.00
	0		0	11, 090			
1. 00	D - GENERAL LIABLILITY INSURA CAP REL COSTS-MVBLE EQUIP	NCE2.00	0	38, 870			1.00
1.00	0			3 <u>8,870</u>			1.00
	E - CAFETERIA						
1. 00	CAFETERI A	<u>11.</u> 00	14 <u>0, 9</u> 96 140, 996	12 <u>5, 9</u> 77 125, 977			1.00
	G - EKG RECLASS		140, 770	123, 777			
1. 00	ELECTROCARDI OLOGY	<u>69.</u> 00	<u>161, 9</u> 54	41, 771			1. 00
	H - MED SUPPLIES DRUGS COGS		161, 954	41, 771			
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	134, 666			1.00
	PATI ENT			000			
2. 00 3. 00	ADULTS & PEDIATRICS LABORATORY	30. 00 60. 00	0	838 7, 609			2. 00 3. 00
4. 00	EMERGENCY	91. 00	o	3, 929			4.00
5.00		0. 00	O	0			5. 00
6. 00			0	0 147, 042			6. 00
	I - COST TO CHARGE	ļ	O <sub>I</sub>	147, 042			
1. 00	OPERATING ROOM	50. 00	0	0			1.00
2. 00 3. 00	LABORATORY BLOOD STORING PROCESSING &	60. 00 63. 00	0	0			2. 00 3. 00
3.00	TRANS.	63.00	o o	U			3.00
4.00	OCCUPATI ONAL THERAPY	67. 00	O	0			4. 00
5.00	SPEECH PATHOLOGY	68.00	0	0			5.00
6. 00 7. 00	ELECTROCARDI OLOGY EMERGENCY	69. 00 91. 00	0	0			6. 00 7. 00
	0						
1 00	J - PROPERTY TAX	1 00	ما	150 154			1.00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT	1. 00 0. 00	0	150, 154 0			1. 00 2. 00
2.00	0 — — — — —			150, 154			2.00
1 00	L - IMPLANTS RECLASS IMPL. DEV. CHARGED TO	72.00	ما	4 440			1.00
1. 00	PATIENTS	72. 00	0	4, 440			1.00
2.00		0.00	0	0			2.00
	O DRUCC PECLACC		0	4, 440			
1. 00	M - DRUGS RECLASS DRUGS CHARGED TO PATIENTS	73. 00	0	332, 849			1.00
2. 00	CENTRAL SERVICES & SUPPLY	<u>14.</u> 00	0	31			2.00
	O INTEREST RESUMES		0	332, 880			
1. 00	O - INTEREST RECLASS CAP REL COSTS-BLDG & FIXT	1. 00	0	1, 819			1.00
50	0		0	1, 819			1.00
500.00	Grand Total: Increases		342, 035	1, 026, 821			500.00

RECLASSI FI CATI ONS

Provider CCN: 15-1334

Peri od: Worksheet A-6 From 01/01/2023

500.00

12/31/2023 Date/Time Prepared: 5/31/2024 6:51 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - LEASES EMPLOYEE BENEFITS DEPARTMENT 4.00 2, 320 10 1.00 0 ADMITTI NG 2.00 5.02 5,008 10 2.00 OTHER ADMIN AND GENERAL 5.05 8.398 0 3.00 3.00 0 0 4.00 OPERATION OF PLANT 7.00 4, 407 4.00 5.00 DI ETARY 10.00 0 0 576 5.00 o 0 6.00 CENTRAL SERVICES & SUPPLY 14.00 534 6.00 15.00 0 0 PHARMACY 7.00 506 7.00 8.00 MEDICAL RECORDS & LIBRARY 16.00 0 5, 755 0 8.00 ADULTS & PEDIATRICS o 0 9.00 30.00 13, 169 9.00 10 00 OPERATING ROOM 50.00 o 50.397 0 10.00 RADI OLOGY-DI AGNOSTI C 0 11.00 54.00 0 2, 150 11.00 12.00 LABORATORY 60.00 o 950 0 12.00 13.00 RESPIRATORY THERAPY 65.00 0 18,663 0 13.00 PHYSICAL THERAPY 0 14 00 66.00 1 581 0 14 00 88.00 15.00 RURAL HEALTH CLINIC 0 51, 863 0 15.00 16.00 **EMERGENCY** 91.00 2, 917 0 16.00 ō 169, 194 B - CNO 1.00 OTHER ADMIN AND GENERAL 5. 05 39, 085 3, 584 0 1.00 39, 085 3, 584 C - CORPORATE PAID BENEFITS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 11, 090 0 1.00 11, 090 D - GENERAL LIABLILITY INSURANCE OTHER ADMIN AND GENERAL 38, 870 1.00 5.05 12 1.00 38, 870 - CAFETERIA 140, 996 125, 977 1.00 DI ETARY 10. 00 0 1.00 140, 996 125, 977 EKG RECLASS 1.00 RESPIRATORY THERAPY 65.00 161, 954 41, 771 0 1.00 161, 954 41, 771 - MED SUPPLIES DRUGS COGS 1.00 CENTRAL SERVICES & SUPPLY 14.00 30, 373 0 1.00 2.00 PHARMACY 15.00 0 29, 844 0 2.00 OPERATING ROOM 3.00 50.00 0 21.247 0 3.00 RADI OLOGY-DI AGNOSTI C 4.00 54.00 0 35, 416 0 4.00 5.00 RESPIRATORY THERAPY 65.00 0 29, 374 0 5.00 6.00 PHYSI CAL THERAPY <u>66.</u>00 788 0 6.00 ō 147, 042 COST TO CHARGE ADULTS & PEDIATRICS 1.00 30.00 1.00 2.00 OPERATING ROOM 50.00 ol 0 2.00 0 RADI OLOGY-DI AGNOSTI C 0 0 3.00 54.00 0 3.00 4.00 RESPIRATORY THERAPY 65.00 0 0 0 4.00 5.00 PHYSICAL THERAPY 66.00 0 0 0 5.00 EMERGENCY 91.00 0 0 6.00 0 6.00 7.00 0.00 0 7.00 ō J - PROPERTY TAX CAP REL COSTS-MVBLE EQUIP 1.00 2.00 0 38, 703 13 1.00 2.00 OTHER ADMIN AND GENERAL 5. 05 111, 451 0 2.00 150, 154 - IMPLANTS RECLASS 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 811 0 1.00 2.00 OPERATING ROOM <u>3, 6</u>29 50.00 0 2.00 4.440 M - DRUGS RECLASS 1.00 PHARMACY 15.00 0 332, 880 0 1.00 2.00 0.00 0 2.00 332, 880 O - INTEREST RECLASS 1.00 INTEREST EXPENSE 113. 00 1, 819 1.00 1,819

342, 035

1, 026, 821

500.00 Grand Total: Decreases

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS SCOTT MEMORIAL HOSPITAL

Provider CCN: 15-1334

			To	12/31/2023	Date/Time Pre 5/31/2024 6:5	pared:
			Acqui si ti ons		7 37 3 17 2024 0. 3	ı aiii
	Beginning	Purchases	Donati on	Total	Disposals and	
	Bal ances				Retirements	
	1. 00	2.00	3. 00	4. 00	5. 00	
PART I - ANALYSIS OF CHANGES IN CAPITAL A	SSET BALANCES					
1. 00 Land	840, 000	0	0	0	412, 000	1.00
2.00 Land Improvements	444, 683	0	0	0	406, 919	2.00
3.00 Buildings and Fixtures	3, 056, 164	0	0	0	517, 551	3.00
4.00 Building Improvements	662, 251	0	0	0	662, 251	4.00
5.00 Fixed Equipment	2, 171, 592	0	0	0	1, 707, 455	5.00
6.00 Movable Equipment	4, 639, 758	0	0	0	3, 999, 452	6.00
7.00 HIT designated Assets	1, 345, 381	0	0	0	1, 345, 381	7.00
8.00   Subtotal (sum of lines 1-7)	13, 159, 829	0	0	0	9, 051, 009	8. 00
9.00 Reconciling Items	0	87, 693		87, 693		9. 00
10.00 Total (line 8 minus line 9)	13, 159, 829	-87, 693	0	-87, 693	9, 051, 009	10.00
	Endi ng	Fully				
	Bal ance	Depreci ated				
		Assets				
DADT I ANALYGIA OF CHANGES IN CARLEY	6.00	7. 00				
PART I - ANALYSIS OF CHANGES IN CAPITAL A						
1. 00 Land	428, 000	0				1.00
2.00 Land Improvements	37, 764	0				2.00
3.00 Buildings and Fixtures	2, 538, 613	0				3.00
4.00 Building Improvements	0	0				4.00
5.00 Fi xed Equipment	464, 137	0				5.00
6.00 Movable Equipment	640, 306	0				6.00
7.00 HIT designated Assets	0	0				7.00
8.00 Subtotal (sum of lines 1-7)	4, 108, 820	0				8.00
9.00 Reconciling Items	87, 693	0				9.00
10.00  Total (line 8 minus line 9)	4, 021, 127	0	I			10.00

Heal th	Financial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-1334	Peri od: From 01/01/2023 To 12/31/2023	Worksheet A-7 Part II Date/Time Pre	pared:
				IMMADY OF OAD	1.741	5/31/2024 6: 5	1 am
			50	IMMARY OF CAP	TIAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
	·				(see	instructions)	
					instructions)		
		9. 00	10. 00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	233, 074	0		0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	364, 890	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	597, 964	0		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)	,				
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	233, 074			l	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	364, 890			ļ	2.00
2 00	T-+-1 (6 1: 1 2)		F07 0/4				1 2 22

0 0 0

233, 074 364, 890 597, 964

1.00 2.00

3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2023 Fo 12/31/2023		
		COMF	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 -			
		1.00	2.00	col . 2) 3.00	4.00	F 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	1. 00	2.00	3.00	4. 00	5. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	3, 468, 514		3, 468, 514	0. 844163	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	640, 306		640, 30		0	2.00
3. 00	Total (sum of lines 1-2)	4, 108, 820		4, 108, 820			3.00
		.,	TION OF OTHER (			F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)	0.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	ENTERS	0		118, 766	50, 632	1. 00
2.00	CAP REL COSTS-BEDG & TTAT	0	0		531, 522		2. 00
3.00	Total (sum of lines 1-2)	0	0		650, 288		3.00
0.00	Total (Sam St Times 1 2)	J	Sl	JMMARY OF CAPI		1077 171	0.00
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)			
			instructions)		ed Costs (see	9 through 14)	
		11. 00	12. 00	13.00	instructions)	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	15.00	
1. 00	CAP REL COSTS-BLDG & FIXT	1, 565	0	150, 154	4 0	321, 117	1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	0	ł			650, 251	2.00
3.00	Total (sum of lines 1-2)	1, 565					3.00
			•	•	•	. '	

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 SCOTT MEMORIAL HOSPITAL Provider CCN: 15-1334 Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/31/2024 6:51 am Expense Classification on Worksheet A

				To/From Which the Amount is t			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3. 00	4. 00	Ref. 5. 00	
1. 00	Investment income - CAP REL	В		CAP REL COSTS-BLDG & FIXT	1. 00	11	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
2.00	COSTS-MVBLE EQUIP (chapter 2)		0	CAL REE COSTS-WVBEE EQUIT	2.00	J	2.00
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4.00	Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
	expenses (chapter 8)		0				
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
	21)						
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0. 00	0	
10. 00	Provi der-based physician adjustment	A-8-2	-864, 313			0	10.00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	121, 958			0	12. 00
13. 00	transactions (chapter 10)		0		0.00	0	13. 00
14. 00	Laundry and linen service Cafeteria-employees and guests	В	-76. 154	CAFETERI A	11. 00	0	
15. 00	Rental of quarters to employee		0		0. 00	0	15. 00
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than						
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and	В	-3	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
	abstracts		-	medione neodros a elbionici			
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
	books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of	В	-322	OTHER ADMIN AND GENERAL	5. 05 0. 00	0	
21.00	interest, finance or penalty		J		0.00	J	21.00
22 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
22.00	overpayments and borrowings to		J		0.00	J	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of						
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	-6, 992	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of						
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL	А	-125, 096	CAP REL COSTS-BLDG & FIXT	1. 00	9	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL	А	137 076	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
	COSTS-MVBLE EQUIP	.,				ĺ	
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0 0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	Ö	OCCUPATIONAL THERAPY	67. 00	Ĭ	30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)				I		I

Wkst. A-7	
Ref.	
	31.00
0	32.00
	33. 01
l	33. 03
0	34.00
	34. 01
0	36.00
0	37.00
0	37. 01
0	37.02
0	37. 03
0	37.04
	50.00
	5. 00 0 0 0 0 0 0 0 0 0 0 0 0

<sup>(1)</sup> 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.

<sup>(3)</sup> 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: 15-1334

Worksheet A-8-1 From 01/01/2023

12/31/2023 Date/Time Prepared: 5/31/2024 6:51 am Li ne No. Cost Center Expense Items Amount of Amount Allowable Cost Included in Wks. A, column 1.00 2 00 3.00 4 00 5.00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00 113.00 I NTEREST EXPENSE HOME OFFICE INTEREST 114, 399 1.00 2.00 5. 05 OTHER ADMIN AND GENERAL HOME OFFICE MANAGEMENT 534.272 442, 276 2.00 5. 05 OTHER ADMIN AND GENERAL 3.00 C SUITE PAYROLL TAXES -9, 158 3.00 4.00 14.00 CENTRAL SERVICES & SUPPLY HPG PURCHASING 7, 338 14, 387 4.00 5. 05 OTHER ADMIN AND GENERAL MALPRACTI CE 4.01 20.815 76,858 4.01 1.00 CAP REL COSTS-BLDG & FIXT 4.02 CAPITAL EXPENSE 10,788 Ω 4.02 4.03 2.00 CAP REL COSTS-MVBLE EQUIP CAPITAL EXPENSE 29, 556 0 4.03 4.04 5. 05 OTHER ADMIN AND GENERAL NON-CAPITAL EXPENSE 322, 891 0 4.04 5. 05 OTHER ADMIN AND GENERAL 4.05 NORTON SYSTEM FEE ALLOCATION 4.05 143, 615 4.06 192.00 PHYSICIANS PRIVATE OFFICES NORTON SYSTEM FEE ALLOCATION 3, 009 4.06 5.00 TOTALS (sum of lines 1-4). 916, 502 794, 544 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

 The first been position to not remove it and the state of								
			Related Organization(s) and/	or Home Office	i			
Symbol (1)	Name	Percentage of	Name	Percentage of	i			
		Ownershi p		Ownershi p				
1. 00	2. 00	3. 00	4. 00	5. 00				
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	OME OFFICE:						

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

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

6.00	В	0. 00 LI FEPOI NT HOSP 100. 00	6.00
7.00		0. 00 HPG 0. 00	7.00
8.00	В	O. OO NORTON HEALTHCA 100. OO	8.00
9. 00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		_

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

Heal th	Financial Syste	ems	SCOTT MEMORIAL	HOSPI TAL	In Lieu	of Form CMS-	2552-10
STATEME OFFICE		SERVICES FROM	RELATED ORGANI ZATI ONS AND HOME	Provider CCN: 15-1334	Peri od: From 01/01/2023	Worksheet A-8	3-1
OTTTCL	00313				To 12/31/2023	Date/Time Pre 5/31/2024 6:5	epared: 51 am
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A RESULT OF TR	RANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:						
1.00	-114, 399	0					1.00
2.00	91, 996	0					2.00
3.00	-9, 158	0					3.00
4.00	-7, 049	0					4.00
4.01	-56, 043	0					4.01
4.02	10, 788	9					4.02
4.03	29, 556	9					4.03
4.04	322, 891	0					4.04
4. 05	-143, 615	0					4.05
4.06	-3, 009	0					4.06

\* 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.

5.00

	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 ei iiibui	Schieff under title Aviii.	
	HOSPITAL MANAGE	6.00
7.00		7.00
8.00	HOME OFFICE	8.00
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.

5.00

121, 958

Provider CCN: 15-1334

Peri od: Worksheet A-8-2 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

							5/31/2024 6: 5	1 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Component	Component		ider Component	
				· ·	•		Hours	
	1.00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	30.00	ADULTS & PEDIATRICS	321, 515	321, 515	5 0	0	0	1.00
2. 00		OPERATING ROOM	313, 164	256, 050		0	0	2. 00
3. 00		RADI OLOGY-DI AGNOSTI C	257, 188	257, 188			0	3. 00
4. 00		LABORATORY	24, 700	24, 700		1	l o	4. 00
5. 00		RESPIRATORY THERAPY	4, 860	4, 860			Ö	5. 00
6. 00		EMERGENCY	618, 082	4,000			0	6. 00
7. 00	0.00		010,002				0	7.00
	0.00						1	
8. 00			0	(			0	8.00
9. 00	0.00		0	(	0	0	0	9.00
10.00	0. 00		0	(	0	0	0	10.00
200.00			1, 539, 509	864, 313			0	200.00
	Wkst. A Line #		Unadj usted RCE			Provi der	Physician Cost	
		ldenti fi er	Li mi t		Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		ADULTS & PEDIATRICS	0	(				1.00
2.00		OPERATING ROOM	0	(	-	0	0	2.00
3. 00		RADI OLOGY-DI AGNOSTI C	0	(		0	0	3. 00
4. 00		LABORATORY	0	(	٥	0	0	4.00
5.00		RESPIRATORY THERAPY	0	(	0	0	0	5. 00
6. 00	91. 00	EMERGENCY	0	(	0	0	0	6.00
7.00	0.00		0	(	0	0	0	7.00
8. 00	0.00		0	(	0	0	0	8. 00
9.00	0.00		0	(	0	0	0	9.00
10.00	0.00		0	(	0	0	O	10.00
200.00			0	(	0	0	o	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance	1		
			Share of col.					
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00	30.00	ADULTS & PEDIATRICS	0	(	0	321, 515		1.00
2.00	50.00	OPERATING ROOM	0	(	0	256, 050		2.00
3.00	54.00	RADI OLOGY-DI AGNOSTI C	l o	(	0	257, 188		3.00
4.00	60.00	LABORATORY	l o	(	0	24, 700		4.00
5. 00		RESPIRATORY THERAPY	0	(	0	4, 860		5. 00
6. 00		EMERGENCY	l o		-	1 ., 555		6. 00
7. 00	0.00		l o	`				7. 00
8. 00	0.00							8.00
9. 00	0.00		0		-			9.00
10. 00	0.00							10.00
200.00	0.00					864, 313		200.00
200.00	I	I	ı	1	<u>ل</u> 0	004, 313	1	200.00

leal th	Financial Systems	SCOTT MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
REASON.	JTSI DE SUPPLI ERS From 01/01/2023 P To 12/31/2023 D						-3 pared: 1 am
					Physical Therapy	Cost	
						1. 00	
	PART I - GENERAL INFORMATION					1.00	
1.00	Total number of weeks worked (excluding aides	s) (see instruct	i ons)			52	1.00
2. 00 3. 00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervi:	sor or therapist	was on provi	der site (se	e instructions)	780 0	2. 00 3. 00
4. 00	Number of unduplicated days in which therapy nor therapist was on provider site (see inst	assistant was o				0	4.00
5.00	Number of unduplicated offsite visits - super				by themony	0	5.00
6. 00	Number of unduplicated offsite visits - thera assistant and on which supervisor and/or the instructions)					0	6. 00
7. 00	Standard travel expense rate					6. 55	7. 00
8. 00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	0.66 Trai nees	8. 00
		1. 00	2.00	3. 00	4. 00	5. 00	
9. 00	Total hours worked	0.00	2, 254. 00	0. (	· ·	0. 00	9. 00
	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	0. 00 48. 81	97. 62 48. 81	0. ( 0. (		0. 00	10.00 11.00
11.00	one-half of column 2, line 10; column 3,	10.01	10.01	0. (			''' 00
	one-half of column 3, line 10)						40.00
	Number of travel hours (provider site) Number of travel hours (offsite)	0	0		0		12. 00 12. 01
	Number of miles driven (provider site)	o	o		o l		13.00
13. 01	Number of miles driven (offsite)	0	0		0		13. 01
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
	Supervisors (column 1, line 9 times column 1,					0	
	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					220, 035 0	15. 00 16. 00
17. 00	Subtotal allowance amount (sum of lines 14 au		atory therapy	or lines 14	-16 for all	220, 035	
10.00	others)	10)				400.000	40.00
	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, li					488, 002 0	18.00 19.00
	Total allowance amount (sum of lines 17-19 for		herapy or lin	es 17 and 18	for all others)	708, 037	
	If the sum of columns 1 and 2 for respiratory	therapy or col	umns 1-3 for	physical the	rapy, speech pat	hol ogy or	
	occupational therapy, line 9, is greater than amount from line 20. Otherwise complete line		o entries on	lines 21 and	22 and enter on	line 23 the	
	Weighted average rate excluding aides and tra	ainees (line 17		m of columns	1 and 2, line 9	0.00	21.00
	for respiratory therapy or columns 1 thru 3,						
	Weighted allowance excluding aides and traine Total salary equivalency (see instructions)	ees (line 2 time	s line 21)			0 708, 037	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	WANCE AND TRAVEL	EXPENSE COMP	UTATION - PR	OVI DER SITE	700,007	20.00
	Standard Travel Allowance						
	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					0	24.00 25.00
	Subtotal (line 24 for respiratory therapy or	sum of lines 24	and 25 for a	II others)		0	26.00
	Standard travel expense (line 7 times line 3				3 and 4 for all	0	27.00
28. 00	others) Total standard travel allowance and standard	travel expense	at the provid	er site (sum	of lines 26 and	0	28. 00
	27)	·					
00 00	Optional Travel Allowance and Optional Travel		2 1: 22 12 )			0	20.00
29. 00 30. 00	Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,		z, iiile 12 )			0	29.00 30.00
	Subtotal (line 29 for respiratory therapy or	,	and 30 for a	II others)		Ö	31.00
32. 00	Optional travel expense (line 8 times columns	s 1 and 2, line	13 for respir	atory therap	y or sum of	0	32.00
33. 00	columns 1-3, line 13 for all others) Standard travel allowance and standard travel	l exnense (line	28)			0	33.00
	Optional travel allowance and standard travel			d 31)		0	34.00
	Optional travel allowance and optional travel					0	35.00
35.00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA						

	Optional Travel Allowance and Optional Travel Expense		l
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of	0	32.00
	columns 1-3, line 13 for all others)		1
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PR	ROVI DER SITE	
	Standard Travel Expense		l
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		l
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three Lir	nes 44, 45, or	l
	46, as appropri ate.		l
	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00
	0.000.000		
MCRIF3	2 - 22. 2. 178. 3		

Health Financial Systems	SCOTT MEMORIAL				u of Form CMS-2	2552-10
REASONABLE COST DETERMINATION FOR THERAPY SERVICES OUTSIDE SUPPLIERS	FURNI SHED BY	Provi der Co	CN: 15-1334	Peri od: From 01/01/2023 To 12/31/2023	Worksheet A-8 Parts I-VI Date/Time Pre 5/31/2024 6:5	pared:
				Physical Therapy	Cost	
					1. 00	
46.00 Optional travel allowance and optional trave						46. 00
	Therapi sts 1.00	Assi stants 2.00	Ai des 3.00	Trai nees 4.00	Total 5. 00	
PART V - OVERTIME COMPUTATION	1.00	2.00	0.00	1. 00	0.00	
47.00 Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0.00	0. (	0.00	0. 00	47.00
48.00 Overtime rate (see instructions)	0.00	0.00	0. (	0.00		48.00
49.00 Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0.00	0. 00	0. (	0.00		49.00
50.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0. 00	0. (	0.00	0.00	50.00
51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0. (	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE 52.00 Adjusted hourly salary equivalency amount	97. 62	0.00	48.8	0.00		52. 00
<ul><li>52.00 Adjusted hourly salary equivalency amount (see instructions)</li><li>53.00 Overtime cost limitation (line 51 times line</li></ul>		0.00		0.00		53.00
52) 54.00 Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
55.00 Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55. 00
56.00 Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0		0 0	0	56.00
					1. 00	
Part VI - COMPUTATION OF THERAPY LIMITATION	AND EXCESS COST	ADJUSTMENT			708, 037	
57.00 Salary equivalency amount (from line 23) Travel allowance and expense - provider site (from lines 33, 34, or 35)) Travel allowance and expense - Offsite services (from lines 44, 45, or 46) Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from your records) Excess over limitation (line 64 minus line 63 - if negative, enter zero)						57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00
LINE 33 CALCULATION  100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others  100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others  100.02 Line 33 = line 28 = sum of lines 26 and 27						100. 00 100. 01 100. 02
LINE 34 CALCULATION  101.00 Line 27 = line 7 times line 3 for respirator 101.01 Line 31 = line 29 for respiratory therapy or 101.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				others	0	101. 00 101. 01 101. 02
102.00 Line 31 = line 29 for respiratory therapy or 102.01 Line 32 = line 8 times columns 1 and 2, line 13 for all others				umns 1-3, line		102. 00 102. 01
102.02 Line 35 = sum of lines 31 and 32					О	102. 02

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1334

				To	12/31/2023	Date/Time Pre 5/31/2024 6:5	
			CAPITAL RELATED COSTS			1 37 3 17 2024 0. 3	alli alli
	Cook Cooker December of	Not Francisco	DIDC & FLVT	MANDLE FOLLID	EMDL OVEE	DATA	
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	DATA PROCESSI NG	
		Allocation			DEPARTMENT	1 11002551110	
		(from Wkst A					
		col. 7)	1.00	2.00	4. 00	5. 01	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	5.01	
1.00	00100 CAP REL COSTS-BLDG & FLXT	321, 117	321, 117				1.00
	00200 CAP REL COSTS-MVBLE EQUIP	650, 251		650, 251	224 224		2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING	831, 836 1, 256, 776		_	831, 836 18, 913		4. 00 5. 01
1	00570 ADMITTING	666, 881	9, 046		50, 309		1
	00560 PURCHASING RECEIVING AND STORES	59, 370			0	_	
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	337, 152			23	102 201	
	00590 OTHER ADMIN AND GENERAL 00700 OPERATION OF PLANT	1, 995, 743 905, 427	41, 863 10, 639		71, 838 22, 222		5. 05 7. 00
9. 00	00900 HOUSEKEEPI NG	414, 500	l		26, 489		9.00
	01000 DI ETARY	119, 523			6, 192	22, 114	1
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	190, 819 53, 759	1		13, 765 3, 816		
	01400 CENTRAL SERVICES & SUPPLY	63, 823	l e	_	6, 681	51, 600	
15. 00	01500 PHARMACY	366, 213	l e	0	20, 124		1
	01600 MEDICAL RECORDS & LIBRARY	633, 168	4, 256	10, 651	42, 388	81, 086	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	2, 074, 232	37, 164	93, 010	129, 538	140, 059	30.00
	03100 INTENSIVE CARE UNIT	5, 999			129, 536		31.00
43.00	04300 NURSERY	0	l		0		
	ANCILLARY SERVICE COST CENTERS	547.445	50.000	100 110	40.045	447.044	
4	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	517, 145	52, 802 0		12, 845 0	117, 944 0	1
4	05400 RADI OLOGY-DI AGNOSTI C	1, 538, 626	1	_	92, 604	125, 315	1
60.00	06000 LABORATORY	1, 351, 613	6, 064		64, 863	66, 343	60.00
	06300 BLOOD STORING PROCESSING & TRANS.	32, 450		_	0	_	1
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	403, 730 809, 875			35, 440 7, 475		
1	06700 OCCUPATI ONAL THERAPY	0	0,327		0	0	67.00
1	06800 SPEECH PATHOLOGY	0	0	_	O	0	
	06900 ELECTROCARDI OLOGY	203, 725	0	0	15, 812 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	134, 666 15, 786	l e	_	0	0	1
	07300 DRUGS CHARGED TO PATIENTS	332, 849		_	Ö	Ō	73.00
	03610 SLEEP LAB	1, 159		0	0	0	
	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC HSCT ACQUISITION	133, 105	1		11, 480 0	73, 715 0	1
	07/00 ALLOGENETE HISCT ACCOUNT TON	0		- 1	0		1
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	537, 188	1		33, 268		1
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 488, 643	17, 816 	44, 586	123, 455	103, 201	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS						72.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS  11300 INTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	19, 447, 149	246, 985	618, 116	810, 008	1, 260, 522	1
į	NONREI MBURSABLE COST CENTERS						
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	,		0		190.00
	19001 MARKETING 19200 PHYSICIANS PRIVATE OFFICES	59, 769 207, 989	l e		3, 126 14, 529		190. 01 192. 00
	19201 SCOTT PHYSICIAN GROUP	0	Ö	Ö	0		192.01
	07950 BUHSE CAMPUS	0	5, 579		0		194. 00
	07951 MEDICAL SPECIALTY	167, 343	5, 591 36, 563		4, 173		194. 01
	07952 MEDICAL OFFICE 07953 VA PROPERTY	0	24, 730	1	0		194. 02 194. 03
	07954 ALREFAI CAMPUS	0	0	1	0		194. 04
	07955 ORTHO CAMPUS	0	0		0		194. 05
	07956 DR. CRAIG CLINIC 07957 DR. OLABIGE CLINIC	0	0	0	0		194. 06 194. 07
	07957 DR. OLABIGE CLINIC 07958 URGENT CARE CLINIC	0	0	0	n		194. 07
194. 09	07959 DR. PACE	0	0	o o	o	0	194. 09
	07960 SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194. 10
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers		_		0	_	200. 00 201. 00
201.00	TOTAL (sum lines 118 through 201)	19, 882, 250	321, 117	650, 251	831, 836		
'				. "	·		

Provider CCN: 15-1334

| Peri od: | Worksheet B | From 01/01/2023 | Part | | Date/Time Prepared: | 5/31/2024 6:51 am |

					5/31/2024 6: 5	<u>1 am </u>
Cost Center Description	ADMITTING	PURCHASING RECEIVING AND	CASHI ERI NG/AC COUNTS	Subtotal	OTHER ADMIN AND GENERAL	
	5. 02	STORES 5. 03	RECEI VABLE 5. 04	5A. 04	5. 05	
GENERAL SERVICE COST CENTERS	2	2.00	2	9 9 .		
1. 00	844, 705 0 0 0 0 0 0 0 0 0	78, 245 0 446 999 2, 373 5, 196 0 0	343, 308 0 0 0 0 0 0 0 0	2, 317, 860 995, 398 458, 537 175, 537 216, 070 57, 575 122, 104 453, 375 771, 638	2, 317, 860 131, 357 60, 509 23, 165 28, 513 7, 598 16, 113 59, 829 101, 828	1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 7. 00 9. 00 10. 00 11. 00 13. 00 14. 00 16. 00
30. 00 03000 ADULTS & PEDIATRICS	133, 866	4, 155	5, 981	2, 618, 005	345, 482	30.00
31. 00   03100   INTENSIVE CARE UNIT 43. 00   04300   NURSERY	2, 995 0	0	134 0	16, 474 0	2, 174 0	31. 00 43. 00
ANCILLARY SERVICE COST CENTERS	F 040	0.444	2 5/0	044 070	444 407	
50.00   05000   OPERATING ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM	5, 812 0		3, 569	844, 370	111, 426 0	50.00 52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 60. 00   06000   LABORATORY	53, 258 151, 088	1, 773 20, 975	85, 928 89, 853	1, 946, 349 1, 765, 975	256, 848 233, 045	54. 00 60. 00
63.00 06300 BLOOD STORING PROCESSING & TRANS.	5, 450			40, 901	5, 397	63.00
65. 00 06500 RESPIRATORY THERAPY	72, 295		16, 299	558, 254	73, 669	65.00
66. 00 06600 PHYSI CAL THERAPY	72, 001	461	19, 673	1, 005, 695	132, 716	
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	38, 350 0	0	3, 593 0	41, 943	5, 535	67. 00 68. 00
69. 00   06900   SPEECH PATHOLOGY	11, 951	0	7, 272	238, 760	0 31, 508	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	103, 607	6, 252		249, 941	32, 983	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	000,007	· ·	52	16, 642	2, 196	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	137, 840		26, 301	521, 426	68, 809	73.00
76. 00   03610   SLEEP LAB	0	3	407	1, 569	207	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	71	2, 939	231, 367	30, 532	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	o	0	77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	_, -,		716, 666	94, 574	88. 00
91. 00 09100 EMERGENCY	56, 192	8, 360	72, 160	2, 914, 413	384, 593	1
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS				0		92.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	ol	0	102.00
SPECIAL PURPOSE COST CENTERS			<u> </u>	<u> </u>		
113. 00 11300   NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	844, 705	78, 141	343, 308	19, 296, 836	2, 240, 606	118. 00
NONREI MBURSABLE COST CENTERS			.1			
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0		0	5, 847		190.00
190. 01 19001 MARKETING 192. 00 19200 PHYSICIANS PRIVATE OFFICES	0		· -	62, 895		190. 01 192. 00
192. 00 19200 PHTSICIANS PRIVATE OFFICES	0	ł .		244, 632		192.00
194. 00 07950  BUHSE CAMPUS	0	1	· -	19, 542		194. 00
194. 01 07951 MEDI CAL SPECI ALTY	o o	1	Ö	191, 205		194. 01
194. 02 07952 MEDI CAL OFFI CE	0	0	0	36, 563	4, 825	194. 02
194. 03 07953 VA PROPERTY	0	0	0	24, 730		194. 03
194.04 07954 ALREFAI CAMPUS	0	1	0	0		194. 04
194. 05 07955 ORTHO CAMPUS	0		0	0		194. 05
194. 06 07956 DR. CRAIG CLINIC	0	1	0	0		194.06
194. 07 07957 DR. OLABI GE CLINI C 194. 08 07958 URGENT CARE CLINI C	0		0	0		194. 07 194. 08
194. 09 07959 DR. PACE				0		194.00
194. 10 07960 SCOTTSBURG FAMILY PRACTICE (RHC)		l 0	0	ol O		194. 10
200.00 Cross Foot Adjustments	]			o		200.00
201.00 Negative Cost Centers	0	0	0	o		201. 00
202.00   TOTAL (sum lines 118 through 201)	844, 705	78, 245	343, 308	19, 882, 250	2, 317, 860	202.00

Provider CCN: 15-1334

| Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared:

				10	12/31/2023	Date/IIme Pre   5/31/2024 6:5	
Cost Ce	enter Description	OPERATION OF PLANT	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	aiii
		7. 00	9. 00	10.00	11.00	N 13. 00	
GENERAL SERV	ICE COST CENTERS	7.00	9.00	10.00	11.00	13.00	
	_ COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REI	_ COSTS-MVBLE EQUIP						2.00
	EE BENEFITS DEPARTMENT						4.00
5. 01  00550 DATA PI							5. 01
5. 02   00570   ADMI TTI							5. 02
	SING RECEIVING AND STORES						5.03
	RING/ACCOUNTS RECEIVABLE ADMIN AND GENERAL						5. 04 5. 05
7. 00 00700 OPERATI		1, 126, 755					7.00
9. 00 00900 HOUSEKI		10, 013	529, 051				9.00
10. 00 01000 DI ETAR		28, 917	0	227, 619			10.00
11. 00 01100 CAFETER	A I S	14, 753	6, 796	0	266, 132		11. 00
13. 00 01300 NURSI NO	G ADMINISTRATION	0	0	0	3, 253	68, 426	13.00
, ,	_ SERVICES & SUPPLY	0	0	0	4, 185	0	14.00
15. 00   01500   PHARMA		0	0	0	7, 010	1, 645	15.00
	RECORDS & LIBRARY	19, 148	14, 308	0	18, 271	14, 606	16. 00
	UTINE SERVICE COST CENTERS  & PEDIATRICS	167, 202	138, 076	206, 953	63, 149	18, 357	30.00
	VE CARE UNIT	8, 834	20, 032	1, 846	1, 662	1, 382	31.00
43. 00   04300 NURSER		0,034	20, 032	0,040	1, 002	0	43.00
	RVICE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u></u>		10.00
50. 00 05000 OPERATI	NG ROOM	237, 552	100, 158	0	10, 069	10, 757	50.00
	RY ROOM & LABOR ROOM	0	0	0	0	0	52.00
	OGY-DI AGNOSTI C	62, 740	24, 324	0	32, 296	0	54.00
60. 00   06000   LABORA		27, 281	40, 063	0	33, 435	0	60.00
	STORING PROCESSING & TRANS.	0	0	0	1, 805	1 240	63.00
65. 00   06500   RESPIRA 66. 00   06600   PHYSI CA	ATORY THERAPY	37, 773 38, 363	20, 032 28, 617	0	16, 638 16, 346	1, 349 0	65. 00 66. 00
	TI ONAL THERAPY	30, 303	28, 017	0	3, 823	0	67.00
68. 00 06800 SPEECH			o	Ö	0, 020	0	68.00
69. 00 06900 ELECTRO		0	11, 447	0	4, 672	0	69.00
	SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
	DEV. CHARGED TO PATLENTS	0	0	0	0	0	72.00
	CHARGED TO PATIENTS	7, 532	7, 154	0	0	0	73.00
76.00 03610 SLEEP I		10.017	7 154	0	688	0	76.00
	C REHABILITATION NEIC HSCT ACQUISITION	12, 917	7, 154 0	0	2, 926 0	1, 645 0	76. 97 77. 00
	CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
	ERVICE COST CENTERS	9	<u> </u>		۹		70.00
	HEALTH CLINIC	40, 054	0	0	0	0	88. 00
91. 00 09100 EMERGE	NCY	80, 152	110, 890	18, 820	44, 981	18, 685	91.00
	ATION BEDS (NON-DISTINCT PART						92.00
	RSABLE COST CENTERS	.1		-	. 1		
102. 00 10200 OPI OI D		0	0	0	0	0	102. 00
113. 00 11300 I NTERES	OSE COST CENTERS		1		1		113. 00
	ALS (SUM OF LINES 1 through 117)	793, 231	529, 051	227, 619	265, 209	68, 426	
	BLE COST CENTERS	770,201	027,001	227,017	200, 207	00, 120	1110.00
	FLOWER COFFEE SHOP & CANTEEN	7, 510	0	0	0	0	190.00
190. 01 19001 MARKETI	NG	0	0	0	923	0	190. 01
	ANS PRIVATE OFFICES	0	0	0	0		192. 00
192. 01 19201 SCOTT I		0	0	0	0		192. 01
194. 00 07950 BUHSE (		25, 100	0	0	0		194.00
194. 01 07951 MEDI CAI 194. 02 07952 MEDI CAI		25, 156	0	0	U O		194. 01 194. 02
194. 03 07953 VA PROF		164, 498 111, 260	0	0	0		194. 02
194. 04 07954 ALREFAI		111, 200	0	0	0		194. 04
194. 05 07955 ORTHO		O	o	0	o		194. 05
194.06 07956 DR. CRA		0	ō	0	ō		194. 06
194. 07 07957 DR. OLA		0	0	0	o		194. 07
194. 08 07958 URGENT		0	0	0	0		194. 08
194. 09 07959 DR. PAG		0	0	0	0		194. 09
	BURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194. 10
	Foot Adjustments ve Cost Centers		_	0		0	200. 00 201. 00
	(sum lines 118 through 201)	1, 126, 755	529, 051	227, 619	266, 132		201.00
232. 33 <sub>1</sub>   101AL	(3 11163 116 till bugil 201)	1, 120, 733	327, 031	221,017	200, 102	00, 420	1-02.00

COST AL	COST ALLOCATION - GENERAL SERVICE COSTS				eri od:	Worksheet B	
				F	rom 01/01/2023 o 12/31/2023	Part     Date/Time Pre	narod:
				'	0 12/31/2023	5/31/2024 6: 5	pareu: 1 am
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	Subtotal	Intern &	
		SERVICES &		RECORDS &		Resi dents	
		SUPPLY		LI BRARY		Cost & Post	
						Stepdown	
		14. 00	15. 00	16. 00	24. 00	Adjustments 25.00	
	GENERAL SERVICE COST CENTERS	14.00	13.00	10.00	24.00	23.00	
	00100 CAP REL COSTS-BLDG & FLXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00550 DATA PROCESSING						5. 01
	00570 ADMI TTI NG						5. 02
	00560 PURCHASING RECEIVING AND STORES						5.03
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI N AND GENERAL						5. 04 5. 05
	00700 OPERATION OF PLANT						7.00
	00900 HOUSEKEEPI NG						9. 00
	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVICES & SUPPLY	142, 402					14.00
	01500 PHARMACY	1, 430	523, 289	000 000			15.00
	01600 MEDICAL RECORDS & LIBRARY	184	0	939, 983			16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	8, 546	o	16, 377	3, 582, 147	0	30.00
	03100 INTENSIVE CARE UNIT	0, 340	o	366		0	31.00
1	04300 NURSERY	o o	o	0	02,770	0	43.00
	ANCILLARY SERVICE COST CENTERS		-1		-,		
50.00	05000 OPERATING ROOM	4, 343	0	9, 773	1, 328, 448	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	3, 647	0	235, 286	2, 561, 490	0	54.00
	06000 LABORATORY	43, 142	0	245, 977	2, 388, 918	0	60.00
	06300 BLOOD STORING PROCESSING & TRANS.	3, 400	0	3, 691	55, 194	0	63.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 225 949	0	44, 629 53, 870	754, 569 1, 276, 556	0	65. 00 66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	9, 838	61, 139	0	67.00
	06800 SPEECH PATHOLOGY	o o	o	0	01, 107	0	68.00
	06900 ELECTROCARDI OLOGY	O	O	19, 911	306, 298	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	12, 859	0	14, 831	310, 614	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 654	0	141	20, 633	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	38, 201	523, 289	72, 017	1, 238, 428	0	73.00
	03610 SLEEP LAB	6	0	1, 115	3, 585	0	76.00
	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC HSCT ACQUISITION	147	0	8, 047 0	294, 735 0	0	76. 97 77. 00
	07700 ALLOGENETE HISET ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	o	0	0	0	78.00
	OUTPATIENT SERVICE COST CENTERS	<u> </u>	٥,		٥١		70.00
	08800 RURAL HEALTH CLINIC	4, 259	0	6, 526	862, 079	0	88. 00
	09100 EMERGENCY	17, 196	0	197, 588	3, 787, 318	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	10200 OPLOLD TREATMENT PROGRAM SPECLAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
	11300 INTEREST EXPENSE		1				113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	142, 188	523, 289	939, 983	18, 884, 921	0	118.00
H	NONREI MBURSABLE COST CENTERS	112, 100	020, 207	707, 700	10,001,721		110.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	14, 129	0	190. 00
190. 01	19001 MARKETI NG	0	0	0	72, 118		190. 01
	19200 PHYSICIANS PRIVATE OFFICES	0	0	0	276, 915		192. 00
	19201 SCOTT PHYSICIAN GROUP	0	0	0	0		192. 01
	07950 BUHSE CAMPUS	0	0	0	47, 221		194.00
	07951 MEDICAL SPECIALTY 07952 MEDICAL OFFICE	214	0	0	241, 807 205, 886		194. 01 194. 02
	07953 VA PROPERTY		0	0	139, 253		194. 02
	07954 ALREFAI CAMPUS	o o	o	0	0		194. 04
	07955 ORTHO CAMPUS	O	О	0	0		194. 05
	07956 DR. CRAIG CLINIC	0	0	0	0		194. 06
	07957 DR. OLABIGE CLINIC	0	0	0	0		194. 07
	07958 URGENT CARE CLINIC	0	0	0	0		194. 08
	07959 DR. PACE 07960 SCOTTSBURG FAMILY PRACTICE (RHC)	0	O	0	0		194. 09 194. 10
200.00	Cross Foot Adjustments	"	٩	Ü	0		200.00
200.00	Negative Cost Centers		n	0	0		200.00
202.00	TOTAL (sum lines 118 through 201)	142, 402	523, 289	939, 983	19, 882, 250		202.00
,	<b>.</b>	. ,			,		

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS SCOTT MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

| Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-1334

			10 12/31/2023   Date/Time Pr   5/31/2024 6:	
	Cost Center Description	Total	1 3, 61, 262. 6.	<u> </u>
		26. 00		
	GENERAL SERVICE COST CENTERS			1 00
	00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP	+		1. 00 2. 00
1	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
1	00550 DATA PROCESSING			5. 01
1	00570 ADMI TTI NG			5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES			5. 03
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 04
	00590 OTHER ADMIN AND GENERAL			5. 05
1	00700 OPERATION OF PLANT			7.00
1	00900 HOUSEKEEPI NG 01000 DI ETARY	+		9. 00 10. 00
	01100 CAFETERI A			11.00
1	01300 NURSI NG ADMI NI STRATI ON			13. 00
1	01400 CENTRAL SERVICES & SUPPLY			14.00
15. 00	01500 PHARMACY			15. 00
	01600 MEDICAL RECORDS & LIBRARY			16. 00
-	INPATIENT ROUTINE SERVICE COST CENTERS	0.500.447		
	03000 ADULTS & PEDIATRICS	3, 582, 147		30.00
	03100   INTENSIVE CARE UNIT 04300   NURSERY	52, 770 0		31.00 43.00
	ANCILLARY SERVICE COST CENTERS	<u> </u>		43.00
	05000 OPERATING ROOM	1, 328, 448		50.00
	05200 DELIVERY ROOM & LABOR ROOM	0		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 561, 490		54.00
	06000 LABORATORY	2, 388, 918		60. 00
1	06300 BLOOD STORING PROCESSING & TRANS.	55, 194		63.00
1	06500 RESPIRATORY THERAPY	754, 569		65.00
1	06600 PHYSI CAL THERAPY	1, 276, 556		66. 00 67. 00
1	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	61, 139		68.00
1	06900 ELECTROCARDI OLOGY	306, 298		69.00
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	310, 614		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	20, 633		72. 00
	07300 DRUGS CHARGED TO PATIENTS	1, 238, 428		73. 00
	03610 SLEEP LAB	3, 585		76. 00
	07697 CARDI AC REHABI LI TATI ON	294, 735		76. 97
1	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0		77. 00 78. 00
+	OUTPATIENT SERVICE COST CENTERS	U <sub>1</sub>		76.00
	08800 RURAL HEALTH CLINIC	862, 079		88. 00
	09100 EMERGENCY	3, 787, 318		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92.00
	OTHER REIMBURSABLE COST CENTERS			
	10200 OPI OI D TREATMENT PROGRAM	0		102.00
	SPECIAL PURPOSE COST CENTERS  11300   INTEREST EXPENSE			112 00
113.00		18, 884, 921		113. 00 118. 00
	NONREI MBURSABLE COST CENTERS	10, 004, 721		1110.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	14, 129		190. 00
	19001 MARKETI NG	72, 118		190. 01
	19200 PHYSICIANS PRIVATE OFFICES	276, 915		192. 00
4	19201 SCOTT PHYSICIAN GROUP	0		192. 01
	07950 BUHSE CAMPUS	47, 221		194.00
	07951 MEDI CAL SPECI ALTY	241, 807		194. 01
	07952 MEDI CAL OFFI CE 07953 VA PROPERTY	205, 886 139, 253		194. 02 194. 03
4	07954 ALREFAI CAMPUS	139, 233		194.03
	07955 ORTHO CAMPUS	o		194. 05
4	07956 DR. CRAIG CLINIC	o		194. 06
194. 07	07957 DR. OLABIGE CLINIC	О		194. 07
4	07958 URGENT CARE CLINIC	0		194. 08
	07959 DR. PACE	0		194. 09
	07960 SCOTTSBURG FAMILY PRACTICE (RHC)	0		194. 10
200. 00 201. 00		0		200. 00 201. 00
201.00		19, 882, 250		201.00
50	, (	, 552, 250		, 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 1/2024 | Prepared: | Pr Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1334

			То	12/31/2023	Date/Time Pre 5/31/2024 6:5	
		CAPI TAL REI	LATED COSTS		7 37 3 17 2024 0. 3	ı allı
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New Capital				BENEFITS DEPARTMENT	
	Related Costs				DEFARTMENT	
	0	1.00	2.00	2A	4. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00   00200   CAP   REL   COSTS - MVBLE   EQUI   P						2.00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5. 01   00550 DATA PROCESSING 5. 02   00570 ADMITTING	0	1, 983 9, 046		6, 947 31, 686	0	5. 01 5. 02
5. 03   00560   PURCHASING RECEIVING AND STORES	0	5, 389		18, 875	0	5.02
5. 04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	1, 751		6, 133	0	5. 04
5. 05 00590 OTHER ADMIN AND GENERAL	62, 104	41, 863	1	208, 736	0	5. 05
7.00 00700 OPERATION OF PLANT	0	10, 639	26, 625	37, 264	0	7. 00
9. 00   00900   HOUSEKEEPI NG	0	2, 226	1	7, 796	0	9. 00
10. 00   01000   DI ETARY	0	6, 427		22, 512	0	10.00
11. 00 01100 CAFETERI A	0	3, 279	8, 207	11, 486	0	11.00
13. 00   01300   NURSI NG   ADMI NI STRATI ON 14. 00   01400   CENTRAL   SERVI CES & SUPPLY	0	0	0	O O	0	13. 00 14. 00
15. 00   01500   PHARMACY	0	0		0	0	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	4, 256	10, 651	14, 907	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS		., ====		,		
30. 00 03000 ADULTS & PEDIATRICS	0	37, 164	93, 010	130, 174	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0		4, 914	6, 878	0	31.00
43. 00   04300   NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS	1 0	F0.000	100 110	404 044		
50.00   05000   OPERATING ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM	0 0			184, 944 0	0	50. 00 52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	13, 945	1	48, 845	0	54.00
60. 00   06000   LABORATORY	0	6, 064		21, 240	0	60.00
63. 00 06300 BLOOD STORING PROCESSING & TRANS.	0	0	0	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0	8, 396	21, 012	29, 408	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	8, 527	21, 340	29, 867	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00   06800   SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	1, 674	4, 190	5, 864	0	73.00
76. 00   03610   SLEEP LAB	0	0	0	0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	2, 871	7, 186	10, 057	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	1		00.004	04 404		
88.00   08800 RURAL HEALTH CLINIC 91.00   09100 EMERGENCY	0 0			31, 184	0	88. 00 91. 00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART	0	17, 816	44, 586	62, 402	U	91.00
OTHER REIMBURSABLE COST CENTERS				<u> </u>		72.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	62, 104	246, 985	618, 116	927, 205	0	118. 00
NONREI MBURSABLE COST CENTERS	1 0	4 ((0	1 4 4 7 0	E 0.47		1.00.00
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 190.01 19001 MARKETING	0	1, 669	4, 178	5, 847		190. 00 190. 01
192. 00 19200 PHYSICIANS PRIVATE OFFICES	0	0		0		190.01
192. 01 19201 SCOTT PHYSI CI AN GROUP	0	0		0		192.00
194. 00 07950 BUHSE CAMPUS	0	5, 579	13, 963	19, 542		194.00
194. 01 07951 MEDI CAL SPECI ALTY	0	5, 591		19, 585		194. 01
194. 02 07952 MEDI CAL OFFI CE	0	36, 563	0	36, 563	0	194. 02
194. 03 07953 VA PROPERTY	0	24, 730	0	24, 730		194. 03
194. 04 07954 ALREFAI CAMPUS	0	0	0	0		194. 04
194. 05 07955 ORTHO CAMPUS	0	0	0	0		194. 05
194. 06 07956 DR. CRAIG CLINIC	0			0		194. 06 194. 07
194. 07 07957  DR. OLABI GE CLI NI C 194. 08 07958  URGENT CARE CLI NI C				0		194.07
194. 09 07959 DR. PACE		0		Ol Ol		194.00
194. 10 07960 SCOTTSBURG FAMILY PRACTICE (RHC)			l ől	ol		194. 10
200.00 Cross Foot Adjustments				ō		200. 00
201.00 Negative Cost Centers		0	0	o		201. 00
202.00   TOTAL (sum lines 118 through 201)	62, 104	321, 117	650, 251	1, 033, 472	0	202. 00

Provider CCN: 15-1334

| Peri od: | Worksheet B | From 01/01/2023 | Part I I | To | 12/31/2023 | Date/Time Prepared:

					0 12/31/2023	Date/Time Pre   5/31/2024 6:5	
	Cost Center Description	DATA PROCESSI NG	ADMI TTI NG	PURCHASING RECEIVING AND STORES	CASHI ERI NG/AC COUNTS RECEI VABLE	OTHER ADMIN AND GENERAL	- diii
		5. 01	5. 02	5. 03	5. 04	5. 05	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 01 5. 02	OO100   CAP REL COSTS-BLDG & FIXT   OO200   CAP REL COSTS-MVBLE EQUIP   OO400   EMPLOYEE BENEFITS DEPARTMENT   OO550   DATA PROCESSING   OO570   ADMITTING	6, 947 519	32, 205				1.00 2.00 4.00 5.01 5.02
5.03	00560 PURCHASI NG RECEI VI NG AND STORES 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	18, 875	I I		5. 03 5. 04
5. 04 5. 05	00590 OTHER ADMIN AND GENERAL	559	0	0 108	-,	209, 403	1
7. 00	00700 OPERATION OF PLANT	160	Ö	241	o	11, 867	1
9. 00	00900 HOUSEKEEPI NG	40	0	572	I I	5, 467	1
10.00	01000 DI ETARY	120	0	.,	I I	2, 093	1
11.00	01100 CAFETERI A	0	0	0	-	2, 576	1
13.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0 279	0	0	-	686	1
14. 00 15. 00	01500 PHARMACY	359	0	168	-	1, 456 5, 405	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	439	0		I	9, 199	1
	INPATIENT ROUTINE SERVICE COST CENTERS		-		, -,	.,	1
30.00	03000 ADULTS & PEDIATRICS	759	5, 103	1, 002	107	31, 212	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	114		I I	196	1
43. 00	04300 NURSERY	0	0	0	0	0	43.00
50. 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM	639	222	509	64	10, 067	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	039	0	309	1	10, 067	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	679	2, 030	1		23, 204	1
60.00	06000 LABORATORY	359	5, 762	5, 060		21, 054	1
63.00	06300 BLOOD STORING PROCESSING & TRANS.	o	208	399	24	488	63.00
65. 00	06500 RESPI RATORY THERAPY	0	2, 756		· •	6, 656	1
66.00	06600 PHYSI CAL THERAPY	359	2, 745	1	I I	11, 990	1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	1, 462 0	0		500 0	1
69. 00	06900 ELECTROCARDI OLOGY		456	1		2, 846	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		3, 950		I I	2, 980	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	194	I I	198	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5, 255	4, 480	469	6, 216	1
76.00	03610 SLEEP LAB	0	0	1	7	19	1
76. 97 77. 00	07697 CARDI AC REHABI LI TATI ON 07700 ALLOGENEI C HSCT ACQUI SITI ON	399	0	17		2, 758 0	
78.00	07800 CAR T-CELL IMMUNOTHERAPY		0	0		0	
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		<u> </u>		70.00
88. 00	08800 RURAL HEALTH CLINIC	599	0	499	42	8, 544	88. 00
91.00	09100 EMERGENCY	559	2, 142	2, 017	1, 285	34, 745	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS		_	_	1 _1		
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102.00
113 00	11300 INTEREST EXPENSE						113.00
118.00		6, 827	32, 205	18, 850	6, 133	202, 422	
	NONREI MBURSABLE COST CENTERS	,	·		,	•	1
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
	19001 MARKETI NG	0	0	0	- 1		190. 01
	19200 PHYSI CLANS PRI VATE OFFI CES	120	0	0	- 1		192.00
	19201   SCOTT PHYSICIAN GROUP   07950   BUHSE CAMPUS	0	0	0	- 1		192. 01 194. 00
	07951 MEDICAL SPECIALTY		0	25	1		194. 00
	07952 MEDI CAL OFFI CE	o	0	0	l l		194. 02
	07953 VA PROPERTY	o	0	O	o		194. 03
	07954 ALREFAI CAMPUS	0	0	O	0		194. 04
	07955 ORTHO CAMPUS	0	0	0	0		194.05
	07956 DR. CRAIG CLINIC	0	0		0		194.06
	7 07957 DR. OLABIGE CLINIC 8 07958 URGENT CARE CLINIC		0				194. 07 194. 08
	07959 DR. PACE		0	0			194.00
	07960 SCOTTSBURG FAMILY PRACTICE (RHC)	o	Ö		o o		194. 10
200.00							200.00
201.00		0	0	0	o		201.00
202. 00	TOTAL (sum lines 118 through 201)	6, 947	32, 205	18, 875	6, 133	209, 403	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1334

| Peri od: | Worksheet B | From 01/01/2023 | Part I I | To | 12/31/2023 | Date/Time Prepared:

			10	12/31/2023	Date/IIme Pre   5/31/2024 6:5	
Cost Center Description	OPERATION OF PLANT	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	aiii
	7. 00	9. 00	10.00	11.00	N 13. 00	
GENERAL SERVICE COST CENTERS	7.00	9.00	10.00	11.00	13.00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01   00550 DATA PROCESSING						5. 01
5. 02   00570   ADMI TTI NG						5.02
5. 03   00560  PURCHASI NG RECEI VI NG AND STORES 5. 04   00580  CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03 5. 04
5. 05   00590 OTHER ADMI N AND GENERAL						5. 05
7. 00   00700   OPERATION OF PLANT	49, 532					7.00
9. 00   00900   HOUSEKEEPI NG	440	14, 315				9.00
10. 00 01000 DI ETARY	1, 271	0	27, 249			10.00
11. 00   01100   CAFETERI A	649	184	0	14, 895		11.00
13.00 01300 NURSING ADMINISTRATION	0	0	0	182	868	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	234	0	14.00
15. 00   01500   PHARMACY	0	0	0	392	21	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	842	387	0	1, 023	185	16. 00
30.00 O3000 ADULTS & PEDIATRICS	7, 350	3, 736	24, 775	3, 532	233	30.00
31. 00   03100   NTENSI VE CARE UNIT	388	5, 730 542	24, 775	93	233 18	31.00
43. 00   04300   NURSERY	0	0	0	79	0	43.00
ANCILLARY SERVICE COST CENTERS		<u> </u>	<u> </u>	<u></u>		10.00
50.00 O5000 OPERATING ROOM	10, 445	2, 710	0	564	136	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	O	o	0	o	0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	2, 758	658	0	1, 808	0	54.00
60. 00   06000   LABORATORY	1, 199	1, 084	0	1, 871	0	60.00
63. 00 06300 BLOOD STORING PROCESSING & TRANS.	0	0	0	101	0	63.00
65. 00   06500   RESPI RATORY THERAPY	1, 660	542	0	931	17 0	65.00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	1, 686	774 0	0	915 214	0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	o	0	0	214	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	o	310	0	262	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	0	o	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	331	194	0	0	0	73.00
76. 00   03610   SLEEP LAB	0	0	0	39	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	568	194	0	164	21	76. 97
77.00   07700   ALLOGENEIC HSCT ACQUISITION 78.00   07800   CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	77. 00 78. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u>U</u>	U	<u> </u>	U	76.00
88. 00 08800 RURAL HEALTH CLINIC	1, 761	O	0	0	0	88. 00
91. 00   09100   EMERGENCY	3, 523	3, 000	2, 253	2, 518	237	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		.,	,	,		92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS				ı		
113.00 11300 INTEREST EXPENSE 118.00  SUBTOTALS (SUM OF LINES 1 through 117	24 071	14 215	27 240	14, 843	0.40	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117 NONREIMBURSABLE COST CENTERS	) 34, 871	14, 315	27, 249	14, 843	808	118. 00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	330	0	0	0	0	190. 00
190. 01 19001 MARKETI NG	0	o	0	52		190. 01
192.00 19200 PHYSICIANS PRIVATE OFFICES	o	o	0	О	0	192. 00
192. 01 19201 SCOTT PHYSICIAN GROUP	0	o	0	o		192. 01
194.00 07950 BUHSE CAMPUS	1, 103	0	0	0		194. 00
194. 01 07951 MEDI CAL SPECI ALTY	1, 106	0	0	0		194. 01
194. 02 07952 MEDI CAL OFFI CE	7, 231	0	0	0		194. 02
194.03 07953 VA PROPERTY 194.04 07954 ALREFAI CAMPUS	4, 891	0	0	0		194. 03 194. 04
194.05 07955 0RTH0 CAMPUS		0	0	٥		194. 04
194. 06 07956 DR. CRAIG CLINIC		0	0	0		194.06
194. 07 07957 DR. OLABIGE CLINIC		ol	Ö	ol		194. 07
194. 08 07958 URGENT CARE CLINIC	0	o	0	o		194. 08
194. 09 07959 DR. PACE	0	o	0	o		194. 09
194.10 07960 SCOTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0	0	194. 10
200.00 Cross Foot Adjustments		_		_	_	200.00
201.00 Negative Cost Centers	40 533	14 21	0 27 240	14 005		201.00
202.00   TOTAL (sum lines 118 through 201)	49, 532	14, 315	27, 249	14, 895	808	202. 00

ALLOCATION OF	CAPITAL RELATED COSTS		Provi der CC		eri od:	Worksheet B	
				Fi To	rom 01/01/2023 b 12/31/2023	Part II Date/Time Pre 5/31/2024 6:5	pared:
Co	ost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14. 00	15. 00	16. 00	24.00	25. 00	
	SERVICE COST CENTERS		T				1 1 00
2. 00 00200 C/ 4. 00 00400 EN 5. 01 00550 D/ 5. 02 00560 P/ 5. 03 00560 P/ 5. 04 00580 C/ 5. 05 00590 O' 7. 00 00700 D/ 9. 00 01000 D/ 11. 00 01300 N/ 14. 00 01400 P/ 15. 00 01500 P/ 16. 00 01600 M/ I NPATLE	AFETERIA URSING ADMINISTRATION ENTRAL SERVICES & SUPPLY HARMACY EDICAL RECORDS & LIBRARY NT ROUTINE SERVICE COST CENTERS	1, 969 20 3	6, 365 0	27, 007			1.00 2.00 4.00 5.01 5.02 5.03 5.04 5.05 7.00 9.00 11.00 13.00 14.00 15.00
	DULTS & PEDIATRICS	118	0	470	208, 571	0	
31. 00   03100   I I 43. 00   04300   NI	NTENSIVE CARE UNIT	0	0	11 0	8, 463 0	0	
	RY SERVICE COST CENTERS	o <sub>l</sub>		<u> </u>	<u> </u>	Ü	10.00
	PERATING ROOM	60	0	281	210, 641	0	1
	ELIVERY ROOM & LABOR ROOM	0	0	0	0	0	
	ADI OLOGY-DI AGNOSTI C ABORATORY	50 596	0	6, 759 7, 070	88, 750 66, 914	0	
1 1	LOOD STORING PROCESSING & TRANS.	47	0	106	1, 373	0	
1 1	ESPI RATORY THERAPY	31	o	1, 282	43, 834	0	
	HYSI CAL THERAPY	13	o	1, 548	50, 358	0	
1 1	CCUPATI ONAL THERAPY	0	0	283	2, 523	0	
1 1	PEECH PATHOLOGY	0	0	0	0	0	
	LECTROCARDIOLOGY EDICAL SUPPLIES CHARGED TO PATIENT	0 178	0	572 426	4, 576 9, 138	0	
	MPL. DEV. CHARGED TO PATIENTS	23	0	420	420	0	1
	RUGS CHARGED TO PATIENTS	528	6, 365	2, 069	31, 771	0	1
	LEEP LAB	0	0	32	98	0	
	ARDI AC REHABI LI TATI ON	2	0	231	14, 463	0	1
	LLOGENEIC HSCT ACQUISITION AR T-CELL IMMUNOTHERAPY	0	0	0	0	0	
	ENT SERVICE COST CENTERS	U	<u> </u>	U	0	0	78.00
	URAL HEALTH CLINIC	59	0	187	42, 875	0	88. 00
91.00 09100 EN	MERGENCY	238	О	5, 676	120, 595	0	91.00
92. 00 09200 OE	BSERVATION BEDS (NON-DISTINCT PART					0	92.00
	EIMBURSABLE COST CENTERS		ما	0	ol	0	100.00
	PIOID TREATMENT PROGRAM PURPOSE COST CENTERS	0	0	0	<u> </u>		102.00
	NTEREST EXPENSE						113.00
	UBTOTALS (SUM OF LINES 1 through 117)	1, 966	6, 365	27, 007	905, 363	0	118. 00
	BURSABLE COST CENTERS		ما				
190. 00 19000 GI	IFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	6, 247 802		190. 00 190. 01
1 1	HYSICIANS PRIVATE OFFICES	0	0	0	3, 037		192.00
	COTT PHYSICIAN GROUP	Ö	Ö	0	0		192. 01
194. 00 07950 Bl		0	o	0	20, 878		194. 00
1 1	EDI CAL SPECI ALTY	3	0	0	22, 999		194. 01
194. 02 07952 ME 194. 03 07953 VA		0	0	0	44, 230		194. 02
194. 03 07953 VA		0	0	0	29, 916 0		194. 03 194. 04
194. 05 07955 OF		Ö	Ö	0	Ö		194. 05
194. 06 07956 DF	R. CRAIG CLINIC	О	o	0	0		194. 06
1 1	R. OLABIGE CLINIC	0	0	0	0		194. 07
194. 08 07958 UF 194. 09 07959 DF	RGENT CARE CLINIC	0	0	0	0		194. 08 194. 09
	R. PACE COTTSBURG FAMILY PRACTICE (RHC)	0	0	0	0		194. 09
	ross Foot Adjustments		ĭ		ol		200.00
201. 00 Ne	egative Cost Centers	О	o	0	O	0	201.00
202. 00 TO	OTAL (sum lines 118 through 201)	1, 969	6, 365	27, 007	1, 033, 472	0	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS SCOTT MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2023 | Part II |
| To | 12/31/2023 | Date/Time | Prepared: | 5/31/2024 | 6:51 am | Provider CCN: 15-1334

				5/31/2024 6:5	
EMPRILE SERVICE COST CENTERS   1 0 00 00000 CAP SET COSTS AND E POLITY   2 0 00 00000 CAP SET COSTS AND E POLITY   2 0 00 00000 CAP SET COSTS AND E POLITY   2 0 00 00000 CAP SET COSTS AND E POLITY   2 0 00 00000 CAP SET COSTS AND E POLITY   2 0 00 000000 CAP SET COSTS AND E POLITY   2 0 00 000000 CAP SET COSTS AND E POLITY   2 0 00 00000 CAP SET COSTS AND E POLITY   2 0 00 00000 CAP SET COSTS AND E POLITY   2 0 00 00000 CAP SET COSTS AND E POLITY   2 0 00 00000 CAP SET COSTS AND E POLITY   2 0 00 00000 CAP SET COSTS AND E POLITY   2 0 00 00000 CAP SET COSTS AND E POLITY   2 0 00 00000 CAP SET COSTS AND E POLI		Cost Center Description			
DOTOR   DOTOR   CAP   FIT COSTS - HIRS & FITX			26. 00	<u> </u>	
2.00					
4.00   00000   PART PROCESSING   5.01   5.05   5.					1
5.01 0.0550 DATA PROCESSING					
0.070   ADMITTHES   0.070   ADMITTHES   0.070   0.07					1
5.03   0.0566   DIRCHASIN R. RECEIVI RG. AND STORES   5.04		•			1
5.04   0.0580  CASHIERIN RYACCOUNTS RECTIVABLE   5.06   5.05   0.0590  OTHER ADMIN AND GENERAL   5.06   5.05   5.05   0.0590  OTHER ADMIN AND GENERAL   7.00   7.					1
5.05   0.0590   OTHER ANNIN AND GENERAL   7.00   0.000   OPERATION OF PLANT   7.000   OPERATION	1	•			1
7.00   00700  DEPATION OF PLANT   7.00   0.0000  DEPATED NO   0.0000  DEPATED NO   0.0000  DEPATED NO   0.000  DEPATED NO	1	•			1
10.00   01000   DETARY	1	l .			1
11.00   10.00   CAFETRIA     11.00   13.00   13.00   13.00   01.00   CRITERIA   SERVICES & SUPPLY	9.00	00900 HOUSEKEEPI NG	·		9.00
13.00   01300   MURSI NA ADMINISTRATION   13.00   15	10.00	01000 DI ETARY			10.00
14.0   00   1400   CENTRAL SERVICES & SUPPLY   15.0   01500   1600   HARDIACY   15.0   01500   HARDIACY   15.0   01500   HARDIACY   15.0   01500   HARDIACY   16.0   01500   HARDIACY   16.0	1				1
15.00	1				
16.00					
IMPATI ENT BOUTUNE SERVICE COST CENTERS   30.00   30.00   30.00   30.00   AUILTS & PEDIATRICS   208, 571   31.00   3	1				1
30.00   3000   ADULTS & PEDIATRICS   208, 571   31, 00   310   00   0	-				16.00
31.00	_		200 E71		20.00
43. 00   ASOO   NURSERY   0   0   0   0   0   0   0   0   0					1
MANULLARY SERVICE COST CENTERS					1
50.00     50.00     50.00   60.00	_		O <sub>1</sub>		1 43.00
52.00   05200   DELI YERY ROOM & LABOR ROOM   0   52.00	_		210, 641		50.00
54. 00   05400   RODI LOGY-DI AGNOSTI C   88, 750   60. 00   6000   LABORATORY   66. 914   60. 00   6000   LABORATORY   FERRAL   65. 00   65. 00   65.00   RESPIRATORY   THERAPY   43, 834   65. 00   66. 00   6					1
63.00	1		88, 750		
65. 00   0.6500   RESPIRATORY THERAPY	60.00	06000 LABORATORY	66, 914		60.00
66. 00   06-600   PHYSI CAL THERAPY   50.358   66. 00	63.00	06300 BLOOD STORING PROCESSING & TRANS.	1, 373		63.00
67. 00   06/700   0	65. 00 C	06500 RESPI RATORY THERAPY	43, 834		65.00
68. 00   06800   SPECCH PATHOLOGY   0   068. 00   069. 00   06900   LECTROCARD IOLOGY   4.576   69. 00   06900   LECTROCARD IOLOGY   4.576   69. 00   071. 00   07100   MDL CAL SUPPLIES CHARGED TO PATIENT   9.138   71. 00   72. 00   07200   MPLD. DEV. CHARGED TO PATIENTS   31. 771   73. 00   76. 00   07300   DRUGS CHARGED TO PATIENTS   31. 771   73. 00   76. 00   03610   SLEP LAB   98   76. 00   76. 77. 00   03610   SLEP LAB   14.63   76. 97   77. 00   07700   ALLOGENEIC HIST ACQUISITION   0   07500   07700   ALLOGENEIC CHIST ACQUISITION   0   07700	1				1
69. 00   06900   ELECTROCARDIOLOGY   4,576   71. 00   0710   MEDICAL SUPPLIES CHARGED TO PATIENT   9,138   71. 00   0720   MPL. DEV. CHARGED TO PATIENTS   31. 771   73. 00   73. 00   07300   MPL. DEV. CHARGED TO PATIENTS   31. 771   73. 00   73. 00   07300   MPL. DEV. CHARGED TO PATIENTS   31. 771   73. 00   76. 00   773. 00   770.	1	•			
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   9,138   72.00   72.00   72.00   072.00   IMPL DeV CHARGED TO PATIENTS   420   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   31,771   73.00   76.00   03610   SLEEP LAB   98   76.00   76.97   07697   CARDIAC REHABILITATION   14,463   76.97   77.00   07700   ALLOGENEIC HSCT ACQUISITION   0   77.00			-		
72.00   OZ200   IMPL. DEV. CHARGED TO PATIENTS   420   72.00   73.00					1
73. 00   07300   DRIGS CHARGED TO PATIENTS   31,771   76. 00   03610   SLEEP LAB   98   76. 00   03610   SLEEP LAB   98   76. 00   076. 70   07697   CARDIAC REHABILITATION   14,463   76. 97   07697   CARDIAC REHABILITATION   14,463   77. 00   07700   ALLOGENEI C HSCT ACQUISITION   0   0   077. 00   0700   ALLOGENEI C HSCT ACQUISITION   0   0   078. 00   078. 00   07800   CART T-CELL IMMUNOTHERAPY   0   0   0   0   0   0   0   0   0		•			1
76. 00   0340  SLEEP LAB   98   76. 00   76. 97   07697   CARDIAC REHABILITATION   14. 463   76. 97   77. 00   77. 00   07700   ALLOGENEI C HSCT ACQUISITION   0   77. 00   07800   CART -CELL I IMMUNOTHERAPY   0   0   77. 00   07900   CART -CELL I IMMUNOTHERAPY   0   0   77. 00   07900   CART -CELL I IMMUNOTHERAPY   0   0   77. 00   07900   CART -CELL I IMMUNOTHERAPY   0   0   0   0   0   0   0   0   0	1	•			1
76. 97   07597   CARDIAC REHABILITATION   14, 463   76. 97   77. 00   07700   ALLOGENEIC HSCT ACQUISITION   0   0770					1
77. 00   0790					
78.00   07800   CAR T-CELL I IMMUNOTHERAPY   0   0   0   0   0   0   0   0   0	1	•			1
88. 00 08800 RURAL HEALTH CLINIC 91. 00 09100   EMERGENCY 91. 00 09200   OSERVATION BEDS (NON-DISTINCT PART 0THER REI MBURSABLE COST CENTERS  102. 00 10200  OPIOLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS  113. 00 11300   INTEREST EXPENSE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONRE! MBURSABLE COST CENTERS  190. 00 19000   GIFT FLOWER COFFEE SHOP & CANTEEN   190. 01 19001   MARKETING   192. 00 19200   PHYSI CI ANS PRI VATE OFFI CES   3, 037 192. 01 19201   SCOTT PHYSI CI AN GROUP   40. 00 19905   BURSC CAMPUS   40. 00 19905   MEDI CAL SPECIALTY   40. 00 19905   40. 00 19905   MEDI CAL SPECIALTY   40. 00 19905   40. 00 19905   MEDI CAL SPECIALTY   40. 00 19905   40.			О		78. 00
91. 00   09100   BERRGENCY   120, 595   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   00   92. 00   OBSERVATION BEDS (NON-DISTINCT PART   00   00   OBSERVATION BEDS (NON-DISTINCT PART   00   OBSERVATION BEDS (NON-DISTINCT PART   00   OBSERVATION BEDS (NON-DISTINCT PART   00   OBSERVATION BEDS (STEERS   00   OBSERVATION BEDS (STEERS   00   OBSERVATION BURNSABLE COST CENTERS   01   00   00   00   00   00   00   0	C	UTPATIENT SERVICE COST CENTERS			
92. 00   09200   09SERVATION BEDS (NON-DISTINCT PART   OTHER REI MBURSABLE COST CENTERS   102. 00   10200   OPI DI TREATMENT PROGRAM   0   10200   OPI DI TREATMENT EXPENSE   113. 00   OPI					1
OTHER REIMBURSABLE COST CENTERS   102.00   10200   0PI 0I D TREATMENT PROGRAM   0   102.00   13000   1910 D TREATMENT PROGRAM   102.00   13000   13000   1NTEREST EXPENSE   113.00   113.00   1NTEREST EXPENSE   113.00   100000   100000   100000   100000   100000   100000   100000   100000   100000   100000   100000   100000   100000   1000000   1000000   1000000   10000000   100000000	1		120, 595		1
102.00   10200   OPI OI D TREATMENT PROGRAM   0   SPECI AL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00   11300   INTEREST EXPENSE   113.00   SUBTOTALS (SUM OF LINES 1 through 117)   905, 363   118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT FLOWER COFFEE SHOP & CANTEEN   802   190.01   19001   MARKETI NG   802   190.01   19020   PHYSI CI ANS PRI VATE OFFI CES   3, 037   192.00   192.00   19200   PHYSI CI ANS PRI VATE OFFI CES   3, 037   192.00   192.01   19201   SCOTT PHYSI CI AN GROUP   0   192.01   194.00   07950   BUHSE CAMPUS   20, 878   194.00   194.01   194.02   194.02   194.02   194.03   195.03   194.00   194.04   194.04   197.05   195.03   196.03   1	-				92.00
SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   113. 00   11300   INTEREST EXPENSE   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   905, 363   118. 00   NONREI MBURSABLE COST CENTERS   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT FLOWER COFFEE SHOP & CANTEEN   802   190. 01   19001   MARKETI NG   802   190. 01   19001   SCOTT PHYSI CI ANS PRI VATE OFFI CES   3, 037   192. 00   192. 01   192. 01   192. 01   192. 01   SCOTT PHYSI CI AN GROUP   0   192. 01   194. 01   195. MPISS   20, 878   194. 01   194. 01   194. 02   07952   MEDI CAL OFFI CE   44, 230   194. 01   194. 02   194. 03   07953   VA PROPERTY   29, 916   194. 03   195. 07955   ORTHO CAMPUS   0   194. 04   194. 05   194. 05   194. 05   194. 05   194. 05   194. 05   194. 05   194. 05   194. 06   197. 07957   DR. CRAI G CLI NI C   0   194. 05   194. 06   194. 07   07957   DR. CRAI G CLI NI C   0   194. 06   194. 07   195. 07955   ORTHO CAMPUS   0   194. 06   194. 07   195. 07957   DR. CRAI G CLI NI C   0   194. 06   194. 07   195. 07957   DR. CRAI G CLI NI C   0   194. 07   194. 08   194. 09   194. 09   194. 10   196. 07058   DR. PACE   0   194. 09   194. 10   196. 07058   DR. PACE   0   194. 09   194. 10   196. 07058   DR. PACE   0   194. 10					100.00
113.00   11300   INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)   905, 363   118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT FLOWER COFFEE SHOP & CANTEEN   802   190.01   192.00   19200   PHYSI CI ANS PRI VATE OFFI CES   3, 037   192.01   19201   SCOTT PHYSI CI ANS ROUP   0   192.01   194.00   07950   BUHSE CAMPUS   20, 878   194.00   194.01   07951   MEDI CAL SPECI ALTY   22, 999   194.01   194.02   07952   MEDI CAL OFFI CE   44, 230   194.01   194.02   07953   VA PROPERTY   29, 916   194.03   194.03   194.04   194.05   07955   ORTHO CAMPUS   0   194.05   194.05   07955   ORTHO CAMPUS   0   194.05   194.06   07956   DR. CRAI G CLI NI C   0   194.05   194.06   079578   URGENT CARE CLI NI C   0   194.07   194.08   07958   URGENT CARE CLI NI C   0   194.07   194.08   07958   URGENT CARE CLI NI C   0   194.07   194.08   07959   DR. PACE   0   194.09   194.00   194.09   194.10   07960   SCOTTSBURG FAMILLY PRACTICE (RHC)   0   194.09   194.10   07960   SCOTTSBURG FAMILLY PRACTICE (RHC)   0   194.00   194.10   194.00			U		102.00
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   905,363   118.00   NONRE I MBURSABLE COST CENTERS   190.00					113 00
NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT FLOWER COFFEE SHOP & CANTEEN   6, 247   190.01   19001   19001   MARKETI NG   802   190.01   192.00   192.00   192.00   192.00   192.00   192.00   192.00   192.01	1		905 363		1
190. 00	_		700,000		1110.00
190. 01 19001 MARKETI NG 802 19200 PHYSI CI ANS PRI VATE OFFI CES 3, 037 192. 01 19201 SCOTT PHYSI CI ANS GROUP 0 192. 01 19201 SCOTT PHYSI CI AN GROUP 0 192. 01 194. 00 07950 BUHSE CAMPUS 20, 878 194. 00 194. 01 107951 MEDI CAL SPECI ALTY 22, 999 194. 01 194. 02 194. 03 07953 VA PROPERTY 22, 999 194. 03 07953 VA PROPERTY 29, 916 194. 03 194. 04 194. 05 07955 ORTHO CAMPUS 0 194. 05 07955 OR. CRAI G CLI NI C 0 194. 06 194. 07 07957 DR. CRAI G CLI NI C 0 194. 08 07958 URGENT CARE CLI NI C 0 194. 08 194. 09 07959 DR. PACE 0 194. 09 07959 DR. PACE 0 194. 09 07959 DR. PACE 0 194. 09 07950 SCOTTSBURG FAMI LY PRACTI CE (RHC) 0 194. 00 201. 00 Negati ve Cost Centers 0 201. 00	_		6, 247		190. 00
192.00					
194. 00	192.001	9200 PHYSICIANS PRIVATE OFFICES	3, 037		192.00
194. 01 07951 MEDI CAL SPECI ALTY 22, 999 194. 02 07952 MEDI CAL OFFI CE 44, 230 194. 03 07953 VA PROPERTY 29, 916 194. 04 07954 ALREFAI CAMPUS 0 194. 06 07956 DR. CRAI G CLI NI C 0 194. 07 07957 DR. OLABI GE CLI NI C 0 194. 08 07958 URGENT CARE CLI NI C 0 194. 09 07959 DR. PACE 0 194. 09 07950 Cross Foot Adjustments 0 201. 00 Negati ve Cost Centers 0			-1		
194. 02 07952 MEDI CAL OFFI CE 44, 230 194. 03 07953 VA PROPERTY 29, 916 194. 03 194. 04 07954 ALREFAI CAMPUS 0 194. 05 07955 ORTHO CAMPUS 0 194. 06 07956 DR. CRAI G CLI NI C 0 194. 07 07957 DR. OLABI GE CLI NI C 0 194. 07 194. 08 07958 URGENT CARE CLI NI C 0 194. 07 194. 08 07958 DR. PACE 0 194. 09 07959 DR. PACE 0 194. 09 07950 DR. PACE 0 194. 09 07960 Cross Foot Adjustments 0 Negati ve Cost Centers 0 Negati ve Cost Centers 0 201. 00					
194. 03 194. 04 194. 05 194. 06 194. 07 194. 07 194. 07 194. 07 194. 07 194. 08 194. 09 194. 0					
194. 04 07954 ALREFAI CAMPUS 0 194. 05 07955 ORTHO CAMPUS 0 194. 05 07956 DR. CRAIG CLINIC 0 194. 07 07957 DR. OLABIGE CLINIC 0 194. 08 07958 URGENT CARE CLINIC 0 194. 08 07958 DR. PACE 0 194. 09 07959 DR. PACE 0 194. 00 194. 10 07960 SCOTTSBURG FAMILY PRACTICE (RHC) 0 194. 10 07960 Negative Cost Centers 0 Negative Cost Centers 0 201. 00					
194. 05 07955 ORTHO CAMPUS 0 194. 06 194. 06 194. 07 07957 DR. CRAIG CLINIC 0 194. 07 194. 08 07958 URGENT CARE CLINIC 0 194. 08 07958 DR. PACE 0 194. 0 0 194. 0 0 194. 0 0 194. 0 0 194. 0 0 0 194. 0 0 0 0 194. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					
194.06 07956 DR. CRAIG CLINIC 0 194.06 194.07 07957 DR. OLABIGE CLINIC 0 194.07 194.08 07958 URGENT CARE CLINIC 0 194.08 194.09 07959 DR. PACE 0 194.09 07959 DR. PACE 0 194.09 07959 SCOTTSBURG FAMILY PRACTICE (RHC) 0 194.09 07950 Negative Cost Centers 0 Negative Cost Centers 0 201.00					
194. 07	1	l .	0		
194.08 07958 URGENT CARE CLINIC 0 194.08 194.09 07959 DR. PACE 0 194.09 194.10 07960 SCOTTSBURG FAMILY PRACTICE (RHC) 0 194.10 200.00 Cross Foot Adjustments 0 200.00 Negative Cost Centers 0 201.00			0		
194.09 07959 DR. PACE 0 194.09 194.10 07960 SCOTTSBURG FAMILY PRACTICE (RHC) 0 194.10 200.00 Cross Foot Adjustments 0 200.00 Negative Cost Centers 0 201.00			0		
194. 10     07960     SCOTTSBURG FAMILY PRACTICE (RHC)     0       200. 00     Cross Foot Adjustments     0       201. 00     Negative Cost Centers     0			o o		
200.00         Cross Foot Adjustments         0         200.00           201.00         Negative Cost Centers         0         201.00			o		
201.00   Negative Cost Centers   0   201.00		, ,	0		200.00
202.00   TOTAL (sum lines 118 through 201)   1,033,472  202.00			-1		
	202. 00	TOTAL (sum lines 118 through 201)	1, 033, 472		202.00

Health Financial Systems SCOTT MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1334 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/31/2024 6:51 am CAPITAL RELATED COSTS ADMITTI NG Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** DATA (SQUARE FEET) (SQUARE FEET) BENEFITS PROCESSI NG (INPATIENT (# OF COMPU DEPARTMENT CHARGES) (GROSS TERS) SALARI ES) 5. 01 1. 00 2.00 4.00 5. 02 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 129, 849 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 105, 064 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 8, 520, 279 4.00 5.01 00550 DATA PROCESSING 802 193, 725 802 174 5.01 5.02 00570 ADMITTING 3,658 3,658 515, 298 13 7, 553, 921 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 2, 179 2, 179 0 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE ol 5 04 708 708 240 0 5 04 00590 OTHER ADMIN AND GENERAL 735, 823 5.05 16, 928 16, 928 0 5.05 4, 302 7.00 00700 OPERATION OF PLANT 4, 302 227, 616 0 7.00 9.00 00900 HOUSEKEEPI NG 900 900 271, 323 0 9.00 01000 DI ETARY 2 599 2 599 10 00 10 00 63 428 0 11.00 01100 CAFETERI A 1, 326 1, 326 140, 996 0 0 11.00 01300 NURSING ADMINISTRATION 39, 085 0 0 13.00 13.00 0 14.00 7 01400 CENTRAL SERVICES & SUPPLY 68, 429 14.00 0 0 9 01500 PHARMACY 15 00 206, 130 0 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 1,721 1,721 434, 170 11 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30 00 15, 028 1, 326, 812 1, 197, 128 30.00 15.028 19 03100 INTENSIVE CARE UNIT 31.00 794 794 4, 792 0 26, 779 31.00 04300 NURSERY 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 21, 351 16 51, 976 50 00 21, 351 131, 565 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 05400 RADI OLOGY-DI AGNOSTI C 948, 518 17 476, 273 54.00 5.639 5.639 54.00 06000 LABORATORY 9 1, 351, 107 60.00 2, 452 2, 452 664, 380 60.00 06300 BLOOD STORING PROCESSING & TRANS. 0 63.00 48, 739 63.00 65.00 06500 RESPIRATORY THERAPY 3, 395 3, 395 363,002 0 646, 509 65.00 66.00 06600 PHYSI CAL THERAPY 3, 448 3, 448 76, 560 643,888 66.00 0 67.00 06700 OCCUPATI ONAL THERAPY 342, 949 67.00 0 C C 06800 SPEECH PATHOLOGY 68 00 0 r  $\cap$  $\cap$ 68.00 161, 954 06900 ELECTROCARDI OLOGY 0 106, 871 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 0 0 0 926, 528 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 C 0 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 232, 665 73.00 677 677 0 73.00 76.00 03610 SLEEP LAB 0 0 76.00 76. 97 07697 CARDIAC REHABILITATION 117, 591 10 76.97 1, 161 1, 161 0 07700 ALLOGENEIC HSCT ACQUISITION 77 00 77.00  $\cap$ 0 Ω 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 340, 753 88.00 3,600 3,600 15 0 09100 EMERGENCY 502, 509 91.00 7, 204 7, 204 1, 264, 514 14 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 99.872 99.872 171 7, 553, 921 118. 00 118.00 8, 296, 704 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 675 675 0 0 190.00 190. 01 19001 MARKETI NG 0 190.01 0 32, 019 0 3 0 192. 00 19200 PHYSICIANS PRIVATE OFFICES 0 0 148, 818 0 192.00 192. 01 19201 SCOTT PHYSICIAN GROUP 0 C 0 192.01 194.00 07950 BUHSE CAMPUS 2, 256 2, 256 0 0 194.00 194. 01 07951 MEDICAL SPECIALTY 2, 261 42, 738 0 0 0 194. 01 2, 261 194. 02 07952 MEDICAL OFFICE 0 194.02 14 785 C 194. 03 07953 VA PROPERTY 0 194.03 10,000 0 194.04 07954 ALREFAI CAMPUS 0 0 194.04 0 C 0 0 0 194. 05 07955 ORTHO CAMPUS 0 0 0 0 194.05 194.06 07956 DR. CRAIG CLINIC 0 0 0 194 06 0 194. 07 07957 DR. OLABIGE CLINIC 0 C 0 0 194. 07 194.08 07958 URGENT CARE CLINIC 0 0 0 194.08 0 194. 09 07959 DR. PACE 0 0 0 o 0 194. 09 194. 10 07960 SCOTTSBURG FAMILY PRACTICE (RHC) 0 0 0 194, 10 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 844, 705 202. 00 Cost to be allocated (per Wkst. B, 321, 117 202.00 650, 251 831, 836 1, 282, 636

2.473003

6. 189094

0.097630

7, 371, 471264

0. 111823 203. 00

203.00

Part I)

Unit cost multiplier (Wkst. B, Part I)

Health Fina	ncial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CCN: 15-1334		Peri od:	Worksheet B-1	
					From 01/01/2023 To 12/31/2023		
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (# OF COMPU TERS)	ADMI TTI NG (I NPATI ENT CHARGES)	
		1. 00	2. 00	4. 00	5. 01	5. 02	
204. 00	Cost to be allocated (per Wkst. B, Part II)			(	6, 947	32, 205	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000000	39. 925287	0. 004263	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST A	ILLOCATION - STATISTICAL BASIS	SCOTT WILMORT	Provi der Co	CN: 15-1334 P	eri od:	Worksheet B-1	
				F	rom 01/01/2023	Date/Time Pre 5/31/2024 6:5	pared:
	Cost Center Description	PURCHASI NG RECEI VI NG AND STORES (COSTED REQUI S. )		Reconciliatio n	OTHER ADMIN AND GENERAL (ACCUMULATE D COST)	OPERATION OF PLANT (SQUARE FEET)	
	OFNEDAL CEDILLOS COCT CENTEDO	5. 03	5. 04	5A. 05	5. 05	7. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00 5. 01 5. 02 5. 03	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING 00570 ADMITTING 00560 PURCHASING RECEIVING AND STORES	1, 536, 085	1				2. 00 4. 00 5. 01 5. 02 5. 03
5. 04 5. 05	OO580   CASHI ERI NG/ACCOUNTS RECEI VABLE   OO590   OTHER ADMI N AND GENERAL	8, 753	,	-2, 317, 860	17, 564, 390		5. 04 5. 05
7. 00	00700 OPERATION OF PLANT	19, 613	1	2,317,000			
9.00	00900 HOUSEKEEPI NG	46, 581		0		900	9.00
10.00	01000 DI ETARY	102, 003	0	0	175, 537		1
11. 00 13. 00	01100   CAFETERI A   01300   NURSI NG   ADMI NI STRATI ON			0	,	1, 326 0	1
	01400 CENTRAL SERVICES & SUPPLY		ő	Ö			
15.00	01500 PHARMACY	13, 648		0	453, 375	0	
16. 00	01600 MEDI CAL RECORDS & LI BRARY	1, 753	0	0	771, 638	1, 721	16.00
30 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	81, 566	1, 197, 128	0	2, 618, 005	15, 028	30.00
31. 00	03100 INTENSIVE CARE UNIT	01,300				794	
43.00	04300 NURSERY	0		0		0	43.00
FO 00	ANCILLARY SERVICE COST CENTERS	41 447	714 207		044 270	24 254	
50. 00 52. 00	05000 OPERATING ROOM   05200 DELIVERY ROOM & LABOR ROOM	41, 447		1			1
54.00	05400 RADI OLOGY-DI AGNOSTI C	34, 805	_				54.00
60.00	06000 LABORATORY	411, 771		1	.,		60.00
63.00	06300 BLOOD STORING PROCESSING & TRANS.	32, 450	1	l .		0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	21, 239 9, 059					1
67.00	06700 OCCUPATI ONAL THERAPY	7,037	719, 164				1
	06800 SPEECH PATHOLOGY	0	0	0	0	0	
69. 00	06900 ELECTROCARDI OLOGY	0	1, 455, 501				
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	122, 733 15, 786		l .	,	0	
	07300 DRUGS CHARGED TO PATIENTS	364, 605	•	_	,		1
76.00	03610 SLEEP LAB	56					1
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 402		l .		1, 161	
	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	1	_		0	
70.00	OUTPATIENT SERVICE COST CENTERS		<u> </u>				70.00
88. 00	08800 RURAL HEALTH CLINIC	40, 649		l .	,		88.00
	09100 EMERGENCY	164, 128	14, 443, 558	0	2, 914, 413	7, 204	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS				<b>I</b>		
113. 00 118. 00	11300 INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)	1, 534, 047	68, 712, 604	-2, 317, 860	16, 978, 976	71 205	113. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	1, 554, 647	00, 712, 004	-2,317,000	10, 970, 970	71, 273	] 10.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	·	675	190. 00
	19001 MARKETI NG	0	_	_			190. 01
	19200 PHYSICIANS PRIVATE OFFICES  19201 SCOTT PHYSICIAN GROUP	0	1	0			192. 00 192. 01
	07950 BUHSE CAMPUS	0	ő	Ö	_		194.00
	07951 MEDICAL SPECIALTY	2, 038	0	0	, =		194. 01
	07952 MEDI CAL OFFI CE	0	0	0			194. 02
	07953 VA PROPERTY  07954 ALREFAI CAMPUS			0			194. 03 194. 04
	07955 ORTHO CAMPUS	0	Ö	Ö	_		194. 05
	07956 DR. CRAIG CLINIC	0	0	0	_		194. 06
	07957   DR. OLABI GE CLI NI C   07958   URGENT CARE CLI NI C	0	0	0			194. 07 194. 08
	07959 DR. PACE		0		0		194.00
	07960 SCOTTSBURG FAMILY PRACTICE (RHC)	0	Ö	Ö	0		194. 10
200.00	, ,						200.00
201.00		70.045	242 202		0 017 0/0	1 10/ 755	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	78, 245	343, 308	1	2, 317, 860	1, 126, 755	202.00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I)	0. 050938 18, 875	1		0. 131964 209, 403	11. 126027 49, 532	203. 00 204. 00

Heal th Fina	ncial Systems	SCOTT MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1		
					From 01/01/2023 To 12/31/2023			
	Cost Center Description		CASHI ERI NG/AC	Reconciliation		OPERATION OF		
		RECEIVING AND	COUNTS	n	AND GENERAL	PLANT		
		STORES	RECEI VABLE		(ACCUMULATE D	(SQUARE FEET)		
		(COSTED	(GROSS CHAR		COST)			
		REQUIS.)	GES)					
		5. 03	5. 04	5A. 05	5. 05	7. 00		
205. 00	Unit cost multiplier (Wkst. B, Part	0. 012288	0. 000089		0. 011922	0. 489099	205. 00	
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00	
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00	

	cost center bescription	(MAN HOURS)	(MEALS SERVED)	(CAF))	ADMINISTRATION N (HOURS SUPERVI)	SERVI CES & SUPPLY (COSTED REQUIS.)	
	GENERAL SERVICE COST CENTERS	9. 00	10. 00	11. 00	13. 00	14. 00	
1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 7. 00 9. 00 10. 00 11. 00 13. 00 15. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING 00570 ADMITTING 00560 PURCHASING RECEIVING AND STORES 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMIN AND GENERAL 00700 OPERATION OF PLANT 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 479 0 19 0 0 0 40	6, 289 0 0 0 0	170, 188 2, 080 2, 676 4, 483 11, 684	2, 080 0 50 444	1, 359, 135 13, 648 1, 753	15. 00
30. 00 31. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY	386 56 0	5, 718 51 0	40, 383 1, 063 0	558 42 0	81, 566 0 0	31.00
E0.00	ANCILLARY SERVICE COST CENTERS	200	ما	4 420	227	41 447	FO 00
50. 00 52. 00 54. 00 60. 00 63. 00 65. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06300 BLOOD STORING PROCESSING & TRANS. 06500 RESPIRATORY THERAPY	280 0 68 112 0 56	0 0 0 0 0	6, 439 0 20, 653 21, 381 1, 154 10, 640	327 0 0 0 0 0 41	41, 447 0 34, 805 411, 771 32, 450 21, 239	60.00
66. 00 67. 00 68. 00 69. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	80 0 0 32	0 0 0 0	10, 453 2, 445 0 2, 988	0 0 0 0	9, 059 0 0 0	67. 00 68. 00 69. 00
72. 00 73. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03610 SLEEP LAB 07697 CARDIAC REHABILITATION	0 0 20 0 20	0 0 0 0	0 0 0 440 1, 871	0 0 0 0 50	122, 733 15, 786 364, 605 56 1, 402	72. 00 73. 00 76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0 0	0	0	0	0	77. 00
88. 00 91. 00 92. 00	08800 RURAL HEALTH CLINIC	310	0 520	0 28, 765	0 568	40, 649 164, 128	1
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
113. 00 118. 00		1, 479	6, 289	169, 598	2, 080	1, 357, 097	113. 00 118. 00
190. 01	NONREIMBURSABLE COST CENTERS  19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19001 MARKETING 19200 PHYSICIANS PRIVATE OFFICES	0 0	0 0 0	0 590 0	0 0 0	0	190. 00 190. 01 192. 00
194. 00 194. 02 194. 02	19201 SCOTT PHYSICIAN GROUP 07950 BUHSE CAMPUS 107951 MEDICAL SPECIALTY 207952 MEDICAL OFFICE	0 0 0	0 0 0	0 0 0 0	0 0 0	0 2, 038 0	192. 01 194. 00 194. 01 194. 02
194. 04 194. 05 194. 06	307953 VA PROPERTY 407954 ALREFAI CAMPUS 507955 ORTHO CAMPUS 507956 DR. CRAIG CLINIC 707957 DR. OLABIGE CLINIC	0 0	0 0 0	0 0 0 0	0 0	0 0 0	194. 03 194. 04 194. 05 194. 06 194. 07
194. 08 194. 09	3 07958 URGENT CARE CLINIC 9 07959 DR. PACE 9 07960 SCOTTSBURG FAMILY PRACTICE (RHC)	0 0	0 0	0 0	0	0	194. 07 194. 08 194. 09 194. 10 200. 00
201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	529, 051	227, 619	266, 132	68, 426	142, 402	201. 00 202. 00
203. 00 204. 00		357. 708587 14, 315	36. 193194 27, 249	1. 563753 14, 895	32. 897115 868	0. 104774 1, 969	203. 00 204. 00

Heal th Fina	ncial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS				Peri od:	Worksheet B-1	
					From 01/01/2023 Fo 12/31/2023		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		(MAN HOURS)	(MEALS	(CAF))	ADMI NI STRATI O	SERVICES &	
			SERVED)		N	SUPPLY	
					(HOURS SUPE	(COSTED	
					RVI)	REQUIS.)	
		9. 00	10. 00	11. 00	13.00	14.00	
205. 00	Unit cost multiplier (Wkst. B, Part	9. 678837	4. 332803	0. 08752	0. 417308	0. 001449	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1334 Period: Worksheet B-1

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1334 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/31/2024 6:51 am Cost Center Description **PHARMACY** MEDI CAL (COSTED RECORDS & REQUIS.) LI BRARY (GROSS CHAR GES) 15. 00 16. 00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00550 DATA PROCESSING 5.01 5.01 00570 ADMITTING 5.02 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 5.05 00590 OTHER ADMIN AND GENERAL 5.05 00700 OPERATION OF PLANT 7 00 7 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 100 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 68, 712, 604 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 1, 197, 128 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 26, 779 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 714, 387 50.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52 00 05400 RADI OLOGY-DI AGNOSTI C 17, 199, 269 54.00 54.00 60.00 06000 LABORATORY 17, 981, 223 60.00 06300 BLOOD STORING PROCESSING & TRANS. 63.00 00000 269, 786 63.00 06500 RESPIRATORY THERAPY 65 00 3, 262, 334 65 00 66.00 06600 PHYSI CAL THERAPY 3, 937, 840 66.00 06700 OCCUPATI ONAL THERAPY 719, 164 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 69.00 06900 ELECTROCARDI OLOGY 1, 455, 501 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 084, 137 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 10, 336 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 100 5, 264, 368 73.00 03610 SLEEP LAB 0 76.00 81.513 76.00 0 76.97 07697 CARDIAC REHABILITATION 588, 221 76.97 77 00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 477,060 88.00 09100 EMERGENCY 91.00 0 14, 443, 558 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 100 68, 712, 604 118.00 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 00 190.00 190. 01 19001 MARKETI NG 0 190.01 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 192.00 00000000000 192. 01 19201 SCOTT PHYSICIAN GROUP 0 192.01 194.00 07950 BUHSE CAMPUS 194. 00 0 194. 01 07951 MEDI CAL SPECIALTY 0 194.01 194. 02 07952 MEDICAL OFFICE 194. 02 194. 03 07953 VA PROPERTY 0 194.03 194. 04 07954 ALREFAI CAMPUS 0 l194. 04 194. 05 07955 ORTHO CAMPUS 0 194.05 194.06 07956 DR. CRAIG CLINIC 0 194.06 194. 07 07957 DR. OLABIGE CLINIC 0 194. 07 194. 08 07958 URGENT CARE CLINIC 0 194.08 194. 09 07959 DR. PACE 0 0 194.09 194. 10 07960 SCOTTSBURG FAMILY PRACTICE (RHC) 0 194. 10 200 00 Cross Foot Adjustments 200 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 523, 289 939, 983 202.00 Part I) 5, 232. 890000 203.00 Unit cost multiplier (Wkst. B, Part I) 0.013680 203.00 204.00 Cost to be allocated (per Wkst. B, 204.00 6, 365 27,007 Part II)

Heal th Fina	ncial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lieu	of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co	CN: 15-1334	Peri od:	Worksheet B-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 6:5	
	Cost Center Description	PHARMACY	MEDI CAL				
		(COSTED	RECORDS &				
		REQUIS.)	LI BRARY				
			(GROSS CHAR				
			GES)				
		15. 00	16. 00				
205. 00	Unit cost multiplier (Wkst. B, Part	63. 650000	0. 000393				205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES  Provider CCN: 15-1334 Period: From 01/01/2023 To 12/31/2023 For 12/31/2024 6: 51	
07 017 2021 0:01	
Title XVIII Hospital Cost	
Costs	

					10 12/31/2023	Date/lime Pre 5/31/2024 6:5	
			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS						1
	3000 ADULTS & PEDIATRICS	3, 582, 147		3, 582, 14		0	00.00
	3100 INTENSIVE CARE UNIT	52, 770		52, 77	0	0	31.00
	4300 NURSERY	0			0 0	0	43.00
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	1, 328, 448		1, 328, 44			50.00
	5200 DELIVERY ROOM & LABOR ROOM	0			0	0	52.00
	5400 RADI OLOGY-DI AGNOSTI C	2, 561, 490		2, 561, 49		0	54.00
	6000 LABORATORY	2, 388, 918		2, 388, 91		0	60.00
	6300 BLOOD STORING PROCESSING & TRANS.	55, 194		55, 19		0	63.00
	6500 RESPI RATORY THERAPY	754, 569	0	754, 56	9 0	0	65.00
	6600 PHYSI CAL THERAPY	1, 276, 556	0	1, 276, 55		0	66.00
	6700 OCCUPATI ONAL THERAPY	61, 139	0	61, 13	9 0	0	67.00
	6800 SPEECH PATHOLOGY	0	0		0	0	68. 00
	6900 ELECTROCARDI OLOGY	306, 298		306, 29		0	69.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	310, 614		310, 61		0	71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	20, 633		20, 63		0	72.00
	7300 DRUGS CHARGED TO PATIENTS	1, 238, 428		1, 238, 42		0	73.00
	3610 SLEEP LAB	3, 585		3, 58		0	76.00
	7697 CARDI AC REHABI LI TATI ON	294, 735		294, 73	5 0	0	76. 97
	7700 ALLOGENEIC HSCT ACQUISITION	0			0	0	77. 00
	7800 CAR T-CELL IMMUNOTHERAPY	0			0 0	0	78. 00
	UTPATIENT SERVICE COST CENTERS						
	8800 RURAL HEALTH CLINIC	862, 079		862, 07			
	9100 EMERGENCY	3, 787, 318		3, 787, 31		_	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	711, 710		711, 71	0	0	92.00
	THER REIMBURSABLE COST CENTERS						
	0200 OPIOID TREATMENT PROGRAM	0			0	0	102.00
	PECIAL PURPOSE COST CENTERS						1
	1300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	19, 596, 631	0	,,			200. 00
201. 00	Less Observation Beds	711, 710		711, 71			201. 00
202.00	Total (see instructions)	18, 884, 921	0	18, 884, 92	1 0	0	202. 00

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1334	From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/31/2024 6:51 am
	Title XVIII	Hospi tal	Cost

					10 12/31/2023	5/31/2024 6: 5	
			Title	XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				_1		
	03000 ADULTS & PEDIATRICS	1, 197, 128		1, 197, 12			30.00
	03100 INTENSIVE CARE UNIT	26, 779		26, 77			31.00
	04300 NURSERY	0			0		43.00
	ANCILLARY SERVICE COST CENTERS	54.07/		744.00	T 4 0505/4		
	05000 OPERATING ROOM	51, 976	662, 411			0.000000	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0.000000		
	05400 RADI OLOGY-DI AGNOSTI C	476, 273	16, 722, 996				
	06000 LABORATORY	1, 351, 107	16, 630, 116				
	06300 BLOOD STORING PROCESSING & TRANS.	48, 739	221, 047			0.000000	63.00
	06500 RESPIRATORY THERAPY	646, 509	2, 615, 825			0.000000	65.00
	06600 PHYSI CAL THERAPY	643, 888	3, 293, 952			0. 000000	66.00
	06700 OCCUPATI ONAL THERAPY	342, 949	376, 215			0. 000000	67.00
	06800 SPEECH PATHOLOGY	0	0		0.000000		
	06900 ELECTROCARDI OLOGY	106, 871	1, 348, 630			0. 000000	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	926, 528	157, 609			0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	10, 336			0.000000	
	07300 DRUGS CHARGED TO PATIENTS	1, 232, 665	4, 031, 703			0. 000000	
	03610 SLEEP LAB	0	81, 513			0. 000000	
	07697 CARDI AC REHABI LI TATI ON	0	588, 221			0. 000000	
	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0. 000000		
	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0. 000000	0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS	1 0	477 040				
	08800 RURAL HEALTH CLINIC	0	477, 060				88.00
	09100 EMERGENCY	502, 509	13, 941, 049				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	19, 817	310, 715	330, 53	2. 153226	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS  10200 OPIOID TREATMENT PROGRAM			Γ			100 00
	SPECIAL PURPOSE COST CENTERS	0	0		0		102.00
	11300 I NTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	7, 573, 738	61, 469, 398	69, 043, 13	6		200.00
200.00		1,515,150	01, 407, 370	07, 043, 13	٥		200.00
201.00		7, 573, 738	61, 469, 398	69, 043, 13	6		201.00
202.00	Total (See Histiactions)	1,010,100	01, 407, 370	07,043,13	Ч	I	1202.00

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1334	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/31/2024 6:51 am
	Ti +1 o V/// /	Hospi tal	Coct

				5/31/2024 6:51 an	m
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00  03000 ADULTS & PEDIATRICS					0. 00
31.00  03100 INTENSIVE CARE UNIT				31.	. 00
43. 00 04300 NURSERY				43.	3. 00
ANCILLARY SERVICE COST CENTERS					
50.00   05000   OPERATING ROOM	0. 000000				0. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000			52.	2. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54.	1.00
60. 00   06000   LABORATORY	0. 000000			60.	0. 00
63.00 06300 BLOOD STORING PROCESSING & TRANS.	0. 000000			63.	3. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.	5. 00
66. 00   06600 PHYSI CAL THERAPY	0. 000000			66.	. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.	7. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.	3. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.	9. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.	. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.	2. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.	3. 00
76. 00   03610   SLEEP LAB	0. 000000			76.	. 00
76. 97 07697 CARDIAC REHABILITATION	0. 000000			76.	o. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77.	7. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78.	3. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC				88.	3. 00
91. 00 09100 EMERGENCY	0. 000000			91.	. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.	2. 00
OTHER REIMBURSABLE COST CENTERS					
102.00 10200 OPI OI D TREATMENT PROGRAM				102	2. 00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300   I NTEREST EXPENSE				113.	. 00
200.00 Subtotal (see instructions)				200	). 00
201.00 Less Observation Beds				201.	. 00
202.00 Total (see instructions)				202	. 00
				· ·	

Health Financial Systems	SCOTT MEMORI.	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/31/2024 6:5	
		Ti tl	e XIX	Hospi tal	Cost	
·				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1 00	2.00	3 00	4 00	5.00	

			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj.		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
11	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00 0	3000 ADULTS & PEDIATRICS	3, 582, 147		3, 582, 147	0	3, 582, 147	30.00
31.00 0	3100 INTENSIVE CARE UNIT	52, 770		52, 770	0	52, 770	31.00
43.00 0	4300 NURSERY	0		0	0	0	43.00
1A	NCILLARY SERVICE COST CENTERS						
50.00 0	5000 OPERATING ROOM	1, 328, 448		1, 328, 448	0	1, 328, 448	50.00
52.00 0	5200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00 0	5400 RADI OLOGY-DI AGNOSTI C	2, 561, 490		2, 561, 490	0	2, 561, 490	54.00
60.00 0	6000 LABORATORY	2, 388, 918		2, 388, 918	0	2, 388, 918	60.00
63.00 0	6300 BLOOD STORING PROCESSING & TRANS.	55, 194		55, 194	0	55, 194	63.00
65.00 0	6500 RESPI RATORY THERAPY	754, 569	0	754, 569	0	754, 569	65.00
66.00 0	6600 PHYSI CAL THERAPY	1, 276, 556	0	1, 276, 556	0	1, 276, 556	66.00
67.00 0	6700 OCCUPATI ONAL THERAPY	61, 139	0	61, 139	0	61, 139	67.00
68.00 0	6800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 0	6900 ELECTROCARDI OLOGY	306, 298		306, 298	0	306, 298	69.00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	310, 614		310, 614	0	310, 614	71.00
72.00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	20, 633		20, 633	0	20, 633	72.00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	1, 238, 428		1, 238, 428	0	1, 238, 428	73.00
76.00 0	3610 SLEEP LAB	3, 585		3, 585	0	3, 585	76.00
76. 97 0	7697 CARDIAC REHABILITATION	294, 735		294, 735	0	294, 735	76. 97
77.00 0	7700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77. 00
78. 00 0°	7800 CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78. 00
Ol	UTPATIENT SERVICE COST CENTERS						
88.00 0	8800 RURAL HEALTH CLINIC	862, 079		862, 079	0	862, 079	88. 00
	9100 EMERGENCY	3, 787, 318		3, 787, 318	0	3, 787, 318	91.00
92. 00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART	711, 710		711, 710		711, 710	92.00
	THER REIMBURSABLE COST CENTERS			<u> </u>		·	
	0200 OPIOID TREATMENT PROGRAM	0		0		0	102.00
SI	PECIAL PURPOSE COST CENTERS						
113.001	1300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	19, 596, 631	0	19, 596, 631	0		
201.00	Less Observation Beds	711, 710		711, 710		711, 710	
202.00	Total (see instructions)	18, 884, 921	l e		0	· ·	ł
- 1					- 1		•

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1334	From 01/01/2023	Worksheet C Part I Date/Time Prepared: 5/31/2024 6:51 am

						10 12/31/2023	5/31/2024 6: 5	
				Ti tl	e XIX	Hospi tal	Cost	
				Charges				
		Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
					+ col. 7)	Ratio	I npati ent	
							Ratio	
	_		6. 00	7. 00	8. 00	9. 00	10.00	
		ENT ROUTINE SERVICE COST CENTERS						
		ADULTS & PEDIATRICS	1, 197, 128		1, 197, 12			30. 00
		INTENSIVE CARE UNIT	26, 779		26, 77	9		31.00
43.00		NURSERY	0			0		43.00
		LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	51, 976	662, 411	714, 38		0. 000000	
52.00		DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0. 000000	
54.00		RADI OLOGY-DI AGNOSTI C	476, 273	16, 722, 996	17, 199, 26	9 0. 148930	0. 000000	
60.00		LABORATORY	1, 351, 107	16, 630, 116			0. 000000	
63.00		BLOOD STORING PROCESSING & TRANS.	48, 739	221, 047			0. 000000	63.00
65.00		RESPI RATORY THERAPY	646, 509	2, 615, 825	3, 262, 33		0. 000000	
66.00		PHYSI CAL THERAPY	643, 888	3, 293, 952	3, 937, 84	0. 324177	0. 000000	66.00
67.00	06700	OCCUPATI ONAL THERAPY	342, 949	376, 215	719, 16	4 0. 085014	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		0. 000000	0.000000	68. 00
69. 00	06900	ELECTROCARDI OLOGY	106, 871	1, 348, 630	1, 455, 50	1 0. 210442	0.000000	69. 00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	926, 528	157, 609	1, 084, 13	7 0. 286508	0.000000	71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	10, 336	10, 33	6 1. 996227	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1, 232, 665	4, 031, 703	5, 264, 36	8 0. 235247	0.000000	73.00
76.00	03610	SLEEP LAB	0	81, 513	81, 51	0. 043981	0.000000	76.00
76. 97	07697	CARDIAC REHABILITATION	0	588, 221	588, 22	1 0. 501062	0.000000	76. 97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		0. 000000	0.000000	77. 00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		0. 000000	0.000000	78. 00
	OUTPA <sup>®</sup>	TIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	477, 060	477, 06	0 1. 807066	0.000000	88. 00
91.00	09100	EMERGENCY	502, 509	13, 941, 049	14, 443, 55	8 0. 262215	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	19, 817	310, 715	330, 53	2. 153226	0.000000	92.00
	OTHER	REIMBURSABLE COST CENTERS						
102.00	0 10200	OPIOID TREATMENT PROGRAM	0	0		0		102.00
	SPECI.	AL PURPOSE COST CENTERS						
113.00	0 11300	INTEREST EXPENSE						113. 00
200.00	0	Subtotal (see instructions)	7, 573, 738	61, 469, 398	69, 043, 13	6		200.00
201.00	0	Less Observation Beds						201.00
202.00	0	Total (see instructions)	7, 573, 738	61, 469, 398	69, 043, 13	6		202.00

Health Financial Systems	SCOTT MEMORIAL	_ HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1334	From 01/01/2023	Worksheet C Part I Date/Time Pre 5/31/2024 6:5	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient	-			

Cost Center Description					5/31/2024 6:51 am
INPATI ENT ROUTI NE SERVI CE COST CENTERS   11.00			Title XIX	Hospi tal	Cost
IMPATI ENT ROUTI NE SERVICE COST CENTERS   30.00   31.00   3	Cost Center Description				
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   330.00   330.00   ADULTS & PEDIATRICS   31.00   330.00   331.00   INTENSIVE CARE UNIT   31.00   ASSOCIATION   31.00   ASSOCIA					
30. 00   03000   ADULTS & PEDIATRICS   31. 00		11. 00			
31.00   03100   INTENSIVE CARE UNIT     31.00   04300   NURSERY     43.00   AMOCI LLARY SERVICE COST CENTERS					
43.00	30. 00   03000   ADULTS & PEDI ATRI CS				30.00
ANCI LLARY SERVICE COST CENTERS	31.00 03100 INTENSIVE CARE UNIT				31.00
50.00					43.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM   0.000000   54. 00   05400   RADI OLOGY-DI AGNOSTI C   0.0000000   0.0000000   0.0000000   0.00000000	ANCILLARY SERVICE COST CENTERS				
54.00	50.00   05000   OPERATING ROOM	0. 000000			50.00
60. 00   06000   LABORATORY   0.000000   66. 00   63. 00   6300   BLOOD STORI NG PROCESSING & TRANS.   0.000000   65. 00   65.00   66.	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
63. 00   06300   BLOOD STORING PROCESSING & TRANS.   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
65. 00   06500   RESPIRATORY THERAPY   0. 000000   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 000000   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0. 000000   68. 00   06800   SPEECH PATHOLOGY   0. 000000   68. 00   69. 00	60. 00   06000   LABORATORY	0. 000000			60.00
66. 00   0600   PHYSI CAL THERAPY   0. 000000   66. 00   67. 00   67. 00   68. 00   69. 00	63.00 06300 BLOOD STORING PROCESSING & TRANS.	0. 000000			63.00
67. 00   06700   OCCUPATI ONAL THERAPY   0.000000   67. 00   68. 00   68. 00   69. 0	65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
68. 00	66. 00   06600 PHYSI CAL THERAPY	0. 000000			66.00
69.00 06900 ELECTROCARDIOLOGY 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 1MPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 72.00 76.00 03610 SLEEP LAB 0.000000 76.00 76.97 07697 CARDI AC REHABI LI TATI ON 0.000000 76.97 77.00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0.000000 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 77.00 0UTPATI ENT SERVI CE COST CENTERS  88.00 08800 RURAL HEALTH CLINI C 0.000000 91.00 EMERGENCY 0.000000 91.00 0 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 92.00 0BSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 0) 0THER REI MBURSABLE COST CENTERS  102.00 10200 OPI OI D TREATMENT PROGRAM 5PECI AL PURPOSE COST CENTERS  113.00 11300 INTEREST EXPENSE 113.00 200.00 Less Observati on Beds	67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
71. 00	68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
72. 00	69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 76. 00 03610 SLEEP LAB 0.000000 76.00 76. 97 07697 CARDIAC REHABILITATION 0.000000 76.97 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 77. 00 000 000 CAR T-CELL IMMUNOTHERAPY 0.000000 78. 00  000 000 CAR T-CELL IMMUNOTHERAPY 0.000000 78. 00  000 000 CAR T-CELL IMMUNOTHERAPY 0.000000 99. 00  000 000 000 000 CAR T-CELL IMMUNOTHERAPY 0.000000 99. 00  000 000 000 000 000 000 000 000 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
76. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
76. 97   07697   CARDI AC REHABILITATION   0.000000   76. 97   77. 00   07700   ALLOGENEIC HSCT ACQUISITION   0.000000   77. 00   07800   CAR T-CELL IMMUNOTHERAPY   0.000000   78. 00   00TPATIENT SERVICE COST CENTERS   88. 00   08800   RURAL HEALTH CLINIC   0.000000   91. 00   09100   EMERGENCY   0.000000   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   0.000000   92. 00   0716R   REIMBURSABLE COST CENTERS   102. 00   10200   09101   TREATMENT PROGRAM   102. 00   SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   113. 00   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
77. 00	76. 00   03610   SLEEP LAB	0. 000000			76.00
78. 00	76. 97 07697 CARDIAC REHABILITATION	0. 000000			76. 97
88.00   08800   RURAL HEALTH CLINIC   0.000000   88.00   91.00   09100   EMERGENCY   0.000000   91.00   09200   095ERVATION BEDS (NON-DISTINCT PART   0.000000   092.00   09100   DTREATMENT PROGRAM   102.00   10200   09101 D TREATMENT PROGRAM   102.00   SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00	77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
88. 00 91. 00 91. 00 91. 00 92. 00 09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0.000000   92. 00 0THER REI MBURSABLE COST CENTERS  102. 00 10200   OPI OI D TREATMENT PROGRAM   102. 00 SPECIAL PURPOSE COST CENTERS  113. 00   11300   INTEREST EXPENSE   113. 00 200. 00   Subtotal (see instructions)   200. 00 201. 00   Less Observation Beds	78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78.00
91. 00	OUTPATIENT SERVICE COST CENTERS				
92. 00	88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88.00
OTHER REIMBURSABLE COST CENTERS   102.00   OPI OI D TREATMENT PROGRAM   102.00   SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00   200.00   Subtotal (see instructions)   200.00   Less Observation Beds   201.00	91. 00 09100 EMERGENCY	0. 000000			91.00
OTHER REIMBURSABLE COST CENTERS   102.00   OPI OI D TREATMENT PROGRAM   102.00   SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00   200.00   Subtotal (see instructions)   200.00   Less Observation Beds   201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00					
113.00       11300       INTEREST EXPENSE       113.00         200.00       Subtotal (see instructions)       200.00         201.00       Less Observation Beds       201.00	102.00 10200 OPIOLD TREATMENT PROGRAM				102. 00
200.00         Subtotal (see instructions)         200.00           201.00         Less Observation Beds         201.00	SPECIAL PURPOSE COST CENTERS				
201.00 Less Observation Beds 201.00	113. 00 11300 I NTEREST EXPENSE				113.00
	200.00 Subtotal (see instructions)				200. 00
202.00 Total (see instructions) 202.00	201.00 Less Observation Beds				201.00
	202.00 Total (see instructions)				202. 00

Harlah Simanai al Contama	CCOTT MEMORIA	AL HOCDITAL		1-11-	6 F OMC (	DEED 40
Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	SCOTT MEMORIA AL COSTS	Provi der C		Period: From 01/01/2023 To 12/31/2023		pared:
		Title	: XVIII	Hospi tal	Cost	
Cost Center Description	Capital Related Cost (from Wkst.	Total Charges (from Wkst. C, Part I,	Ratio of Cos to Charges (col. 1 ÷		Capital Costs (column 3 x column 4)	
	B, Part II, col. 26)	col. 8)	col. 2)			
	1. 00	2. 00	3.00	4.00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	210, 641	714, 387	0. 29485	6 18, 623	5, 491	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	0. 00000		0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	88, 750		•			54.00
60. 00   06000   LABORATORY	66, 914					60.00
63.00 O6300 BLOOD STORING PROCESSING & TRANS.	1, 373					63.00
65. 00  06500 RESPIRATORY THERAPY	43, 834					
66. 00  06600 PHYSI CAL THERAPY	50, 358				•	
67. 00  06700 0CCUPATI ONAL THERAPY	2, 523	719, 164			140	67.00
68.00   06800   SPEECH PATHOLOGY	0	0	0. 00000	0	0	68.00
69. 00  06900  ELECTROCARDI OLOGY	4, 576	1, 455, 501	0. 00314	4 52, 651		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9, 138	1, 084, 137	0. 00842	9 233, 898	1, 972	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	420	10, 336	0. 04063	5 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	31, 771	5, 264, 368	0. 00603	5 292, 986	1, 768	73.00
76.00 03610 SLEEP LAB	98	81, 513	0. 00120	2 0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	14, 463	588, 221	0. 02458	8 0	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 00000	0	0	77.00
70 00 07000 CAD T CELL LAMMINOTHEDADY	1	1 ^	0 00000		1 ^	70 00

42, 875 120, 595

41, 439

729, 768

477, 060 14, 443, 558

67, 819, 229

330, 532

110, 885

5, 117 1, 468, 658

78.00

88.00 0

91.00

642 92.00

15, 923 200. 00

0

926

0.000000

0. 089873

0.008349

0. 125371

07800 CAR T-CELL IMMUNOTHERAPY

OUTPATIENT SERVICE COST CENTERS
08800 RURAL HEALTH CLINIC

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50 through 199)

88. 00

91. 00 09100 EMERGENCY

Health Financial Systems	SCOTT MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1334		Worksheet D
THROUGH COSTS			From 01/01/2023	Part IV

				0 12/31/2023	Date/lime Pre 5/31/2024 6:5	
		Title	e XVIII	Hospi tal	Cost	ı uııı
Cost Center Description	Non Physician		Nursi ng		Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS	_					
50.00   05000   OPERATING ROOM	0	0	(	0	0	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	(	0	0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	(	0	0	54.00
60. 00   06000   LABORATORY	0	0	(	0	0	60.00
63.00 06300 BLOOD STORING PROCESSING & TRANS.	0	0	(	0	0	63.00
65. 00   06500   RESPI RATORY THERAPY	0	0	(	0	0	65.00
66. 00  06600 PHYSI CAL THERAPY	0	0	(	0	0	66.00
67. 00   06700 OCCUPATI ONAL THERAPY	0	0	(	0	0	67.00
68. 00   06800   SPEECH PATHOLOGY	0	0	(	0	0	68.00
69. 00  06900  ELECTROCARDI OLOGY	0	0	(	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73.00
76. 00   03610   SLEEP LAB	0	0	(	0	0	76.00
76. 97   07697   CARDI AC   REHABI LI TATI ON	0	0	(	0	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	(	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	(	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	_			_		
88.00   08800   RURAL HEALTH CLINIC	0	0	(	0	0	00.00
91. 00   09100   EMERGENCY	0	0	(	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	92.00
200.00   Total (lines 50 through 199)	0	0	(	0	0	200.00

Health Financial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2023		
				To 12/31/2023	Date/Time Pre	pared:
					5/31/2024 6: 5	1 am
		Ti tl e	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	

		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0	0	0	714, 387		50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	0	17, 199, 269	0.000000	54.00
60. 00   06000   LABORATORY	0	0	0	17, 981, 223	0.000000	60.00
63.00 06300 BLOOD STORING PROCESSING & TRANS.	0	0	0	269, 786	0.000000	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0	0	3, 262, 334	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	3, 937, 840	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	719, 164	0.000000	67.00
68.00 O6800 SPEECH PATHOLOGY	0	0	0	0	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	1, 455, 501	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1, 084, 137	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10, 336	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	5, 264, 368	0.000000	73.00
76.00 03610 SLEEP LAB	0	0	0	81, 513	0.000000	76.00
76. 97   07697   CARDI AC   REHABI LI TATI ON	0	0	0	588, 221	0.000000	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	C	477, 060	0.000000	88. 00
91. 00   09100   EMERGENCY	0	0	0	14, 443, 558	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	330, 532	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	0	67, 819, 229		200. 00

Heal th	Financial Systems	SCOTT MEMORIAL	_ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE SH COSTS	RVICE OTHER PASS		F	Period: From 01/01/2023 To 12/31/2023		pared: 1 am
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷		Costs (col. 8		Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS			,			
50.00	05000 OPERATING ROOM	0. 000000	18, 623	(	0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	١ ٠	0	0	
54.00	05400  RADI OLOGY-DI AGNOSTI C	0. 000000	120, 985		0	0	54.00
60.00	06000 LABORATORY	0. 000000	381, 819		0	0	60.00
63.00	06300 BLOOD STORING PROCESSING & TRANS.	0. 000000	3, 574	(	0	0	63.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	143, 242		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	64, 913	(	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	39, 965	(	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	0	(	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	52, 651	(	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	233, 898	(	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	(	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	292, 986	(	0	0	73.00
76.00	03610 SLEEP LAB	0. 000000	0		0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0	0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0	(	0	0	88.00
91.00	09100 EMERGENCY	0. 000000	110, 885		0	0	1
92 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0 000000	5 117		0	0	92 00

0.000000

5, 117 1, 468, 658

0 91.00 0 92.00 0 200.00

0 0 0

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00) Total (lines 50 through 199)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1334 Peri od: Worksheet D From 01/01/2023 Part V 12/31/2023 Date/Time Prepared: 5/31/2024 6:51 am Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Ded. & Coins. Part I, col. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 119, 485 50.00 1.859564 05200 DELIVERY ROOM & LABOR ROOM 0. 000000 0 52.00 52.00 0 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 3, 006, 612 0.148930 0 54.00 60.00 06000 LABORATORY 0.132856 0 3, 062, 290 0 0 0 0 0 0 0 60.00 63.00 06300 BLOOD STORING PROCESSING & TRANS. 0. 204584 29, 881 0 63.00 06500 RESPIRATORY THERAPY 583, 491 65.00 0.231297 0 65.00 06600 PHYSI CAL THERAPY 66.00 0. 324177 0 862, 157 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.085014 81, 981 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.000000 0 68.00 0 393, 421 06900 ELECTROCARDI OLOGY 0.210442 0 69.00 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.286508 0 106, 126 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1. 996227 0 0 72.00 2,720 72.00 07300 DRUGS CHARGED TO PATIENTS 985, 693 0. 235247 0 73.00 73 00 838 0 03610 SLEEP LAB 17, 303 76.00 0.043981 0 0 0 76.00 76. 97 07697 CARDIAC REHABILITATION 0.501062 0 179, 243 0 0 76.97 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0.000000 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 78.00 78.00 0 0 Ω OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 91.00 09100 EMERGENCY 0. 262215 0 1, 632, 635 ol 0 91.00 92.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 2. 153226 0 65, 700 0 Ωl 200.00 Subtotal (see instructions) 0 11, 128, 738 838 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 201.00 0 Only Charges

0

11, 128, 738

838

0 202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	SCOTT MEMORIAL	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1334	Peri od: From 01/01/2023	Worksheet D Part V

AFFORTIONWENT OF WEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	FI OVI dei C		From 01/01/2023 To 12/31/2023	Part V Date/Time Pr 5/31/2024 6:	epared: 51 am
			XVIII	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	222, 190	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	447, 775	0				54.00
60. 00   06000 LABORATORY	406, 844					60.00
63.00 06300 BLOOD STORING PROCESSING & TRANS.	6, 113					63.00
65. 00 06500 RESPIRATORY THERAPY	134, 960	0				65.00
66. 00 06600 PHYSI CAL THERAPY	279, 491	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	6, 970	0				67. 00
68.00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	82, 792	0				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	30, 406	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	5, 430	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	231, 881	197				73.00
76. 00   03610   SLEEP LAB	761	0				76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	89, 812	0				76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
OUTPATIENT SERVICE COST CENTERS	1	I	T			
88. 00 08800 RURAL HEALTH CLINIC	400 404					88. 00
91. 00 09100 EMERGENCY	428, 101	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	141, 467					92.00
200.00 Subtotal (see instructions)	2, 514, 993	197				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges 202.00 Net Charges (line 200 - line 201)	2, 514, 993	197				202. 00
202.00	2, 314, 993	197	I			1202.00

Health Financial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023		nonod.
				To 12/31/2023	Date/Time Pre 5/31/2024 6:5	
		Ti tl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Servi ces Not		
	Worksheet C,	inst.)	Subject To	Subj ect To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	1. 859564	l .	10, 88	8 0	0	
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000			0	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 148930	0	323, 72	0 0	0	54.00
60. 00   06000   LABORATORY	0. 132856	0	294, 92	3 0	0	60.00
63.00 06300 BLOOD STORING PROCESSING & TRANS.	0. 204584	0	83	1 0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 231297	0	43, 77	4 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 324177	0	17, 46	6 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 085014	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 210442	0	24, 62	9 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 286508	0	4, 09	5 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1. 996227	0		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 235247	0	57, 82	1 0	0	73.00
76.00 03610 SLEEP LAB	0. 043981	0	1, 61	5 0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	0. 501062	0	5, 38	8 0	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0	0	78.00
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC						88. 00
91. 00 09100 EMERGENCY	0. 262215	0	366, 58	7 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2. 153226	0		0 0	0	92.00
200.00 Subtotal (see instructions)		0	1, 151, 73	7 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	1, 151, 73	7 0	0	202. 00

Health Financial Systems	SCOTT MEMORIAL HOSPITA	AL In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST Provi	der CCN: 15-1334   Peri od:   Worksheet D   From 01/01/2023   Part V

				From 01/01/2023 To 12/31/2023	Part V Date/Time Pre 5/31/2024 6:5	
		Ti tl	e XIX	Hospi tal	Cost	
	Cos	ts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOLILIARY OFFICE COOT, OFFITFE	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS	00.047	_				F0.00
50. 00 05000 OPERATING ROOM	20, 247	0				50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0	0				52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	48, 212	0	1			54.00
60. 00   06000   LABORATORY	39, 182	0	1			60.00
63. 00 06300 BLOOD STORING PROCESSING & TRANS.	170	0				63.00
65. 00 06500 RESPIRATORY THERAPY	10, 125	0				65.00
66. 00 06600 PHYSI CAL THERAPY	5, 662	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	1			67.00
68. 00   06800   SPEECH PATHOLOGY	0	0	1			68. 00
69. 00 06900 ELECTROCARDI OLOGY	5, 183	0	1			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 173	0	1			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	13, 602	0	1			73.00
76. 00   03610   SLEEP LAB	71	0	1			76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	2, 700	0	1			76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	1			78. 00
OUTPATIENT SERVICE COST CENTERS	T		T			
88. 00 08800 RURAL HEALTH CLINIC	0, 105					88. 00
91. 00 09100 EMERGENCY	96, 125	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
200.00 Subtotal (see instructions)	242, 452	0	1			200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges	242 452	_				202 00
202.00   Net Charges (line 200 - line 201)	242, 452	0	1			202. 00

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1334	Peri od: From 01/01/2023	Worksheet D-1	
		To 12/31/2023	Date/Time Pre 5/31/2024 6:5	
	Title XVIII	Hospi tal	Cost	
Cost Center Description				
· ·			1 00	

		Title XVIII	Hospi tal	5/31/2024 6: 5 Cost	1 am
	Cost Center Description	THE ANTI	поэрт саг		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			2, 332	1.00
2. 00	Inpatient days (including private room days, excluding swing-	<i>y</i> ,		1, 245	2.00
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	iys). If you have only pr	rivate room days,	0	3.00
4. 00	Semi-private room days (excluding swing-bed and observation b	ed days)		814	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decembe	er 31 of the cost	893	5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om daya) after Dagambar	21 of the cost	0	6. 00
6.00	reporting period (if calendar year, enter 0 on this line)	oolii days) ai tei beceilibei	31 Of the Cost	U	0.00
7. 00	Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	194	7. 00
0.00	reporting period		11 -6 +1+	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	si or the cost	0	8.00
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	334	9.00
40.00	newborn days) (see instructions)			400	40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		room days)	420	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e			_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including privat	te room days)	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y				
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00
	Nursery days (title V or XIX only)			0	
	SWI NG BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	of the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
10.00	reporting period	des arter becomber or or	1110 0031		10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	266. 32	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	the cost	266. 32	20.00
20.00	reporting period	3 ditei becember 31 di	ine cost	200. 32	20.00
21.00				3, 582, 147	1
22. 00	Swing-bed cost applicable to SNF type services through Decemb $5 \times 1$ ine 17)	er 31 of the cost report	ting period (line	0	22. 00
23. 00		31 of the cost reportir	ng period (line 6	0	23.00
	x line 18)	·			
24. 00	Swing-bed cost applicable to NF type services through Decembe $7 \times 1$ ine 19)	er 31 of the cost reporti	ng period (line	51, 666	24.00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)		, , ,		
26.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		1, 526, 277 2, 055, 870	
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	(TITIE 21 IIITIUS TITIE 20)		2,055,670	27.00
28. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	28. 00
29.00				0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) 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)	11116 20)		0. 00	1
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		ctions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	110 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		1
	27 minus line 36)	·	·		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	LISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 651. 30	38.00
39. 00	Program general inpatient routine service cost (line 9 x line	2 38)		551, 534	39. 00
	Medically necessary private room cost applicable to the Progr	•		0 EE1 E24	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ 11110 40 <i>)</i>		551, 534	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	SCOTT MEMORIAL		CN: 15-1334	Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 6:5	
	Cost Center Description	Total	Ti tle Total	Average Per	Hospital Program Days	Cost Program Cost	
	cost center bescription	Inpatient	Inpati ent	Di em (col.		(col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
2 00	NUDCEDY (+; +1 o V e VIV only)	1.00	2.00	3.00	4.00	5. 00	42.
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units			<u>J</u> 0. (	0	0	42.
3. 00	INTENSIVE CARE UNIT	52, 770	749	70. 4	15 5	352	43.
4. 00	CORONARY CARE UNIT						44.
5.00	BURN INTENSIVE CARE UNIT						45.
6. 00 7. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46.
7.00	Cost Center Description	LL		<u> </u>			77.
3. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	line 200)			1. 00 348, 791	48
3. 01	Program inpatient cellular therapy acquisiti	on cost (Worksh	eet D-6, Part	III, line 10	, column 1)	0	
9. 00	Total Program inpatient costs (sum of lines	41 through 48.0	1)(see instru	ctions)		900, 677	49
0.00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp	ationt routing	convices (fra	m Wkst D su	m of Dorte L and	0	50.
J. 00	[Flass through costs appricable to Program The	attent routine	services (iid	III WKSt. D, Su	III OI PALLS I AIIC		30.
1. 00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.
2 00	and IV)	FO 1 F4\				_	
2. 00 3. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non-ph	vsician anest	hetist and	0	
. 00	medical education costs (line 49 minus line						] 33
	TARGET AMOUNT AND LIMIT COMPUTATION						
1. 00 5. 00	Program di scharges Target amount per di scharge					0.00	54
5. 01	Permanent adjustment amount per discharge					0.00	
5. 02	Adjustment amount per discharge (contractor	use onl v)				0.00	
. 00	Target amount (line 54 x sum of lines 55, 55					0	1
. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (	line 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	on line EE from	+ho ooo+ ron	anting nariad	anding 1004	0	
0. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)		the cost rep	orting period	enarng 1996,	0. 00	39
0. 00	Expected costs (lesser of line 53 ÷ line 54,		m prior year	cost report,	updated by the	0.00	60
1. 00	market basket) Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les					0	61
	53) are less than expected costs (lines 54 x enter zero. (see instructions)						
2. 00 3. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	62
	PROGRAM INPATIENT ROUTINE SWING BED COST	(000					
1. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost report	ing period (See	693, 546	64
5. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decembe	or 21 of the	cost roportin	a pariod (Soo	0	65
). 00	instructions)(title XVIII only)	ts arter becemb	er 31 or the	cost reportin	g perrou (see		03
5. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	<pre>II only); for</pre>	693, 546	66
	CAH, see instructions	0 000to th	Docombo: 24	of the e+	oporting named a	_	, -
, UU	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs inrough	pecelliper, 31	or the cost r	eporting period	"	67
3. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost rep	orting period	0	68
0. 00	(line 13 x line 20)  Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + lin	ie 68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY,	AND ICF/IID	ONLY			
	Skilled nursing facility/other nursing facil				)		70
. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine 70 ÷ IIne	: 2)			71
	Medically necessary private room cost applic		(line 14 x l	ine 35)			73
. 00	Total Program general inpatient routine serv	•	•				74
. 00	Capital -related cost allocated to inpatient	routine service	costs (from	Worksheet B,	Part II, column		75
. 00	26, line 45)  Per diem capital-related costs (line 75 ÷ li	ne 2)					76
. 00	Program capital -related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minu	s line 77)					78
	Aggregate charges to beneficiaries for exces						79
. 00	Total Program routine service costs for comp		ost limitatio	n (IIne 78 mi	nus line 79)		80
. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)				81
. 00	Reasonable inpatient routine service cost in attom (						83
. 00	Program inpatient ancillary services (see in		- /				84
. 00	Utilization review - physician compensation	(see instruction					85
. 00	Total Program inpatient operating costs (sum		rough 85)				86
	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					431	87
. 00							

Health Financial Systems SCOTT MEMORIAL HOSPITAL In Lieu			u of Form CMS-2	2552-10		
		Peri od:	Worksheet D-1			
				From 01/01/2023 To 12/31/2023		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions	)			711, 710	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	208, 571	3, 582, 147	0. 05822	5 711, 710	41, 439	90.00
91.00 Nursing Program cost	0	3, 582, 147	0.00000	0 711, 710	o	91.00
92.00 Allied health cost	0	3, 582, 147	0.00000	0 711, 710	o	92.00
93.00 All other Medical Education	0	3, 582, 147	0. 00000	0 711, 710	0	93.00

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1334	Peri od: From 01/01/2023	Worksheet D-1	
		To 12/31/2023	Date/Time Prep 5/31/2024 6:5	
	Title XIX	Hospi tal	Cost	
Cost Center Description				

Cost Center Description  1.00  PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS  1.00 Inpatient days (including private room days and swing-bed days, excluding newborn)  2.00 Inpatient days (including private room days, excluding swing-bed and newborn days)  3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	ost	
PART I - ALL PROVIDER COMPONENTS  INPATIENT DAYS  1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		
PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS  1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 1.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		
<ul> <li>2.00 Inpatient days (including private room days, excluding swing-bed and newborn days)</li> <li>3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.</li> </ul>		
3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	, 332	1.00
do not complete this line.	, 245	2.00
	0	3. 00
4.00 Semi-private room days (excluding swing-bed and observation bed days)	814	4.00
5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	893	5. 00
reporting period		
6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	194	7. 00
reporting period	174	7.00
8.00   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
reporting period (if calendar year, enter 0 on this line)		
9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and	14	9. 00
newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
through December 31 of the cost reporting period (see instructions)	۷	10.00
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
through December 31 of the cost reporting period	0	12 00
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	٥	13. 00
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00 Total nursery days (title V or XIX only)	0	15.00
16.00 Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT		47.00
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17. 00
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
reporting period		
	6. 32	19.00
reporting period	, ,,	20.00
20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period	6. 32	20. 00
21.00 Total general inpatient routine service cost (see instructions)  3,582	, 147	21.00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
5 x line 17)		
23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
	666	24.00
7 x line 19)	,	
25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
x line 20) 26.00 Total swing-bed cost (see instructions) 1,526	277	26. 00
		27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	7070	27.00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00 Private room charges (excluding swing-bed charges)	0	29. 00
30.00   Semi-private room charges (excluding swing-bed charges) 31.00   General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.00	0000	30. 00 31. 00
	0. 00	32.00
	0. 00	33.00
	0. 00	34.00
	0. 00	35.00
36.00 Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2,055	, 870	37.00
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	1. 30	38.00
39.00 Program general inpatient routine service cost (line 9 x line 38)	, 118	39.00
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)	, 118	41. 00

Heal th	Financial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST				eriod: rom 01/01/2023	Worksheet D-1	
					o 12/31/2023	Date/Time Pre 5/31/2024 6:5	
				e XIX	Hospi tal	Cost	- aiii
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col. 2)	1.00	col. 4)	
42. 00	NURSERY (title V & XIX only)	1. 00	2.00	3.00	4.00	5. 00	42.00
	Intensive Care Type Inpatient Hospital Units		7.6	70.45		70	
43. 00 44. 00	INTENSIVE CARE UNIT	52, 770	749	70. 45	1	70	43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT						45.00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description			•		1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			1. 00 18, 815	48. 00
48. 01	Program inpatient cellular therapy acquisiti	•			column 1)	0	48. 01
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	or)(see instru	ctions)		42, 003	49. 00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50. 00
51. 00	<pre>                                    </pre>	atient ancillar	y services (f	rom Wkst. D, s	um of Parts II	0	51.00
F2 00	and IV)	EO and E1)				0	F2 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated, non-ph	ysician anesth	etist, and	0	52. 00 53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)	·	-			
54. 00	Program di scharges					0	54.00
55. 00 55. 01	Target amount per discharge					0. 00 0. 00	•
55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				0.00	1
56.00	Target amount (line 54 x sum of lines 55, 55			line E/ minue	lina E2)	0	56.00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (	line 56 minus	iine 53)	0	57. 00 58. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54,		n the cost rep	orting period	endi ng 1996,	0. 00	59. 00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		om prior year	cost report, u	pdated by the	0.00	60.00
61. 00	market basket) Continuous improvement bonus payment (if Lin	e 53 ÷ line 54	is less than	the lowest of	lines 55 nlus	0	61.00
01.00	$55.01$ , or line $59$ , or line $60$ , enter the lesser of $50\%$ of the amount by which operating costs (line $53$ ) are less than expected costs (lines $54 \times 60$ ), or $1 \%$ of the target amount (line $56$ ), otherwise						01.00
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	per 31 of the	cost reporting	period (See	0	65. 00
44 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costs (line	44 plus line	4E) (+i +l o V)/I I	l only): for	0	44 00
66. 00	CAH, see instructions	THE COSTS (TTHE	64 prus irrie	os)(title xvii	i diliy), idi	O	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after [	December 31 of	the cost repo	rting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (	(line 67 + lin	e 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY			
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70. 00 71. 00
72.00	Program routine service cost (line 9 x line	71)					72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv	9	•				73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)				art II, column		75. 00
76.00	Per diem capital related costs (line 75 ÷ li	,					76. 00 77. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				us lino 70)		79. 00 80. 00
81.00	Inpatient routine service costs for comp		JUST TIMITATIO	(IIIIC /O IIIIII	us IIIIc /9)		81.00
82.00	Inpatient routine service cost limitation (I						82.00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		15)				83. 00 84. 00
85.00	Utilization review - physician compensation	(see instruction					85. 00 86. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ıı ouyı1 85)				00.00
	Total observation bed days (see instructions Adjusted general inpatient routine cost per	)	Line 2)			431 1, 651. 30	87.00
	Indiasted general impatrent routine cost per	arem (TITIE 27 =				1, 051. 30	1 00.00

Health Financial Systems SCOTT MEMORIAL HOSPITAL In Lieu			u of Form CMS-2	2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co	Provi der CCN: 15-1334 Per		Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)				711, 710	89.00	
Cost Center Description	Cost	Routine Cost (from line	column 1 ÷ column 2	Total Observation	Observation Bed Pass	
		21)	COI UIIII 2	Bed Cost	Through Cost	
		21)		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	208, 571	3, 582, 147	0. 05822	25 711, 710	41, 439	90.00
91.00 Nursing Program cost	0	3, 582, 147	0. 00000	711, 710	0	91.00
92.00 Allied health cost	0	3, 582, 147	0. 00000	711, 710	0	92.00
93.00 All other Medical Education	0	3, 582, 147	0. 00000	711, 710	0	93.00

Health Financial Cyctoms	SCOTT MEMORIAL HOSPITAL		In Lie	u of Form CMS-2	DEE2 10
Health Financial Systems INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CO		Peri od:	Worksheet D-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 6:5	
	Title	: XVIII	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)	
LNDATLENT DOUTLNE CEDVLOE COCT OFNITEDO		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		ı	007.507		00.00
30.00   03000   ADULTS & PEDIATRICS 31.00   03100   NTENSIVE CARE UNIT			297, 527		30.00
43. 00   04300   NURSERY			7, 620		31.00 43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		1. 85956	4 18, 623	34, 631	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 00000		0 1, 001	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 14893		18, 018	ł
60. 00   06000   LABORATORY		0. 13285			
63.00 06300 BLOOD STORING PROCESSING & TRANS.		0. 20458		731	63.00
65. 00 06500 RESPIRATORY THERAPY		0. 23129	7 143, 242	33, 131	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 32417	7 64, 913	21, 043	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 08501	4 39, 965	3, 398	67.00
68. 00 06800 SPEECH PATHOLOGY		0.00000	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 21044		11, 080	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 28650		67, 014	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		1. 99622		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 23524		68, 924	
76. 00   03610   SLEEP LAB		0. 04398		0	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 50106		0	76. 97
77. 00 07700 ALLOGENEI C HSCT ACQUISITION		0.00000		0	77.00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY		0. 00000	0 0	0	78. 00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	88. 00
91. 00   09100   EMERGENCY		0. 26221			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		2. 15322			1
200.00 Total (sum of lines 50 through 94 and	96 through 98)	2. 13322	1, 468, 658	348, 791	•
201.00 Less PBP Clinic Laboratory Services-Pr			1, 400, 030		200.00
202.00 Net charges (line 200 minus line 201)	ogram om y charges (Title OT)		1, 468, 658		202.00
,		1	.,, 000	ı	

<u> </u>	RIAL HOSPITAL			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1334	Peri od: From 01/01/2023	Worksheet D-3	
	Component	CCN: 15-Z334	To 12/31/2023	5/31/2024 6: 5	
	Title		Swing Beds - SNF		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program Charges	Program Costs (col. 1 x	
			3	col . 2)	
		1. 00	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
43. 00 O4300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 OPERATI NG ROOM		1. 85956	0.4	0	50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM		0. 00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 14893		ľ	
60. 00 06000 LABORATORY		0. 13285			
63.00 06300 BLOOD STORING PROCESSING & TRANS.		0. 20458	34 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY		0. 23129	13, 436	3, 108	65.00
66. 00   06600   PHYSI CAL THERAPY		0. 32417		66, 661	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 08501		8, 370	
68. 00 06800 SPEECH PATHOLOGY		0. 00000		0	
69. 00 06900 ELECTROCARDI OLOGY		0. 21044		11, 131	
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS		0. 28650 1. 99622		50, 060 0	
73. 00 07300 DRUGS CHARGED TO PATTENTS		0. 23524		47, 211	
76. 00   03610   SLEEP LAB		0. 23324		47,211	1
76. 97   07697   CARDI AC   REHABI LI TATI ON		0. 50106		Ö	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000		Ō	
78.00 07800 CAR T-CELL IMMUNOTHERAPY		0. 00000	00	0	78. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	
91. 00   09100   EMERGENCY		0. 26221		0	,
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2)	2. 15322		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98			907, 947	208, 434	
201.00 Less PBP Clinic Laboratory Services-Program only cl	narges (Tine 61)		007.047		201.00
202.00 Net charges (line 200 minus line 201)		I	907, 947	I	202. 00

Health Financial Systems	SCOTT MEMORIAL HOSPITAL		In lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der (	CCN: 15-1334	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-3	epared:
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
LUBATI FUT DOUTLINE OFFILIAS OOOT OFFITEDO		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			75.044		00.00
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   NTENSI VE CARE UNI T			75, 941		30.00
31. 00   03100   I NTENSI VE CARE UNI T 43. 00   04300   NURSERY			1, 524 0		43.00
ANCILLARY SERVICE COST CENTERS			0		43.00
50. 00 05000 OPERATING ROOM		1. 85956	54 0	0	50.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM		0. 00000			
54. 00   05400   RADI OLOGY - DI AGNOSTI C		0. 14893		_	
60. 00   06000   LABORATORY		0. 1328			60.00
63.00 06300 BLOOD STORING PROCESSING & TRANS.		0. 20458	34 0	0	63.00
65. 00 06500 RESPIRATORY THERAPY		0. 23129	97 35, 068	8, 111	65.00
66. 00   06600 PHYSI CAL THERAPY		0. 3241	77 775	251	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 0850		0	
68. 00 06800 SPEECH PATHOLOGY		0.00000		1	
69. 00   06900   ELECTROCARDI OLOGY		0. 2104			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 28650			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		1. 99622		1	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 23524			
76. 00 03610 SLEEP LAB		0. 04398			
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 5010		-	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000			
78. 00 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS		0.00000	00 0	0	78. 00
88. 00 08800 RURAL HEALTH CLINIC		1. 8070	56 0	0	88.00
91. 00   09100   EMERGENCY		0. 2622		_	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		2. 15322		4, 536	1
200.00 Total (sum of lines 50 through 94 and	96 through 98)	2. 15522	88, 999		200.00
201.00 Less PBP Clinic Laboratory Services-Pr			00, 777	10, 013	201.00
202.00 Net charges (line 200 minus line 201)	ogiam only charges (Title 01)	1	88, 999		202.00

Health Financial Systems	SCOTT MEMORIAL HO	OSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1334	From 01/01/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 6:51 am
		T		

		Title XVIII	Hospi tal	5/31/2024 6:5 Cost	1 am
			·	1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			2, 515, 190	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	ti ons)		0	2.00
3. 00 4. 00	OPPS or REH payments			0	3. 00 4. 00
4. 00	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	4.00
5. 00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0.000	5.00
6.00	Line 2 times line 5	ŕ		0	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	7.00
8. 00	Transitional corridor payment (see instructions)	at araduata madi aal adua	ation costs from	0	8.00
9. 00	Ancillary service other pass through costs including REH direction Wkst. D. Pt. IV, col. 13, line 200	ct graduate medical educ	cation costs from	0	9. 00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			2, 515, 190	1
	COMPUTATION OF LESSER OF COST OR CHARGES				
40.00	Reasonable charges		1		1 40 00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ino 60)		0	12. 00 13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	THE 09)		0	14.00
00	Customary charges				
15.00	Aggregate amount actually collected from patients liable for patients	payment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for	. 3	on a chargebasis	0	16.00
17. 00	had such payment been made in accordance with 42 CFR §413.13( Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			0.000000	18.00
19. 00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	0	19.00
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	ne 18) (see	0	20.00
21. 00	instructions) Lesser of cost or charges (see instructions)			2, 540, 342	21.00
22. 00	Interns and residents (see instructions)			2, 540, 542	22.00
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructi ons)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	·		0	24.00
05.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			24.004	
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions	•	cuctions)	36, 234 1, 550, 659	•
27. 00	Deductibles and Coinsurance amounts relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)]			953, 449	
27.00	instructions)	D. 40 1.10 04 01 111100 22	20] (000	7007 117	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, II	ine 50)		0	28. 00
28. 50	REH facility payment amount (see instructions)			_	28. 50
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27, 28, 28.50 and 29)			0 953, 449	29. 00 30. 00
31. 00	Primary payer payments			955, 449 551	1
32. 00	Subtotal (line 30 minus line 31)			952, 898	•
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIO	CES)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34. 00 35. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			145, 683 94, 694	•
36. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		97, 050	
37. 00	Subtotal (see instructions)	. 40 (. 65)		1, 047, 592	
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)	5)		0	39.50
39. 75 39. 97	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration			0	39. 75 39. 97
39. 98	Partial or full credits received from manufacturers for replacements	ced devices (see instruc	ctions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	`	,	0	39. 99
40.00	Subtotal (see instructions)			1, 047, 592	1
40. 01	Sequestration adjustment (see instructions)			20, 952	1
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40. 02 40. 03
41. 00	Interim payments			788, 375	
41. 01	Interim payments-PARHM			,	41.01
42.00	Tentative settlement (for contractors use only)			0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)			222 2:=	42.01
43.00	Balance due provider/program (see instructions)			238, 265	43.00
43. 01 44. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2	chanter 1	50, 989	43. 01 44. 00
¬+. UU	\$115. 2	nee with owe rub. 19-2,	Shapter I,	30, 709	77.00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 00	91.00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92. 00 93. 00
	1.1.1.1.3 . 3.1.3.3 . 3.1		l l	0	, , 5. 55

Health Financial Systems	SCOTT MEMORIAL I	HOSPI TAL	In Lieu	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1334	Peri od: From 01/01/2023	Worksheet E	
				Date/Time Pre 5/31/2024 6:5	pared: 1 am
		Title XVIII	Hospi tal	Cost	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200.00

Health Financial Systems SCOO ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provi der CCN: 15-1334

			'	0 12/31/2023	5/31/2024 6: 5	
		Ti tl e	XVIII	Hospi tal	Cost	
		I npati er	nt Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4.00	
1.00	Total interim payments paid to provider		433, 032		788, 375	1.00
2.00	Interim payments payable on individual bills, either		C		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero					3. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		l			
3. 01	ADJUSTMENTS TO PROVIDER				0	3. 01
3.02				1	o	3.02
3. 03			C	1	0	3.03
3.04				)	0	3.04
3.05			C		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		C		0	3.50
3. 51			C		0	3. 51
3. 52			C		0	3. 52
3. 53			C		0	3. 53
3. 54			C		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		C		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		433, 032		788, 375	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		433, 032		100, 313	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5.02			C		0	5.02
5. 03			C		0	5. 03
	Provi der to Program					
5. 50 5. 51	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51 5. 52					0 0	5. 51 5. 52
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					5. 52 5. 99
5. 99	5. 50-5. 98)				ا	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
3. 00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		300, 925		238, 265	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		733, 957		1, 026, 640	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00			0	1. 00	2. 00	
8.00	Name of Contractor			1		8.00

Provider CCN: 15-1334 | Period: | Worksheet E-1 | From 01/01/2023 | To 12/31/2024 6: 51 am | From 01/01/2023 | Part I | Provider CCN: 15-1334

		Component	3014. 10 2001	127 0 17 2020	5/31/2024 6: 5	1 am
				Swing Beds - SNF		
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		481, 79	7	0	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	
3. 02				0	0	
3. 03				0	0	
3.04				0	0	
3. 05				0	0	3.05
	Provider to Program					1
3.50	ADJUSTMENTS TO PROGRAM			0	0	
3. 51				0	0	
3. 52				0	0	
3. 53				0	0	
3.54				0	0	
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)		481, 79	7	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					-
F 00	TO BE COMPLETED BY CONTRACTOR				Г	- 00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			o	0	5.01
5. 02	TENTATIVE TO TROVIDER			Ö	ĺ	
5. 02				Ö	0	
0.00	Provider to Program			<u> </u>		0.00
5. 50	TENTATI VE TO PROGRAM			0	0	5.50
5. 51				0	Ō	
5. 52				0	0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	Ō	
	5. 50-5. 98)				_	
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		398, 63	4	0	6.01
6. 02	SETTLEMENT TO PROGRAM			0	0	
7. 00	Total Medicare program liability (see instructions)		880, 43	1	0	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2. 00	
	Name of Contractor					8.00

Heal th	Financial Systems SCOTT MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1334 Period:				
			From 01/01/2023 To 12/31/2023		nared.
			10 12/31/2023	5/31/2024 6: 5	
		Title XVIII	Hospi tal	Cost	
	TO BE COMPLETED BY CONTRACTOR FOR MONOTANDARD COOT REPORTS			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	A.I			-
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO		. 11		1 00
1.00	Total hospital discharges as defined in AARA §4102 from Wkst	. S-3, Pt. I COI. IS IIIn	e 14		1.00
2. 00	Medicare days (see instructions)				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4. 00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00
		, ,	, '		

Health Financial Systems	SCOTT MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1334	Peri od:	Worksheet E-2
			From 01/01/2023	
		Component CCN: 15-Z334	To 12/31/2023	Date/Time Prepared:
				5/31/2024 6:51 am

		Component CCN: 15-Z334	o 12/31/2023	Date/Time Pre 5/31/2024 6:5	
		Title XVIII S	wing Beds - SNF		
			Part A	Part B	
			1. 00	2. 00	
4 00	COMPUTATION OF NET COST OF COVERED SERVICES		700 404		
1.00	Inpatient routine services - swing bed-SNF (see instructions)		700, 481	0	
2. 00 3. 00	Inpatient routine services - swing bed-NF (see instructions) Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A and sum of Wkst D	210, 518	0	2.00
3.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi		210, 516	U	3.00
	instructions)	ng bed pass tim dagii, see			
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4.00	Per diem cost for interns and residents not in approved teach	ing program (see		0.00	4.00
	instructions)				
5. 00	Program days		420	0	
6.00	Interns and residents not in approved teaching program (see i			0	6.00
7.00	Utilization review - physician compensation - SNF optional me Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	thod only	910, 999	0	7. 00 8. 00
8. 00 9. 00	Primary payer payments (see instructions)		910, 999	0	
10. 00	Subtotal (line 8 minus line 9)		910, 999	0	
11. 00	Deductibles billed to program patients (exclude amounts applied	cable to physician	0	0	
	professional services)			_	
12.00	Subtotal (line 10 minus line 11)		910, 999	0	12.00
13.00	Coinsurance billed to program patients (from provider records)	) (exclude coinsurance	12, 600	0	13.00
	for physician professional services)				
14. 00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		898, 399	0	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	-)	0	0	16. 00 16. 50
16. 50 16. 55	Rural community hospital demonstration project (§410A Demonst		0		16. 55
10. 55	adjustment (see instructions)	ration) payment	U		10.55
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		0	0	
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	0	18. 00
19. 00	Total (see instructions)		898, 399	0	
19. 01	Sequestration adjustment (see instructions)		17, 968	0	
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	
19. 03 19. 25	Sequestration adjustment-PARHM pass-throughs		0	0	19. 03 19. 25
20. 00	Sequestration for non-claims based amounts (see instructions) Interim payments		481, 797	0	20.00
	Interim payments  Interim payments-PARHM		401, 777	O	20.00
21. 00	Tentative settlement (for contractor use only)		0	0	
21. 01	Tentative settlement-PARHM (for contractor use only)				21.01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.0.	2, 19.25, 20, and 21)	398, 634	0	22.00
22. 01	Balance due provider/program-PARHM (see instructions)				22. 01
23. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				
200.00	Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration pe				200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	Trod under the 21st			200.00
	Cost Reimbursement				1
201.00	Medicare swing-bed SNF inpatient routine service costs (from	Wkst. D-1, Pt. II, line			201.00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst. D-3, col. 3, line			202. 00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)	£!£	+ F	4	204.00
	Computation of Demonstration Target Amount Limitation (N/A in period)	Tirst year of the curren	t 5-year demons	tration	
205.00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 t	imes line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs		'		
207.00	Program reimbursement under the §410A Demonstration (see inst				207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-	2, col. 1, sum of lines 1			208.00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209.00
210.00	Reserved for future use				210.00
215 00	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare swing-bed SNF PPS payment (line.	200 plus Lino 210) (cos			215. 00
∠ 10. UU	instructions)	207 prus i i ile 210) (See			213.00
	<del>/</del>		'		1

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1334	From 01/01/2023	Worksheet E-3 Part V Date/Time Prepared: 5/31/2024 6:51 am
	Title XVIII	Hospi tal	Cost

				5/31/2024 6: 5	<u> 1 am </u>
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	RELMBURSEMENT		
1.00	Inpati ent services			900, 677	1.00
2. 00	Nursing and Allied Health Managed Care payment (see instructi	ons)		0	2.00
3. 00	Organ acquisition			0	3.00
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4. 00	Subtotal (sum of lines 1 through 3.01)			900, 677	4. 00
5. 00	Primary payer payments			700, 077	5.00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			909, 684	
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			707, 004	0.00
	Reasonable charges				
7 00				0	7. 00
7. 00	Routine service charges			- 1	
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9.00
10. 00	Total reasonable charges			0	10. 00
	Customary charges			-	44.00
11.00	Aggregate amount actually collected from patients liable for		9	-	11.00
12. 00	Amounts that would have been realized from patients liable for	1 3	on a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e	·)			
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	
14. 00	Total customary charges (see instructions)			0	14.00
15. 00	Excess of customary charges over reasonable cost (complete or	ly if line 14 exceeds li	ne 6) (see	0	15.00
	instructions)				
16. 00	Excess of reasonable cost over customary charges (complete or	lly if line 6 exceeds lir	ne 14) (see	0	16. 00
	instructions)				
17. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18. 00	Direct graduate medical education payments (from Worksheet E-	4, line 49)		0	
19. 00	Cost of covered services (sum of lines 6, 17 and 18)			909, 684	
20.00	Deductibles (exclude professional component)			170, 994	20.00
21. 00	Excess reasonable cost (from line 16)			0	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			738, 690	22.00
23.00	Coi nsurance			0	23.00
24.00	Subtotal (line 22 minus line 23)			738, 690	24.00
25.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		15, 763	25.00
26.00	Adjusted reimbursable bad debts (see instructions)			10, 246	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			748, 936	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29.00
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	29. 50
29. 98	Recovery of accelerated depreciation.	,		0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			748, 936	
30. 01	Sequestration adjustment (see instructions)			14, 979	
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03	Sequestration adjustment-PARHM			_	30. 03
31. 00	Interim payments			433, 032	
31. 01	Interim payments-PARHM			100,002	31. 01
32. 00	Tentative settlement (for contractor use only)			0	
32. 00	Tentative settlement-PARHM (for contractor use only)			O	32. 00
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.0	12 31 and 32)		300, 925	33. 00
33. 00	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m		and 32 01)	300, 723	33. 00
34. 00	Protested amounts (nonallowable cost report items) in accorda			5, 517	
54.00	\$115. 2	mice with ows rub. 10-2,	chapter I,	5, 517	34.00
	13113. 2		ı	l	1

Health Financial Systems	SCOTT MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1334	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2024 6:51 am

			10 12/31/2023	5/31/2024 6:5	1 am
		Title XIX	Hospi tal	Cost	
	<u> </u>		I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				]
1.00	Inpatient hospital/SNF/NF services		42, 003		1.00
2.00	Medical and other services			242, 452	2.00
3.00	Organ acquisition (certified transplant programs only)		0	,	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		42, 003	242, 452	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)		42, 003	242, 452	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		12,000	212, 102	7.00
	Reasonable Charges				1
8. 00	Routine service charges		0		8.00
9. 00	Ancillary service charges		88, 999	1, 151, 737	9.00
10.00	Organ acquisition charges, net of revenue		00, 777	1, 131, 737	10.00
11. 00	Incentive from target amount computation		0		11.00
	Total reasonable charges (sum of lines 8 through 11)		88, 999	1 151 707	
12.00	CUSTOMARY CHARGES		00, 999	1, 151, 737	12.00
13. 00	Amount actually collected from patients liable for payment for	r corvi coc en e cherce	0	0	13.00
13.00		r services on a charge	U	U	13.00
14. 00	basis	r normant for condinos or	0	0	14 00
14.00	Amounts that would have been realized from patients liable for		·	U	14.00
15. 00	a charge basis had such payment been made in accordance with Ratio of line 13 to line 14 (not to exceed 1.000000)	42 CFR 9413. 13(e)	0. 000000	0. 000000	15.00
	,				
16.00	Total customary charges (see instructions)	l., ! €   ! == 1/	88, 999	1, 151, 737	
17. 00	Excess of customary charges over reasonable cost (complete on	ry it line to exceeds	46, 996	909, 285	17.00
10.00	line 4) (see instructions)	:£ linn 4		0	10 00
18. 00	Excess of reasonable cost over customary charges (complete on	ry ir irne 4 exceeds irne	0	0	18.00
40.00	16) (see instructions)			0	10.00
19.00	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see inst		0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line		42, 003	242, 452	21.00
00.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid		0	00.00
	Other than outlier payments		0	0	
	Outlier payments		0	0	
	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		25.00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		42, 003	242, 452	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	)	42, 003	242, 452	
32.00	Deducti bl es		0	0	
33.00	Coi nsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	42, 003	242, 452	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		42, 003	242, 452	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		42, 003	242, 452	40.00
41.00	Interim payments		42, 003	242, 452	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2	·			
	Jonapeon 1, 3110.2				1

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

Provider CCN: 15-1334

Peri od: Worksheet G
From 01/01/2023
To 12/31/2023 Date/Time Prepared: 5/31/2024 6:51 am

UIII y)					5/31/2024 6: 5	1 am
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	248, 278	0	0	0	1.00
2.00	Temporary investments	0	0	0		2.00
3.00	Notes receivable	0	0	0	0	3.00
4. 00	Accounts receivable	4, 114, 530	1	0	0	4.00
5. 00 6. 00	Other receivable Allowances for uncollectible notes and accounts receivable	236, 033 -1, 277, 819		0	0	5. 00 6. 00
7. 00	Inventory	486, 420		0	0	7. 00
8. 00	Prepaid expenses	172, 671		0	Ö	8. 00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	3, 980, 113	0	0	0	11. 00
12 00	FIXED ASSETS	120,000	l ol	0	0	12.00
12. 00 13. 00	Land improvements	428, 000 37, 764	0	0	0	12. 00 13. 00
14. 00	Accumulated depreciation	-633	_	0	0	14. 00
15. 00	Bui I di ngs	2, 538, 613	1	0	Ö	15. 00
16.00	Accumulated depreciation	-53, 941	0	0	0	16.00
17. 00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	464, 137 -13, 373		0	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	-13, 3/3		0	0	20. 00 21. 00
22. 00	Accumulated depreciation		0	0	0	22.00
23. 00	Major movable equipment	640, 306	_	0	Ö	23.00
24.00	Accumulated depreciation	-71, 056	1	0	0	24.00
25.00	Mi nor equi pment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27.00
28. 00 29. 00	Accumulated depreciation	0	0	0	0	28. 00 29. 00
30.00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	3, 969, 817		0	-	30.00
30.00	OTHER ASSETS	3, 707, 017	<u> </u>		0	30.00
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33. 00	Due from owners/officers	0	0	0	0	33.00
34. 00	Other assets	-9, 019, 205	1	0	0	34.00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	-9, 019, 205 -1, 069, 275	1	0	0	35. 00 36. 00
30.00	CURRENT LIABILITIES	-1,007,273	0		0	30.00
37.00	Accounts payable	-607, 630	0	0	0	37.00
38.00	Salaries, wages, and fees payable	393, 839	0	0	0	38.00
39. 00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and Loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	3, 226	0	0	0	41.00
42. 00 43. 00	Accel erated payments Due to other funds	0		0	0	42. 00 43. 00
44. 00	Other current liabilities	94, 195		0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	-116, 370	1	0		45. 00
	LONG TERM LIABILITIES		·			
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	_	0	0	47.00
48. 00	Unsecured Loans	0	0	0	-	48.00
49.00	Other long term liabilities	172, 867 172, 867		0	0	49. 00 50. 00
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	56, 497	1	0		50.00
31.00	CAPITAL ACCOUNTS	30, 477	١		0	31.00
52.00	General fund balance	-1, 125, 772				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	57. 00 58. 00
56.00	replacement, and expansion					50.00
59. 00	Total fund balances (sum of lines 52 thru 58)	-1, 125, 772	o	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	-1, 069, 275	i i	0	0	60.00
	[59]					

SCOTT MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-1334

					To 12/31/2023	Date/Time Pre 5/31/2024 6:5	
		General	Fund	Speci al P	urpose Fund	Endowment Fund	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) UNEXPLAINED VARIANCE	2, 156 0 0 0	2, 861, 928 -2, 861, 928		000000000000000000000000000000000000000		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00	,	-1, 734, 000 0 0 0 0 0	2, 156 -2, 859, 772 -1, 734, 000 -1, 125, 772		0 0 0 0 0 0 0 0 0	0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
	Short (The Trimings Trie 19)	Endowment Fund	PI ant	Fund			
		4 00	7.00	0.00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) UNEXPLAINED VARIANCE	6.00	7.00 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) SCOTT NET INCOME BEFORE NORTON ACQUI  Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0	,	000000000000000000000000000000000000000		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

| Peri od: | Worksheet G-2 | From 01/01/2023 | Parts | & II | To | 12/31/2023 | Date/Time | Prepared: Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1334

		T	o 12/31/2023	Date/Time Pre 5/31/2024 6:5	
	Cost Center Description	I npati ent	Outpati ent	Total	- Cili
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	•			
	General Inpatient Routine Services				
1.00	Hospi tal	3, 378, 685		3, 378, 685	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3, 378, 685		3, 378, 685	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	26, 779		26, 779	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	26, 779		26, 779	16.00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	3, 405, 464		3, 405, 464	17.00
18.00	Ancillary services	3, 723, 828	48, 539, 746	52, 263, 574	18.00
19.00	Outpati ent servi ces	379, 084	12, 517, 955	12, 897, 039	19.00
20.00	RURAL HEALTH CLINIC	0	477, 060	477, 060	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22. 00	HOME HEALTH AGENCY				22.00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE				26.00
27. 00	PRO FEES	0	510, 058	510, 058	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	7, 508, 376	62, 044, 819	69, 553, 195	28. 00
20.00	G-3, line 1)	7,000,070	02, 011, 017	07, 000, 170	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		22, 626, 740		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	beboot (Si corri)				38. 00
39. 00		0			39.00
40. 00		0			40.00
41. 00			}		40.00
41.00	Total deductions (sum of lines 37-41)				41.00
42.00	Total deductions (sum of fines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	r	22, 626, 740		42.00
43.00	to Wkst. G-3, line 4)	'	22, 020, 740		43.00
	10 WASE 0-3, TITE 4)	1	1		

		T MEMORIAL HOSPITAL		u of Form CMS-2	
STATEM	IENT OF REVENUES AND EXPENSES	Provi der CCN: 15-1334	Peri od: From 01/01/2023	Worksheet G-3	
	To 12/31/2023				pared:
			1	5/31/2024 6: 5	1 am
	T			1.00	4.0
1.00	Total patient revenues (from Wkst. G-2, Part I, co			69, 553, 195	1.00
2. 00	Less contractual allowances and discounts on patie	ents' accounts		50, 846, 960	2.0
3. 00	Net patient revenues (line 1 minus line 2)	11 11 11 11 11 11		18, 706, 235	3.0
1.00	Less total operating expenses (from Wkst. G-2, Par			22, 626, 740	
5. 00	Net income from service to patients (line 3 minus	line 4)		-3, 920, 505	5.00
5. 00	OTHER INCOME Contributions, donations, bequests, etc			0	6.0
7. 00	Income from investments			0	7.0
7. 00 3. 00	Revenues from telephone and other miscellaneous co	mmuni aati an aasul aaa		0	8.0
9. 00	Revenue from television and radio service	ommunication services		0	9.0
0.00	Purchase di scounts			0	10.0
	Rebates and refunds of expenses			0	11.0
12.00	Parking lot receipts			0	12.0
	Revenue from Laundry and Linen service			0	13.0
	Revenue from meals sold to employees and quests			0	14. (
5. 00	Revenue from rental of living quarters			0	15.0
	Revenue from sale of medical and surgical supplies	to other than nationts		0	16.0
	Revenue from sale of drugs to other than patients	s to other than patrents		0	17. (
	Revenue from sale of medical records and abstracts			0	18. (
	Tuition (fees, sale of textbooks, uniforms, etc.)	,		0	19. (
	Revenue from gifts, flowers, coffee shops, and can	nteen		0	20. (
	Rental of vending machines	recon		0	21. (
2. 00	Rental of hospital space			0	22.0
3. 00	Governmental appropriations			0	23. (
4. 00	OTHER OPERATING INCOME			1, 058, 577	24. (
	COVI D-19 PHE Funding			0	24.
	Total other income (sum of lines 6-24)			1, 058, 577	
	Total (line 5 plus line 25)			-2, 861, 928	
	OTHER EXPENSES (SPECIFY)			2,001,720	27. (
	Total other expenses (sum of line 27 and subscript	(2)		0	28.
	Net income (or loss) for the period (line 26 minus			-2, 861, 928	

111 41-	Financial Contant	CCOTT MEMORIA	AL HOCDITAL				2552 40
	Financial Systems SIS OF HOSPITAL-BASED RHC/FQHC COSTS	SCOTT MEMORIA	Provider C	CN, 1E 1224	Period:	u of Form CMS-: Worksheet M-1	
ANALYS	SIS OF HOSPITAL-BASED RHC/FUHC COSTS		Provider C		From 01/01/2023	worksneet w-i	
			Component	CCN: 15-8523	To 12/31/2023		pared:
					RHC I	5/31/2024 6: 5	1 am
		Compensation	Other Costs	Total (col	1 Reclassi fi cat	Cost Reclassi fi ed	
		Compensation	Other costs	+ col . 2)	ions	Tri al Balance	
				' 55 2)	1 01.0	(col. 3 +	
						col . 4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	,					
1.00	Physi ci an	0	-		0 0		
2. 00	Physician Assistant	0	1		0 0	. 0	2.00
3.00	Nurse Practitioner	78, 749	0	78, 74		78, 749	3.00
4.00	Visiting Nurse	100 400		100 40	0 0	100 400	
5. 00 6. 00	Other Nurse Clinical Psychologist	180, 492		180, 49	0	180, 492 0	1
7. 00	Clinical Social Worker	0				0	1
7. 10	Marriage and Family Therapist	0			0	U	7.10
7. 10	Mental Health Counselor						7. 10
8. 00	Laboratory Techni ci an	0	0		0 0	0	1
9. 00	Other Facility Health Care Staff Costs	0			0 0	o o	1
10.00	Subtotal (sum of lines 1 through 9)	259, 241	l o	259, 24	11 0	259, 241	
11.00	Physician Services Under Agreement	0	0	,	0 0	0	1
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14.00
15.00	Medical Supplies	0	3, 407	3, 40	0 0	3, 407	15.00
16. 00	Transportation (Health Care Staff)	0	0		0	0	
17. 00	Depreciation-Medical Equipment	0	0		0	0	17.00
18.00	Professional Liability Insurance	0	0		0	0	
19.00	Other Health Care Costs Allowable GME Costs	0	0		0	0	1
20. 00 21. 00	Subtotal (sum of lines 15 through 20)	0	3, 407	3, 40	07	3, 407	20.00
21.00	Total Cost of Health Care Services (sum of	259, 241		262, 64		262, 648	1
22.00	lines 10, 14, and 21)	257, 241	3, 407	202, 04	0	202, 040	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						1
23. 00	Pharmacy	0	0		0 0	0	23. 00
24.00	Dental	0	O		0 0	0	24.00
25.00	Optometry	0	0		0 0	0	25.00
25. 01	Tel eheal th	0	0		0 0	0	25. 01
25. 02	Chronic Care Management	0	0		0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0 0	0	26. 00
27. 00	Nonallowable GME costs						27.00

0 81, 512

81, 512

340, 753

0

-51, 863 -51, 863

-51, 863

8, 662 317, 741

326, 403

589, 051

8, 662 236, 229 244, 891

248, 298

0 28.00

29.00

30.00

31.00

32.00

8, 662 265, 878 274, 540

537, 188

28.00

FACILITY OVERHEAD

30.00 Administrative Costs

29.00 Facility Costs

and 31)

30)

Total Nonreimbursable Costs (sum of lines 23 through 27)

31.00 Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28

Health Financial Systems	SCOTT MEMORIA	AL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der (	CCN: 15-1334	Peri od:	Worksheet M-1	
		Component	CCN: 15-8523	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 6:5	pared: 1 am
				RHC I	Cost	
	Adjustments	Net Expenses				
		for				
		Allocation				
		(col. 5 +				
		col. 6)				
	6. 00	7. 00				

		Adjustments	Net Expenses		
			for		
			Allocation		
			(col. 5 +		
			col. 6)		
		6. 00	7. 00		
	FACILITY HEALTH CARE STAFF COSTS				1
1. 00	Physi ci an	0	1		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	78, 749		3.00
4.00	Visiting Nurse	0	0		4. 00
5.00	Other Nurse	0	180, 492		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7. 10	Marriage and Family Therapist				7. 10
7. 11	Mental Health Counselor				7. 11
8.00	Laboratory Techni ci an	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	259, 241		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	3, 407		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	3, 407		21.00
22.00	Total Cost of Health Care Services (sum of	0	262, 648		22.00
	lines 10, 14, and 21)				
	COSTS OTHER THAN RHC/FQHC SERVICES				1
23.00	Pharmacy	0	0		23. 00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25. 01	Tel eheal th	0	0		25. 01
25. 02	Chronic Care Management	0	0		25. 02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		28. 00
	through 27)				
	FACILITY OVERHEAD				1
29. 00		0	8, 662		29. 00
30.00	Administrative Costs	0	265, 878		30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	· ·	l .	31.00
	30)				
32.00	Total facility costs (sum of lines 22, 28	0	537, 188		32.00
	and 31)				

	Financial Systems	SCOTT MEMORIA				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component	CCN: 15-8523	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 6:5	
					RHC I	Cost	
		Number of FTE	Total Visits	Producti vi ty	/ Minimum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						1
1. 00	Physi ci an	0.00					1.00
2.00	Physici an Assistant	0.00		_,			2.00
3.00	Nurse Practitioner	1. 03					3.00
4.00	Subtotal (sum of lines 1 through 3)	1. 03			2, 163	2, 163	
5.00	Visiting Nurse	0.00				0	
6.00	Clinical Psychologist	0.00				0	
7.00	Clinical Social Worker	0.00				0	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	1
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
7.03	Marriage and Family Therapist						7. 03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4	1. 03	2, 084			2, 163	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASE	ED RHC/FQHC SEI	RVICES		1. 00	
10.00	Total costs of health care services (from Wk					262, 648	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,					0	1
12. 00	Cost of all services (excluding overhead) (s					262, 648	
13. 00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14. 00	,					274, 540	
15. 00	Parent provider overhead allocated to facili					324, 891	
16. 00	Total overhead (sum of lines 14 and 15)	., (222	/			599, 431	
17. 00	Allowable GME overhead (see instructions)					0	1
18. 00	Enter the amount from line 16					599, 431	
19. 00	Overhead applicable to hospital-based RHC/FC	HC services (Li	ine 13 x line	18)		599, 431	
	Total allowable cost of hospital-based RHC/F					862, 079	

llool +b	Financial Cystems COTT MEMORIAL	LIOCOL TAI	la li o	u of Form CMC (	DEE2 10
	Financial Systems SCOTT MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI (		Component CCN: 15-8523	From 01/01/2023 To 12/31/2023		pared:
	Title XVIII RHC I				
		THE XVIII	1010	Cost	
				1. 00	
1. 00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES  Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst M 2 lino 20)		862, 079	1.00
2. 00	Cost of injections/infusions and their administration (from W			002,079	2.00
3. 00	Total allowable cost excluding injections/infusions (line 1 m			862, 079	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2, 163	4. 00
5. 00 6. 00	Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5)	line 9)		0 2, 163	5. 00 6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			398. 56	
7.00	The detect of the transfer that the transfer of the transfer o		Cal cul ati on		7100
			Rate Period N/A	Rate Period 1	
			IN/ A	(01/01/2023 through	
				12/31/2023)	
			1. 00	2. 00	
8. 00 9. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 Rate for Program covered visits (see instructions)	.6 or your contractor)	0.00	224. 08 224. 08	8. 00 9. 00
9.00	CALCULATION OF SETTLEMENT		0.00	224.00	9.00
10.00	Program covered visits excluding mental health services (from	contractor records)	0	419	10.00
11. 00	Program cost excluding costs for mental health services (line	•	0	93, 890	
12.00	Program covered visits for mental health services (from contr	•	0	0	12.00
13. 00 14. 00	Program covered cost from mental health services (line 9 x li Limit adjustment for mental health services (see instructions		0	0	13. 00 14. 00
15. 00	Graduate Medical Education Pass Through Cost (see instruction	,			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	93, 890	16.00
16. 01	Total program charges (see instructions)(from contractor's re	•		93, 060	•
16. 02	Total program preventive charges (see instructions) (from prov	•		221	16. 02
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0			223 64, 673	16. 03 16. 04
10.01	(Titles V and XIX see instructions.)	o and roy trines . ooy		01,070	10.01
16. 05	Total program cost (see instructions)		0	64, 896	16. 05
17. 00	Primary payer amounts	(6		0	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		12, 826	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		16, 003	19. 00
00.00	records)			(4.00/	00.00
20. 00 21. 00	Net program cost excluding injections/infusions (see instruct Program cost of vaccines and their administration (from Wkst.	*		64, 896 0	20. 00 21. 00
21. 50	Total program IOP OPPS payments (see instructions)	M-4, TITIE 10)		U	21.00
21. 55	Total program IOP Costs (see instructions)				21. 55
21. 60	Program IOP deductible and coinsurance (see instructions)				21. 60
22. 00	Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21.60)		64, 896	
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24. 00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	25. 50
25. 99	Demonstration payment adjustment amount before sequestration			64 904	25. 99
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			64, 896 1, 298	•
26. 02	Demonstration adjustment (see mistractions)  Demonstration payment adjustment amount after sequestration			1, 2, 0	26. 02
27. 00	Interim payments			63, 578	•
28. 00	Tentative settlement (for contractor use only)			0	28. 00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.			20	•
30. 00	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	INCE WITH CMS PUB. 15-11,		0	30.00
			1	'	•

Health Financial Systems	SCOTT MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA		Provider CCN: 15-1334 Component CCN: 15-8523	From 01/01/2023 To 12/31/2023	

		Component Con. 13-8323	10 12/31/2023	5/31/2024 6: 5	
			RHC I	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2, 00	
00	Total interim payments paid to hospital-based RHC/FQHC			63, 578	1.
00	Interim payments payable on individual bills, either submit	ted or to be submitted to		l	2.
	the contractor for services rendered in the cost reporting period. If none, write				
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount	based on subsequent			3
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
)1				0	3
)2				0	3
)3				0	3
04				0	3
05				0	3
	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.			0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line	:	63, 578	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	k review. Also show date o	OT		5
	each payment. If none, write "NONE" or enter a zero. (1)				
01	Program to Provider			0	5
)2					5
)3				0	5
	Provider to Program			0	,
50	Tovider to Trogram			0	5
51				o o	5
52				l ől	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5
0	Determined net settlement amount (balance due) based on the				ì
1	SETTLEMENT TO PROVIDER			20	
)2	SETTLEMENT TO PROGRAM			0	
00	Total Medicare program liability (see instructions)			63, 598	
	1.112		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	