	j			
This report is	required by law (42 USC 1395g; 42 CFR 413.20(b)).	Failure to report can resu	lt in all interim	FORM APPROVED
payments made	since the beginning of the cost reporting period be	ing deemed overpayments (4)	2 USC 1395g).	OMB NO. 0938-0050
				EXPIRES 09-30-2025
HOSPITAL AND H	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATI	ON Provider CCN: 15-0058	Peri od: From 01/01/2022	Worksheet S Parts I-III
AND SETTLEMENT	Опити			Date/Time Prepared: 5/31/2023 11:28 am
PART I - COST	REPORT STATUS			
Provi der	1. [ X ] Electronically prepared cost report		Date: 5/31/20	23 Time: 11:28 am
use only	2. [ ] Manually prepared cost report			
	3.[0] If this is an amended report enter the numb 4.[F] Medicare Utilization. Enter "F" for full,			ost report
Contractor use only	5. [ 1 ] Cost Report Status (1) As Submitted 7. Contractor No. (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	for this Provider CCN 12.		

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL OF SOUTH BEND, INC (15-0058) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 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 FINANCIAL OFFICER OR ADM	MI NI STRATOR CHECKBOX	ELECTRONI C SI GNATURE STATEMENT	
1		2	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

			Title XVIII				
		Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	494, 580	-91, 966	0	0	1. 00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	37, 131	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
200.00	TOTAL	0	531, 711	-91, 966	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

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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0058 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/31/2023 11:28 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 615 N MICHIGAN ST 1.00 PO Box: 1.00 State: IN 2.00 City: SOUTH BEND Zip Code: 46601 County: ST. **JOSEPH** 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 MEMORIAL HOSPITAL OF 150058 43780 01/01/1984 Ν Р 3.00 1 SOUTH BEND, INC Subprovi der - IPF 4.00 4 00 REHABILITATION UNIT 5.00 Subprovider - IRF 15T058 43780 5 01/01/1984 Ν Р Ρ 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -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 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ 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 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Υ 22.01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N 22.03 N Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 N below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

HOSPI 7	n Financial Systems MEMORIAL HOS	TIAL OF SO	OTH DEND, I	110		TIT LICE	01 101	00 2	2552-10
	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC	N: 15-0058	Period: From 01/0 To 12/3	1/2022	Part I	eet S-2 me Prep	
							5/31/20	023 11: 2	
		In-State	In-State	Out-of	Out-of	Medi ca		ther	
		Medicai d	Medicaid	State	State	HMO da	<i>-</i>	di cai d	
		paid days	el i gi bl e unpai d	Medicaid paid days	Medicaid eligible		'	days	
			days	paru uays	unpai d				
		1.00	2.00	3. 00	4. 00	5. 00		5. 00	
24. 00	If this provider is an IPPS hospital, enter the	5, 920			1, 993		243	0	24. 00
21.00	in-state Medicaid paid days in column 1, in-state	0, 720		/01	1, 770	20,	2 10		21.00
	Medicaid eligible unpaid days in column 2,								
	out-of-state Medicaid paid days in column 3,								
	out-of-state Medicaid eligible unpaid days in column								
	4, Medicaid HMO paid and eligible but unpaid days in								
	column 5, and other Medicaid days in column 6.			_					
25. 00		34	373	0	24		770		25. 00
	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2,								
	out-of-state Medicaid days in column 3, out-of-state								
	Medicaid eligible unpaid days in column 4, Medicaid								
	HMO paid and eligible but unpaid days in column 5.								
		•			Urban/R	ural S	Date of	Geogr	
					1.	00	2.	00	
26.00			at the beg	inning of t	he	1			26.00
	cost reporting period. Enter "1" for urban or "2" fo								
27. 00		age) status	at the end	of the cos	t	1			27. 00
	reporting period. Enter in column 1, "1" for urban o			plicable,					
35. 00	enter the effective date of the geographic reclassifulf this is a sole community hospital (SCH), enter the			∐ ctatuc in		0			35. 00
33.00	effect in the cost reporting period.	e number or	perrous so	ii status ii	'	ď			33.00
	orrect in the cost reporting period.				Begi n	ni ng:	Endi	ng:	
					1.	00	2.		
36. 00	Enter applicable beginning and ending dates of SCH s	tatus. Subs	cript line	36 for numb	er				36.00
	of periods in excess of one and enter subsequent date								
37. 00		r the numbe	r of period	s MDH statu	S	0			37.00
	is in effect in the cost reporting period.								
37. 01									37. O
	accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)	or yes or	N TOP NO.	(See					
38. 00		s of MDH st	atus Ifli	ne 37 is					38. 00
	greater than 1, subscript this line for the number of								
	enter subsequent dates.								
					Υ/		Y/		
					1.		2.		
39. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i)					l l	N		39. 00
	1 "Y" for yes or "N" for no. Does the facility meet				""				
	accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i	ii)? Enter	in column 2	"Y" for ve	s				
	or "N" for no. (see instructions)	,	00 2						
40.00		n adjustmen	t? Enter "Y	" for yes o	r N	ı	N	ı	40.00
	"N" for no in column 1, for discharges prior to Octo	ber 1. Ente	r "Y" for v	os or "N" f	or				40.00
	no in column 2, for discharges on or after October 1			es or in i					40.00
		. (see inst		es of 10 1					40. 00
		. (see inst		es of N i		V 1.000	XVIII	XIX	40.00
	Description Downers System (DDS) Control	. (see inst		es or iv i		V 1. 00			40.00
45.00	Prospective Payment System (PPS)-Capital		ructions)			1.00	2.00	3.00	
45. 00	Does this facility qualify and receive Capital paymen		ructions)						
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	nt for disp	ructi ons)	e share in	accordance	1. 00	2. 00 Y	3. 00 N	45. 00
45. 00 46. 00	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exceeds	nt for disp	ructi ons) roporti onat extraordi na	e share in ry circumst	accordance	1.00	2.00	3.00	45. 00
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	nt for disp	ructi ons) roporti onat extraordi na	e share in ry circumst	accordance	1. 00	2. 00 Y	3. 00 N	45. 00
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	nt for disp eption for t. L, Pt. I	roportionat extraordina	e share in ry circumst . L-1, Pt.	accordance ances I through	1. 00	2. 00 Y	3. 00 N	45. 00 46. 00
46. 00 47. 00	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excupursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.  Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen	nt for disp eption for t. L, Pt. I capital? E	roportionat extraordina II and Wkst	e share in ry circumst . L-1, Pt. yes or "N"	accordance ances I through for no.	1. 00 N	Y N	3. 00 N N	45. 00 46. 00 47. 00
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46. 00 47. 00 48. 00 56. 00	Does this facility qualify and receive Capital paymewith 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.  Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals  Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to convolved in training residents in approved GME programd are you are impacted by CR 11642 (or applicable of "Y" for yes; otherwise, enter "N" for no in column 2 is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in	nt for disp eption for t. L, Pt. I capital? E t? Enter "  approved G "Y" for yes r 27, 2020, olumn 1 is ams in the CRs) MA dir . er 27, 2020 residents n column 1.	roportionat extraordina II and Wkst nter "Y for Y" for yes ME programs or "N" for under 42 C "Y", or if prior year ect GME pay , if line 5 in approved If column	e share in ry circumst . L-1, Pt. yes or "N" or "N" for ? For cost no in colu FR 413.78(b this hospit or penul tim ment reduct 6, column 1 GME progra 1 is "Y", co	accordance ances I through for no. no. reporting mn 1. For )(2), see al was ate year, ion? Enter , is yes, ms trained id	1. 00	Y N N N N	3. 00 N N	45. 00 46. 00 47. 00 48. 00 56. 00
46. 00 47. 00 48. 00 56. 00	Does this facility qualify and receive Capital paymewith 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.  Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals  Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to cinvolved in training residents in approved GME progrand are you are impacted by CR 11642 (or applicable of "Y" for yes; otherwise, enter "N" for no in column 2. For cost reporting periods beginning prior to Decembe is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this facility.	nt for disp eption for t. L, Pt. I capital? E t? Enter "  approved G "Y" for yes r 27, 2020, olumn 1 is ams in the CRs) MA dir . er 27, 2020 residents n column 1. cost report	roportionat extraordina II and Wkst nter "Y for Y" for yes  ME programs or "N" for under 42 0 "Y", or if prior year ect GME pay , if line 5 in approved If column ing period?	e share in ry circumst . L-1, Pt. yes or "N" or "N" for ? For cost no in colu FR 413.78(t this hospit or penul tin ment reduct 6, column 1 GME progra 1 is "Y", c Enter "Y"	accordance ances I through for no. no. reporting mn 1. For )(2), see al was ate year, ion? Enter , is yes, ms trained id for yes on	1. 00	Y N N N N	3. 00 N N	45. 00 46. 00 47. 00 48. 00 56. 00
46. 00 47. 00 48. 00 56. 00	Does this facility qualify and receive Capital paymewith 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.  Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals  Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to convolved in training residents in approved GME progrand are you are impacted by CR 11642 (or applicable of "Y" for yes; otherwise, enter "N" for no in column 2 for cost reporting periods beginning prior to Decembe is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this of "N" for no in column 2. If column 2 is "Y", complete	nt for disp eption for t. L, Pt. I capital? E t? Enter "  approved G "Y" for yes r 27, 2020, olumn 1 is ams in the CRs) MA dir . er 27, 2020 residents n column 1. cost report e Worksheet	roportionat extraordina II and Wkst nter "Y for Y" for yes  ME programs or "N" for under 42 0 "Y", or if prior year ect GME pay , if line 5 in approved If column ing period? E-4. If co	e share in ry circumst . L-1, Pt. yes or "N" or "N" for ? For cost no in colu FR 413.78(b this hospit or penul tim ment reduct 6, column 1 GME progra 1 is "Y", c Enter "Y"	accordance ances I through for no. no. reporting mn 1. For )(2), see al was ate year, ion? Enter , is yes, ms trained id for yes on N",	1. 00	Y N N N N	3. 00 N N	45. 00 46. 00 47. 00 48. 00 56. 00
46. 00 47. 00 48. 00 56. 00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.  Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals  Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, entercost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to cinvolved in training residents in approved GME progrand are you are impacted by CR 11642 (or applicable ""Y" for yes; otherwise, enter "N" for no in column 2 For cost reporting periods beginning prior to Decembis this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this "N" for no in column 2. If column 2 is "Y", complete Complete Wkst. D, Parts III & IV and D-2, Pt. II, if	nt for disp eption for t. L, Pt. I capital? E t? Enter "  approved G "Y" for yes r 27, 2020, olumn 1 is ams in the CRs) MA dir . er 27, 2020 residents resolumn 1. cost report e Worksheet	roportionat extraordina II and Wkst nter "Y for Y" for yes  ME programs or "N" for under 42 0 "Y", or if prior year ect GME pay , if line 5 in approved If column ing period? E-4. If co. For cost	e share in ry circumst . L-1, Pt. yes or "N" or "N" for ? For cost no in colu FR 413.78(t this hospit or penultin ment reduct 6, column 1 GME progra 1 is "Y", c Enter "Y" lumn 2 is " reporting p	accordance ances I through for no. no. reporting mn 1. For )(2), see al was ate year, ion? Enter , is yes, ms trained id for yes on N", periods	1. 00	Y N N N N	3. 00 N N	45. 00 46. 00 47. 00 48. 00 56. 00
46. 00 47. 00 48. 00 56. 00	Does this facility qualify and receive Capital paymewith 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.  Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals  Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to cinvolved in training residents in approved GME progrand are you are impacted by CR 11642 (or applicable of "Y" for yes; otherwise, enter "N" for no in column 2. For cost reporting periods beginning prior to Decembis this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no ir residents start training in the first month of this "N" for no in column 2. If column 2 is "Y", complete Complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFI	nt for disp eption for t. L, Pt. I capital? E t? Enter "  approved G "Y" for yes r 27, 2020, olumn 1 is ams in the CRs) MA dir . er 27, 2020 residents n column 1. cost report e Worksheet applicable R 413.77(e	roportions)  roportionat  extraordina II and Wkst  nter "Y for yes  ME programs or "N" for under 42 C "Y", or if prior year ect GME pay , if line 5 in approved If column ing period? E-4. If co. For cost )(1)(iv) an	e share in ry circumst . L-1, Pt. yes or "N" or "N" for ? For cost no in colu FR 413.78(t this hospit or penultin ment reduct 6, column 1 GME progra 1 is "Y", c Enter "Y" reporting p d (v), rega	accordance ances I through for no. no. reporting mn 1. For )(2), see al was ate year, ion? Enter , is yes, ms trained id for yes on N", eriods rdless of	1. 00	Y N N N N	3. 00 N N	45. 00 46. 00 47. 00 48. 00 56. 00
46. 00 47. 00 48. 00 56. 00	Does this facility qualify and receive Capital paymewith 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.  Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals  Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after December the instructions. For column 2, if the response to convolved in training residents in approved GME programd are you are impacted by CR 11642 (or applicable of "Y" for yes; otherwise, enter "N" for no in column 2. For cost reporting periods beginning prior to December this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no incolumn 2. If column 2 is "Y", complete Complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CF which month(s) of the cost report the residents were	nt for disp eption for t. L, Pt. I capital? E t? Enter " approved G "Y" for yes r 27, 2020, olumn 1 is ams in the CRs) MA dir . er 27, 2020 residents n column 1. cost report e Worksheet tapplicable R 413.77(e on duty, i	roportions) roportionat extraordina II and Wkst nter "Y for Y" for yes  ME programs or "N" for under 42 C "Y", or if prior year ect GME pay , if line 5 in approved If column ing period? E-4. If cot . For cost )(1)(iv) an f the respo	e share in ry circumst . L-1, Pt. yes or "N" or "N" for ? For cost no in colu FR 413.78(E this hospit or penultin ment reduct 6, column 1 GME progra 1 is "Y", c Enter "Y" lumn 2 is " reporting p d (v), reganse to line	accordance ances I through for no. no. reporting mn 1. For )(2), see al was ate year, ion? Enter , is yes, ms trained id for yes of N", eriods rdless of 56 is "Y"	1. 00	Y N N N N	3. 00 N N	45. 00 46. 00 47. 00 48. 00 56. 00
46. 00 47. 00 48. 00 56. 00	Does this facility qualify and receive Capital paymewith 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.  Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals  Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to cinvolved in training residents in approved GME progrand are you are impacted by CR 11642 (or applicable "Y" for yes; otherwise, enter "N" for no in column 2 For cost reporting periods beginning prior to Decembe is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this "N" for no in column 2. If column 2 is "Y", complete complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CF which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not complete	nt for disp eption for t. L, Pt. I capital? E t? Enter "  approved G "Y" for yes r 27, 2020, olumn 1 is ams in the CRs) MA dir . er 27, 2020 residents n column 1. cost report e Worksheet applicable R 413.77(e on duty, i ete column	roportionat extraordina II and Wkst nter "Y for Y" for yes  ME programs or "N" for under 42 C "Y", or if prior year ect GME pay , if line 5 in approved If column ing period? E-4. If cc . For cost ()(1)(iv) an f the respo	e share in ry circumst . L-1, Pt. yes or "N" or "N" for ? For cost no in colu FR 413.78(b this hospit or penul tim ment reduct 6, column 1 GME progra 1 is "Y", c Enter "Y" lumn 2 is " reporting g d (v), rega nse to line lete Worksh	accordance ances I through for no. no. reporting mn 1. For )(2), see al was ate year, ion? Enter , is yes, ms trained id for yes on N", eriods rdless of 156 is "Y" eet E-4.	1. 00	Y N N N N	3. 00 N N	45. 00 46. 00 47. 00 48. 00 56. 00
46. 00 47. 00 48. 00 56. 00	Does this facility qualify and receive Capital paymewith 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.  Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital payment Teaching Hospitals  Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after December the instructions. For column 2, if the response to coinvolved in training residents in approved GME programd are you are impacted by CR 11642 (or applicable of "Y" for yes; otherwise, enter "N" for no in column 2. For cost reporting periods beginning prior to December is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this of "N" for no in column 2. If column 2 is "Y", complete complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CF which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not complete.	nt for disp eption for t. L, Pt. I capital? E t? Enter "  approved G "Y" for yes r 27, 2020, ol umn 1 is ams in the CRs) MA dir. er 27, 2020 residents n col umn 1. cost report e Worksheet applicable R 413. 77(e on duty, i ete col umn bursement fi	roportionat extraordina II and Wkst nter "Y for Y" for yes  ME programs or "N" for under 42 0 "Y", or if prior year ect GME pay , if line 5 in approved If column ing period? E-4. If co For cost )(1)(iv) an f the respo	e share in ry circumst . L-1, Pt. yes or "N" or "N" for ? For cost no in colu FR 413.78(b this hospit or penul tim ment reduct 6, column 1 GME progra 1 is "Y", c Enter "Y" lumn 2 is " reporting g d (v), rega nse to line lete Worksh	accordance ances I through for no. no. reporting mn 1. For )(2), see al was ate year, ion? Enter , is yes, ms trained id for yes on N", eriods rdless of 156 is "Y" eet E-4.	1. 00	Y N N N N	3. 00 N N	45. 00 46. 00 47. 00 48. 00 56. 00

Health Financial Systems MEMORIAL HOSE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		F SOUTH BEND, Provider CO	CN: 15-0058 P	In Lie eriod: rom 01/01/2022 o 12/31/2022		pared:
				V	XVIII XIX	
FO OO Are costs algimed on line 100 of Workshoot A2 If yes		Lata Wkat D 2	D+ 1	1. 00 N	2.00 3.00	59. 00
59.00   Are costs claimed on line 100 of Worksheet A? If yes	s, compi	Tete WKSt. D-2,	NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1. 00	2. 00	3.00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent Cadjustment? Enter "Y" for yes or "N" for no in colum of 11 line 60 is yes, complete columns 2 and 3 for each instructions)	85? (s umn 1. CR) NAHI nn 2.	see If column 1 E MA payment	Y	N 23. 00	1	60. 00
Histi uctions)	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	0.00	0.00			
61.00 Did your hospital receive FTE slots under ACA	1. 00 Y	2. 00	3. 00	4.00	5.00	61.00
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	Y			3.00	3.00	61.00
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 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see						61. 03
instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).						61. 04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61. 05
61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 06
	Pr	ogram Name	Program Code		Direct GME FTE Count	
61.10 Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3. 00	4.00	61. 10
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				3. 00		
61.20 Of the FTEs in line 61.05, specify each expanded 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.				0. 00	0. 00	61. 20
					1.00	
ACA Provisions Affecting the Health Resources and Ser	rvi ces	Administration	(HRSA)		1.00	
62.00 Enter the number of FTE residents that your hospital	trai ned			od for which	0.00	62. 00
your hospital received HRSA PCRE funding (see instruction 62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC process.	a Teachi gram. (s	<u>see instructio</u>		your hospital	0.00	62. 01
Teaching Hospitals that Claim Residents in Nonprovide 63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co			N	63. 00

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 + column 4)). (see instructions)

	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes Column 3: If column 2 is Y, indicate which program year began during this co								
	(see instructions)	ost reporting	perrou.						
	Inpatient Rehabilitation Facility PPS								
75. 00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it con	tain an IRF	Y			75. 00			
76 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 t	he most N	l N	0	76. 00			
70.00	recent cost reporting period ending on or before November 15, 2004? Enter "			"	Ü	70.00			
	no. Column 2: Did this facility train residents in a new teaching program in		with 42						
	CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column indicate which program year began during this cost reporting period. (see in								
	printing the program year began during this cost reporting period. (see it	iisti ucti olis)							
				1.00					
00.00	Long Term Care Hospital PPS			l N		00.00			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no is this a LTCH co-located within another hospital for part or all of the come "Y" for yes and "N" for no.	st reporting	period? Enter	N N		80.00			
	TEFRA Provi ders								
	Is this a new hospital under 42 CFR Section $$413.40(f)(1)(i)$ TEFRA? Enter Did this facility establish a new Other subprovider (excluded unit) under $4.5413.40(f)(1)(ii)$ ? Enter "Y" for yes and "N" for no.			N		85. 00 86. 00			
87. 00	Is this hospital an extended neoplastic disease care hospital classified un 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87. 00					
			Approved for	Number Approv					
	Permanent Adjustment								
	(Y/N)								
	1.00								
88. 00	8.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions)  Column 2: Enter the number of approved permanent adjustments.								
		Wkst. A Line	Effective Date	Approv	ed				
		No.		Permane	nt				
				Adj ustm					
				Amount Di schar					
		1. 00	2. 00	3.00	90				
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.		V	XI X					
			1. 00	2.00					
	Title V and XIX Services			1					
90. 00	Does this facility have title V and/or XIX inpatient hospital services? Entryes or "N" for no in the applicable column.	er "Y" for	N	Y		90. 00			
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report	either in	N	N		91. 00			
	full or in part? Enter "Y" for yes or "N" for no in the applicable column.	30.7							
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification instructions) Enter "Y" for yes or "N" for no in the applicable column.	n)? (see		N		92. 00			
93. 00	Does this facility operate an ICF/IID facility for purposes of title V and I "Y" for yes or "N" for no in the applicable column.	XIX? Enter	N	N		93. 00			
94. 00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no	in the	N	N		94. 00			
05 00	applicable column.  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	0. 00 N	N 0.00		96.00			
	applicable column.								
97. 00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0. 00	0.00		97. 00			

nancial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC	In Lieu of Form CMS-2552-10

HOSPI TA	Financial Systems MEMORIAL HOSPITAL OF AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CN: 15-0058 F	Peri od:	u of Form CMS- Worksheet S-2	
				From 01/01/2022 To 12/31/2022		epared
				V	5/31/2023 11: XIX	:28 am
				1.00	2.00	1
5	Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f column 1 for title V, and in column 2 for title XIX.			Y	Y	98. 0
98. 01   (	Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX.			Y	Y	98. 0
98. 02   	Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o for title V, and in column 2 for title XIX.			Y	Y	98. 0
98. 03   I	Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye for title V, and in column 2 for title XIX.	N	N	98. 0		
98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.	N	N	98. 0		
98. 05   N	Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c column 2 for title XIX.			Y	Y	98. 0
98. 06   [ 	Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.	Y	Y	98. 0		
105. 00 l 106. 00 l	Rural Providers Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-	inclusive met	hod of payment	N		105. 0 106. 0
107. 00	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for co training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IP			107. 0		
108. 00 l	Enter "Y" for yes or "N" for no in column 2. (see instructi Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche		N		108. 0
		Physi cal 1.00	0ccupati onal 2.00	Speech 3.00	Respiratory 4.00	
-	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N N	N	N N	N N	109. C
					1. 00	-
]	Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes or	"N" for no. I	f yes,	N N	110. (
				1. 00	2. 00	
i	If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	st reporting lumn 1 is Y, ticipating in	period? Enter enter the column 2.	N N	2.00	111. C
			1.00		0.00	
	Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost re period? Enter "Y" for yes or "N" for no in column 1. If co	porti ng	1. 00 N	2. 00	3.00	112.0
i C	"Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable.	ating in the				
-	Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no.					113. (
15. 00 i	Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	, or E only) 3" percent includes	N			0 115. (
1	THE MELLIN FLOOR FILE CWG PUD. 13-1. CHADLE! ZZ. 9ZZUB. I.	for was or	N			116. 0
1  -   116. 00	Is this facility classified as a referral center? Enter "Y"	Tor yes or				
1 116. 00 117. 00		-	Y			117. 0

142.00 Street: 615 N MICHIGAN ST	PO Box:					142. 00
143.00 City: SOUTH BEND	State:	I N	Zi p Code:	4660	1	143. 00
					1.00	
144.00 Are provider based physicians' co	sts included in Wo	rksheet A?			Υ	144. 00
				1. 00	2.00	
145.00 If costs for renal services are c	laimed on Wkst. A,	line 74, are the	e costs for			145. 00
inpatient services only? Enter "Y	" for yes or "N" fo	or no in column '	1. If column 1 is			
no, does the dialysis facility in	clude Medicare util	lization for this	s cost reporting			
period? Enter "Y" for yes or "N"	for no in column :	2.				
146.00 Has the cost allocation methodolo	gy changed from the	e previously file	ed cost report?	N		146. 00
Enter "Y" for yes or "N" for no i	n column 1. (See Cl	MS Pub. 15-2, cha	apter 40, §4020) If			
yes, enter the approval date (mm/	dd/yyyy) in column	2.				

Health Financial Systems		L OF SOUTH BEND, I				u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CC			iod: m 01/01/2022 12/31/2022	Worksheet S- Part I Date/Time Pr 5/31/2023 11	epared:
						3/31/2023 11	. 20 aiii
						1.00	
147.00 Was there a change in the statisti						N	147. 00
148.00 Was there a change in the order of 149.00 Was there a change to the simplifi				for no		N N	148. 00 149. 00
149.00 was there a change to the shiphith	ed cost irriding method	Part A	Part		Title V	Title XIX	149.00
		1, 00	2.00		3.00	4.00	_
Does this facility contain a provi	der that qualifies for						
or charges? Enter "Y" for yes or '							
155. 00 Hospi tal		N	N		N	N	T155. 00
156.00 Subprovider - IPF		N	N		N	N	156. 00
157.00 Subprovi der - IRF		N	N		N	N	157. 00
158. 00 SUBPROVI DER							158. 00
159. 00 SNF		N	N		N	N	159.00
160.00 HOME HEALTH AGENCY		N	N		N	N	160.00
161. 00 CMHC			N N		N	N	161. 00
						1.00	-
Mul ti campus							
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has	one or more campu	ıses in di	fferent	CBSAs?	N	165. 00
Enter 1 for yes of N for no.	Name	County	State	Zip Cc	ode CBSA	FTE/Campus	
	0	1. 00	2.00	3.00		5. 00	
166.00 If line 165 is yes, for each						0. 0	00 166. 00
campus enter the name in column							
O, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in column 5 (see instructions)							
corumii 5 (see mistructrons)							
						1.00	
Health Information Technology (HI	) incentive in the Ame	ri can Recovery and	d Reinvest	ment A	ct		
167.00 Is this provider a meaningful user						Y	167. 00
168.00 If this provider is a CAH (line 10			167 is "	Y"), er	nter the		168. 00
reasonable cost incurred for the H							
168.01 If this provider is a CAH and is r					nardshi p		168. 01
exception under §413.70(a)(6)(ii)					onton the	0.0	99169. 00
169.00 If this provider is a meaningful utransition factor. (see instruction		and is not a can (	Tine 105	15 N)	i, enter the	9. \	79 169. UC
transition factor. (see instruction	115)				Begi nni ng	Endi ng	
					1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	eginning date and endi	ng date for the re	porti ng				170. 00
period respectivery (illiii/dd/yyyy)							
					1. 00	2. 00	
171.00 If line 167 is "Y", does this prov					N		0 171. 00
section 1876 Medicare cost plans r							
"Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s		es, enter the numb	er or sec	tion			
11070 Medicale days III column 2. (S	dee Thisti ucti ons)			1	ļ	I	1

Ν

18.00

19.00

Ν

If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed

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

Report data for corrections of other PS&R Report

cost report? If yes, see instructions.

information? If yes, see instructions.

but are not included on the PS&R Report used to file this

Heal th	Financial Systems MEMORIAL HOSPITAL 0	F SOUTH BEND,	INC	In Lie	u of Form CMS-	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0058	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pro 5/31/2023 11:	epared:
			i pti on	Y/N	Y/N	
20.00	If line 14 or 17 is yes were adjustments made to DSAD		0	1. 00 N	3. 00 N	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:			IN	IN	20.00
	Troper t data for other books be the other day detimented	Y/N	Date	Y/N	Date	
		1. 00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	lOSPI TALS)		1.00	
	Capi tal Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	ing the cost	N	23. 00		
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost re	porting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	rting period?	If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	cost reportir	ng period? If	yes, submit	N	27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	itered into dur	ing the cost	reporting	N	28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	eserve Fund)	N	29. 00		
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If yes	, see	N	30. 00
31. 00	instructions. Has debt been recalled before scheduled maturity without is	suance of new	debt? If yes,	, see	N	31. 00
	Instructions. Purchased Services					
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		ed through co	ntractual	N	32. 00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	olied pertainir	ng to competi	tive bidding? If	N	33. 00
	Provi der-Based Physi ci ans				.,	
34. 00	Were services furnished at the provider facility under an alf yes, see instructions.	· ·	·	. ,	Υ	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		nts with the p		N	35. 00
				Y/N	Date	
	Home Office Costs			1. 00	2. 00	
36. 00				Υ		36.00
37. 00	If line 36 is yes, has a home office cost statement been pr	epared by the	home office?			37. 00
38. 00	If yes, see instructions.					38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe	of the home of	offi ce.			39. 00
40. 00	see instructions.	·	,	N		40. 00
	instructions.					10.00
		1.	00	2.	00	
	Cost Report Preparer Contact Information					
41. 00	held by the cost report preparer in columns 1, 2, and 3,	JEN		BREDEN		41. 00
42. 00		BEACON HEALTH	SYSTEM			42. 00
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	574-647-1144		JBREDEN@BEACONI RG	HEALTHSYSTEM. O	43. 00
	proport proparer in corumns i and 2, respectivery.	ı		μιο		II

Heal th	Financial Systems	MEMORIAL HOSPITAL	OF S	SOUTH BEND,	INC		In Lieu	of Form CMS-	2552-10
HOSPI 7	FAL AND HOSPITAL HEALTH CARE REIMBURSEMEN	T QUESTI ONNAI RE		Provi der 0	CCN: 15-0058		om 01/01/2022	Worksheet S-2 Part II Date/Time Pre	
						L		5/31/2023 11:	28 am
				3.	. 00				
	Cost Report Preparer Contact Information	า							
41.00	Enter the first name, last name and the	title/position	REI	I MBURSEMENT	ANALYST				41.00
	held by the cost report preparer in col	umns 1, 2, and 3,							
	respecti vel y.								
42.00	Enter the employer/company name of the	cost report							42.00
	preparer.								
43.00	Enter the telephone number and email ad	dress of the cost							43.00
	report preparer in columns 1 and 2, res	pecti vel y.							

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

Provider CCN: 15-0058

Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared:

				'	,,, 2022	5/31/2023 11:	28 am
	·					I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line No.		Avai I abl e			
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	363	132, 495	0. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		363	132, 495	0.00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	36	13, 140	0.00	0	8. 00
8.01	NEONATAL INTENSIVE CARE UNIT	31. 01	30	10, 950	0.00	0	8. 01
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY	43. 00				0	13.00
14.00	Total (see instructions)		429	156, 585	0.00	0	14.00
15.00	CAH vi si ts					0	15. 00
16.00	SUBPROVI DER - I PF	40. 00	0	0		0	16. 00
17.00	SUBPROVI DER - I RF	41. 00	20	7, 300		0	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)	30. 00					24. 10
25. 00	CMHC - CMHC	00.00					25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)	07.00	449			· ·	27. 00
28. 00	Observation Bed Days		77/			0	28. 00
29. 00	Ambul ance Tri ps					· ·	29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see l'istruction)						31. 00
32. 00	Labor & delivery days (see instructions)		9	3, 285			32.00
32. 00			9	3, 203			32. 00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days						33. 00
33. 00	LTCH site neutral days and discharges						33. 00
	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	0		0	
54.00	Transportat y Expansion Covid-17 File Acute Calle	30.00	Ч	Ч		·	34.00

33.01

34.00

0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 15-0058

Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

5/31/2023 11:28 am Full Time Equivalents I/P Days / O/P Visits / Trips Component Title XVIII Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 10.00 6.00 7.00 8.00 9.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 88, 099 1.00 20, 560 4, 338 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 22, 101 34, 287 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider 4.00 0 1.167 Hospital Adults & Peds. Swing Bed SNF 5.00 0 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 20, 560 4, 338 88,099 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 1, 758 7, 146 90 8.00 8.01 NEONATAL INTENSIVE CARE UNIT 1, 132 8,604 8.01 9.00 CORONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 SURGICAL INTENSIVE CARE UNIT 11.00 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 3, 953 13.00 NURSERY 350 13.00 Total (see instructions) 22.318 5. 910 107, 802 27. 25 2, 298, 97 14.00 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 0 0.00 0.00 16.00 SUBPROVIDER - IRF 17.00 1, 245 34 4, 924 0.00 22.80 17.00 18 00 SUBPROVI DER 18 00 SKILLED NURSING FACILITY 19.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 22 00 22 00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 24. 00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 380 24. 10 CMHC - CMHC 25.00 25.00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 0.00 26.25 Total (sum of lines 14-26) 2, 321. 77 27.00 27.00 27. 25 Observation Bed Days 28 00 Ω 9.840 28 00 29. 00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 0 Employee discount days - IRF 0 31.00 31.00 32.00 Labor & delivery days (see instructions) 84 235 32.00 Total ancillary labor & delivery room 32.01 0 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00

33.01

LTCH site neutral days and discharges

34.00 Temporary Expansion COVID-19 PHE Acute Care

 Heal th Financial
 Systems
 MEMORIAL HOSF

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provider CCN: 15-0058

Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared:

							5/31/2023 11:	28 am
		Full Time Equivalents			Di sch	arges		
	Component	Nonpai d Workers	Title V		Title XVIII	Title XIX	Total All Patients	
		11. 00	12.00		13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			0	3, 915	580	19, 390	1. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)				3, 265	5, 754 0 79		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 8. 01 9. 00 10. 00 11. 00 12. 00 13. 00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY							8. 00 8. 01 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00	Total (see instructions) CAH visits	0. 00		0	3, 915	580	19, 390	14. 00 15. 00
16. 00	SUBPROVI DER - I PF	0.00		0	0	0	0	16. 00
17. 00	SUBPROVI DER - I RF	0. 00		o	117	3	376	17. 00
	SUBPROVI DER							18. 00
19.00	SKILLED NURSING FACILITY			- [				19. 00
20.00	NURSING FACILITY			- 1				20.00
21.00	OTHER LONG TERM CARE			- 1				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							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00						26. 25
	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 outpatient days (see instructions)							32. 01
33.00	LTCH non-covered days				0			33. 00
	LTCH site neutral days and discharges				0			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care							34. 00

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 01/01/2022 Part II
To 12/31/2022 Date/Time Prepared: 5/31/2023 11: 28 am

							5/31/2023 11:	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Adj usted Sal ari es (col . 2 ± col .	Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	A-6) 3.00	3) 4. 00	col . 4	6. 00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5. 00	0.00	
	SALARI ES	222 22	100 000 500		400 000 500			
1. 00	Total salaries (see instructions)	200. 00	199, 083, 502	0	199, 083, 502	4, 829, 272. 00	41. 22	1. 00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0. 00	2. 00
3. 00	Non-physician anesthetist Part B		0	0	0	0. 00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		1, 415, 014	0	1, 415, 014	7, 696. 00	183. 86	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non Physician-Part B		2, 664, 775 0	0	_,,	22, 418. 00 0. 00	l e	
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0. 00	0.00	6. 00
7. 00	Interns & residents (in an approved program)	21. 00	0	2, 280, 624	2, 280, 624	56, 682. 86	40. 23	7. 00
7. 01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7. 01
8.00	Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 5, 204, 733	0 3, 341	0 5, 208, 074	0. 00 158, 061. 00		
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient Care		20, 487, 518	0	20, 487, 518	219, 169. 00	93. 48	11. 00
12. 00	Contract labor: Top level management and other management and administrative		0	0	0	0.00	0. 00	12. 00
13. 00	services Contract Labor: Physician-Part A - Administrative		311, 982	0	311, 982	2, 889. 00	107. 99	13. 00
14. 00	Home office and/or related organization salaries and		0	О	О	0.00	0.00	14. 00
14. 01	wage-related costs Home office salaries		23, 294, 762	0	23, 294, 762	621, 393. 00	37. 49	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	1	_	0. 00 0. 00		14. 02 15. 00
16. 00	- Administrative Home office and Contract		0	0	0	0. 00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0. 00	0. 00	16. 01
16. 02	- Teaching Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		44, 980, 982	0	44, 980, 982			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		1, 226, 364 0	0	.,,			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	B Physician Part A -		0	0	0			22. 00
	Administrative Physician Part A - Teaching		267, 951	0	267, 951			22. 01
24.00	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		0 0 433, 809	0 0	0 0 433, 809			23. 00 24. 00 25. 00
25. 50	approved program) Home office wage-related		7, 240, 149	0	7, 240, 149			25. 50
25. 51	(core) Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25. 52

In Lieu of Form CMS-2552-10 Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0058 Peri od: Worksheet S-3 From 01/01/2022 Part II 12/31/2022 Date/Time Prepared: 5/31/2023 11:28 am Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly Number on of Salaries Sal ari es Related to Wage (col. 4 Reported col . 5) (from Wkst. (col.2 ± col. Salaries in A-6)3) col. 4 2.00 5. 00 1.00 6.00 3.00 4.00 0 25.53 - Teaching - wage-related (core) OVERHÉAD COSTS - DIRECT SALARIES 4 00 2,080.00 26.00 Employee Benefits Department 73.355 73. 355 35. 27 Administrative & General 5.00 5, 482, 359 -223, 503 5, 258, 856 256, 502. 00 20. 50 27.00 Administrative & General under 3, 728, 298 3, 728, 298 37, 557. 00 99. 27 28.00

Total overhead cost (see

instructions)

7.00

27.63

7.00

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0058 Peri od: Worksheet S-3 From 01/01/2022 To 12/31/2022 Part III Date/Time Prepared: 5/31/2023 11:28 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) (from Salaries in 3) col. 4 Worksheet A-6) 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 200, 147, 025 -2, 280, 624 197, 866, 401 4, 787, 728. 14 1.00 41. 33 instructions) 2.00 5, 204, 733 5, 208, 074 158, 061. 00 32. 95 2.00 Excluded area salaries (see 3, 341 instructions) 3.00 Subtotal salaries (line 1 194, 942, 292 -2, 283, 965 192, 658, 327 4, 629, 667. 14 41.61 3.00 minus line 2) 4.00 Subtotal other wages & related 44, 094, 262 44, 094, 262 843, 451. 00 52. 28 4.00 costs (see inst.) Subtotal wage-related costs 27. 11 5.00 52, 221, 131 C 52, 221, 131 0.00 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 291, 257, 685 -2, 283, 965 288, 973, 720 5, 473, 118. 14 52 80

-6, 602, 018

29, 018, 646

1, 050, 287. 00

35, 620, 664

14, 387, 656

0

60

0

0

1,055

4<u>6, 909, 017</u>

17 00

18.00

19.00

20.00

21.00

22.00

23.00

24.00

25.00

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10 HOSPITAL WAGE RELATED COSTS Provider CCN: 15-0058 Peri od: Worksheet S-3 From 01/01/2022 Part IV 12/31/2022 Date/Time Prepared: 5/31/2023 11:28 am Amount Reported 1.00 PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 1.00 401K Employer Contributions 6, 250, 059 1.00 2 00 Tax Sheltered Annuity (TSA) Employer Contribution 2.00 0 3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3.00 Qualified Defined Benefit Plan Cost (see instructions) 0 4.00 4.00 PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 5.00 5.00 401K/TSA Plan Administration fees 0 6.00 Legal /Accounting/Management Fees-Pension Plan 0 6.00 7.00 Employee Managed Care Program Administration Fees 0 7.00 HEALTH AND INSURANCE COST 8.00 Health Insurance (Purchased or Self Funded) 0 8.00 8.01 Health Insurance (Self Funded without a Third Party Administrator) 0 8.01 8.02 Health Insurance (Self Funded with a Third Party Administrator) 24, 613, 630 8.02 Health Insurance (Purchased) 8.03 0 8.03 9.00 Prescription Drug Plan 9.00 Dental, Hearing and Vision Plan 321, 058 10.00 10.00

Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see

FICA-Employers Portion Only

Day Care Cost and Allowances

Unemployment Insurance

Tuition Reimbursement

instructions))

Medicare Taxes - Employers Portion Only

Total Wage Related cost (Sum of lines 1 -23)

State or Federal Unemployment Taxes

Part B - Other than Core Related Cost OTHER WAGE RELATED COSTS (SPECIFY)

17 00

18.00

19.00

20.00

21.00

22.00

23.00

24.00

OTHER

MCRI F32 - 19. 1. 175. 2

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0058	Peri od:	Worksheet S-3

			1011 01/01/2022	Part V	
		T	o 12/31/2022		
				5/31/2023 11: 2	28 am_
	Cost Center Description		Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		22, 618, 617	46, 756, 069	1.00
2.00	Hospi tal		22, 618, 617	46, 756, 069	2.00
3.00	SUBPROVI DER - I PF		0	0	3.00
4.00	SUBPROVI DER - I RF		0	0	4.00
5.00	Subprovi der - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	SKILLED NURSING FACILITY				8.00
9. 00	NURSING FACILITY				9.00
10.00	OTHER LONG TERM CARE I				10.00
11. 00	Hospi tal -Based HHA				11.00
12.00	AMBULATORY SURGICAL CENTER (D. P. ) I				12.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospi tal -Based-CMHC				16.00
17. 00	RENAL DIALYSIS I		0	0	17.00
18. 00	Other		0	0	18.00
	•		'	'	

	Financial Systems MEMORIAL HOSPITAL OF				eu of Form CMS-2				
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co		Peri od: From 01/01/2022	Worksheet S-10	0			
				To 12/31/2022	Date/Time Prep 5/31/2023 11:3				
	1.00								
4 00	Uncompensated and indigent care cost computation		000 1	0)	0.054005	1			
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 c	divided by li	ne 202 column	8)	0. 254005	1. 00			
2 00	Medicaid (see instructions for each line)				147 017 205	2 00			
2. 00 3. 00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				147, 917, 295 Y	2.00			
4. 00	If line 3 is yes, does line 2 include all DSH and/or suppleme	ntal naumant	a from Madiaa	: 40	Y	4.00			
4. 00 5. 00	If line 4 is no, then enter DSH and/or supplemental payments			ıur	32, 634, 566				
6. 00	Medicaid charges	II OIII Wedi Cai	u		452, 497, 477				
7. 00	Medicaid cost (line 1 times line 6)				114, 936, 622	1			
8. 00	Difference between net revenue and costs for Medicaid program	n (lino 7 min	us sum of lin	os 2 and 5: if	114, 930, 622				
6.00	<pre>  &lt; zero then enter zero)</pre>	ıı (ııne / ııııı	ius suiii 01 1111	les 2 and 5, 11	١	0.00			
	Children's Health Insurance Program (CHIP) (see instructions	for each lin	e)						
9. 00	Net revenue from stand-alone CHIP	TOT CUCH TITE	<u> </u>		0	9.00			
10.00	Stand-alone CHIP charges					10.00			
	Stand-alone CHIP cost (line 1 times line 10)				1, 436	1			
12. 00	Difference between net revenue and costs for stand-alone CHIF	P (line 11 mi	nus line 9: i	f < zero then	1, 436				
	enter zero)	(**************************************			.,				
	Other state or local government indigent care program (see in	nstructions f	or each line)						
13.00	Net revenue from state or local indigent care program (Not ir	ncluded on li	nes 2, 5 or 9	)	28, 468	13. 00			
14.00	Charges for patients covered under state or local indigent ca				358, 335	14. 00			
	10)								
15. 00	State or local indigent care program cost (line 1 times line				91, 019				
16. 00	Difference between net revenue and costs for state or local i	ndigent care	program (lin	e 15 minus line	62, 551	16. 00			
	13; if < zero then enter zero)								
	Grants, donations and total unreimbursed cost for Medicaid, C	THIP and stat	e/local indig	ent care program	ns (see				
17 00	instructions for each line)	£				17.00			
17.00	Private grants, donations, or endowment income restricted to				0	1			
18.00	Government grants, appropriations or transfers for support of			/	0	1			
19.00	Total unreimbursed cost for Medicaid , CHIP and state and loc $8,\ 12$ and $16)$			`	63, 987	19. 00			
			Uni nsured	Insured	Total (col. 1				
			patients	pati ents	+ col . 2)				
			1.00	2. 00	3. 00				
	Uncompensated Care (see instructions for each line)			400.070	00.000.010				
20. 00	Charity care charges and uninsured discounts for the entire f	гаситту	28, 890, 84	438, 370	29, 329, 219	20. 00			
	(see instructions) Cost of patients approved for charity care and uninsured disc	counts (cos	7, 338, 42	438, 370	7, 776, 790	21. 00			
21 00	poosi or patrents approved for charity care and uninsured disc	Louits (See	1, 338, 42	.0 438, 370	1, 116, 190	21.00			
21. 00	instructions)								
21. 00	instructions)  Payments received from patients for amounts previously writte	en off as		0	ام	22 00			
21. 00 22. 00	instructions) Payments received from patients for amounts previously writte charity care	en off as		0 0	0	22. 00			

		NAL HOSPITAL OF	SOUTH BEND, I	NC	In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der CC	F	eriod: rom 01/01/2022 o 12/31/2022	Worksheet A  Date/Time Pre 5/31/2023 11:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	20 diii
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		0	0	22, 522, 377	22, 522, 377	1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0	0		10, 731, 473	
3.00	00300 OTHER CAPITAL RELATED COSTS		0	0		0	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	73, 355	1, 973, 932	2, 047, 287		2, 820, 383	
5.00	00500 ADMINI STRATI VE & GENERAL	5, 482, 359	137, 020, 652	142, 503, 011 0		109, 294, 593	1
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	2, 984, 916	9, 514, 692	12, 499, 608		97, 949 12, 486, 682	1
8. 00	00800 LAUNDRY & LINEN SERVICE	2, 704, 710	1, 494, 463	1, 494, 463		1, 494, 463	1
9. 00	00900 HOUSEKEEPI NG	3, 312, 834	2, 470, 622	5, 783, 456	1	5, 785, 974	1
10.00	01000 DI ETARY	3, 635, 928	3, 285, 968	6, 921, 896		4, 041, 041	1
11. 00	01100 CAFETERI A	0	0	0	2, 884, 083	2, 884, 083	11. 00
13.00	01300 NURSING ADMINISTRATION	4, 061, 723	1, 200, 298	5, 262, 021		5, 267, 502	•
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 039, 687	10, 159, 066	12, 198, 753		11, 575, 183	•
15.00	01500 PHARMACY	7, 727, 455	39, 259, 657	46, 987, 112		13, 412, 442	
16.00	01600 MEDI CAL RECORDS & LI BRARY	2 574 100	0.41 000	2 414 000	-	2 410 245	
17. 00 21. 00	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD	2, 574, 109	841, 900	3, 416, 009	2, 256 2, 280, 624	3, 418, 265 2, 280, 624	•
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	4, 911, 296	2, 025, 128	6, 936, 424		4, 638, 500	•
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	114, 303	48, 581	162, 884		162, 956	
23. 01	02301 PARAMED ED	0	0	0		0	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	56, 548, 405	27, 957, 799	84, 506, 204	-2, 156, 595	82, 349, 609	
31. 00	03100 INTENSIVE CARE UNIT	10, 128, 634	6, 504, 430	16, 633, 064		16, 330, 451	1
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	8, 794, 533	2, 293, 368	11, 087, 901	-686, 798	10, 401, 103	1
40.00	04000 SUBPROVI DER - I PF	2 102 220	1 025 102	4 009 422	2 492	4 005 050	
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	2, 183, 239	1, 825, 193	4, 008, 432 0		4, 005, 950 2, 314, 271	1
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>		2, 314, 271	2, 314, 271	43.00
50. 00	05000 OPERATING ROOM	21, 185, 521	50, 710, 143	71, 895, 664	-33, 553, 261	38, 342, 403	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 093, 352	3, 600, 200	10, 693, 552		10, 458, 265	
54.00	05400 RADI OLOGY-DI AGNOSTI C	10, 250, 312	11, 281, 600	21, 531, 912	-5, 930, 019	15, 601, 893	54.00
57. 00	05700 CT SCAN	1, 348, 624	998, 386	2, 347, 010	-11, 805	2, 335, 205	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	465, 839	1, 557, 303	2, 023, 142	1	2, 023, 166	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 134, 246	10, 431, 525	12, 565, 771		2, 371, 990	
60.00	06000 LABORATORY 06001 BLOOD LABORATORY	3, 309, 091	13, 771, 605	17, 080, 696	2, 666	17, 083, 362	1
60. 01 65. 00	06500 RESPIRATORY THERAPY	0 3, 238, 006	4, 630, 963	7, 868, 969	-851, 028	0 7, 017, 941	
66. 00	06600 PHYSI CAL THERAPY	3, 205, 921	1, 234, 106	4, 440, 027		4, 311, 140	
66. 01	06602 PHYSI CAL THERAPY EAST BANK	1, 025, 180	322, 621	1, 347, 801		1, 336, 246	
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	493, 909	117, 962	611, 871		612, 074	•
67. 00	06700 OCCUPATI ONAL THERAPY	1, 708, 987	537, 003	2, 245, 990		2, 246, 577	
	06701 OCCUPATIONAL THERAPY LIVING CENTER	294, 266	72, 833	367, 099		367, 290	•
	06800 SPEECH PATHOLOGY	995, 595	245, 692	1, 241, 287		1, 241, 066	
68. 10	06801 SPEECH THERAPY LIVING CENTER	236, 919	52, 343	289, 262	-1, 101	288, 161	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	18, 778, 352	0 18, 778, 352	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32, 702, 165	32, 702, 165	
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	o	0	33, 579, 209	33, 579, 209	
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	1
76.00	03020 CARDI OLOGY	1, 943, 566	1, 153, 620	3, 097, 186	-37, 524	3, 059, 662	76. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
00.00	OUTPATIENT SERVICE COST CENTERS		اه				00.00
90. 00 90. 10	09000 CLINIC 09001 FAMILY PRACTICE CLINIC	0	0	0	0	0	90. 00 90. 10
90. 10	09001 FAMILY PRACTICE CLINIC	797, 102	294, 479	1, 091, 581	596	1, 092, 177	
90. 50	09004 SLEEP DI SORDERS CLINIC	556, 762	278, 058	834, 820		834, 005	
91. 00	09100 EMERGENCY	21, 320, 337	18, 305, 456	39, 625, 793		39, 552, 753	
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
440.00	SPECIAL PURPOSE COST CENTERS		ام				1440 00
	11300 INTEREST EXPENSE	104 174 211	247 471 447	E42 447 0E9	04 093		113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)     NONREIMBURSABLE COST CENTERS	196, 176, 311	367, 471, 647	563, 647, 958	-96, 982	563, 550, 976	110.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	ol	0	O	0	190. 00
	19300 NONPAI D WORKERS	275, 468	177, 133	452, 601	298	452, 899	
	19301 HEALTH PROPERTIES	2, 418, 163	3, 142, 604	5, 560, 767		5, 657, 085	
	19303 LEIGHTON CENTER	О	0	0	0		193. 40
	19305 WELLNESS CENTER	0	115, 352	115, 352	0	115, 352	
	19308 UNUSED SPACE	O	0	0	0		193. 80
193. 90	19309 OCCUPATI ONAL HEALTH	O	O	0	ı O	0	193. 90

Health Financial Systems MEMOF	RIAL HOSPITAL O	SOUTH BEND,	I NC	In Lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO		eri od:	Worksheet A	
				rom 01/01/2022 o 12/31/2022	Date/Time Pre	
					5/31/2023 11:	28 am _
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
193. 91 19310 RESEARCH AND PROTOCOL	0	0	C	0	0	193. 91
193. 92 19311 CCOP	0	0	C	0	0	193. 92
193. 93 19312 REASEARCH ADMIN	213, 560	48, 011	261, 571	366	261, 937	193. 93
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	o	0	C	0	0	194. 00
200.00   TOTAL (SUM OF LINES 118 through 199)	199, 083, 502	370, 954, 747	570, 038, 249	0	570, 038, 249	200. 00

Health Financial Systems MEMORIAL HOSPIT RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

od: Worksheet A 01/01/2022 12/31/2022 Date/Time Prepared:

In Lieu of Form CMS-2552-10

5/31/2023 11:28 am Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6.00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FLXT -3, 765, 829 18, 756, 548 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 3, 861, 473 14, 592, 946 2.00 2.00 3.00 00300 OTHER CAPITAL RELATED COSTS 3.00 00400 EMPLOYEE BENEFITS DEPARTMENT -1,075 2, 819, 308 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL -33, 454, 229 75, 840, 364 5.00 00600 MAINTENANCE & REPAIRS 95, 141 6.00 -2.808 6.00 7.00 00700 OPERATION OF PLANT -609, 683 11, 876, 999 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 0 1, 494, 463 8 00 9.00 00900 HOUSEKEEPI NG 5, 785, 974 9.00 10.00 01000 DI ETARY -217, 904 3, 823, 137 10 00 01100 CAFETERI A -1.843.235 11 00 11 00 1,040,848 13.00 01300 NURSING ADMINISTRATION -10, 491 5, 257, 011 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY -65,606 11, 509, 577 14.00 01500 PHARMACY 13, 408, 907 -3, 535 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 16.00 17.00 01700 SOCIAL SERVICE 0 3, 418, 265 17.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 21.00 2, 280, 624 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 4, 638, 500 22.00 0 23.00 02300 PARAMED ED PRGM-(SPECIFY) -15, 725 147, 231 23 00 02301 PARAMED ED 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS -265, 201 82, 084, 408 30.00 31.00 03100 INTENSIVE CARE UNIT -1, 092, 580 15, 237, 871 31.00 -161, 795 31.01 02060 NEONATAL INTENSIVE CARE UNIT 10, 239, 308 31.01 04000 SUBPROVIDER - IPF 40.00 40.00 04100 SUBPROVI DER - I RF 41.00 0 4,005,950 41.00 43.00 04300 NURSERY 2, 314, 271 43.00 ANCILLARY SERVICE COST CENTERS 50.00 35, 827, 802 50.00 05000 OPERATING ROOM -2, 514, 601 05200 DELIVERY ROOM & LABOR ROOM 52.00 -1, 853, 717 8,604,548 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C -330, 896 15, 270, 997 54.00 57.00 05700 CT SCAN -61, 376 2, 273, 829 57.00 58 00 05800 MAGNETIC RESONANCE I MAGING (MRI) -468 475 1, 554, 691 58 00 05900 CARDIAC CATHETERIZATION 59.00 2, 371, 990 59.00 06000 LABORATORY 0 17, 083, 362 60.00 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06500 RESPIRATORY THERAPY 65.00 35 7, 017, 976 65.00 66.00 06600 PHYSI CAL THERAPY -165, 283 4, 145, 857 66.00 06602 PHYSI CAL THERAPY EAST BANK 66.01 -22, 409 1, 313, 837 66.01 06601 PHYSICAL THERAPY LIVING CENTER 66 10 612.074 66 10 06700 OCCUPATIONAL THERAPY 67.00 -195, 025 2,051,552 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 367, 290 67.10 06800 SPEECH PATHOLOGY 0 1, 241, 066 68.00 68.00 06801 SPEECH THERAPY LIVING CENTER 0 68 10 68 10 288, 161 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 18, 778, 352 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 32, 702, 165 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS -338, 705 73.00 33, 240, 504 73.00 74.00 07400 RENAL DIALYSIS 74.00 03020 CARDI OLOGY 76.00 -12, 150 3, 047, 512 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 0 90 10 09001 FAMILY PRACTICE CLINIC 0 Ω 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 1, 092, 177 90.30 0 90.30 09004 SLEEP DISORDERS CLINIC 90.50 834,005 90.50 09100 EMERGENCY 91.00 91.00 -5, 215, 081 34, 337, 672 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) -48, 825, 906 514, 725, 070 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 193.00 19300 NONPAID WORKERS 190. 00 0 452, 899 193. 00 193. 10 19301 HEALTH PROPERTIES 5, 657, 085 193. 10 193. 40 19303 LEI GHTON CENTER 193. 40 0 0 193. 50 19305 WELLNESS CENTER 115, 352 193. 50 193.80 19308 UNUSED SPACE 193.80 Ω 193. 90 19309 OCCUPATIONAL HEALTH 0 0 193. 90 193. 91 19310 RESEARCH AND PROTOCOL 0 193. 91 193. 92 19311 CCOP 193. 92 0

Health Financial Systems	MEMORIAL HOSPITAL OF S	SOUTH BEND, INC	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TI	RIAL BALANCE OF EXPENSES	Provider CCN: 15-0058	Peri od: From 01/01/2022	Worksheet A
			To 12/31/2022	Date/Time Prepared: 5/31/2023 11:28 am

			5/31/2023 11: 28 am
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6.00	7.00	
193. 93 19312 REASEARCH ADMIN	0	261, 937	193. 93
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	-48, 825, 906	521, 212, 343	200. 00

					5/31/2023 11:	
		Increases				
	Cost Center	Li ne #	Salary	0ther		
	2. 00	3.00	4. 00	5. 00		
1 00	A - DRUGS CHARGED TO PATIENTS		ما	27 070 517		1 00
1. 00	DRUGS CHARGED TO PATIENTS TOTALS		0	<u>27, 078, 5</u> 17 27, 078, 517		1.00
	B - SUPPLIES CHARGED TO PATIE	NTS	U <sub>I</sub>	27,076,317		
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	51, 480, 517		1.00
	PATI ENTS	,	٦	0.1, 100, 0.7		
2.00		0.00	O	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10. 00		0.00	0	0		10. 00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	0		12. 00
13. 00		0.00	0	0		13. 00
14. 00		0.00	0	0		14. 00
15.00		0.00	0	0		15. 00
16.00		0.00	0	0		16.00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18.00
19. 00 20. 00		0. 00 0. 00	0	0		19. 00 20. 00
21. 00		0.00	0	0		20.00
22. 00		0.00	0	0		22. 00
22.00				51, 480, 517		22.00
	C - AMORTIZATION TO CAPITAL		<u> </u>	31, 400, 317		ł
1. 00	NEW CAP REL COSTS-BLDG &	1.00	0	781, 459		1.00
1.00	FIXT	1.00	ď	701, 437		1.00
	0	+				
	D - INTEREST TO CAPITAL	L	-1			
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	5, 005, 844		1.00
	FLXT			., ,		
	0 — — — — —			5, 005, 844		
	H - EE UTILIZATION OF H&L					
1.00		0.00	0	0		1. 00
	0		0	0		
	M - NICU					
1.00	ADULTS & PEDIATRICS	30. 00	53 <u>3, 4</u> 02	13 <u>9, 3</u> 44		1. 00
	TOTALS		533, 402	139, 344		
	N - RECLASS NURSERY FROM MATE					
1. 00	NURSERY	43. 00	<u>1, 843, 5</u> 07	<u>470, 7</u> 64		1. 00
	0		1, 843, 507	470, 764		
	O - CAFETERIA FROM DIET SALAF		4 544 040	-		
1. 00	CAFETERI A	11. 00	1, 514, 949	0		1. 00
	O DEDATES		1, 514, 949	0		
1 00	R - REBATES	0.00	ما	0		1 00
1. 00		0.00		0		1. 00
	W - WORKERS COMP EH&W		U	U		+
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	773, 096		1.00
1.00	O DEFARTMENT			773, 096		1.00
	X - PROPERTY INSURANCE TO CAR	L	<u> </u>	773,070		•
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	387, 282		1.00
1.00	FIXT	1.00	Ĭ	007, 202		1.00
2.00	NEW CAP REL COSTS-MVBLE	2. 00	o	61, 538		2. 00
	EQUI P			·		
	0			448, 820		
	Y - GARAGE TO A&G					
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	117, 542		1. 00
	0		0	117, 542		
	Z - INCENTIVE					
1.00		0.00	0	0		1. 00
2.00	MAINTENANCE & REPAIRS	6. 00	97, 949	0		2. 00
3.00	OPERATION OF PLANT	7. 00	3, 704	0		3. 00
4.00	HOUSEKEEPI NG	9. 00	2, 518	0		4. 00
5.00	DI ETARY	10. 00	3, 228	0		5. 00
6.00	NURSING ADMINISTRATION	13. 00	5, 508	0		6. 00
7.00	CENTRAL SERVICES & SUPPLY	14. 00	2, 008	0		7. 00
8.00	PHARMACY	15. 00	5, 006	0		8. 00
9. 00	SOCI AL SERVI CE	17. 00	2, 256	0		9. 00
10. 00	I &R SERVICES-OTHER PRGM	22. 00	15, 482	0		10. 00
	COSTS APPRVD					1

Peri od: From 01/01/2022 To 12/31/2022

Date/Time Prepared: 5/31/2023 11:28 am

		Lnorososo			5/31/2023 11: 2	<u>:8 am</u>
	Cost Center	Increases Line #	Sal ary	Other		
	2. 00	3.00	4. 00	5. 00		
11. 00	PARAMED ED PRGM-(SPECIFY)	23.00	72	5.00		11. 00
12. 00	ADULTS & PEDIATRICS	30.00	27, 170	0		12. 00
13. 00	INTENSIVE CARE UNIT	31.00	3, 951	0		13. 00
14. 00	NEONATAL INTENSIVE CARE UNIT	31.00	2, 855	0		14. 00
15. 00	SUBPROVI DER - I RF	41.00	1, 221	0		15. 00
16. 00	OPERATING ROOM	50.00	9, 878	0		16. 00
17. 00	DELIVERY ROOM & LABOR ROOM	52.00	2, 356	0		17. 00
18. 00	RADI OLOGY-DI AGNOSTI C	54. 00	11, 166	Ö		18. 00
19. 00	CT SCAN	57.00	573	Ö		19. 00
20. 00	MAGNETIC RESONANCE I MAGING	58. 00	24	Ö		20. 00
20.00	(MRI)	55.55	- '	S .		20.00
21. 00	CARDÍ AC CATHETERI ZATI ON	59. 00	537	0		21.00
22. 00	LABORATORY	60.00	2, 666	0		22.00
23. 00	RESPIRATORY THERAPY	65.00	1, 824	0		23.00
24.00	PHYSI CAL THERAPY	66.00	3, 208	0		24.00
25.00	PHYSICAL THERAPY EAST BANK	66. 01	561	0		25.00
26.00	PHYSICAL THERAPY LIVING	66. 10	203	0		26.00
	CENTER					
27. 00	OCCUPATI ONAL THERAPY	67.00	835	0		27.00
28. 00	OCCUPATIONAL THERAPY LIVING	67. 10	191	0		28. 00
	CENTER					
29. 00	SPEECH PATHOLOGY	68. 00	501	0		29. 00
30. 00	SPEECH THERAPY LIVING CENTER	68. 10	143	0		30. 00
31. 00	CARDI OLOGY	76. 00	3, 205	0		31.00
32. 00	HEMATOLOGY ONCOLOGY CLINIC	90. 30	644	0		32. 00
33. 00	SLEEP DI SORDERS CLINIC	90. 50	310	0		33. 00
34. 00	EMERGENCY	91. 00	9, 702	0		34. 00
35. 00	NONPALD WORKERS	193.00	298	0		35. 00
36.00	HEALTH PROPERTIES	193. 10	1, 384	0		36.00
37. 00	REASEARCH ADMIN	1 <u>93.</u> 93	366	0		37. 00
	AD DEDDECLATION TO CADITAL		223, 503	0		
1. 00	AB - DEPRECIATION TO CAPITAL NEW CAP REL COSTS-BLDG &	1.00	0	16, 631, 735		1. 00
1.00	FIXT	1.00	U	10, 031, 733		1.00
2. 00	NEW CAP REL COSTS-MVBLE	2.00	0	9, 438, 417		2. 00
2.00	EQUI P	2.00	٦	7, 430, 417		2.00
	0			<u>26, 070, 1</u> 52		
	BA - IMPLANTS CHARGED TO PATI	ENTS	<u>'</u>			
1.00	IMPL. DEV. CHARGED TO	72.00	0	32, 702, 165		1.00
	PATI ENTS					
	0		0	32, 702, 165		
	DA - DACC TP CAPITAL					
1.00	NEW CAP REL COSTS-MVBLE	2. 00	0	1, 234, 611		1.00
	EQUI P					
2.00	CENTRAL SERVICES & SUPPLY	14. 00	0	4, 218		2. 00
3.00		0. 00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0. 00 0. 00	0	O O		9.00
10. 00 11. 00		0.00	O	0		10. 00 11. 00
12. 00		0.00	0	0		12.00
13. 00		0.00	0	0		13. 00
14. 00		0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	n n	ő		17. 00
18. 00		0.00	o	ő		18. 00
19. 00		0.00	Ö	ő		19. 00
	<u> </u>	— — <del></del> • •	— — <del>ŏ</del>	1, 238, 829		
	DD - INTEREST EXPENSE		-1			
1.00	INTEREST EXPENSE	113. 00	0	5, 005, 844		1.00
	0			5, 005, 844		
	IR - INTERNS SALARY FROM LN 2	22 TO LN 21				
1.00	I&R SERVICES-SALARY &	21. 00	2, 280, 624	0		1. 00
	FRI_NGES_ APPRVD	L	+			
	0		2, 280, 624	0		
4 00	OO - CAFETERIA FROM DIET NON-			4 0/2 42:		4 00
1. 00	CAFETERI A	<u>11.</u> 00		1, 369, 134		1. 00
	0	ı	O	1, 369, 134		

Heal th	Financial Systems	MEMO	RIAL HOSPITAL	OF SOUTH BEND,	INC	In Lie	u of Form CMS-	-2552-10
RECLASS	SIFICATIONS			Provi der (	CCN: 15-0058	Peri od: From 01/01/2022	Worksheet A-	5
						To 12/31/2022	Date/Time Pro 5/31/2023 11:	epared: :28 am
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
	PH - PHARMACY							
1.00	DRUGS CHARGED TO PATIENTS	73. 00	6, 500, 692	0				1.00
	0		6, 500, 692	0				
	YY - PROPERTIES							
1.00	HEALTH PROPERTIES	193. 10	0	283, 943				1.00
	0		0	283, 943				
500.00	Grand Total: Increases		12, 896, 677	152, 965, 970				500.00

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

Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/31/2023 11:28 am

						5/31/2023 11:	28 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15. 00	0	27, 078, 517	0		1.00
	TOTALS		- — <del>-</del>	27, 078, 517			1
	B - SUPPLIES CHARGED TO PATIE	NTS	<u> </u>	2770707017			1
1.00	NURSING ADMINISTRATION	13. 00	O	27	0		1. 00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	0	629, 796			2. 00
		l l	o o	· ·			1
3. 00	PHARMACY	15. 00	0	467			3. 00
4.00	ADULTS & PEDIATRICS	30.00	0	485, 070			4. 00
5.00	INTENSIVE CARE UNIT	31. 00	0	304, 217	0		5. 00
6.00	NEONATAL INTENSIVE CARE UNIT	31. 01	0	16, 907	0		6. 00
8.00	SUBPROVI DER - I RF	41. 00	0	1, 341	0		8. 00
9.00	OPERATING ROOM	50.00	o	32, 792, 345	o		9. 00
10. 00	DELIVERY ROOM & LABOR ROOM	52. 00	ol	237, 643			10.00
11. 00	RADI OLOGY-DI AGNOSTI C	54.00	ol	5, 941, 185			11. 00
12. 00	CT SCAN	57.00	0	12, 378			12. 00
	CARDI AC CATHETERI ZATI ON	59.00	0				13. 00
13.00			U	10, 173, 609			1
14. 00	RESPI RATORY THERAPY	65. 00	0	803, 405			14. 00
15. 00	PHYSI CAL THERAPY	66. 00	0	33, 457			15. 00
16. 00	PHYSICAL THERAPY EAST BANK	66. 01	0	12, 116			16. 00
17. 00	OCCUPATI ONAL THERAPY	67. 00	0	248	0		17. 00
18.00	SPEECH PATHOLOGY	68. 00	0	722	0		18. 00
19.00	SPEECH THERAPY LIVING CENTER	68. 10	0	1, 244	o		19. 00
20.00	CARDI OLOGY	76. 00	o	764	ol		20. 00
21. 00	HEMATOLOGY ONCOLOGY CLINIC	90. 30	٥	48			21. 00
22. 00	EMERGENCY	91.00	0	33, 528			22. 00
22.00	LINERGENCT	— <del>- 71.</del> 00					22.00
	0		<u> </u>	51, 480, 517			ł
	C - AMORTIZATION TO CAPITAL				1		1
1. 00	ADMI NI STRATI VE & GENERAL	5. 00		78 <u>1, 4</u> 59			1. 00
	0		0	781, 459			l
	D - INTEREST TO CAPITAL						1
1.00	INTEREST EXPENSE	113. 00	0	5, 005, 844	11		1.00
		+		5, 005, 844			1
	H - EE UTILIZATION OF H&L			-,,			1
1.00	II EE OTTELENTION OF TIME	0.00	O	0	0		1.00
1.00				0			1.00
	M - NICU		υ	U			1
1 00		21 01	F22 402	120 244			1 00
1. 00	NEONATAL INTENSIVE CARE UNIT	31.01	533, 402	13 <u>9, 3</u> 44			1. 00
	TOTALS		533, 402	139, 344			1
	N - RECLASS NURSERY FROM MATE				T		
1. 00	ADULTS & PEDIATRICS	30. 00	<u>1, 843, 5</u> 07	47 <u>0, 7</u> 64			1. 00
	0		1, 843, 507	470, 764			l
	O - CAFETERIA FROM DIET SALAR	I ES					1
1.00	DI ETARY	10.00	1, 514, 949	0	0		1. 00
			1, 514, 949				1
	R - REBATES						1
1.00	IN TRESTITES	0.00	n	0	0		1.00
1.00			- — — <del>}</del>	— — — <u> </u>	$$ $ ^{4}$		1.00
	W WORKERS COMP FILEW		<u> </u>				1
4 00	W - WORKERS COMP EH&W	F 00		770.00/			4 00
1. 00	ADMI NI STRATI VE & GENERAL			<u>773, 0</u> 96			1. 00
	0		0	773, 096			l
	X - PROPERTY INSURANCE TO CAP						l
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	448, 820			1. 00
2.00		0.00	0	0	12		2. 00
	0		0	448, 820			1
	Y - GARAGE TO A&G						1
1.00	HEALTH PROPERTIES	193. 10	0	117, 542	0		1.00
	0		- — <del> </del>	117, 542			1
	Z - INCENTIVE		9	717,042			I
1 00	ADMINISTRATIVE & GENERAL	5. 00	223, 503	0	0		1 00
1.00	ADWINISTRATIVE & GENERAL	l l					1.00
2.00		0.00	0	0			2. 00
3.00		0.00	0	0			3. 00
4. 00		0.00	0	0			4. 00
5.00		0.00	0	0	0		5. 00
6.00		0.00	ol	0	o		6. 00
7.00		0.00	o	0			7. 00
8.00		0.00	ó	n	o		8. 00
9. 00		0.00	0	0			9. 00
		0.00	Š	0			10.00
10.00		l l	U				
11.00		0.00	0	0			11.00
12. 00		0.00	0	0			12. 00
13. 00		0.00	0	0			13. 00
14.00		0.00	0	0	0		14. 00
15.00		0.00	0	0	0		15. 00
16.00		0.00	0	0	o		16. 00

MEMORIAL HOSPITAL OF SOUTH BEND, INC Provider CCN: 15-0058 Health Financial Systems RECLASSIFICATIONS

Peri od: From 01/01/2022 To 12/31/2022

Date/Time Prepared: 5/31/2023 11:28 am

		Dogranges				5/31/2023 11:	28 am
	Cost Center	Decreases Li ne #	Salary	Other W	kst. A-7 Ref.		
	6. 00	7.00	8. 00	9.00	10.00		
17. 00	0. 00	0.00	0	0	0		17. 00
18. 00		0.00	o	Ö	o		18. 00
19.00		0.00	o	0	O		19.00
20.00		0.00	O	0	O		20.00
21.00		0.00	o	0	o		21. 00
22.00		0.00	0	0	0		22. 00
23.00		0.00	0	0	0		23. 00
24.00		0.00	0	0	0		24. 00
25. 00		0.00	0	0	0		25. 00
26. 00	1	0.00	0	0	0		26. 00
27. 00		0.00	0	0	0		27. 00
28. 00		0.00	0	0	0		28. 00
29. 00 30. 00		0. 00 0. 00	0	0	0		29. 00 30. 00
31. 00		0.00	0	0	0		31.00
32. 00		0.00	0	0	0		32.00
33. 00		0.00	Ö	0	Ö		33. 00
34. 00		0.00	Ö	0	o		34.00
35. 00		0.00	Ö	o	O		35. 00
36.00		0.00	O	0	0		36. 00
37.00		0.00	0	0	0		37. 00
	0 — — — — —		223, 503				
	AB - DEPRECIATION TO CAPITAL						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	26, 070, 152	9		1. 00
2.00		0.00	•	0	9		2. 00
	0		0	26, 070, 152			_
	BA - IMPLANTS CHARGED TO PATI						4
1. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	32, 702, 165	0		1. 00
	PATI ENTS	+		32, 702, 165			
	DA - DACC TP CAPITAL		U	32, 702, 103			1
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	23, 086	10		1.00
2. 00	OPERATION OF PLANT	7. 00	ő	16, 630	10		2. 00
3.00		0.00	Ö	0	10		3. 00
4. 00	NEW CAP REL COSTS-MVBLE	2.00	Ö	3, 093	10		4. 00
	EQUI P			, , , , ,			
5.00	I&R SERVICES-OTHER PRGM	22. 00	o	32, 782	10		5. 00
	COSTS APPRVD						
6.00	ADULTS & PEDIATRICS	30.00	0	57, 170	10		6. 00
7. 00	INTENSIVE CARE UNIT	31.00	0	2, 347	10		7. 00
8. 00	SUBPROVI DER – I RF	41.00	0	2, 362	10		8. 00
9.00	OPERATING ROOM	50.00	0	770, 794	10		9.00
10.00	CARRIAC CATHETERI ZATION	0.00	0	0	10		10.00
11. 00 12. 00	CARDIAC CATHETERIZATION	59. 00 0. 00	0	20, 709	10 10		11.00
	RESPIRATORY THERAPY	65.00	0	49, 447	10		12. 00 13. 00
	PHYSICAL THERAPY	66.00	0	98, 638	10		14. 00
	CARDI OLOGY	76.00	o	39, 965	10		15. 00
	SLEEP DI SORDERS CLINIC	90. 50	0	1, 125	10		16. 00
	EMERGENCY	91.00	o	49, 214	10		17. 00
	HEALTH PROPERTIES	193. 10	Ö	71, 467	10		18. 00
19.00		0.00	O	0	10		19. 00
				1, 238, 829			
	DD - INTEREST EXPENSE						1
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	5, 005, 844	0		1. 00
	0		0	5, 005, 844			
	IR - INTERNS SALARY FROM LN 2						
1. 00	I&R SERVICES-OTHER PRGM	22. 00	2, 280, 624	0	0		1. 00
	COSTS APPRVD						
	0	041.451.50	2, 280, 624	0			-
	00 - CAFETERIA FROM DIET NON-			4 0/0 404			4 00
1. 00	DI ETARY	10.00		1, 369, 134 1, 369, 134	0		1. 00
	PH - PHARMACY		U	1, 309, 134			-
1. 00	PHARMACY PHARMACY	15. 00	6, 500, 692	0	0		1.00
1.00	0	13.00	6, 500, 692		— — — Ч		1.00
	YY - PROPERTIES		5, 500, 072	J			1
1. 00	NEW CAP REL COSTS-BLDG &	1.00	ol	283, 943	14		1.00
55	FIXT		Ĭ	_55, , .6			
	0			283, 943	1		
500.00	Grand Total: Decreases		12, 896, 677	152, 965, 970			500.00
		·	•	·			

9.00

Reconciling Items

10.00 Total (line 8 minus line 9)

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-0058 Peri od: Worksheet A-7 From 01/01/2022 Part I 12/31/2022 Date/Time Prepared: 5/31/2023 11:28 am Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 26, 898, 864 367, 885 367, 885 284, 988 1.00 4, 737, 942 0 2.00 Land Improvements 561, 842 561, 842 2.00 0 3.00 514, 439, 487 14, 441, 410 14, 441, 410 4, 964, 980 3.00 Buildings and Fixtures 0 4.00 Building Improvements 324, 743 0 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 242, 951, 369 12, 512, 987 12, 512, 987 453, 973 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 789, 352, 405 27, 884, 124 27, 884, 124 5, 703, 941 8.00 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) 789, 352, 405 5, 703, 941 10.00 27, 884, 124 27, 884, 124 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 26, 981, 761 435, 320 1.00 2.00 Land Improvements 5, 299, 784 2, 786, 878 2.00 . Buildings and Fixtures 523, 915, 917 3.00 156, 322, 129 3.00 4.00 Building Improvements 324, 743 295, 663 4.00 5.00 Fixed Equipment 5.00 6.00 Movable Equipment 255, 010, 383 172, 211, 860 6.00 7. 00 7.00 HIT designated Assets Subtotal (sum of lines 1-7) 8.00 811, 532, 588 332, 051, 850 8.00

811, 532, 588

332, 051, 850

					5/31/2023 11:	28 am
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
				instructions)	instructions)	
	9. 00	10.00	11. 00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	0	(	0	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	(	0	0	2. 00
3.00 Total (sum of lines 1-2)	o	0	(	0	0	3.00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1) (sum				
	Capi tal -Rel ate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
	14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	0				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3.00 Total (sum of lines 1-2)	0	0				3. 00
	-1		•			

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC	In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 15-0058	Peri od: Worksheet A-7

RECONCI	LIATION OF CAPITAL COSTS CENTERS		Provider Co	F	Period: From 01/01/2022 To 12/31/2022		pared: 28 am
		COMF	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
				(col. 1 - col. 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
	NEW CAP REL COSTS-BLDG & FLXT	556, 562, 785	0	556, 562, 785		0	1.00
	NEW CAP REL COSTS-MVBLE EQUIP	255, 199, 072				0	2.00
3. 00	Total (sum of lines 1-2)	811, 761, 857					3. 00
		ALLOCAT	TION OF OTHER (			F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)	0.00	10.00	
- In	DART III DECONOLILATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENSE OF CAPITAL COSTS - SENSE OF CAPITAL COSTS - SEN	INTERS			12 527 2//	002 102	1. 00
	NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP	0	0		13, 537, 266		2. 00
	Total (sum of lines 1-2)	0	0		9, 438, 417 22, 975, 683		2. 00 3. 00
3.00	Total (Suil of Titles 1-2)	U	<u> </u>	IU JMMARY OF CAPI		7, 107, 394	3.00
	Cost Center Description		Insurance (see			Total (2) (sum	
			instructions)	instructions)			
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
-	PART III - RECONCILIATION OF CAPITAL COSTS CE		007.000		1 217 125	10.75/.5/0	
	NEW CAP REL COSTS-BLDG & FIXT	5, 787, 303			-1, 947, 495		1.00
	NEW CAP REL COSTS-MVBLE EQUIP	-792, 723					2.00
3. 00	Total (sum of lines 1-2)	4, 994, 580	448, 820	(	-2, 236, 983	33, 349, 494	3. 00

| Peri od: | Worksheet A-8 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES MEMORIAL HOSPITAL OF SOUTH BEND, INC
Provider CCN: 15-0058

					o 12/31/2022		pared:
				Expense Classification on	Worksheet A	5/31/2023 11:	28 am
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1. 00	Investment income - NEW CAP	1.00	2.00	3.00 NEW CAP REL COSTS-BLDG &	4. 00	5. 00	1. 00
1.00	REL COSTS-BLDG & FIXT (chapter		O	FIXT	1.00		1.00
2. 00	2) Investment income - NEW CAP		0	NEW CAP REL COSTS-MVBLE	2.00	0	2. 00
2.00	REL COSTS-MVBLE EQUIP (chapter		O	EQUIP	2.00		2.00
3. 00	2)		0		0.00	0	3. 00
3.00	Investment income - other (chapter 2)		O		0.00		3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5.00	Refunds and rebates of		0		0.00	o	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
0.00	suppliers (chapter 8)		O		0.00		0.00
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	О	9. 00
10. 00	Provi der-based physician adjustment	A-8-2	-11, 161, 780			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	o	11. 00
12. 00	(chapter 23) Related organization	A-8-1	1 054 101			0	12. 00
12.00	transactions (chapter 10)	A-0-1	1, 854, 191				12.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	1 274 101	CAFETERIA	0. 00 11. 00	1	13. 00 14. 00
15. 00	Rental of quarters to employee		-1, 376, 101 0	CAPETERIA	0.00	1	15. 00
14 00	and others		0		0.00	0	14 00
16. 00	Sale of medical and surgical supplies to other than		U		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
17.00	patients		O		0.00		17.00
18. 00	Sale of medical records and abstracts		0		0.00	0	18. 00
19. 00	Nursing and allied health		0		0.00	О	19. 00
	education (tuition, fees, books, etc.)						
19. 01	Nursing and allied health		0		0.00	0	19. 01
	education (tuition, fees, books, etc.)						
	Vending machines		0		0.00	1	
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00
	charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
	limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)			NEW OAR REV. COOKS			
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FLXT		0	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	26. 00
27. 00	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		n	EQUIP *** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	0	29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
20.00	limitation (chapter 14)		_	ADULTO A DEDLATRICO	00.55		20.00
30. 99	Hospice (non-distinct) (see instructions)		O	ADULTS & PEDIATRICS	30.00		30. 99
	•	. '		•		. '	-

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provider CCN: 15-0058 

				To	12/31/2022	Date/Time Prep 5/31/2023 11:3	
				Expense Classification on		3/31/2023 11.2	20 4111
				To/From Which the Amount is t	.o be Adjusted		
	Coot Conton Decement on	Dani o (Codo (2)	Amount	Coot Contor	lino #	Wkst. A-7 Ref.	
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	5. 00	
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0. 00	0	32. 00
33. 00	Depreciation and Interest PENSION ADJUSTMENT	Α	0	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 00
33. 01	OTHER REVENUE - MED STAFF	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	OFFICE MEDICAL OVERFLOW	В	0	ADULTS & PEDIATRICS	30. 00	0	33. 02
33. 03	TAXABLE SALES - SUBWAY	В		CAFETERI A	11. 00	0	33. 03
33. 04	CAFETERI A OTHER REVENUE - CBU	В	-5 775	DELIVERY ROOM & LABOR ROOM	52. 00	0	33. 04
33. 05	TAXABLE SALES - FCMC	В	-263, 143	ADULTS & PEDIATRICS	30. 00	0	33. 05
33.06	OTHER REVENUE - OTHER ADMIN	В		ADMINISTRATIVE & GENERAL	5.00	0	33.06
33. 07 33. 08	OTHER REVENUE - BCC OTHER REVENUE - CARD NSG ADMIN	B B		RADI OLOGY-DI AGNOSTI C CARDI OLOGY	54. 00 76. 00	0	33. 07 33. 08
33. 09	QUALITY INCENTIVE	В		ADMINISTRATIVE & GENERAL	5. 00	Ö	33. 09
33. 10	CONTRACTED SERVICES	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 10
33. 11	INTEREST INCOME - WORKING CAPITAL	В	-49, 482	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	11	33. 11
33. 12	PRIVATE LABEL PBM RXM REVENUE	В		PHARMACY	15. 00	0	33. 12
33. 13	OTHER REVENUE - MATERNAL CHILD SUPPO	В	70	ADULTS & PEDIATRICS	30. 00	0	33. 13
33. 14	OTHER REVENUE - BIOMED	В	0	MAINTENANCE & REPAIRS	6. 00	0	33. 14
33. 15	PROGRAM MEAL OFFSET	В	-188, 466		10. 00	0	33. 15
33. 16 33. 17	VISITOR MEAL OFFSET OTHER REVENUE - ENGINEERING	B B		CAFETERIA OPERATION OF PLANT	11. 00 7. 00	0	33. 16 33. 17
33. 17	OTHER REVENUE - LAB	В		EMERGENCY	91.00	0	33. 17
33. 19	ENVIORMENTAL SERVICES	В		HOUSEKEEPI NG	9. 00	0	33. 19
33. 20	OTHER REVENUE - EMPLOYEE BENEFITS	В	0	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 20
33. 22	OTHER REVENUE - RADIOLOGY DIAGN	В	0	RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 22
33. 23	UR AND SOCIAL SERVICES PSYCH	В	0	SUBPROVIDER - IPF	40. 00	0	33. 23
33. 24 33. 25	OTHER REVENUE - NICU OTHER REVENUE-MRI	B B		NEONATAL INTENSIVE CARE UNIT MAGNETIC RESONANCE IMAGING	31. 01 58. 00	0	33. 24 33. 25
33. 23	OTTIER REVENUE-WRI	В	-400, 475	(MRI)	56.00		33. 23
33. 26	OTHER REVENUE - NEONATAL SERVICES	В	-1, 330	NEONATAL INTENSIVE CARE UNIT	31. 01	0	33. 26
33. 27	OTHER REVENUE - GROUND TRANSPORT	В	-8, 665	EMERGENCY	91. 00	0	33. 27
33. 28	INTEREST INCOME - WORKING CAPITAL	Α	0	NEW CAP REL COSTS-BLDG & FLXT	1. 00	10	33. 28
33. 30	OTHER REVENUE - DRI VER'S ED CON	В	0	OCCUPATI ONAL THERAPY	67. 00	0	33. 30
33. 33	OTHER REVENUE - RAD ADMIN	В		RADI OLOGY-DI AGNOSTI C	54. 00		
33. 35	NONALLOWABLE CAPITALIZED INTERE	Α	-13, 123	NEW CAP REL COSTS-BLDG & FLXT	1. 00	10	33. 35
33. 36	OTHER REVENUE - MAIN STREET PT	В	0	PHYSICAL THERAPY	66. 00	0	33. 36
33. 39	PACE COMPONENT DEPREC 29 V 23	А	0	NEW CAP REL COSTS-BLDG &	1. 00	10	33. 39
33. 42	EXCESS CAPITALIZED INTEREST PAC	А	-9, 762	NEW CAP REL COSTS-BLDG &	1. 00	10	33. 42
33. 46	ALLOWABLE CAPITALZED INTEREST	А	10, 626	NEW CAP REL COSTS-BLDG & FLXT	1. 00	10	33. 46
33. 48	NONALLOWABLE CAPITALIZED INTERE	А	-3, 092	NEW CAP REL COSTS-BLDG &	1. 00	10	33. 48
33. 50	INCORRECT LIFING ON ASBESTOS AN	Α	0	NEW CAP REL COSTS-BLDG &	1. 00	10	33. 50
33. 55	OTHER REVENUE - RENT	В	-990, 589	NEW CAP REL COSTS-BLDG & FLXT	1. 00	14	33. 55
33. 57	MEMBERSHIP REVENUE	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	33. 57
33. 58	SPECIAL PROGRAM REVENUE	В	0	ADMINISTRATIVE & GENERAL	5. 00		33. 58
33. 59 33. 63	SEMINAR REVENUE STERILIZATION REVENUE	B B		EMPLOYEE BENEFITS DEPARTMENT DELIVERY ROOM & LABOR ROOM	4. 00 52. 00		33. 59 33. 63
33. 66	OTHER REVENUE - NUTRITIONAL	В		DI ETARY	10. 00		33. 66
33. 76	SER OTHER REVENUE - CATH LAB	В	0	CARDIAC CATHETERIZATION	59. 00	0	33. 76
33. 76	OTHER REVENUE - CATH LAB	В		PHYSICAL THERAPY	66.00		33. 76
33. 94	EDUC SERVICES EMS	В		PARAMED ED PRGM-(SPECIFY)	23. 00		33. 94

| Period: | Worksheet A-8 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES MEMORIAL HOSPITAL OF SOUTH BEND, INC
Provider CCN: 15-0058

					To 12/31/2022	Date/Time Prep 5/31/2023 11:2	
				Expense Classification on		3/31/2023 11.2	zo alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
00.04	DADKING GADAGE ODEDATING	1.00	2.00	3.00	4. 00	5. 00	22.04
33. 96 33. 97	PARKING GARAGE - OPERATING PARKING GARAGE - CAPITAL	A A		ADMINISTRATIVE & GENERAL NEW CAP REL COSTS-BLDG &	5. 00 1. 00		
				FLXT			
34. 03	NON ALLOWABLE 1999 INTEREST	A	-743, 241	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	34. 03
34. 23	ADMISSION REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00		34. 23
34. 31	SKYWAY INTEREST AMORTIZATION	A	3, 580	NEW CAP REL COSTS-BLDG &	1.00	10	34. 31
34. 36	OLD CAPITAL - BUILDING	A	32, 782	NEW CAP REL COSTS-BLDG &	1.00	14	34. 36
34. 37	NEW CAPITAL BUILDING	A	-5 543	FIXT  NEW CAP REL COSTS-BLDG &	1.00	14	34. 37
				FLXT			
35. 02	OTHER REVENUE - AMBULANCE SUPPL	В	-65, 606	CENTRAL SERVICES & SUPPLY	14. 00	0	35. 02
36. 01	LOBBY EXPENSE	A	0	ADMINISTRATIVE & GENERAL	5. 00	0	36. 01
36. 05	HAF EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00		36. 05
36. 18 36. 23	TRUSTEE FEES CONTRI BUTI ONS	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00		36. 18 36. 23
36. 25	NON-ALLOWED EXPENSES	A		ADMINISTRATIVE & GENERAL	5. 00		36. 25
36. 26	ENTRY FEES	В		ADMINISTRATIVE & GENERAL	5. 00	O	36. 26
37. 00	OTHER REVENUE - MATERNAL CHILD ADMIN	В	-380	ADULTS & PEDIATRICS	30.00	0	37. 00
37. 01	OTHER REVENUE - OSTC	В	-10, 491	NURSING ADMINISTRATION	13.00	О	37. 01
37. 03	OTHER REV - TRAUMA SVCS	В	-26, 894	EMERGENCY	91. 00	0	37. 03
39.00	OTHER REVENUE - TEAM PHARMACY	В		DRUGS CHARGED TO PATIENTS	73.00		39. 00
40. 00 41. 00	OTHER REVENUE - PEDS REHAB OT OTHER REVENUE - FCMC	B B		OCCUPATIONAL THERAPY ADULTS & PEDIATRICS	67. 00 30. 00		40. 00 41. 00
42. 00	OTHER REVENUE - PULMONARY	В		ADULTS & PEDIATRICS	30.00		42. 00
44.00	MED/SURG	D.		CARRIAGOSV	7/ 00		44.00
44. 00 44. 01	OTHER REVENUE - CARDI AC REHAB OTHER REVENUE - OSTC	B B		CARDIOLOGY PHYSICAL THERAPY EAST BANK	76. 00 66. 01	0	44. 00 44. 01
44. 02	OTHER REVENUE - SAFETY	В		NURSING ADMINISTRATION	13. 00	_	44. 02
44. 03	OTHER REVENUE - 11 SOUTH	В		ADULTS & PEDIATRICS	30.00		44. 03
44. 04 44. 05	OTHER REVENUE - 12 SOUTH OTHER REVENUE - SOCIAL	B B		ADULTS & PEDIATRICS SOCIAL SERVICE	30. 00 17. 00		44. 04 44. 05
44. 05	SERVICES	В	0	SOCIAL SERVICE	17.00		44.05
44. 06	OTHER REVENUE - PHARMACY	В	· ·	DRUGS CHARGED TO PATIENTS	73.00		44.06
44. 07 44. 08	PULMONARY OTHER REVENUE - GRANGER ADMIN	B B		RESPIRATORY THERAPY ADMINISTRATIVE & GENERAL	65. 00 5. 00		44. 07 44. 08
44. 09	OTHER REVENUE - INDIGENT CARE	В		SOCI AL SERVI CE	17. 00		44. 09
44. 10	OTHER REVENUE - ORNISH CARDIAC	В	0	CARDI OLOGY	76. 00	O	44. 10
44 11	REHAB OTHER REVENUE - RES SVCS	В	0	NURSING ADMINISTRATION	13. 00	0	44. 11
	OTHER REVENUE - 8 SOUTH	В		ADULTS & PEDIATRICS	30.00		
44. 13	OTHER REVENUE - SOCIAL SVCS	В	0	SOCI AL SERVI CE	17. 00		44. 13
44. 14 44. 15	BREMEN SALARIES TO HOME OFFICE OTHER REVENUE - NSG FLOATS	A B	0	NURSING ADMINISTRATION	0.00		44. 14 44. 15
44. 16	OTHER REVENUE - INSIG FLOATS	В		EMERGENCY	13. 00 91. 00	_	44. 15
44. 17	OTHER REVENUE - EPWORTH ADULT	В	0	ADULTS & PEDIATRICS	30.00	O	44. 17
44. 18	ACUTE OTHER REVENUE - ENVIRONMENTAL	В	Ω	HOUSEKEEPI NG	9.00	0	44. 18
	PSYCH						
44. 19	OTHER REVENUE - HEART VASCULAR	B B		CARDI OLOGY	76. 00 5. 00		44. 19 44. 20
44. 20 44. 21	OTHER REVENUE - GIFT SHOP OTHER REVENUE - GROUNDS	В		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5. 00 7. 00		44. 20 44. 21
44. 22	HOME OFFICE ADJUSTMENT	A	-274, 131	NEW CAP REL COSTS-BLDG &	1.00		44. 22
44. 23	BUILDING TO HOME OFFICE	A		FLXT NEW CAP REL COSTS-BLDG &	1.00	1.4	44. 23
44. 23	BUILDING TO HOME OFFICE	A	-700, 202	FIXT	1.00	14	44. 23
44. 24	MME TO HOME OFFICE	A	-289, 488	NEW CAP REL COSTS-MVBLE	2. 00	14	44. 24
44. 25	MAINTENANCE TO HOME OFFICE	A	-2 808	EQUIP MAINTENANCE & REPAIRS	6. 00	0	44. 25
44. 26	1	Ä		OPERATION OF PLANT	7. 00		
44. 27	OTHER REVENUE-AQUATICS CENTER	В	0	OCCUPATI ONAL THERAPY	67. 00	O	44. 27
44. 28	OTHER REVENUE-SURGERY	В		OPERATING ROOM	50.00		44. 28
44. 29 44. 30	OTHER REVENUE-SURGERY ADMIN AFFLIATE RENT	B B		OPERATING ROOM NEW CAP REL COSTS-BLDG &	50. 00 1. 00		44. 29 44. 30
				FLXT			
44. 31	OTHER REVENUE-PICU OTHER REVENUE-GH EMERGENCY	B B		INTENSIVE CARE UNIT EMERGENCY	31. 00 91. 00		44. 31 44. 32
<del></del>	TOTALK KEVENOE-GIT EMERGENCY	ا ت	-02	- ILIMEROLING I	71.00	<u> </u>	77. 32

Heal th	Financial Systems	MEMOR	IAL HOSPITAL O	F SOUTH BEND, INC	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2022		
					To 12/31/2022	Date/Time Pre 5/31/2023 11:	
				Expense Classification or	Workshoot A	3/31/2023 11.	20 4111
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4. 00	5. 00	
44. 33	OTHER REVENUE-COMMUNITY HEALTH	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	44. 33
50.00	TOTAL (sum of lines 1 thru 49)		-48, 825, 906				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,	В	0	ADMINISTRATIVE & GENERAL			

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

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

  B. Amount Received if cost cannot be determined.
  (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
  Note: See instructions for column 5 referencing to Worksheet A-7.

OFFICE COSTS

-0058 | Period: | Wo From 01/01/2022 | To 12/31/2022 | Da

OTTTOE	00313			To 12/31/2022	Date/Time Pre 5/31/2023 11:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX		1, 057, 934	0	1. 00
2.00	2. 00	NEW CAP REL COSTS-MVBLE EQUI		4, 943, 684	0	2. 00
3.00	5. 00	ADMINISTRATIVE & GENERAL		63, 475, 119	0	3. 00
4.00	5. 00	ADMINISTRATIVE & GENERAL		0	67, 622, 546	4.00
5.00	TOTALS (sum of lines 1-4).			69, 476, 737	67, 622, 546	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

				Related Organization(s) and/	or Home Office		
	Symbol (1)	Name	Percentage of	Name	Percentage of		
	•		Ownershi p		Ownershi p		
	1. 00	2. 00	3.00	4. 00	5. 00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							
	-			-			

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

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

6. 00	В	100. 00 BEACON HLTH SYS 100. 00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

Heal th	Financial Syste	ems	MEMO	RIAL HOSPITAL OF	SOUTH BEND,	INC		In Lie	u of Form C	MS-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZ	ZATIONS AND HOME	Provi der C	CN: 15-0058	Perio		Worksheet	A-8-1
OFFICE	COSTS							01/01/2022		
							To	12/31/2022		
									5/31/2023	<u>11:28 am</u>
	Net	Wkst. A-7 Ref.								
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6. 00	7. 00								
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED A	AS A RESULT OF TR	ANSACTIONS W	ITH RELATED O	ORGANI.	ZATIONS OR (	CLAI MED	
	HOME OFFICE CO	STS:								
1.00	1, 057, 934	10								1. 00
2.00	4, 943, 684	10								2. 00
3.00	63, 475, 119	0								3. 00
4.00	-67, 622, 546	0								4.00

\* 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

nas not	been posted to worksheet A,	cordinate and the amount arrowable should be murcated in cordinate and this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

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

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

1, 854, 191

| Period: | Worksheet A-8-2 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0058

						To 12/31/2022	Date/Time Pre 5/31/2023 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1. 00		INTENSIVE CARE UNIT	1, 092, 580			0  C		
2.00		NEONATAL INTENSIVE CARE UNIT	160, 300	•		0  C	0	
3.00		OPERATING ROOM	2, 514, 601	2, 514, 60		0  C	0	
4.00		DELIVERY ROOM & LABOR ROOM	1, 847, 942			0  C	0	
5.00		RADI OLOGY-DI AGNOSTI C	330, 758			0  C	0	
6.00		CT SCAN	61, 376	61, 37	6	0  C	0	6. 00
7. 00		CARDI OLOGY	12, 150			0  C	0	
8. 00		EMERGENCY	5, 142, 073			0  C	0	0.00
9. 00	0.00		0		0	0  C	0	7.00
10. 00	0. 00		0	1	0	O C	0	
200.00			11, 161, 780			0	0	
	Wkst. A Line #		Unadjusted RCE			Provi der	Physician Cost	
		l denti fi er	Limit		E Memberships &		of Mal practice	:
				Limit	Conti nui ng	Share of col.	Insurance	
	4 00	0.00	0.00	0.00	Educati on	12	11.00	
1 00	1.00	2.00 I NTENSI VE CARE UNI T	8.00	9. 00	12. 00	13.00	14.00	1. 00
1. 00 2. 00		NEONATAL INTENSIVE CARE UNIT		1	<u> </u>		1	
3.00		OPERATING ROOM		1	0			1
4. 00		DELIVERY ROOM & LABOR ROOM	0		0			1
5. 00		RADI OLOGY-DI AGNOSTI C	0		0			
6. 00		CT SCAN			0			1
7. 00		CARDI OLOGY			0			1
8. 00		EMERGENCY			0			
9. 00	0.00	LINERGENCT			0			1
10. 00	0.00				0			
200.00	0.00				0			
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	,	200.00
		I denti fi er	Component	Limit	Di sal I owance	/ taj do tilior t		
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		INTENSIVE CARE UNIT	0		0	0 1, 092, 580		1. 00
2.00	31. 01	NEONATAL INTENSIVE CARE UNIT	0		0	0 160, 300		2. 00
3.00		OPERATING ROOM	0		0	0 2, 514, 601		3. 00
4.00	52. 00	DELIVERY ROOM & LABOR ROOM	0		0	0 1, 847, 942	2	4. 00
5.00	54. 00	RADI OLOGY-DI AGNOSTI C	0		0	0 330, 758	3	5. 00
6.00	57. 00	CT SCAN	0		0	0 61, 376		6. 00
7.00	76. 00	CARDI OLOGY	0		0	0 12, 150		7. 00
8.00		EMERGENCY	0		0	0 5, 142, 073	3	8. 00
9. 00	0. 00		0		0	o  c	)	9. 00
10.00	0.00		0		0	o  c	)	10. 00
200.00			0		o	0 11, 161, 780	)	200. 00

| Period: | Worksheet B | From 01/01/2022 | Part | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0058

					o 12/31/2022	Date/Time Pre	pared:
			CAPI TAL REI	LATED COSTS		5/31/2023 11:	28 am
					5451 0455		
	Cost Center Description	Net Expenses for Cost	NEW BLDG & FLXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		Allocation	1170	2011	DEPARTMENT		
		(from Wkst A					
		col. 7) 0	1. 00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS	-					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	18, 756, 548	18, 756, 548				1.00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	14, 592, 946 2, 819, 308	0	14, 592, 946 C			2. 00 4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL	75, 840, 364	815, 643			77, 365, 094	5. 00
6. 00	00600 MAINTENANCE & REPAIRS	95, 141	53, 052			190, 856	1
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	11, 876, 999 1, 494, 463	3, 125, 936 2, 963			17, 477, 312 1, 499, 731	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	5, 785, 974	373, 303			6, 496, 683	9. 00
10.00	01000 DI ETARY	3, 823, 137	476, 372			4, 700, 230	1
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	1, 040, 848 5, 257, 011	83, 349 202, 474			1, 210, 506 5, 674, 634	
14. 00	01400 CENTRAL SERVICES & SUPPLY	11, 509, 577	609, 307			12, 621, 862	1
15.00	01500 PHARMACY	13, 408, 907	297, 515			13, 955, 344	15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0 2 410 245	104 470	02.000		0	16.00
21. 00	02100   &R SERVICES-SALARY & FRINGES APPRVD	3, 418, 265 2, 280, 624	106, 679 0	82, 998 C		3, 644, 441 2, 312, 934	17. 00 21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	4, 638, 500	287, 063	223, 340	1	5, 186, 391	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	147, 231	0	1	,	148, 851	1
23. 01	O2301   PARAMED ED     I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	C	0	0	23. 01
30. 00	03000 ADULTS & PEDIATRICS	82, 084, 408				90, 367, 113	1
31.00	03100 I NTENSI VE CARE UNI T	15, 237, 871	521, 109			16, 307, 961	31.00
31. 01 40. 00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	10, 239, 308 0	504, 030 0			11, 252, 559 0	31. 01 40. 00
41. 00	04100 SUBPROVI DER - I RF	4, 005, 950	186, 975		_	4, 369, 342	1
43. 00	04300 NURSERY	2, 314, 271	75, 717	58, 909	26, 117	2, 475, 014	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	35, 827, 802	1, 885, 788	1, 467, 178	300, 275	39, 481, 043	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 604, 548	547, 024	425, 595	100, 525	9, 677, 692	52. 00
54. 00	05400   RADI OLOGY-DI AGNOSTI C   05700   CT   SCAN	15, 270, 997	1, 241, 549			17, 623, 868	
57. 00 58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 273, 829 1, 554, 691	45, 006 67, 779			2, 372, 965 1, 681, 803	
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 371, 990				2, 849, 921	59. 00
60.00	06000 LABORATORY	17, 083, 362	182, 144	1		17, 454, 135	1
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	7, 017, 976	0 116, 520	1	_	0 7, 271, 050	60. 01 65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 145, 857	208, 706		1	4, 562, 404	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	1, 313, 837	0	1		1, 328, 369	
66. 10 67. 00	O6601   PHYSICAL THERAPY LIVING CENTER   O6700   OCCUPATIONAL THERAPY	612, 074 2, 051, 552	0 29, 489	1	.,	619, 074 2, 128, 207	66. 10 67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	367, 290				371, 462	
68. 00	06800 SPEECH PATHOLOGY	1, 241, 066	6, 286			1, 266, 354	1
68. 10 70. 00	06801   SPEECH THERAPY LIVING CENTER   07000   ELECTROENCEPHALOGRAPHY	288, 161 0	0	C	· · · · · · · · · · · · · · · · · · ·	291, 519 0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 778, 352	0	d	-	18, 778, 352	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	32, 702, 165	0	C		32, 702, 165	
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	33, 240, 504 0	0	0	, , , , , , , , , , , , , , , , , , , ,	33, 332, 599 0	73. 00 74. 00
76. 00	03020 CARDI OLOGY	3, 047, 512	51, 184		_	3, 166, 098	1
77. 00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0	0	C	0	0	77. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	O	0	С	o	0	90.00
90. 10	09001 FAMILY PRACTICE CLINIC	0	0	1		0	90. 10
90. 30 90. 50	09002 HEMATOLOGY ONCOLOGY CLINIC 09004 SLEEP DISORDERS CLINIC	1, 092, 177	286, 649			1, 613, 147 928, 784	90. 30 90. 50
90. 50	09100 EMERGENCY	834, 005 34, 337, 672	48, 867 1, 374, 538			37, 083, 809	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	31, 331, 31	., ., .,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	332, 133	0	92. 00
102.00	OTHER REIMBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM	O	0	С	ol	0	102. 00
102.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0		<u> </u>		102.00
	11300 I NTEREST EXPENSE	F4 . 707	40.00= =:	44.051.11	0.775	E40 04: :::	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	514, 725, 070	18, 282, 888	14, 224, 430	2, 778, 092	513, 841, 678	J178. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	85, 505			152, 029	
	19300 NONPALD WORKERS	452, 899 E 457, 005	65, 731			573, 677	
	19301   HEALTH PROPERTI ES   19303   LEI GHTON CENTER	5, 657, 085 0	202, 689 113, 180			6, 051, 748 201, 236	
	19305 WELLNESS CENTER	115, 352				115, 352	
		<u> </u>			<u> </u>		

Provider CCN: 15-0058 

					5/31/2023 11:	28 am
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal	
	for Cost Allocation	FLXT	EQUI P	BENEFITS DEPARTMENT		
	(from Wkst A			DEPARTMENT		
	col. 7)					
	0	1.00	2.00	4. 00	4A	
193. 80 19308 UNUSED SPACE	0	0	0	0	0	193. 80
193. 90 19309 OCCUPATI ONAL HEALTH	0	0	0	0	0	193. 90
193. 91 19310 RESEARCH AND PROTOCOL	0	0	0	0	0	193. 91
193. 92 19311 CCOP	0	0	0	0		193. 92
193. 93 19312 REASEARCH ADMIN	261, 937	6, 555	5, 100	3, 031	276, 623	193. 93
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0	0		201. 00
202.00   TOTAL (sum lines 118 through 201)	521, 212, 343	18, 756, 548	14, 592, 946	2, 819, 308	521, 212, 343	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared: | 5/31/2023 | 11: 28 am

					5/31/2023 11:	28 am
Cost Center Description	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL 5.00	REPAI RS 6. 00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	
GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	0.00	7.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	77, 365, 094					5. 00
6.00 00600 MAINTENANCE & REPAIRS	33, 267	224, 123				6. 00
7.00 O0700 OPERATION OF PLANT	3, 046, 400	39, 166				7. 00
8.00   00800   LAUNDRY & LINEN SERVICE	261, 412	37				8. 00
9. 00   00900   HOUSEKEEPI NG	1, 132, 411	4, 677	l	0	8, 153, 771	1
10. 00   01000   DI ETARY	819, 278	5, 969		0	1,	1
11. 00   01100   CAFETERI A	210, 998	1, 044			0	11. 00
13.00 O1300 NURSING ADMINISTRATION	989, 123	2, 537	l		8, 120	1
14.00 01400 CENTRAL SERVICES & SUPPLY	2, 200, 066	7, 634	l		122, 782	14. 00
15. 00   01500   PHARMACY	2, 432, 500	3, 728	414, 429	0	20, 870	
16. 00   01600   MEDI CAL RECORDS & LI BRARY	(05.040	0	0	0	0	16.00
17. 00 01700 SOCI AL SERVI CE	635, 248	1, 337	148, 600	0	10, 557	
21. 00   02100   1&R SERVI CES-SALARY & FRINGES APPRVD	403, 158	2 507	200 0/0	0	0	21.00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	904, 019	3, 597	399, 869	0	0	1
23.00   02300   PARAMED ED PRGM-(SPECIFY) 23.01   02301   PARAMED ED	25, 946 0	0		0	0	23. 00 23. 01
23. 01   02301  PARAMED ED   I NPATI ENT ROUTI NE SERVI CE COST CENTERS	U U	0	<u> </u>	0	0	23.01
30. 00 03000 ADULTS & PEDIATRICS	15, 751, 386	52, 848	5, 875, 649	707, 721	4, 369, 952	30.00
31. 00   03100   NTENSI VE CARE UNI T	2, 842, 575	6, 529				1
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	1, 961, 389	6, 315	1			
40. 00   04000   SUBPROVI DER -   I PF	1, 701, 307	0, 319	1	13,017	007,030	40.00
41. 00 04100 SUBPROVI DER - I RF	761, 603	2, 343	_	47, 703	l .	
43. 00   04300   NURSERY	431, 410	949				
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	6, 881, 783	23, 628	2, 626, 841	371, 578	817, 732	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 686, 880	6, 854				1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 071, 946	15, 556	l		434, 202	1
57. 00 05700 CT SCAN	413, 622	564				57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	293, 148	849	94, 413	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	496, 758	3, 155	350, 736	0	84, 453	59. 00
60. 00   06000   LABORATORY	3, 042, 360	2, 282	253, 721	0	62, 690	60.00
60. 01   06001   BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	1, 267, 388	1, 460	162, 309	0	12, 830	65. 00
66. 00 06600 PHYSI CAL THERAPY	795, 254	2, 615	290, 721	0	45, 881	66. 00
66. 01   06602 PHYSI CAL THERAPY EAST BANK	231, 543	0	0	0	0	66. 01
66.10   06601   PHYSI CAL THERAPY LIVING CENTER	107, 908	0	· ·	0	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	370, 959	369	l :	0	9, 501	1
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	64, 748	0	_	0	0	67. 10
68. 00   06800   SPEECH PATHOLOGY	220, 733	79	8, 756	0	1, 868	
68. 10 06801 SPEECH THERAPY LIVING CENTER	50, 814	0	0	0	0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	3, 273, 179	0		0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	5, 700, 184	0		0	0	72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 74. 00   07400   RENAL DIALYSIS	5, 810, 072	0	1	0	1	73. 00 74. 00
74. 00   07400   RENAL DI ALYSI S 76. 00   03020   CARDI OLOGY	551, 870	0 641				
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	331, 870	041	/ 1, 290	0	l .	77.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	<u> </u>	0	0	77.00
90. 00 09000 CLINIC	O	0	0	0	0	90.00
90. 10 09001 FAMILY PRACTICE CLINIC	o	0	0	_	Ö	90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	281, 181	3, 592	_	_	Ö	90. 30
90. 50 09004 SLEEP DI SORDERS CLINIC	161, 893	612	1	0	Ö	90. 50
91. 00   09100   EMERGENCY	6, 463, 930	17, 222		273, 552		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1 7, 100, 100	, ===	1,,	,	,	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	<u> </u>					
113. 00 11300   NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117	76, 080, 342	218, 188	19, 903, 084	1, 765, 308	8, 140, 859	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	26, 500	1, 071	119, 105	0		190. 00
193. 00 19300 NONPALD WORKERS	99, 995	824	91, 562	0	10, 557	193. 00
193. 10 19301 HEALTH PROPERTIES	1, 054, 856	2, 540	282, 340	0		193. 10
193. 40 19303 LEI GHTON CENTER	35, 077	1, 418	157, 656	0	<b>l</b>	193. 40
193. 50 19305 WELLNESS CENTER	20, 107	0	0	0		193. 50
193. 80 19308 UNUSED SPACE	0	0	0	0		193. 80
193. 90 19309 OCCUPATI ONAL HEALTH	0	0	0	0		193. 90
193. 91 19310 RESEARCH AND PROTOCOL	0	0	9	0		193. 91
193. 92 19311 CCOP	0	0	_	0	0	193. 92
193. 93 19312 REASEARCH ADMIN	48, 217	82	9, 131	0	2, 355	193. 93

Health Financial Systems	MEMORIAL HOSPITAL OF S	OUTH BEND, INC	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0058	From 01/01/2022	Worksheet B Part I Date/Time Prepared:

						5/31/2023 11:	28 am
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5.00	6.00	7. 00	8. 00	9. 00	
194.0007950	OTHER NONREIMBURSABLE COST CENTERS	0	0	C	0	0	194. 00
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	0	C	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	77, 365, 094	224, 123	20, 562, 878	1, 765, 308	8, 153, 771	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

Period: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

5/31/2023 11:28 am Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI ON SERVICES & **SUPPLY** 10.00 11.00 13.00 15.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 6,607,983 10 00 01100 CAFETERI A 1, 538, 651 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 0 45, 196 7,001,650 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 36, 180 15, 837, 270 14.00 15.00 01500 PHARMACY 0 64, 073 659 16, 891, 603 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16,00 0 C 0 16.00 0 17.00 01700 SOCIAL SERVICE 19, 456 14,073 0 Ω 17.00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 0 0 21.00 0 0 22.00 02200 & SERVICES-OTHER PRGM COSTS APPRVD 35, 487 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 1, 299 50 Λ 23.00 23.01 02301 PARAMED ED 0 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 6, 921 30.00 03000 ADULTS & PEDIATRICS 5, 418, 294 3, 044, 960 0 458, 756 30.00 31.00 03100 INTENSIVE CARE UNIT 735,837 76,088 673, 130 0 Λ 31.00 31.01 02060 NEONATAL INTENSIVE CARE UNIT 60, 532 545, 739 0 2, 761 31.01 04000 SUBPROVI DER - I PF 0 40.00 40.00 0 o 41 00 04100 SUBPROVIDER - IRF 18, 368 116, 094 41 00 366 651 0 04300 NURSERY 43.00 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 163, 020 937, 641 0 135 50.00 05200 DELIVERY ROOM & LABOR ROOM 87, 201 0 52.00 48, 425 443.513 531 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 96,050 122, 621 1, 431 54.00 57.00 05700 CT SCAN 0 12, 422 0 57.00 C 0 0 58 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 4 345 7 861 58 00 0 05900 CARDIAC CATHETERIZATION 59.00 13,886 47, 370 1, 571 59.00 06000 LABORATORY 0 0 60.00 46, 081 34 0 60.00 0 60.01 06001 BLOOD LABORATORY 0 0 0 60.01 C 0 06500 RESPIRATORY THERAPY 29, 219 1, 300 65 00 0 65 00 16, 321 0 66.00 06600 PHYSI CAL THERAPY 30, 285 0 66.00 06602 PHYSI CAL THERAPY EAST BANK 0 66.01 11, 624 66.01 66, 10 06601 PHYSICAL THERAPY LIVING CENTER 00000 4, 770 0 0 66, 10 0 06700 OCCUPATIONAL THERAPY 0 67 00 17, 369 0 67.00 67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER 3, 244 67.10 68.00 06800 SPEECH PATHOLOGY 9, 829 0 0 68.00 06801 SPEECH THERAPY LIVING CENTER o 2, 209 0 68. 10 68.10 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 0 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS C 0 9, 660, 735 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 6, 176, 535 72 00 07300 DRUGS CHARGED TO PATIENTS 0 0 16, 864, 105 73.00 0 73.00 C 74.00 07400 RENAL DIALYSIS 0 0 Λ 74.00 03020 CARDI OLOGY 76.00 76.00 16,843 53, 913 577 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 O 0 0 90.00 90.10 09001 FAMILY PRACTICE CLINIC 0 C 0 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 0 66, 875 90.30 90.30 8, 585 0 0 90.50 09004 SLEEP DISORDERS CLINIC 0 6, 486 0 Λ 90.50 09100 EMERGENCY 0 903, 393 91.00 91.00 156, 881 12, 266 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 994, 247 6, 607, 983 1, 497, 008 15, 837, 270 16<u>, 891, 603</u> 118. 00 118.00 NONREIMBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 193. 00 19300 NONPALD WORKERS 3.815 59 0 193.00 193. 10 19301 HEALTH PROPERTIES 0 193, 10 35, 772 3,049 193. 40 19303 LEI GHTON CENTER 0 0 0 0 193. 40 0 193. 50 19305 WELLNESS CENTER 0 0 0 0 193. 50 193. 80 19308 UNUSED SPACE 0 0 193. 80 Ω 0 193. 90 19309 OCCUPATIONAL HEALTH C 0 0 193. 90 193. 91 19310 RESEARCH AND PROTOCOL 0 193. 91 193. 92 19311 CCOP 0 0 193. 92

| Period: | Worksheet B | From 01/01/2022 | Part | | Date/Time | Prepared: | 5/31/2023 | 11: 28 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS MEMORIAL HOSPITAL OF SOUTH BEND, INC Provider CCN: 15-0058

						3/31/2023 11.	20 aiii
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI ON	SERVICES &		
					SUPPLY		
		10.00	11. 00	13. 00	14.00	15. 00	
193. 93 1931:	2 REASEARCH ADMIN	0	2, 056	4, 295	0	0	193. 93
194. 00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
200. 00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	6, 607, 983	1, 538, 651	7, 001, 650	15, 837, 270	16, 891, 603	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

5/31/2023 11:28 am INTERNS & RESIDENTS PARAMED ED MEDI CAL SOCI AL SERVI CE SERVI CES-SALAR SERVI CES-OTHER Cost Center Description RECORDS & Y & FRINGES PRGM COSTS **PRGM** LI BRARY 23.00 16.00 17.00 21.00 22.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 4, 473, 712 17.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21 00 2 716 092 21 00 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 6, 529, 363 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 176, 146 23.00 23.00 02301 PARAMED ED 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 2, 236, 853 1, 728, 331 4, 154, 832 0 30.00 0 03100 INTENSIVE CARE UNIT 497, 079 31.00 7.974 19, 169 31.00 31.01 0 02060 NEONATAL INTENSIVE CARE UNIT 248, 540 0 0 31.01 0 04000 SUBPROVIDER - IPF 0 40.00 40 00 0 0 04100 SUBPROVI DER - I RF 0 41.00 248, 540 0 0 0 41.00 04300 NURSERY 43.00 248, 540 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0 248, 540 99.673 239, 610 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 248, 540 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 248, 540 4, 984 11, 980 54.00 57.00 05700 CT SCAN 000000000 57.00 0 C 0 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58 00 C 0 0 0 58 00 05900 CARDIAC CATHETERIZATION 0 59.00 59.00 o 60.00 06000 LABORATORY O 60.00 06001 BLOOD LABORATORY 60.01 60.01 0 0 0 65.00 06500 RESPIRATORY THERAPY 32, 892 79.071 0 65.00 66,00 06600 PHYSI CAL THERAPY 0 66, 00 06602 PHYSICAL THERAPY EAST BANK 0 66.01 0 66.01 06601 PHYSICAL THERAPY LIVING CENTER 0 0 66.10 Λ 66.10 67.00 06700 OCCUPATIONAL THERAPY 00000000 0 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 67.10 67.10 06800 SPEECH PATHOLOGY 0 68.00 0 0 68.00 68.10 06801 SPEECH THERAPY LIVING CENTER 0 0 68.10 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 C 07200 I MPL. DEV. CHARGED TO PATIENTS 14, 951 72 00 35, 941 0 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 07400 RENAL DIALYSIS 0 74.00 0 0 74.00 03020 CARDI OLOGY 174, 915 76.00 0 72, 761 76.00 0 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 0 09001 FAMILY PRACTICE CLINIC Ω 604, 019 1, 452, 034 90 10 90 10 0 0 90.30 09002 HEMATOLOGY ONCOLOGY CLINIC 0 90.30 09004 SLEEP DISORDERS CLINIC 0 90.50 90.50 0 91.00 09100 EMERGENCY 0 248, 540 142, 533 342, 642 176, 146 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 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) 0 4, 473, 712 2, 708, 118 6, 510, 194 176, 146 118. 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 0 193. 00 19300 NONPALD WORKERS C 7,974 19, 169 0 193, 00 193. 10 19301 HEALTH PROPERTIES 0 193. 10 0 193. 40 19303 LEI GHTON CENTER 0 0 0 0 193. 40 0 193. 50 19305 WELLNESS CENTER 0 0 193.50 0 193. 80 19308 UNUSED SPACE 0 0 0 0 193. 80 193. 90 19309 OCCUPATIONAL HEALTH 0 0 193. 90

MEMORIAL HOSPITAL OF SOUTH BEND, INC

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0058

| Period: | Worksheet B | From 01/01/2022 | Part | | Date/Time Prepared: | 5/31/2023 | 11: 28 am

					3/31/2023 11.	zo alli
			INTERNS &	RESI DENTS		
Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	
	RECORDS &		Y & FRINGES	PRGM COSTS	PRGM	
	LI BRARY					
	16.00	17.00	21.00	22.00	23.00	
193. 91 19310 RESEARCH AND PROTOCOL	0	0	0	0	0	193. 91
193. 92 19311 CCOP	0	0	0	0	0	193. 92
193.93 19312 REASEARCH ADMIN	0	0	0	0	0	193. 93
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
200.00 Cross Foot Adjustments			0	0	0	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00   TOTAL (sum lines 118 through 201)	0	4, 473, 712	2, 716, 092	6, 529, 363	176, 146	202. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0058

			То	12/31/2022	Date/Time Prepared: 5/31/2023 11:28 am
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	07 0 17 2020 11. 20 dill
			Residents Cost		
			& Post Stepdown		
			Adjustments		
CENEDAL CEDIU CE COCT CENTEDO	23. 01	24. 00	25. 00	26. 00	
1.00 OO100 NEW CAP REL COSTS-BLDG & FLXT					1. 00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP					2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00   00500   ADMI NI STRATI VE & GENERAL					5. 00
6.00   00600   MAINTENANCE & REPAIRS 7.00   00700   OPERATION OF PLANT					6. 00
8. 00   00800 LAUNDRY & LINEN SERVICE					8.00
9. 00   00900   HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10.00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON					11. 00
13. 00   01300   NURSI NG   ADMI NI STRATI ON 14. 00   01400   CENTRAL   SERVI CES & SUPPLY					14.00
15. 00   01500   PHARMACY					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00   01700   SOCI AL SERVI CE					17. 00
21.00   02100   L&R SERVICES-SALARY & FRINGES APPRVD 22.00   02200   L&R SERVICES-OTHER PRGM COSTS APPRVD					21. 00 22. 00
23. 00   02300   PARAMED ED   PRGM-(SPECIFY)					23. 00
23. 01   02301   PARAMED ED	o				23. 01
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS	0	134, 173, 616		128, 290, 453	30.00
31. 00   03100   INTENSIVE CARE UNIT 31. 01   02060   NEONATAL   INTENSIVE CARE UNIT	0	21, 968, 993 15, 431, 987		21, 941, 850 15, 431, 987	31. 00 31. 01
40. 00   04000   SUBPROVI DER -   1 PF		13, 431, 707	1	0	40. 00
41. 00   04100   SUBPROVI DER -   I RF	ō	6, 455, 984	i l	6, 455, 984	41. 00
43. 00 04300 NURSERY	0	3, 389, 485	0	3, 389, 485	43. 00
ANCILLARY SERVICE COST CENTERS  50. 00 05000 OPERATING ROOM	l	51, 891, 224	-339, 283	51, 551, 941	50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM		13, 467, 717		13, 467, 717	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	Ö	23, 360, 616		23, 343, 652	54. 00
57. 00   05700   CT   SCAN	0	2, 970, 665		2, 970, 665	57. 00
58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI)	0	2, 082, 419		2, 082, 419	58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON 60. 00   06000   LABORATORY		3, 847, 850 20, 861, 303		3, 847, 850 20, 861, 303	59. 00 60. 00
60. 01   06001   BLOOD LABORATORY	o	0	Ö	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0	8, 857, 519	-111, 963	8, 745, 556	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	5, 743, 481		5, 743, 481	66. 00
66. 01   06602 PHYSI CAL THERAPY EAST BANK 66. 10   06601 PHYSI CAL THERAPY LIVING CENTER	0	1, 571, 536 731, 752		1, 571, 536 731, 752	66. 01 66. 10
67. 00   06700   OCCUPATI ONAL THERAPY		2, 567, 483		2, 567, 483	67. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	o	439, 454		439, 454	67. 10
68.00 06800 SPEECH PATHOLOGY	0	1, 507, 624	1	1, 507, 624	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	0	344, 542 0		344, 542	68. 10
70.00   07000   ELECTROENCEPHALOGRAPHY 71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS		31, 712, 266	1 1	31, 712, 266	70. 00 71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	o	44, 629, 776		44, 578, 884	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	O	56, 006, 776		56, 006, 776	73. 00
74. 00   07400   RENAL DI ALYSI S	0	0	-	0	74.00
76. 00   03020   CARDI OLOGY 77. 00   07700   ALLOGENEI C   STEM   CELL   ACQUI SI TI ON	0	4, 108, 916	-247, 676	3, 861, 240 0	76. 00 77. 00
OUTPATIENT SERVICE COST CENTERS	ı U	0	1 0	U	77.00
90. 00 09000 CLI NI C	0	0	0	0	90.00
90. 10 09001 FAMILY PRACTICE CLINIC	0	2, 056, 053		0	90. 10
90. 30   09002   HEMATOLOGY ONCOLOGY CLINIC	0	2, 372, 674		2, 372, 674	90. 30
90. 50   09004   SLEEP DI SORDERS CLINIC 91. 00   09100   EMERGENCY		1, 165, 846 48, 084, 539	i I	1, 165, 846 47, 599, 364	90. 50 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		.5, 554, 557	0	, 5, 7, 304	92. 00
OTHER REIMBURSABLE COST CENTERS					
102. 00 10200 OPI OI D TREATMENT PROGRAM	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)	О	511, 802, 096	-9, 218, 312	502, 583, 784	118. 00
NONREI MBURSABLE COST CENTERS	-				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	298, 705		298, 705	190. 00
193. 00 19300 NONPALD WORKERS	0	807, 632		780, 489	193. 00
193. 10 19301 HEALTH PROPERTIES 193. 40 19303  LEIGHTON CENTER	0	7, 430, 305 395, 387		7, 430, 305 395, 387	193. 10 193. 40
193. 50 19305 WELLNESS CENTER		135, 459		135, 459	193. 40
193. 80 19308 UNUSED SPACE	0	0		0	193. 80
193. 90 19309 OCCUPATI ONAL HEALTH	0	0	O	o	193. 90

Health Financial Systems ME	MORIAL HOSPITAL O	SOUTH BEND,	INC	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B
				From 01/01/2022 To 12/31/2022	Part I Date/Time Prepared:
					5/31/2023 11: 28 am
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	
			Residents Cos	t	
			& Post		
			Stepdown		
			Adjustments		
	23. 01	24.00	25. 00	26. 00	
193. 91 19310 RESEARCH AND PROTOCOL	0	0	1	0 0	193. 91
193. 92 19311 CCOP	o	0	1	o o	193. 92
193. 93 19312 REASEARCH ADMIN	o	342, 759		0 342, 759	193. 93
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	o	0		o o	194. 00
200.00 Cross Foot Adjustments	o	0	)	o o	200. 00
201.00 Negative Cost Centers	ol	0	)	ol o	201. 00
202.00   TOTAL (sum lines 118 through 201)	O	521, 212, 343	-9, 245, 45	5 511, 966, 888	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | T Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0058

				Io	12/31/2022	Date/lime Pre 5/31/2023 11:	
			CAPI TAL REI	LATED COSTS		0,01,2020 111	20
	Cost Center Description	Directly Assigned New Capital	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs	1.00	2.00	2.4	4.00	
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	2A	4. 00	
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	0	815, 643		1, 450, 228	0	5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	53, 052		94, 327	0	6. 00 7. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE		3, 125, 936 2, 963		5, 557, 973 5, 268	0	8.00
9. 00	00900 HOUSEKEEPI NG		373, 303		663, 740	0	9. 00
10.00	01000 DI ETARY	o	476, 372		846, 999	0	10.00
11. 00	01100 CAFETERI A	o	83, 349	64, 847	148, 196	0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	202, 474		360, 003	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	609, 307		1, 083, 360	0	14.00
15. 00 16. 00	01600 MEDI CAL RECORDS & LI BRARY		297, 515 0	231, 472	528, 987 0	0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE		106, 679		189, 677	0	17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	o	0	0	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	287, 063	223, 340	510, 403	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
23. 01	O2301   PARAMED ED     I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	23. 01
30. 00	03000 ADULTS & PEDIATRICS	l ol	4, 218, 082	3, 281, 747	7, 499, 829	0	30.00
31. 00	03100 I NTENSI VE CARE UNI T		521, 109		926, 542	0	31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	o	504, 030		896, 175	0	31. 01
40.00	04000 SUBPROVI DER - I PF	0	0	١	0	0	40. 00
41.00	04100 SUBPROVI DER - I RF	0	186, 975		332, 445	0	41.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	75, 717	58, 909	134, 626	0	43. 00
50. 00	05000 OPERATING ROOM		1, 885, 788	1, 467, 178	3, 352, 966	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	l o	547, 024		972, 619	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	1, 241, 549	965, 948	2, 207, 497	0	54. 00
57. 00	05700 CT SCAN	0	45, 006		80, 022	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	67, 779		120, 512	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	251, 790 182, 144		447, 688 323, 855	0	59. 00 60. 00
60. 00	06001 BLOOD LABORATORY		102, 144	141, 711	323, 633 0	0	60.00
65. 00	06500 RESPI RATORY THERAPY		116, 520	-	207, 175	0	65. 00
66.00	06600 PHYSI CAL THERAPY	o	208, 706		371, 083	0	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	0	0	0	0	0	66. 01
66. 10	06601 PHYSI CAL THERAPY LIVING CENTER	0	0	0	0	0	66. 10
67. 00 67. 10	06700   OCCUPATIONAL THERAPY   06701   OCCUPATIONAL THERAPY LIVING CENTER	0	29, 489	22, 943	52, 432 0	0	67. 00 67. 10
68. 00	06800 SPEECH PATHOLOGY		6, 286		11, 176	0	68. 00
	06801 SPEECH THERAPY LIVING CENTER		0, 200	1	0	Ö	68. 10
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	0	0	0	73. 00 74. 00
76. 00	03020 CARDI OLOGY		51, 184	39, 822	91, 006	0	76.00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	l o	01, 101	1	71, 000	Ö	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0	0	90. 00
90. 10	09001 FAMILY PRACTICE CLINIC	0	0	0	0	0	90. 10
90. 30 90. 50	09002 HEMATOLOGY ONCOLOGY CLINIC 09004 SLEEP DISORDERS CLINIC	0	286, 649 48, 867		509, 668 86, 887	0	90. 30 90. 50
91.00	09100 EMERGENCY		1, 374, 538		2, 443, 954	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1, 0, 1, 000	1,007,110	2, 110, 701	Ŭ	92. 00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS	1					
	11300   INTEREST EXPENSE		10 202 000	14 224 420	22 507 210	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	0	18, 282, 888	14, 224, 430	32, 507, 318	0	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	85, 505	66, 524	152, 029	0	190. 00
	19300 NONPALD WORKERS	0	65, 731		116, 871		193. 00
	19301 HEALTH PROPERTIES	0	202, 689	157, 696	360, 385		193. 10
	19303 LEI GHTON CENTER	0	113, 180	1	201, 236		193. 40
	19305   WELLNESS CENTER   19308   UNUSED SPACE	0	0		0		193. 50 193. 80
173.00	ALL VOOD ONOTED OF NOT	<u>ı</u>	0	ı U	U	0	1173.00

					5/31/2023 11:	28 am_
		CAPI TAL REI	_ATED COSTS			
Cost Center Description	Di rectly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	Assigned New	FLXT	EQUI P		BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2. 00	2A	4. 00	
193. 90 19309 OCCUPATI ONAL HEALTH	0	0	0	0	0	193. 90
193. 91 19310 RESEARCH AND PROTOCOL	0	0	0	0	0	193. 91
193. 92 19311 CCOP	0	0	0	0	0	193. 92
193. 93 19312 REASEARCH ADMIN	0	6, 555	5, 100	11, 655	0	193. 93
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	18, 756, 548	14, 592, 946	33, 349, 494	0	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0058

Peri od: Worksheet B From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared:

5/31/2023 11:28 am Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 1, 450, 228 5 00 6.00 00600 MAINTENANCE & REPAIRS 94, 951 6.00 624 00700 OPERATION OF PLANT 57, 098 7.00 16, 593 5, 631, 664 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 4, 900 16 1, 130 11, 314 8.00 00900 HOUSEKEEPI NG 1, 982 829, 362 9.00 21, 225 142, 415 9 00 2, 529 10.00 01000 DI ETARY 15, 356 181, 736 42, 612 10.00 11.00 01100 CAFETERI A 3, 955 442 31, 798 0 Ω 11.00 01300 NURSING ADMINISTRATION 826 18.539 1.075 77. 244 0 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 41, 236 3, 234 232, 450 0 12, 489 14.00 15.00 01500 PHARMACY 45, 592 1,579 113, 502 0 2, 123 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16, 00 0 16,00 01700 SOCIAL SERVICE 11, 906 1,074 17.00 566 40, 698 17.00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 7,556 C 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 22.00 16, 944 1,524 109, 514 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 486 23.00 C 0 02301 PARAMED ED 23.01 0 0 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 295, 406 22, 388 1, 609, 194 4, 535 444, 490 30.00 03100 INTENSIVE CARE UNIT 53, 278 31.00 2,766 198, 803 315 2,808 31.00 31.01 02060 NEONATAL INTENSIVE CARE UNIT 36, 762 2,675 192, 287 276 61, 948 31.01 40.00 04000 SUBPROVIDER - IPF 0 0 40.00 04100 SUBPROVI DER - I RF 14, 275 992 71, 331 306 26, 943 41.00 41.00 04300 NURSERY 43.00 8,086 402 28, 886 169 10, 341 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 719, 427 128, 985 10, 010 2, 382 83, 176 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 31, 617 2.904 208.690 883 37, 466 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 57, 577 6, 590 473,650 0 44, 165 54.00 57.00 05700 CT SCAN 7,752 239 17, 170 695 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 5, 494 360 25, 858 0 0 58.00 05900 CARDIAC CATHETERIZATION 8, 590 59 00 9 311 1 337 96 058 0 59 00 06000 LABORATORY 0 60.00 57,023 967 69, 488 6, 377 60.00 06001 BLOOD LABORATORY 0 60.01 0 60.01 0 65.00 06500 RESPIRATORY THERAPY 23.755 619 44, 452 1.305 65.00 14, 905 06600 PHYSI CAL THERAPY 66.00 1, 108 79, 621 4,667 66.00 0 66.01 06602 PHYSICAL THERAPY EAST BANK 4,340 C C 0 66.01 06601 PHYSICAL THERAPY LIVING CENTER 66.10 2,023 C 0 0 66.10 67 00 06700 OCCUPATIONAL THERAPY 6, 953 11, 250 966 157 67 00 06701 OCCUPATIONAL THERAPY LIVING CENTER 67.10 1, 214 C 0 67.10 0 06800 SPEECH PATHOLOGY 2, 398 190 68.00 68.00 4.137 33 06801 SPEECH THERAPY LIVING CENTER 952 0 0 68.10 68.10 0 0 07000 ELECTROENCEPHALOGRAPHY 70 00 0 70 00 Ω Ω 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 61, 349 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 106.838 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 108, 898 0 0 0 73.00 07400 RENAL DIALYSIS 0 74 00 C 0 74 00 76.00 03020 CARDI OLOGY 10, 344 272 19, 527 0 0 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0 0 0 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 0 0 0 0 0 90 00 90.10 09001 FAMILY PRACTICE CLINIC 0 0 90.10 90 30 09002 HEMATOLOGY ONCOLOGY CLINIC 5, 270 1, 522 109, 357 0 O 90.30 09004 SLEEP DISORDERS CLINIC 18, 643 90.50 3,034 259 0 0 90.50 91.00 09100 EMERGENCY 121, 153 7, 296 524, 386 1, 753 35, 492 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 102. 00 0 0 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 828<u>, 048</u> 118. 00 118.00 1, 426, 148 92, 436 5, 450, 963 11, 314 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 497 454 32,620 0 193. 00 19300 NONPALD WORKERS 1,874 349 25, 076 1, 074 193. 00 0 193. 10 19301 HEALTH PROPERTIES 19,771 1,076 77, 326 0 193, 10 193. 40 19303 LEI GHTON CENTER 657 601 43, 178 0 193. 40 193. 50 19305 WELLNESS CENTER 0 193. 50 377 0 0 0 193. 80 19308 UNUSED SPACE 0 0 193. 80 0 C 193. 90 19309 OCCUPATIONAL HEALTH 0 0 0 193, 90 C 193. 91 19310 RESEARCH AND PROTOCOL 0 C 0 0 0 193. 91 193. 92 19311 CCOP o 0 193. 92 193. 93 19312 REASEARCH ADMIN 904 35 240 193. 93 2 501

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0058 | Period: From 01/01/2022 | Part II To 12/31/2022 | Part II To 12/31/2023 | Part II To 12/31/202

						5/31/2023 11:	28 alli
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5.00	6. 00	7. 00	8. 00	9. 00	
194. 00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	1, 450, 228	94, 951	5, 631, 664	11, 314	829, 362	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0058

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | T

			10	12/31/2022	Date/lime Pre 5/31/2023 11:	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI ON	SERVICES &		
	10.00	11. 00	13. 00	SUPPLY 14.00	15. 00	
GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	13.00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
2. 00   00200   NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00   00500   ADMI NI STRATI VE & GENERAL						5. 00
6. 00 00600 MAI NTENANCE & REPAI RS						6.00
7. 00   00700   0PERATION OF PLANT 8. 00   00800   LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	1, 089, 232					10.00
11. 00   01100   CAFETERI A	0	184, 391				11.00
13.00 01300 NURSING ADMINISTRATION	o	5, 416	463, 103			13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	4, 336		1, 377, 105		14. 00
15. 00   01500   PHARMACY	0	7, 678		0	699, 505	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16.00
17. 00   01700   SOCIAL SERVICE 21. 00   02100   &R SERVICES-SALARY & FRINGES APPRVD	0	2, 332	931	0	0	17. 00 21. 00
21.00   02100   1&R SERVI CES-SALARY & FRINGES APPRVD 22.00   02200   1&R SERVI CES-OTHER PRGM COSTS APPRVD	0	4, 253	0	0	0	22.00
23. 00   02300   PARAMED ED   PRGM-(SPECIFY)	0	156		0	0	23. 00
23. 01   02301   PARAMED   ED   TROMIT (SI EST TY)	o	0		ő	0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS	· · ·			-,		
30. 00 03000 ADULTS & PEDIATRICS	893, 129	54, 977	201, 399	0	287	30. 00
31.00 03100 INTENSIVE CARE UNIT	121, 292	9, 118		0	0	31.00
31. 01   02060   NEONATAL   INTENSIVE CARE UNIT	0	7, 254	36, 096	0	114	31. 01
40. 00   04000   SUBPROVI DER -   1 PF	0	0	0	0	0	40.00
41. 00   04100   SUBPROVI DER -   1 RF 43. 00   04300   NURSERY	60, 437	2, 201	7, 679	0	0	41.00
43. 00   04300  NURSERY   ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	43. 00
50. 00 05000 OPERATING ROOM	O	19, 536	62, 018	ol	6	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	14, 374	5, 803		o	22	52.00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	0	11, 511	8, 110	0	59	54.00
57. 00   05700   CT   SCAN	0	1, 489	0	o	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	521	520	0	0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	1, 664	3, 133	0	65	59. 00
60. 00   06000   LABORATORY	0	5, 522	2	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	2 502	0	0	0	60. 01
65. 00   06500   RESPI RATORY THERAPY 66. 00   06600   PHYSI CAL THERAPY	0	3, 502 3, 629		0	54 0	65. 00 66. 00
66. 01   06602 PHYSI CAL THERAPY EAST BANK	0	1, 393		0	0	66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	o	572	1	ol Ol	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	o	2, 082		ō	0	67. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	О	389		o	0	67. 10
68. 00 06800 SPEECH PATHOLOGY	0	1, 178	0	0	0	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	0	265	0	0	0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	840, 034	0	71.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS 73.00   07300   DRUGS CHARGED TO PATIENTS	0	0	0	537, 071 0	-	72.00
74. 00   07400   RENAL DI ALYSI S	0	0	0	0	698, 366 0	73. 00 74. 00
76. 00 03020 CARDI OLOGY	Ö	2, 018	3, 566	Ö	24	76. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	o	0	0	Ö	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0	0	0	90. 00
90. 10 09001 FAMILY PRACTICE CLINIC	0	0	0	0	0	90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	1, 029		0	0	90. 30
90. 50 09004 SLEEP DI SORDERS CLINIC	0	777		0	0	90. 50
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	0	18, 800	59, 752	O	508	91.00
OTHER REIMBURSABLE COST CENTERS						92. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	o	0	102. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		102.00
113. 00 11300   NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 089, 232	179, 401	462, 613	1, 377, 105	699, 505	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
193. 00 19300 NONPALD WORKERS	0	457		0		193. 00
193. 10 19301 HEALTH PROPERTIES	0	4, 287	202	O		193. 10
193. 40 19303  LEI GHTON CENTER 193. 50 19305  WELLNESS CENTER		0		0		193. 40 193. 50
193. 50 19305 WELLNESS CENTER 193. 80 19308 UNUSED SPACE		0		O A		193. 50
193. 80 19308 UNUSED SPACE 193. 90 19309 OCCUPATI ONAL HEALTH	0	0		0		193. 60
193. 91 19310 RESEARCH AND PROTOCOL	o	0	l o	ő		193. 91
193. 92 19311 CCOP	Ö	0	Ö	o		193. 92
	''			'		*

| Peri od: | Worksheet B | From 01/01/2022 | Part II | Date/Time Prepared: | 5/31/2023 | 11:28 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MEMORIAL HOSPITAL OF SOUTH BEND, INC Provider CCN: 15-0058

						5/31/2023 11:	28 am_
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI ON	SERVICES &		
					SUPPLY		
		10.00	11. 00	13. 00	14.00	15. 00	
193. 93 19312	REASEARCH ADMIN	0	246	284	0	0	193. 93
194. 00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	1, 089, 232	184, 391	463, 103	1, 377, 105	699, 505	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0058

Peri od: Worksheet B From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared:

193. 90

5/31/2023 11:28 am INTERNS & RESIDENTS SOCI AL SERVI CE SERVI CES-SALAR SERVI CES-OTHER PARAMED ED MEDI CAL Cost Center Description RECORDS & Y & FRINGES PRGM COSTS PRGM LI BRARY 22.00 23.00 16.00 17.00 21.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 0 0 247, 184 17.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21 00 7 556 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 C 642, 638 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 645 23.00 23.00 C 02301 PARAMED ED 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 123, 595 30.00 0 03100 INTENSIVE CARE UNIT 31.00 27, 465 31.00 0 13, 732 31.01 02060 NEONATAL INTENSIVE CARE UNIT 31.01 04000 SUBPROVI DER - I PF 40.00 40.00 04100 SUBPROVI DER - I RF 0 41.00 13, 732 41.00 04300 NURSERY 43.00 13, 732 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0 13, 732 52.00 05200 DELIVERY ROOM & LABOR ROOM 00000000000000000000000 13, 732 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 13, 732 54.00 57.00 05700 CT SCAN 57.00 C 05800 MAGNETIC RESONANCE I MAGING (MRI) 58 00 C 58 00 05900 CARDIAC CATHETERIZATION 59.00 59.00 06000 LABORATORY 60.00 0 60.00 06001 BLOOD LABORATORY 60.01 60.01 0 06500 RESPIRATORY THERAPY 65.00 0 65.00 66,00 06600 PHYSI CAL THERAPY 66, 00 06602 PHYSI CAL THERAPY EAST BANK 66.01 66.01 06601 PHYSICAL THERAPY LIVING CENTER 0 66.10 66.10 67.00 06700 OCCUPATIONAL THERAPY 67.00 67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER 67.10 06800 SPEECH PATHOLOGY 68.00 68.00 68.10 06801 SPEECH THERAPY LIVING CENTER 68.10 07000 ELECTROENCEPHALOGRAPHY 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 C 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 07400 RENAL DIALYSIS 74.00 0 74.00 03020 CARDI OLOGY 76.00 0 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 0 90.00 0 90 10 09001 FAMILY PRACTICE CLINIC C 90 10 |09002|HEMATOLOGY ONCOLOGY CLINIC 90.30 C 90.30 09004 SLEEP DISORDERS CLINIC 0 90.50 90.50 0 91.00 09100 EMERGENCY 13, 732 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 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 247, 184 0 0 0 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 193. 00 19300 NONPALD WORKERS C 193.00 0 0 0 193. 10 19301 HEALTH PROPERTIES 193. 10 193. 40 19303 LEI GHTON CENTER 0 193. 40 193. 50 19305 WELLNESS CENTER 193 50 0 0 193.80 19308 UNUSED SPACE 0 193.80

193. 90 19309 OCCUPATIONAL HEALTH

MEMORIAL HOSPITAL OF SOUTH BEND, INC

| Peri od: | Worksheet B | From 01/01/2022 | Part II | Date/Time Prepared: | 5/31/2023 | 11:28 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0058

					5/31/2023 11:	28 am_
			INTERNS &	RESI DENTS		
Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	
	RECORDS &		Y & FRINGES	PRGM COSTS	PRGM	
	LI BRARY					
	16. 00	17. 00	21.00	22. 00	23. 00	
193. 91 19310 RESEARCH AND PROTOCOL	0	0				193. 91
193. 92 19311 CCOP	0	0				193. 92
193.93 19312 REASEARCH ADMIN	0	0				193. 93
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0				194. 00
200.00 Cross Foot Adjustments			7, 556	642, 638	645	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00   TOTAL (sum lines 118 through 201)	0	247, 184	7, 556	642, 638	645	202. 00

Health Financial Systems In Lieu of Form CMS-2552-10 MEMORIAL HOSPITAL OF SOUTH BEND, INC ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0058 Peri od: Worksheet B From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/31/2023 11:28 am Cost Center Description PARAMED ED Total Subtotal Intern & Residents Cost & Post Stepdown Adjustments 23.01 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21 00 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 02301 PARAMED ED 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 11, 149, 229 0 11, 149, 229 30.00 03100 INTENSIVE CARE UNIT 1, 386, 909 0 1, 386, 909 31.00 31.00 31.01 02060 NEONATAL INTENSIVE CARE UNIT 1, 247, 319 0 1, 247, 319 31.01 04000 SUBPROVI DER - I PF 0 40 00 40.00 04100 SUBPROVI DER - I RF 0 41.00 530, 341 530, 341 41.00 04300 NURSERY 43.00 196, 242 196, 242 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 4, 392, 238 0 4, 392, 238 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 317, 445 0 1, 317, 445 52.00 05400 RADI OLOGY-DI AGNOSTI C 2, 822, 891 0 54.00 2, 822, 891 54.00 107, 367 57.00 05700 CT SCAN 0 107, 367 57.00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58 00 153, 265 153, 265 58 00 59.00 05900 CARDIAC CATHETERIZATION 567, 846 567, 846 59.00 06000 LABORATORY 0 60.00 463, 234 463, 234 60.00 06001 BLOOD LABORATORY 0 60.01 60.01 280, 862 06500 RESPIRATORY THERAPY 280, 862 65.00 65.00 66,00 06600 PHYSI CAL THERAPY 476, 093 0 476, 093 66, 00 06602 PHYSI CAL THERAPY EAST BANK 5, 733 0 5, 733 66.01 66.01 06601 PHYSICAL THERAPY LIVING CENTER 0 2, 595 2, 595 66.10 66.10 67.00 06700 OCCUPATIONAL THERAPY 73, 840 0 73,840 67.00 67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER 1, 603 0 1, 603 67.10 06800 SPEECH PATHOLOGY 0 68.00 19, 112 19, 112 68.00 68.10 06801 SPEECH THERAPY LIVING CENTER 1, 217 1, 217 68.10 07000 ELECTROENCEPHALOGRAPHY 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 901, 383 0 901, 383 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 643.909 643.909 72 00 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 807, 264 807, 264 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 0 03020 CARDI OLOGY 76.00 126, 757 126, 757 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 0 0 90.00 90 10 09001 FAMILY PRACTICE CLINIC 0 90 10 0 09002 HEMATOLOGY ONCOLOGY CLINIC 0 90.30 631, 269 631, 269 90.30 90. 50 09004 SLEEP DISORDERS CLINIC 109, 600 109, 600 90.50 91.00 09100 EMERGENCY 3, 226, 826 0 3, 226, 826 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 O 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 118.00 31, 642, 389 31, 642, 389 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 185, 600 185, 600 190. 00 193. 00 19300 NONPALD WORKERS 145, 705 0 145, 705 193.00 193. 10 19301 HEALTH PROPERTIES 0 463, 047 193. 10 463, 047

245, 672

377

0

0

0

245, 672

377

0

0

193. 40

193 50

193.80

193. 90

193. 40 19303 LEI GHTON CENTER

193. 50 19305 WELLNESS CENTER

193. 90 19309 OCCUPATIONAL HEALTH

193.80 19308 UNUSED SPACE

Health Financial Systems MEMO	ORIAL HOSPITAL OF	SOUTH BEND,	INC	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Peri od:	Worksheet B
				From 01/01/2022	Part II
				To 12/31/2022	Date/Time Prepared: 5/31/2023 11:28 am
0 1 0 1 5 11	DADAMED ED	6 1 1 1 1		T 1 1	5/31/2023 11: 28 alli
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	
			Residents Cos	st	
			& Post		
			Stepdown		
			Adjustments		
	23. 01	24. 00	25. 00	26.00	
193. 91 19310 RESEARCH AND PROTOCOL		0		0 0	193. 91
193. 92 19311 CCOP		0		0	193. 92
193. 93 19312 REASEARCH ADMIN		15, 865		0 15, 865	193. 93
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS		0		0 0	194. 00
200.00 Cross Foot Adjustments	0	650, 839		0 650, 839	200. 00
201.00 Negative Cost Centers	0	0		0 0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	33, 349, 494		0 33, 349, 494	202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 MEMORIAL HOSPITAL OF SOUTH BEND, INC Provider CCN: 15-0058 

				T	o 12/31/2022	Date/Time Pre 5/31/2023 11:	
		CAPITAL REL	ATED COSTS			3/31/2023 11.	20 aiii
		NEW DLDO A	NEW MADE	ENDLOVEE		ADMINI CEDATINE	
	Cost Center Description	NEW BLDG & FLXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Reconciliation.	ADMINISTRATIVE & GENERAL	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FEET)	FEET)	(GROSS		COST)	
		1 00	2.00	SALARI ES)	ΕΛ	F 00	
	GENERAL SERVICE COST CENTERS	1. 00	2. 00	4.00	5A	5. 00	
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	1, 044, 388					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		1, 044, 388				2. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0 45, 416	0 4E 414			442 047 240	4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS	2, 954	45, 416 2, 954			443, 847, 249 190, 856	1
7. 00	00700 OPERATION OF PLANT	174, 056	174, 056			17, 477, 312	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	165	165			1, 499, 731	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	20, 786 26, 525	20, 786 26, 525		l .	6, 496, 683 4, 700, 230	
11. 00	01100 CAFETERI A	4, 641	4, 641		l .	1, 210, 506	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	11, 274	11, 274		l	5, 674, 634	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	33, 927	33, 927			12, 621, 862	1
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	16, 566	16, 566	1, 231, 769	l l	13, 955, 344 0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	5, 940	5, 940		-	3, 644, 441	17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	2, 280, 624	l .	2, 312, 934	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	15, 984	15, 984			5, 186, 391	1
23. 00 23. 01	02300 PARAMED ED PRGM-(SPECIFY) 02301 PARAMED ED	0	0			148, 851 0	1
23.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	0		ı o	0	23.01
30.00	03000 ADULTS & PEDI ATRI CS	234, 868	234, 868	55, 265, 470	0	90, 367, 113	30.00
31.00	03100 I NTENSI VE CARE UNI T	29, 016	29, 016			16, 307, 961	
31. 01 40. 00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	28, 065	28, 065 0		l .	11, 252, 559 0	31. 01 40. 00
41. 00	04100 SUBPROVI DER - I RF	10, 411	10, 411		-	4, 369, 342	1
43.00	04300 NURSERY	4, 216	4, 216		I	2, 475, 014	
	ANCILLARY SERVICE COST CENTERS	405 000	105 000		1	20 101 010	
50. 00 52. 00	O5000   OPERATING ROOM   O5200   DELIVERY ROOM & LABOR ROOM	105, 003 30, 459	105, 003 30, 459		l .	39, 481, 043 9, 677, 692	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	69, 131	69, 131		l .	17, 623, 868	1
57. 00	05700 CT SCAN	2, 506	2, 506		l .	2, 372, 965	1
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	3, 774	3, 774		l	1, 681, 803	1
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	14, 020 10, 142	14, 020 10, 142		l .	2, 849, 921 17, 454, 135	1
60. 01	06001 BLOOD LABORATORY	0	0			0	60. 01
65. 00	06500 RESPI RATORY THERAPY	6, 488	6, 488		l .	7, 271, 050	1
66. 00 66. 01	06600 PHYSI CAL THERAPY 06602 PHYSI CAL THERAPY EAST BANK	11, 621	11, 621 0			4, 562, 404 1, 328, 369	1
66. 10	06601 PHYSI CAL THERAPY LIVING CENTER	0	0	494, 112		619, 074	1
67. 00	06700 OCCUPATI ONAL THERAPY	1, 642	1, 642		l .	2, 128, 207	1
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0			371, 462	
	O6800   SPEECH PATHOLOGY   O6801   SPEECH THERAPY LIVING CENTER	350 0	350 0			1, 266, 354 291, 519	
70. 00	07000 ELECTROENCEPHALOGRAPHY	o	0	237,002	l	291, 319	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	C		18, 778, 352	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	-	32, 702, 165	
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	6, 500, 692	0	33, 332, 599 0	73. 00 74. 00
76. 00	03020 CARDI OLOGY	2, 850	2, 850	1, 946, 771		3, 166, 098	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	C	l .	0	77. 00
00.00	OUTPATIENT SERVICE COST CENTERS				1 0		00.00
90. 00 90. 10	09000 CLINIC 09001 FAMILY PRACTICE CLINIC		0			0	90. 00 90. 10
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	15, 961	15, 961		-	1, 613, 147	90. 30
90. 50	09004 SLEEP DI SORDERS CLINIC	2, 721	2, 721	557, 072	0	928, 784	90. 50
91.00	09100 EMERGENCY	76, 536	76, 536	21, 330, 039	0	37, 083, 809	1
92. 00	O9200   OBSERVATI ON BEDS (NON-DI STINCT PART)   OTHER REIMBURSABLE COST CENTERS						92.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	С	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
113. 00 118. 00	11300 INTEREST EXPENSE	1 010 014	1 010 014	106 100 000	77 245 004	126 174 504	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	1, 018, 014	1, 018, 014	196, 100, 908	-77, 365, 094	436, 476, 584	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 761	4, 761		0	152, 029	
	19300 NONPAI D WORKERS	3, 660	3, 660			573, 677	
	19301   HEALTH PROPERTI ES   19303   LEI GHTON CENTER	11, 286 6, 302	11, 286 6, 302			6, 051, 748 201, 236	
	19303   LEIGHTON CENTER   19305   WELLNESS CENTER	0, 302	0, 302	1		201, 236 115, 352	
	• •	1					·

Provider CCN: 15-0058 

			'	0 12/01/2022	5/31/2023 11:	
	CAPITAL RELA	ATED COSTS				
Cost Center Description	NEW BLDG &	NEW MVBLE		Reconciliation	ADMI NI STRATI VE	
	FIXT	EQUI P	BENEFITS		& GENERAL	
	(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
	FEET)	FEET)	(GROSS		COST)	
	1.00	2.00	SALARI ES) 4. 00	5A	5. 00	
193. 80 19308 UNUSED SPACE	1.00	2.00	4.00	0		193. 80
193. 90 19309 OCCUPATI ONAL HEALTH		0	0	0		193. 90
193. 91 19310 RESEARCH AND PROTOCOL	0	0	0	0		193. 91
193. 92 19311 CCOP	o	0	0	0		193. 92
193. 93 19312 REASEARCH ADMIN	365	365	213, 926	0	276, 623	1
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	O	0	0	0		194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	18, 756, 548	14, 592, 946	2, 819, 308		77, 365, 094	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	17. 959368	13. 972725	0. 014167		0. 174306	1
204.00 Cost to be allocated (per Wkst. B,			0		1, 450, 228	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part			0. 000000		0. 003267	205. 00
206.00 NAHE adjustment amount to be allocated						204 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						207.00
1 1. 4. 45 1.1. 4.14 1 1)	1				ı	ı

Provider CCN: 15-0058

				1	0 12/31/2022	Date/lime Pre   5/31/2023 11:	
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DIETARY (MEALS SERVED)	
		6.00	7. 00	8. 00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 14.00 15.00 16.00 17.00 21.00 22.00 23.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02100 I & SERVICES-SALARY & FRINGES APPRVD 02200 I & SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)	996, 018 174, 056 165 20, 786 26, 525 4, 641 11, 274 33, 927 16, 566 0 5, 940 0 15, 984	821, 962 165 20, 786 26, 525 4, 641 11, 274 33, 927 16, 566 0 5, 940 0 15, 984 0	3, 520, 410 0 0 0 0 0 0 0 0 0	100, 410 5, 159 0 100 1, 512 257 0 130 0	469, 145 0 0 0 0 0 0 0 0	11. 00 13. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00 31. 01 40. 00 41. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	234, 868 29, 016 28, 065 0 10, 411	234, 868 29, 016 28, 065 0 10, 411	1, 411, 349 98, 022 85, 790 0 95, 130	340 7, 500 0	384, 681 52, 242 0 0 26, 031	30. 00 31. 00 31. 01 40. 00 41. 00
43.00	04300 NURSERY	4, 216	4, 216	52, 714	1, 252	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
72. 00 73. 00 74. 00 76. 00 77. 00 90. 00 90. 10 90. 30 90. 50 91. 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06602 PHYSICAL THERAPY EAST BANK 06601 PHYSICAL THERAPY LIVING CENTER 06700 OCCUPATIONAL THERAPY 06701 OCCUPATIONAL THERAPY 06701 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06801 SPEECH THERAPY LIVING CENTER 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 03020 CARDIOLOGY 07700 ALLOGENEIC STEM CELL ACQUISITION 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 FAMILY PRACTICE CLINIC 09001 FAMILY PRACTICE CLINIC 09000 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	105, 003 30, 459 69, 131 2, 506 3, 774 14, 020 10, 142 0 6, 488 11, 621 0 0 1, 642 0 350 0 0 0 2, 850 0 0 15, 961 2, 721 76, 536	105, 003 30, 459 69, 131 2, 506 3, 774 14, 020 10, 142 0 6, 488 11, 621 0 0 1, 642 0 350 0 0 2, 850 0 0 15, 961 2, 721 76, 536	741, 008 274, 701 0 216, 174 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4, 536 5, 347 0 0 1, 040 772 0 158 565 0 0 117 0 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 6, 191 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	71. 00 72. 00 73. 00 74. 00 76. 00 77. 00 90. 00 90. 10 90. 30
102.00	OTHER REIMBURSABLE COST CENTERS  10200 OPI OI D TREATMENT PROGRAM	O	O	0	ol	0	102. 00
	SPECIAL PURPOSE COST CENTERS	. 91					
113. 00 118. 00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	969, 644	795, 588	3, 520, 410	100, 251	469, 145	113. 00 118. 00
193. 00 193. 10 193. 40 193. 50 193. 80 193. 90	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19300 NONPAID WORKERS 19301 HEALTH PROPERTIES 19303 LEIGHTON CENTER 19305 WELLNESS CENTER 19308 UNUSED SPACE 19309 OCCUPATIONAL HEALTH 19310 RESEARCH AND PROTOCOL	4, 761 3, 660 11, 286 6, 302 0 0 0	4, 761 3, 660 11, 286 6, 302 0 0 0	0 0 0 0 0 0 0	0 130 0 0 0 0 0	0 0 0 0 0	190. 00 193. 00 193. 10 193. 40 193. 50 193. 80 193. 90 193. 91

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10

Provider CCN: 15-0058 Peri od: Worksheet B-1 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

						5/31/2023 11:	<u>28 am</u>
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(HOURS OF	(MEALS	
		(SQUARE	(SQUARE	(POUNDS OF	SERVICE)	SERVED)	
		FEET)	FEET)	LAUNDRY)			
		6. 00	7. 00	8. 00	9. 00	10.00	
193. 92 19311	CCOP	0	0	0	0	0	193. 92
193. 93 19312	REASEARCH ADMIN	365	365	0	29	0	193. 93
194. 00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	224, 123	20, 562, 878	1, 765, 308	8, 153, 771	6, 607, 983	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 225019	25. 016823	0. 501450	81. 204770	14. 085161	203. 00
204. 00	Cost to be allocated (per Wkst. B,	94, 951	5, 631, 664	11, 314	829, 362	1, 089, 232	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 095331	6. 851489	0. 003214	8. 259755	2. 321738	205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

| Peri od: | Worksheet B-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0058

					T	o 12/31/2022	Date/Time Pre	
		Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	5/31/2023 11: MEDI CAL	28 am
			(HOURS OF	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
			SERVI CE)	(DI RECT	SUPPLY (COSTED	REQUIS.)	LIBRARY (TIME	
				NRSING HRS)	REQUIS.)		SPENT)	
	CENED	AL CEDIUSE COST CENTEDS	11. 00	13.00	14.00	15. 00	16. 00	
1. 00	-	AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 6. 00		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS						5. 00 6. 00
7.00	00700	OPERATION OF PLANT						7. 00
8.00	1	LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY						9. 00 10. 00
11. 00	1	CAFETERI A	4, 110, 160					11. 00
13. 00	1	NURSING ADMINISTRATION	120, 730					13. 00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	96, 646 171, 157		100			14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	171, 137	0		27, 119, 137	0	1
17. 00		SOCIAL SERVICE	51, 972	3, 355	C	0	0	17. 00
21. 00		I &R SERVICES-SALARY & FRINGES APPRVD	04.705	0	O	0	0	
22. 00 23. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRVD   PARAMED ED PRGM-(SPECIFY)	94, 795 3, 471		_	0	0	
23. 01		PARAMED ED	0	1			0	1
		TENT ROUTINE SERVICE COST CENTERS		705 000				
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	1, 225, 471 203, 251		[		0	1
31. 01	1	NEONATAL INTENSIVE CARE UNIT	161, 697		Č	4, 432	0	1
40.00	1	SUBPROVI DER - I PF	0	0	C	0	0	
41. 00 43. 00	1	SUBPROVIDER - IRF	49, 066	27, 677	[		0	1
43.00		NURSERY LARY SERVICE COST CENTERS	0	,j		ı o	0	43.00
50.00	05000	OPERATING ROOM	435, 471		C		0	
52.00	1	DELIVERY ROOM & LABOR ROOM	129, 356				0	1
54. 00 57. 00		RADI OLOGY-DI AGNOSTI C CT SCAN	256, 576 33, 183			2, 298 0	0	
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	11, 606	1	d	O	0	
59.00	1	CARDI AC CATHETERI ZATI ON	37, 092			2, 522	0	
60. 00 60. 01	1	LABORATORY BLOOD LABORATORY	123, 096	8		0	0	
65. 00	1	RESPI RATORY THERAPY	78, 052		d	ı	0	
66. 00	1	PHYSI CAL THERAPY	80, 899		O	0	0	
66. 01 66. 10	1	PHYSICAL THERAPY EAST BANK PHYSICAL THERAPY LIVING CENTER	31, 050 12, 743		0	0	0	66. 01 66. 10
67. 00	1	OCCUPATIONAL THERAPY	46, 398	1		0	0	67. 00
67. 10	1	OCCUPATIONAL THERAPY LIVING CENTER	8, 665		C	0	0	67. 10
68.00	1	SPEECH PATHOLOGY	26, 255		O	8	0	
68. 10 70. 00		SPEECH THERAPY LIVING CENTER ELECTROENCEPHALOGRAPHY	5, 900 0	0	C   C	_	0	
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö	61	o	0	
72.00		I MPL. DEV. CHARGED TO PATIENTS	0	0	39		0	
73. 00 74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0			27, 075, 010 0	0	1
76. 00	03020	CARDI OLOGY	44, 991	_	ď	926	0	1
77. 00		ALLOGENEIC STEM CELL ACQUISITION	0	0	C	0	0	77. 00
90. 00		TIENT SERVICE COST CENTERS	0	0		O	0	90.00
90. 10	09001	FAMILY PRACTICE CLINIC	0	o	d	O	0	1
90. 30		HEMATOLOGY ONCOLOGY CLINIC	22, 933	1	C	0	0	1
90. 50 91. 00		SLEEP DISORDERS CLINIC EMERGENCY	17, 327 419, 072			19, 693	0	
		OBSERVATION BEDS (NON-DISTINCT PART)	417,072	213,370	Ĭ	17,075	0	92. 00
	OTHER	REIMBURSABLE COST CENTERS						
102.00		OPIOID TREATMENT PROGRAM  AL PURPOSE COST CENTERS	0	0	C	0	0	102. 00
113.00		INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3, 998, 921	1, 667, 438	100	27, 119, 157	0	118. 00
190 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		O	Λ	190. 00
	1	NONPAID WORKERS	10, 191			o		193. 00
		HEALTH PROPERTIES	95, 556	1	C	O		193. 10
		LEIGHTON CENTER WELLNESS CENTER	0	0		0		193. 40 193. 50
		UNUSED SPACE	0	0		o		193. 80
	1	OCCUPATI ONAL HEALTH	0	0	C	0		193. 90

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10 MEMORIAL HOSPITAL OF SOUTH BEND, INC

Provi der CCN: 15-0058 

					12/31/2022	5/31/2023 11:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(HOURS OF	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
		SERVI CE)		SUPPLY	REQUIS.)	LI BRARY	
			(DI RECT	(COSTED		(TIME	
			NRSING HRS)	REQUIS.)		SPENT)	
		11. 00	13.00	14. 00	15. 00	16. 00	
193. 91 19310	RESEARCH AND PROTOCOL	0	0	0	0		193. 91
193. 92 1931	1 CCOP	0	0	0	0		193. 92
193. 93 19312	2 REASEARCH ADMIN	5, 492	1, 024	0	0	0	193. 93
194. 00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 538, 651	7, 001, 650	15, 837, 270	16, 891, 603	0	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 374353	4. 194607	158, 372. 700000	0. 622866	0.000000	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	184, 391	463, 103	1, 377, 105	699, 505	0	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 044862	0. 277440	13, 771. 050000	0. 025794	0. 000000	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
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0058 

				To	12/31/2022	Date/Time Pre 5/31/2023 11:	
			INTERNS &	RESI DENTS		3/31/2023 11.	20 aiii
	Cost Center Description	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	PARAMED ED	
	oost content beschiptron		Y & FRINGES	PRGM COSTS	PRGM	(ASSI GNED	
		(TIME SPENT)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSI GNED TI ME)	TIME)	
		17. 00	21. 00	22.00	23. 00	23. 01	
1. 00	GENERAL SERVICE COST CENTERS O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-BEDG & TTAT						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 6. 00	OO5OO  ADMINISTRATIVE & GENERAL   OO6OO  MAINTENANCE & REPAIRS						5. 00 6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900  HOUSEKEEPI NG  01000  DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11.00
13.00	01300 NURSING ADMINISTRATION						13. 00
14. 00 15. 00	01400   CENTRAL SERVI CES & SUPPLY   01500   PHARMACY						14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCIAL SERVICE	37, 440					17. 00
21. 00 22. 00	02100   1 & R SERVI CES-SALARY & FRINGES APPRVD   02200   1 & R SERVI CES-OTHER PRGM COSTS APPRVD	0	2, 725	2, 725			21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0		2, 723	100		23. 00
23. 01	02301 PARAMED ED	0				100	23. 01
30. 00	INPATI ENT ROUTI NE SERVI CE COST CENTERS   03000   ADULTS & PEDI ATRI CS	18, 720	1, 734	1, 734	0	0	30. 00
31. 00	03100 INTENSIVE CARE UNIT	4, 160			0	-	
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	2, 080	0	0	0	0	
40. 00 41. 00	04000  SUBPROVI DER -   PF   04100  SUBPROVI DER -   RF	2, 080	0   0		0	0	
43. 00	04300 NURSERY	2, 080	0		0	-	1
FO 00	ANCILLARY SERVICE COST CENTERS	0.000	400	100			F0 00
50. 00 52. 00	05000   OPERATING ROOM   05200   DELIVERY ROOM & LABOR ROOM	2, 080 2, 080			0		1
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 080	5	5	0	0	
57.00	05700 CT SCAN	0	0	0	0	0	
58. 00 59. 00	05800   MAGNETI C RESONANCE I MAGING (MRI)   05900   CARDIAC CATHETERIZATION	0	0	0	0	0	1
60.00	06000 LABORATORY	0	0		0		1
60. 01	06001 BLOOD LABORATORY	0	0		0	0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	33 0		0	0	65. 00 66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	0	0	0	0	0	66. 01
66. 10	06601 PHYSI CAL THERAPY LIVING CENTER	0	0	0	0	0	
67. 00 67. 10	O6700   OCCUPATIONAL THERAPY   O6701   OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0	
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	-	
	06801   SPEECH THERAPY LIVING CENTER   07000   ELECTROENCEPHALOGRAPHY	0	0   0	0	0	0 0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	15		0	0	
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0 0	-	0	0	
76. 00	03020 CARDI OLOGY	0	73		0	0	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
90. 00	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC	0	0	0	0	0	90. 00
90. 10	09001 FAMILY PRACTICE CLINIC	0	606		0	0	1
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0	0	0	
90. 50 91. 00	09004 SLEEP DI SORDERS CLINIC 09100 EMERGENCY	2, 080	143	0 143	100	0 100	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,000		110	100	100	92. 00
400.00	OTHER REIMBURSABLE COST CENTERS					0	100 00
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
113.00	11300   NTEREST EXPENSE						113. 00
118. 00		37, 440	2, 717	2, 717	100	100	118. 00
190. 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	O	0	0	190. 00
193.00	19300 NONPALD WORKERS	0	8	8	0	0	193. 00
	19301 HEALTH PROPERTIES	0	0	0	0		193. 10
	19303 LEIGHTON CENTER  19305 WELLNESS CENTER	0	0   0	0	0		193. 40 193. 50
	19308 UNUSED SPACE	0	0	ő	Ö		193. 80

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0058 

						5/31/2023 11:	28 am
			INTERNS &	RESI DENTS			
	Cost Center Description	SOCIAL SERVICE			PARAMED ED	PARAMED ED	
		(7.115	Y & FRINGES	PRGM COSTS	PRGM	(ASSI GNED	
		(TIME	(ASSI GNED	(ASSI GNED	(ASSI GNED	TIME)	
		SPENT) 17.00	TI ME) 21. 00	TI ME) 22. 00	TI ME) 23. 00	23. 01	
193 90 10	2309 OCCUPATIONAL HEALTH	17.00	21.00	22.00	23.00		193. 90
	9310 RESEARCH AND PROTOCOL		0	0	o O		193. 91
	9311 CCOP		0	0	ol		193. 92
	9312 REASEARCH ADMIN		0	0	ol		193. 93
	7950 OTHER NONREIMBURSABLE COST CENTERS	o	0	0	o		194. 00
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	4, 473, 712	2, 716, 092	6, 529, 363	176, 146	0	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	119. 490171	996. 731009	2, 396. 096514	1, 761. 460000		1
204.00	Cost to be allocated (per Wkst. B,	247, 184	7, 556	642, 638	645	0	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	6. 602137	2. 772844	235. 830459	6. 450000	0. 000000	205. 00
00/ 00							
206. 00	NAHE adjustment amount to be allocated				O	0	206. 00
207.00	(per Wkst. B-2)				0.000000	0.000000	207 00
207. 00	NAHE unit cost multiplier (Wkst. D,				0. 000000	0. 000000	207.00
	Parts III and IV)	( J			J		l

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0058 Peri od: Worksheet C From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/31/2023 11:28 am Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 1.00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 128, 290, 453 128, 290, 453 128, 290, 453 30.00 03100 INTENSIVE CARE UNIT 21, 941, 850 21, 941, 850 0 21, 941, 850 31.00 31.00 02060 NEONATAL INTENSIVE CARE UNIT 0 31.01 15, 431, 987 15, 431, 987 15, 431, 987 31.01 04000 SUBPROVI DER - I PF 0 40.00 40.00 0 04100 SUBPROVI DER - I RF 6, 455, 984 6, 455, 984 41.00 6, 455, 984 0 41.00 43.00 04300 NURSERY 3, 389, 485 3, 389, 485 3, 389, 485 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 51, 551, 941 50.00 51, 551, 941 0 51, 551, 941 52.00 05200 DELIVERY ROOM & LABOR ROOM 13, 467, 717 13, 467, 717 0 13, 467, 717 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 23, 343, 652 23, 343, 652 0 0 0 23, 343, 652 54.00 05700 CT SCAN 2, 970, 665 2, 970, 665 2, 970, 665 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 2,082,419 2, 082, 419 2, 082, 419 58.00 59.00 05900 CARDIAC CATHETERIZATION 3, 847, 850 3, 847, 850 3, 847, 850 59.00 06000 LABORATORY 60.00 20, 861, 303 20, 861, 303 0 0 0 0 0 20, 861, 303 60.00 06001 BLOOD LABORATORY 60 01 60 01 0 8, 745, 556 8, 745, 556 65.00 06500 RESPIRATORY THERAPY 8, 745, 556 65.00 06600 PHYSI CAL THERAPY 5, 743, 481 5, 743, 481 5, 743, 481 66.00 66.00 66. 01 06602 PHYSICAL THERAPY EAST BANK 1, 571, 536 1, 571, 536 1, 571, 536 66.01 06601 PHYSICAL THERAPY LIVING CENTER 731, 752 66 10 731, 752 731, 752 66 10 67.00 0 06700 OCCUPATIONAL THERAPY 2, 567, 483 2, 567, 483 2, 567, 483 67.00 439, 454 67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER 439, 454 439, 454 0 67.10 1, 507, 624 06800 SPEECH PATHOLOGY 1 507 624 1, 507, 624 68 00 68 00 06801 SPEECH THERAPY LIVING CENTER 68.10 344, 542 344, 542 344, 542 68.10 0 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 31, 712, 266 31, 712, 266 0 31, 712, 266 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 44, 578, 884 72 00 44, 578, 884 44, 578, 884 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 56, 006, 776 56, 006, 776 56, 006, 776 73.00 07400 RENAL DIALYSIS 0 74.00 0 74.00 76.00 03020 CARDI OLOGY 3, 861, 240 3.861.240 3, 861, 240 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 90.10 09001 FAMILY PRACTICE CLINIC 0 90. 10 0 0 09002 HEMATOLOGY ONCOLOGY CLINIC 90.30 0 2, 372, 674 2, 372, 674 2, 372, 674 90 30 90.50 09004 SLEEP DISORDERS CLINIC 1, 165, 846 1, 165, 846 0 1, 165, 846 90.50 91.00 09100 EMERGENCY 47, 599, 364 47, 599, 364 47, 599, 364 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 12, 889<u>,</u> 416 12, 889, 416 12, 889, 416 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 515, 473, 200 515, 473, 200 200. 00 200.00 Subtotal (see instructions) 515, 473, 200 Ω 0 201.00 Less Observation Beds 12, 889, 416 12, 889, 416 12, 889, 416 201. 00

502, 583, 784

502, 583, 784

502, 583, 784 202. 00

202.00

Total (see instructions)

	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Rati o	Inpatient	
		4.00	7.00	0.00	9. 00	Ratio	
	INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7. 00	8. 00	9.00	10. 00	
30. 00		280, 738, 216		280, 738, 216			30.00
31. 00		48, 090, 575		48, 090, 575			31.00
31. 00	02060 NEONATAL INTENSIVE CARE UNIT	29, 808, 678		29, 808, 678		ļ	31.00
40. 00		29, 606, 676		29, 606, 676	l .		40.00
41. 00	04100 SUBPROVIDER - I RF	15, 243, 763		15, 243, 763			41.00
43.00		5, 804, 230		5, 804, 230		l	43.00
43.00	ANCILLARY SERVICE COST CENTERS	3, 604, 230		3, 604, 230			43.00
50. 00		68, 838, 130	95, 225, 204	164, 063, 334	0. 314220	0. 000000	50.00
52. 00		23, 105, 001	1, 898, 828		l .	0. 000000	52.00
54. 00		45, 926, 106	126, 675, 380			0. 000000	54.00
57. 00		37, 284, 505	49, 036, 926			0. 000000	57. 00
58. 00		5, 440, 489	2, 932, 176			0. 000000	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	17, 814, 041	19, 499, 484			0. 000000	59. 00
60. 00		120, 786, 855	60, 945, 074			0. 000000	60.00
60. 01	06001 BLOOD LABORATORY	120, 700, 033	00, 943, 074	101, 731, 727	l I	0. 000000	60. 01
65. 00		46, 179, 679	2, 521, 836	· · ·	l .	0. 000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	6, 960, 082	6, 480, 966		l .	0. 000000	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	1, 874	5, 240, 475		l .	0. 000000	66. 01
66. 10	06601 PHYSI CAL THERAPY LIVING CENTER	3, 741	2, 667, 519		l .	0. 000000	66. 10
67. 00		6, 084, 980	2, 058, 468		l .	0. 000000	67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	2, 755	1, 428, 882		l .	0. 000000	67. 10
68. 00		2, 691, 352	2, 166, 878			0. 000000	68. 00
68. 10		6, 283	1, 207, 902			0. 000000	68. 10
70. 00		0, 203	1, 207, 702	1	l .	0. 000000	70.00
71. 00		102, 931, 618	74, 223, 649	1	l .	0. 000000	71.00
72. 00		126, 574, 046	65, 474, 407			0. 000000	72. 00
73. 00	l l	140, 806, 769	164, 720, 518			0. 000000	73.00
74. 00		140,000,707	104, 720, 310		l I	0. 000000	74.00
76. 00		14, 734, 451	14, 375, 397	1 ~		0. 000000	76. 00
77. 00		0	0 11, 070, 077	1	l I	0. 000000	77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			0. 000000	0.00000	, , ,
90. 00		0	0	0	0.000000	0. 000000	90. 00
90. 10		0	0	0	0. 000000	0. 000000	90. 10
90. 30		54, 990	1, 561, 159	1, 616, 149	l .	0. 000000	90. 30
90. 50		0	4, 150, 673		l :	0. 000000	90. 50
91. 00		22, 020, 951	70, 093, 502		l :	0. 000000	91.00
92. 00	• • • • • • • • • • • • • • • • • • •	O	36, 115, 217		l .	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS	,		, , , , ,			
102.0	0 10200 OPI OI D TREATMENT PROGRAM	0	0	0			102. 00
	SPECIAL PURPOSE COST CENTERS						
113. 0	0 11300   NTEREST EXPENSE						113. 00
200.0		1, 167, 934, 160	810, 700, 520	1, 978, 634, 680		ļ	200. 00
201.0							201. 00
202.0	Total (see instructions)	1, 167, 934, 160	810, 700, 520	1, 978, 634, 680		ļ	202. 00

Peri od: Worksheet C From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/31/2023 11: 28 am

-			T: +1 - W/III	11	5/31/2023 11:	28 alli
	0 1 0 1 5 11	DDC 1 11 1	Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
	INDATIENT POUTINE CERVICE COCT CENTERS	11.00				
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					20.00
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100   NTENSI VE CARE UNI T					31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT					31. 01
40.00	04000 SUBPROVI DER - I PF					40.00
41. 00	04100 SUBPROVI DER – I RF					41. 00
43. 00	04300 NURSERY					43. 00
	ANCILLARY SERVICE COST CENTERS	0.044000				
50. 00	05000 OPERATI NG ROOM	0. 314220				50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 538626				52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 135246				54. 00
57. 00	05700 CT SCAN	0. 034414				57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 248716				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 103122				59. 00
60. 00	06000 LABORATORY	0. 114792				60. 00
60. 01	06001 BLOOD LABORATORY	0. 000000				60. 01
65. 00	06500 RESPI RATORY THERAPY	0. 179575				65. 00
66.00	06600 PHYSI CAL THERAPY	0. 427309				66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	0. 299777				66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	0. 273935				66. 10
67.00	06700 OCCUPATI ONAL THERAPY	0. 315282				67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0. 306959				67. 10
68.00	06800 SPEECH PATHOLOGY	0. 310324				68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	0. 283764				68. 10
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000				70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 179008				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 232123				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 183312				73. 00
74.00	07400 RENAL DIALYSIS	0. 000000				74. 00
76.00	03020 CARDI OLOGY	0. 132644				76. 00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000				77. 00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0.000000				90.00
90. 10	09001 FAMILY PRACTICE CLINIC	0. 000000				90. 10
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	1. 468103				90. 30
90. 50	09004 SLEEP DISORDERS CLINIC	0. 280881				90. 50
91. 00	09100 EMERGENCY	0. 516742				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 356897				92.00
72.00	OTHER REIMBURSABLE COST CENTERS	0.000077				1 /2:00
102 00	10200 OPI OI D TREATMENT PROGRAM					102. 00
102.00	SPECIAL PURPOSE COST CENTERS					1.02.00
113 00	11300   I NTEREST EXPENSE					113. 00
200.00	1					200. 00
201.00						201. 00
202.00	1					202. 00
202.00	1.512. (500 111511 4011 5115)	1				1-02.00

In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0058 Peri od: Worksheet C From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/31/2023 11:28 am Title XIX Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 1.00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 128, 290, 453 128, 290, 453 128, 290, 453 30.00 03100 INTENSIVE CARE UNIT 21, 941, 850 21, 941, 850 0 21, 941, 850 31.00 31.00 02060 NEONATAL INTENSIVE CARE UNIT 0 31.01 15, 431, 987 15, 431, 987 15, 431, 987 31.01 04000 SUBPROVI DER - I PF 0 40.00 40.00 C 0 04100 SUBPROVI DER - I RF 6, 455, 984 6, 455, 984 41.00 6, 455, 984 0 41.00 43.00 04300 NURSERY 3, 389, 485 3, 389, 485 3, 389, 485 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 51, 551, 941 50.00 51, 551, 941 0 51, 551, 941 52.00 05200 DELIVERY ROOM & LABOR ROOM 13, 467, 717 13, 467, 717 0 13, 467, 717 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 23, 343, 652 23, 343, 652 0 0 0 23, 343, 652 54.00 05700 CT SCAN 2, 970, 665 2, 970, 665 2, 970, 665 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 2,082,419 2, 082, 419 2, 082, 419 58.00 59.00 05900 CARDIAC CATHETERIZATION 3, 847, 850 3, 847, 850 3, 847, 850 59.00 06000 LABORATORY 60.00 20, 861, 303 20, 861, 303 0 0 0 0 0 20, 861, 303 60.00 06001 BLOOD LABORATORY 60 01 60 01 0 8, 745, 556 8, 745, 556 65.00 06500 RESPIRATORY THERAPY 8, 745, 556 65.00 06600 PHYSI CAL THERAPY 5, 743, 481 5, 743, 481 5, 743, 481 66.00 66.00 66. 01 06602 PHYSICAL THERAPY EAST BANK 1, 571, 536 1, 571, 536 1, 571, 536 66.01 06601 PHYSICAL THERAPY LIVING CENTER 731, 752 66 10 731, 752 731, 752 66 10 67.00 0 06700 OCCUPATIONAL THERAPY 2, 567, 483 2, 567, 483 2, 567, 483 67.00 439, 454 67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER 439, 454 439, 454 0 67.10 1, 507, 624 06800 SPEECH PATHOLOGY 1 507 624 1, 507, 624 68 00 68 00 06801 SPEECH THERAPY LIVING CENTER 68.10 344, 542 344, 542 344, 542 68.10 0 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 31, 712, 266 31, 712, 266 0 31, 712, 266 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 44, 578, 884 72 00 44, 578, 884 44, 578, 884 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 56, 006, 776 56, 006, 776 56, 006, 776 73.00 07400 RENAL DIALYSIS 0 74.00 0 74.00 76.00 03020 CARDI OLOGY 3, 861, 240 3.861.240 3, 861, 240 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 90.10 09001 FAMILY PRACTICE CLINIC 0 90. 10 0 0 09002 HEMATOLOGY ONCOLOGY CLINIC 90.30 0 2, 372, 674 2, 372, 674 2, 372, 674 90 30 90.50 09004 SLEEP DISORDERS CLINIC 1, 165, 846 1, 165, 846 0 1, 165, 846 90.50 91.00 09100 EMERGENCY 47, 599, 364 47, 599, 364 47, 599, 364 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 12, 889<u>,</u> 416 12, 889, 416 12, 889, 416 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS

515, 473, 200

502, 583, 784

12, 889, 416

515, 473, 200

12, 889, 416

502, 583, 784

Ω

113.00

515, 473, 200 200. 00

12, 889, 416 201. 00

502, 583, 784 202. 00

0

113. 00 11300 I NTEREST EXPENSE

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

200.00

201.00

202.00

113.00

200 00

201. 00

202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0058 Peri od: Worksheet C From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/31/2023 11:28 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 280, 738, 216 280, 738, 216 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 48, 090, 575 48, 090, 575 31.00 02060 NEONATAL INTENSIVE CARE UNIT 29, 808, 678 31.01 29, 808, 678 31.01 04000 SUBPROVIDER - IPF 40.00 40.00 04100 SUBPROVI DER - I RF 41.00 15, 243, 763 15, 243, 763 41.00 43.00 04300 NURSERY 5, 804, 230 5, 804, 230 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 68, 838, 130 95, 225, 204 164, 063, 334 0.314220 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 23, 105, 001 1, 898, 828 25, 003, 829 0.538626 0.000000 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 45, 926, 106 126, 675, 380 172, 601, 486 0.135246 0.000000 54.00 57.00 05700 CT SCAN 37, 284, 505 49, 036, 926 86, 321, 431 0.034414 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 2, 932, 176 0.248716 0.000000 58.00 5.440.489 8, 372, 665 58.00 05900 CARDIAC CATHETERIZATION 59.00 17, 814, 041 19, 499, 484 37, 313, 525 0.103122 0.000000 59.00 06000 LABORATORY 120, 786, 855 60, 945, 074 0.114792 0.000000 60.00 181, 731, 929 60.00 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 60.01 06500 RESPIRATORY THERAPY 46, 179, 679 2, 521, 836 48, 701, 515 0 179575 65.00 0.000000 65 00 66.00 06600 PHYSI CAL THERAPY 6, 960, 082 6, 480, 966 13, 441, 048 0. 427309 0.000000 66.00 06602 PHYSI CAL THERAPY EAST BANK 5, 240, 475 5, 242, 349 0. 299777 66, 01 1,874 0.000000 66.01 06601 PHYSICAL THERAPY LIVING CENTER 3,741 2, 667, 519 2, 671, 260 0.273935 0.000000 66.10 66.10 06700 OCCUPATI ONAL THERAPY 2, 058, 468 67.00 6, 084, 980 8, 143, 448 0.315282 0.000000 67.00 67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER 2,755 1, 428, 882 1, 431, 637 0.306959 0.000000 67.10 68.00 06800 SPEECH PATHOLOGY 2, 691, 352 2, 166, 878 4, 858, 230 0.310324 0.000000 68.00 06801 SPEECH THERAPY LIVING CENTER 6, 283 1, 207, 902 1, 214, 185 0 283764 0 000000 68 10 68 10 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 102, 931, 618 74, 223, 649 177, 155, 267 0.179008 0.000000 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 126, 574, 046 65, 474, 407 192, 048, 453 0. 232123 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 140, 806, 769 164, 720, 518 305, 527, 287 0.183312 0.000000 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0.000000 74.00 03020 CARDI OLOGY 76.00 14, 734, 451 14, 375, 397 29, 109, 848 0.132644 0.000000 76.00 77 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0.000000 0.000000 77 00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0.000000 90.00 0 0 0 90. 10 09001 FAMILY PRACTICE CLINIC 0 0 0.000000 0.000000 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 54, 990 0 000000 90 30 90.30 1, 561, 159 1, 616, 149 1 468103 09004 SLEEP DISORDERS CLINIC 90.50 4, 150, 673 4, 150, 673 0.280881 0.000000 90.50 70, 093, 502 09100 EMERGENCY 22, 020, 951 92, 114, 453 0.000000 91.00 0.516742 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 36, 115, 217 36, <u>1</u>15, 217 0.356897 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS

1, 167, 934, 160

1, 167, 934, 160

810, 700, 520 1, 978, 634, 680

810, 700, 520 1, 978, 634, 680

113.00 11300 INTEREST EXPENSE

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

200.00

201.00

Period: Worksheet C From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/31/2023 11:28 am

NATI ENT ROUTI NE SERVI CE COST CENTERS   11.00   30.00   3000   ADULTS & PEDIATRI CS   31.00   31.0						5/31/2023 11: 28 am
NPATI ENT ROUTINE SERVICE COST CENTERS   11.00			1	Title XIX	Hospi tal	PPS
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   30000 ADULTS & PEDIATRICS   30.00   30000 ADULTS & PEDIATRICS   31.00   31.01   31.00   31.01   31.00   31.01   31.00   31.01   31.00   31.00   31.01   31.00   31.01   31.00   31		Cost Center Description				
IMPATIE ENT ROUTINE SERVICE COST CENTERS   30.00   30.00   30.00   AULTS & PEDIATRICS   31.00   31.0						
30.00			11.00			
31.00						
31.01   20500   NEDRATAL INTENSIVE CARE UNIT						30.00
40.00   04000   SUBPROVI DER - I PF	31.00	03100 INTENSIVE CARE UNIT				31.00
1.00   04100   SUBPROVI DER - I RF	31. 01	02060 NEONATAL INTENSIVE CARE UNIT				31. 01
43. 00	40.00	04000 SUBPROVI DER - I PF				40.00
ANCILLARY SERVICE COST CENTERS	41.00	04100 SUBPROVI DER - I RF				41. 00
50.00	43.00	04300 NURSERY				43.00
52.00		ANCILLARY SERVICE COST CENTERS				
54.00	50.00	05000 OPERATING ROOM	0. 314220			50.00
54.00   05400   RADI OLOGY-DI AGNOSTI C   0. 135246   57.00   570.00   580.00   06500   06500   06600   LABORATORY   0. 1011792   60.00	52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 538626			52. 00
58. 00   05800   MAGNETIC RESONANCE IMAGINC (MRI)   0. 248716   58. 00   05900   CARDIAC CATHETERIZATION   0. 103122   59. 00   06000   CARDIAC CATHETERIZATION   0. 103122   60. 00   06000   LABORATORY   0. 000000   0. 01   06001   BLODD LABORATORY   0. 000000   0. 01   06000   RESPIRATORY THERAPY   0. 1797575   66. 00   06500   RESPIRATORY THERAPY   0. 427309   06. 00   06600   PHYSI CAL THERAPY EAST BANK   0. 299777   0. 000000   06700   0CCUPATIONAL THERAPY LIVING CENTER   0. 273935   06. 10   06600   PHYSI CAL THERAPY LIVING CENTER   0. 273935   06. 10   06700   0CCUPATIONAL THERAPY LIVING CENTER   0. 306959   0. 310324   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000			0. 135246			54.00
59, 00   05900   CARDI AC CATHETERI ZATI ON	57.00	05700 CT SCAN	0. 034414			57. 00
59, 00   05900   CARDI AC CATHETERI ZATI ON	58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 248716			58.00
60. 00   0.0000   LABORATORY   0. 114792   0. 00000   0.0001   BLOOD LABORATORY   0. 0.00000   0. 0. 00000   0. 0. 00000   0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.			1			•
60.01   0.001   0.001   0.0001   0.000000   0.0000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000			1			•
65.00   06500   RSPI RATORY THERAPY   0.179575   0.600   06600   PHYSI CAL THERAPY EAST BANK   0.299777   0.60.00   0.6000   PHYSI CAL THERAPY EAST BANK   0.299777   0.60.00   0.6000   PHYSI CAL THERAPY EAST BANK   0.273935   0.6700		l l	1			•
66. 00   06600   PHYSI CAL THERAPY   0. 427309   0. 6600   0. 6600   PHYSI CAL THERAPY EAST BANK   0. 299777   0. 66. 01   0. 6600   PHYSI CAL THERAPY EAST BANK   0. 299777   0. 66. 01   0. 6600   PHYSI CAL THERAPY EAST BANK   0. 299777   0. 66. 01   0. 0600   PHYSI CAL THERAPY LIVING CENTER   0. 273935   0. 67. 00   0. 0700   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 000000   0. 00000   0. 00000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000						
66. 01   06602   PHYSI CAL THERAPY EAST BANK   0. 299777   66. 10   06601   PHYSI CAL THERAPY LIVING CENTER   0. 279375   66. 10   06700   0CCUPATI ONAL THERAPY LIVING CENTER   0. 315282   67. 00   06700   0CCUPATI ONAL THERAPY LIVING CENTER   0. 306959   67. 10   06701   0CCUPATI ONAL THERAPY LIVING CENTER   0. 306959   68. 00   06800   SPEECH PATHOLOGY   0. 310324   68. 00   06800   SPEECH PATHOLOGY   0. 310324   68. 00   06801   SPEECH THERAPY LIVING CENTER   0. 283764   68. 10   06801   SPEECH THERAPY LIVING CENTER   0. 283764   68. 10   07. 00   07.						•
66. 10		l				
67. 00   06700   0CCUPATI ONAL THERAPY   0. 315282   67. 00   06701   0CCUPATI ONAL THERAPY LIVING CENTER   0. 306959   67. 10   06800   SPECH PATHOLOGY   0. 310324   68. 00   06800   SPECH PATHOLOGY   0. 310324   68. 00   06800   SPECH PATHOLOGY   0. 310324   68. 00   07000   ELECTROENCEPHALOGRAPHY   0. 000000   70. 00   07000   ELECTROENCEPHALOGRAPHY   0. 000000   71. 00   71		l	1			
67. 10		l	1			· ·
68. 00   06800   SPECH PATHOLOGY   0.310324   68. 00   06801   SPECH THERAPY LIVING CENTER   0.283764   68. 10   07000   ELECTROENCEPHAL GORAPHY   0.000000   07000   ELECTROENCEPHAL GORAPHY   0.000000   07000   07000   MPL SCHARGED TO PATIENTS   0.179008   71. 00   72. 00   07200   MPL DEV. CHARGED TO PATIENTS   0.232123   72. 00   07300   DRUGS CHARGED TO PATIENTS   0.183312   73. 00   07400   RENAL DIALYSIS   0.000000   0740		l l	1			·
68. 10		l l	1			•
70. 00   07000   CLECTROENCEPHALOGRAPHY   0. 000000   70. 00   7		l l	1			
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 179008   72. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 232123   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 183312   73. 00   74. 00   07400   RENAL DI ALYSIS   0. 000000   74. 00   07400   RENAL DI ALYSIS   0. 03020   CARDI OLOGY   0. 132644   76. 00   07700   ALLOGENEIC STEM CELL ACQUISITION   0. 000000   000000						
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 232123 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 183312 73. 00 74. 00 07400 RENAL DIALYSIS 0. 000000 74. 00 03020 CARDIOLOGY 0. 132644 76. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0. 000000 77. 00 00000 0000 00000 00000 00000 00000 0000						
73. 00		l	1			•
74. 00			1			•
76. 00 03020 CARDI OLOGY 0. 132644 76. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0. 000000 77. 00 0UTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 0. 000000 90. 10 09001 FAMI LY PRACTI CE CLI NI C 0. 000000 90. 10 09001 FAMI LY PRACTI CE CLI NI C 0. 000000 90. 30 09002 HEMATOLOGY ONCOLOGY CLI NI C 1. 468103 90. 30 90. 50 09004 SLEEP DI SORDERS CLI NI C 0. 280881 90. 50 91. 00 09100 EMERGENCY 0. 516742 91. 00 9200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 356897 92. 00 070HER REI MBURSABLE COST CENTERS  102. 00 10200 OPI OID TREATMENT PROGRAM 92. 00 10200 OPI OID TREATMENT PROGRAM 102. 00 11300 INTEREST EXPENSE 113. 00 11300 Less Observati on Beds 113. 00 200. 00 Less Observati on Beds						· ·
77. 00						· ·
OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICE COST CENTERS     90. 00						· ·
90. 00	77.00		0.000000			77.00
90. 10   09001   FAMILY PRACTICE CLINIC   0.000000   90. 10   90. 30   90. 30   90. 50   90. 40   SLEEP DI SORDERS CLINIC   0. 280881   90. 50   91. 00   91. 00   92. 00   09100   EMERGENCY   0. 516742   91. 00   92. 00   09200   09101   TREATMENT PROGRAM   92. 00   102. 00   09101   TREATMENT PROGRAM   102. 00   10300   09101   TREATMENT PROGRAM   102. 00   10300   107   10300   10300   107   10300	00 00		0.000000			00.00
90. 30						
90. 50		l l	1			•
91. 00   09100   EMERGENCY   0. 516742   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0. 356897   92. 00   OTHER REIMBURSABLE COST CENTERS   102.00   OPI 01D TREATMENT PROGRAM   102.00   SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   200. 00   Subtotal (see instructions)   Less Observation Beds   201. 00   201. 00   Control of the c		l l				•
92. 00			1			•
OTHER REIMBURSABLE COST CENTERS   102.00   10200   OPI OI D TREATMENT PROGRAM   102.00			1			•
102. 00	92. 00		0. 356897			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
200.00         Subtotal (see instructions)         200.00           201.00         Less Observation Beds         201.00			1			
201. 00 Less Observation Beds 201. 00						•
						•
202 00   Tatal (ass instructions)		· · · · · · · · · · · · · · · · · · ·				•
202. 00     Total (see Histractions)	202.00	Total (see instructions)				202. 00

Health Financial Systems MEMORIAL HOSPITA CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY

Provi der CCN: 15-0058

					5/31/2023 11:	28 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
'	(Wkst. B, Part			Reducti on	Reduction	
	1, col. 26)		Cost (col. 1 -		Amount	
	,	ĺ	col . 2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	51, 551, 941	4, 392, 238	47, 159, 703	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	13, 467, 717	1, 317, 445		0	o o	
54. 00   05400   RADI OLOGY - DI AGNOSTI C	23, 343, 652	2, 822, 891		0	0	54.00
57. 00   05700 CT   SCAN	2, 970, 665	107, 367		0	o o	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 082, 419			0	0	•
59. 00   05900   CARDI AC CATHETERI ZATI ON	3, 847, 850			0	0	59.00
60. 00   06000   LABORATORY	20, 861, 303			0	0	60.00
	20, 861, 303			0	1	
60. 01   06001   BLOOD LABORATORY	1 4	0		0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	8, 745, 556			0	0	65.00
66. 00   06600   PHYSI CAL THERAPY	5, 743, 481	476, 093		0	0	66.00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	1, 571, 536			0	0	66. 01
66. 10 06601 PHYSICAL THERAPY LIVING CENTER	731, 752	2, 595		0	0	66. 10
67. 00  06700 OCCUPATI ONAL THERAPY	2, 567, 483	73, 840		0	0	67. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	439, 454	1, 603	437, 851	0	0	67. 10
68. 00 06800 SPEECH PATHOLOGY	1, 507, 624	19, 112	1, 488, 512	0	0	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	344, 542	1, 217	343, 325	0	0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	31, 712, 266	901, 383	30, 810, 883	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	44, 578, 884	643, 909	43, 934, 975	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	56, 006, 776	807, 264		0	0	73. 00
74. 00   07400   RENAL DI ALYSI S	0	0		0	0	74. 00
76. 00   03020 CARDI OLOGY	3, 861, 240	_		0	o o	76.00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	3,001,240	120, 737		0	Ö	1
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	<u> </u>		0	17.00
90. 00   09000   CLI NI C		0	0	0	0	90.00
90. 10 09001 FAMILY PRACTICE CLINIC	0	0		0	0	90. 10
90. 30   09002   HEMATOLOGY ONCOLOGY CLINIC	2, 372, 674	_		0	0	90. 10
90. 50   09004   SLEEP DI SORDERS CLINIC				0	0	90. 50
	1, 165, 846			0		1
91. 00   09100   EMERGENCY	47, 599, 364			· ·	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	12, 889, 416	1, 120, 168	11, 769, 248	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS		0				400 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						111 00
113. 00 11300   INTEREST EXPENSE	220 0/2 444	10 252 547	221 710 221	_	_	113.00
200.00 Subtotal (sum of lines 50 thru 199)	339, 963, 441			0		200.00
201.00 Less Observation Beds	12, 889, 416			0		201. 00
202.00   Total (line 200 minus line 201)	327, 074, 025	17, 132, 349	309, 941, 676	0	1 0	202. 00

Heal th Financial Systems MEMORIAL HOSPITA CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY

Provi der CCN: 15-0058

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | 5/31/2023 | 11: 28 am

Title XIX   Hospital   PPS							5/31/2023 II: 28 am
Capital and Operating Cost Part I, column Ratio (col. 6   Reduction   Reduct						Hospi tal	PPS
ANCI LLARY SERVICE COST CENTERS		Cost Center Description					
Reduction   8							
ANCILLARY SERVICE COST CENTERS							
ANCILLARY SERVICE COST CENTERS   50.00   S00.00   DEPAIT ING ROOM   51, 551, 541   164, 063, 334   0. 314220   52.00   52.00   05200   DELIVERY ROOM & LABOR ROOM   13, 467, 717   25, 003, 829   0. 538626   52.00   54.00   05200   DELIVERY ROOM & LABOR ROOM   13, 467, 717   25, 003, 829   0. 538626   52.00   54.00   05200   DELIVERY ROOM & LABOR ROOM   13, 467, 717   25, 003, 829   0. 538626   54.00   57.00   05700   CT SCAN   SCAN ROOM   23, 343, 652   172, 601, 489   0. 135246   54.00   57.00   05700   CT SCAN   SCAN ROOM   23, 47, 580   37, 47, 57.00   05700   CT SCAN   SCAN ROOM   20, 681, 193   20, 681, 193   20, 665   0. 248716   58.00   05800   MAGNETI C RESONANCE I MAGI ING (MRI )   2, 082, 419   8, 372, 665   0. 248716   58.00   05900   CARDI AC CATHETERI ZATI ON   3, 847, 850   37, 313, 525   0. 103122   59.00   00.00   00.000   0. 00000   0. 00000   0. 00000   0. 00000   0. 0000000   0. 00000000							
50. 00   05000  0FERATI NO ROOM   51.551, 941   104, 063, 334   0.314220   5.0 0.52. 00   52.00   62			6. 00	7. 00	8. 00		
52.00   05200   DELIVERY ROOM & LABOR ROOM   13, 467, 717   25, 003, 829   0, 538626   52, 00   540   05400   RAON RADI DLOGY-DIAGNOSTIC   23, 343, 652   172, 661, 486   0, 135246   54, 00   05700   CT SCAN   2, 970, 665   86, 321, 431   0, 034414   57, 00   580   0   05800   MAGRETIC RESONANCE IMAGING (MRI)   2, 082, 419   8, 372, 665   0, 103122   59, 00   05900   CARDIAC CATHETERI ZATI ON   3, 847, 850   37, 313, 525   0, 103122   59, 00   00   00   00   00   00   00   00		ANCILLARY SERVICE COST CENTERS					
54.00   05400 RADIOLOGY-DIANOSTIC   23,343,652   172,601,486   0.135246   54.00   057.00   05700 CT SCAN   2.970,665   86.321,30.034414   57.00   58.00   05900 MAGNETIC RESONANCE IMAGING (MRI)   2.082,419   8.372,665   0.248716   58.00   05900 CARDIAC CATHERER ZATION   3,847,850   37,313,525   0.103122   59.00   0.00000   0.00000   0.0000000   0.0000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.0000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000	50.00	05000 OPERATING ROOM	51, 551, 941	164, 063, 334	0. 314220		50.00
57.00   05700   CT SCAN   C. 95700   CT SCAN   C. 970. 665   86, 321, 431   C. 0.34414   57.00	52.00	05200 DELIVERY ROOM & LABOR ROOM	13, 467, 717	25, 003, 829	0. 538626		52. 00
SB 00   OSB00   MAGNETIC RESONANCE IMAGING (MRI)   2, 082, 419   8, 372, 665   0, 248716   58, 00   59.00   05900   CARDIA C CATHETERI ZATION   3, 847, 850   37, 313, 255   0, 103122   59, 00   06.00   06000   LABORATORY   20, 861, 303   181, 731, 929   0, 114792   60, 00   06.00   06000   LABORATORY   0   0, 0000000   60, 01   06000   06000   LABORATORY   0   0, 0000000   60, 01   060000   06000   06000   06000   06000   060000   06000   06000   06000   06000   060000   060000   060000   060000   060000   0600000   060000   0600000   06000000   060000000   0600000000	54.00	05400 RADI OLOGY-DI AGNOSTI C	23, 343, 652	172, 601, 486	0. 135246		54.00
59.00   05900   CARDI AC CATHETERI ZATI ON   3, 847, 850   37, 313, 525   0, 103122   60.00   06000   LABORATORY   20, 861, 303   181, 731, 929   0, 114792   60.00   06000   16000   LABORATORY   20, 861, 303   181, 731, 929   0, 114792   60.00   060.01   06001   180.000   LABORATORY   8, 745, 556   48, 701, 515   0, 179575   65.00   06500   RESPI RATORY THERAPY   8, 745, 556   48, 701, 515   0, 179575   65.00   066.00   06600   PhySI CAL THERAPY   EAST BANK   1, 571, 536   5, 242, 349   0, 299777   66.01   06601   PhySI CAL THERAPY LIVING CENTER   731, 752   2, 671, 260   0, 273935   67.00   0700   0CCUPATI ONAL THERAPY   2, 567, 483   8, 143, 448   0, 315282   67.00   0700   0CCUPATI ONAL THERAPY   2, 567, 483   8, 143, 448   0, 315282   67.00   0700   0CCUPATI ONAL THERAPY   1, 1VING CENTER   439, 454   1, 431, 637   0, 306959   67.10   06801   SPEECH THERAPY LIVING CENTER   344, 542   1, 214, 185   0, 283764   68.00   06800   SPEECH PATHOLOGY   1, 507, 624   4, 858, 230   0, 310324   68.00   0700   07000   LEUCTROENCEPHALOGRAPHY   0 0 0, 0000000   70.00   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   31, 712, 266   177, 155, 267   0, 179008   71.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   31, 712, 266   177, 155, 267   0, 179008   71.00   71.00   07400   RENAL DI ALYSIS   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57.00	05700  CT SCAN	2, 970, 665	86, 321, 431	0. 034414		57. 00
60. 00   06000   LABORATORY   20, 861, 303   181, 731, 929   0, 114,792   060. 00   060000   06000   06000   06000   06000   060000   06000   06000   06000   060000   060000   060000   060000   060000   060000   060000   060000   060000   0600000   0600000   0600000   0600000   0600000   06000000   06000000   060000000   060000000   0600000000	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 082, 419	8, 372, 665	0. 248716		58. 00
60. 00   06000   LABORATORY   20, 861, 303   181, 731, 929   0, 114.792   0, 00   060. 01   06001   BLODD LABORATORY   0   0   0   0, 0000000   060. 01   06000   06500   RESPI RATORY THERAPY   5, 743, 481   13, 441, 048   0. 427309   060. 00   060. 00   060. 00   060. 00   060. 00   060. 00   060. 00   060. 00   06000   060. 00   06	59.00	05900 CARDI AC CATHETERI ZATI ON	3, 847, 850	37, 313, 525	0. 103122		59. 00
60.01   60.01   60.01   60.00   LABORATORY   0 0 0 0.000000   60.01	60.00	06000 LABORATORY					60. 00
65.00   06500   RESPIRATORY THERAPY   8, 745, 556   48, 701, 515   0.179575   0.60   066.00   06600   PHYSI CAL THERAPY   5, 743, 481   13, 441, 048   0.427309   0.60   066.00   06601   06602   PHYSI CAL THERAPY EAST BANK   1, 571, 536   5, 242, 349   0.299777   0.60   0.00	60. 01	06001 BLOOD LABORATORY	1				
66. 00   06600   PHYSI CAL THERAPY   5, 743, 481   13, 441, 048   0. 427309   66. 00   66. 01   06601   PHYSI CAL THERAPY EAST BANK   1, 571, 536   5, 242, 349   0. 299777   66. 01   67. 00   06601   PHYSI CAL THERAPY LIVI NG CENTER   731, 752   2, 671, 260   0. 273935   66. 10   67. 10   06701   0CCUPATI ONAL THERAPY   1VI NG CENTER   439, 454   1, 431, 637   0. 306959   67. 10   68. 00   06800   SPEECH PATHOLOGY   1, 507, 624   4, 858, 230   0. 310324   68. 00   68. 10   06801   SPEECH THERAPY LIVI NG CENTER   344, 542   1, 214, 185   0. 283764   68. 10   67. 00   07000   ELECTRONCEPHALOGRAPHY   0   0   0. 000000   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   31, 712, 266   177, 155, 267   0. 179008   71. 00   72. 00   07300   DRUGS CHARGED TO PATI ENTS   56, 006, 776   305, 527, 287   0. 183312   73. 00   74. 00   07400   RENAL DI ALYSI S   0   0   0. 000000   74. 00   77. 00   07700   ALLOGENEI C STEM CELL ACQUISITION   0   0   0. 000000   77. 00   77. 00   07000   LECTRONCEPHALOGRY NOR CHARGED TO PATI ENTS   56, 006, 776   3, 861, 240   29, 109, 848   0. 132644   76, 00   77. 00   07000   ALLOGENEI C STEM CELL ACQUISITION   0   0   0. 000000   77. 00   77. 00   07000   ALLOGENEI C STEM CELL ACQUISITION   0   0   0. 000000   77. 00   77. 00   07000   MERGENCY   47, 599, 364   92, 114, 453   0. 280881   99, 50   79. 00   09000   CLINI C   0   0   0. 000000   90. 00   79. 00   09000   ELESTRONCE CLINIC   1, 165, 846   4, 150, 673   0. 280881   99, 50   79. 00   09000   SLEEP DI SORDERS CLINIC   1, 165, 846   4, 150, 673   0. 280881   99, 50   79. 00   09000   MERGENCY   47, 599, 364   92, 114, 453   0. 516742   91, 00   79. 00   010   DI TREATMENT PROGRAM   0   0   0. 000000   0. 000000   70   010   O10   TREATMENT PROGRAM   0   0   0. 000000   70   010   010   TREATMENT PROGRAM   0   0   0. 000000   71   020   000   010   TREATMENT PROGRAM   0   0   0. 000000   71   020   000   010   TREATMENT PROGRAM   0   0   0. 000000   71   020   000   010   TREATMENT PROGRAM   0   0   0. 000000   7			8, 745, 556	48, 701, 515			
66. 01 06602 PHYSICAL THERAPY EAST BANK 1, 571, 536 5, 242, 349 0. 299777 66. 10 06601 PHYSICAL THERAPY LIVING CENTER 731, 752 2, 671, 260 0. 273935 66. 10 06700 0CCUPATIONAL THERAPY 2, 2, 567, 483 8, 143, 448 0. 315282 67. 00 06700 0CCUPATIONAL THERAPY LIVING CENTER 439, 454 1, 431, 637 0. 306959 67. 10 06701 0CCUPATIONAL THERAPY LIVING CENTER 439, 454 1, 431, 637 0. 306959 67. 10 06801 SPEECH PATHOLOGY 1, 507, 624 4, 858, 230 0. 310324 68. 00 06800 SPEECH PATHOLOGY 1, 507, 624 4, 858, 230 0. 310324 68. 10 06801 SPEECH THERAPY LIVING CENTER 344, 542 1, 214, 185 0. 283764 68. 10 070. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0. 0.000000 70. 00 071. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 31, 712, 266 177, 155, 267 0. 179008 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 44, 578, 884 192, 048, 453 0. 232123 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 44, 578, 884 192, 048, 453 0. 232123 72. 00 07300 DRUGS CHARGED TO PATIENTS 56, 006, 776 305, 527, 287 0. 183312 73. 00 07300 DRUGS CHARGED TO PATIENTS 56, 006, 776 305, 527, 287 0. 183312 73. 00 07400 RENAL DIALYSIS 0 0 0 0.000000 74. 00 0 0.000000 74. 00 0 0.000000 74. 00 0 0.000000 74. 00 0 0.000000 74. 00 0 0.000000 74. 00 0 0.000000 77. 00 000000 77. 00 000000 0 0.000000 0 0.000000 0 0.000000					•		
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER 731,752 2,671,260 0.273935 66. 10 67. 00 06700 0CCUPATI ONAL THERAPY 2,567,483 8,143,448 0.315282 67. 00 67. 01 06701 0CCUPATIONAL THERAPY 2,567,483 8,143,448 0.315282 67. 00 06800 SPEECH PATHOLOGY 1,507,624 4,858,230 0.310324 68. 00 68. 00 06800 SPEECH PATHOLOGY 1,507,624 4,858,230 0.310324 68. 00 68. 10 06801 SPEECH THERAPY LIVING CENTER 344,542 1,214,185 0.283764 68. 10 06801 SPEECH THERAPY LIVING CENTER 344,542 1,214,185 0.283764 68. 10 06801 SPEECH THERAPY LIVING CENTER 344,542 1,214,185 0.283764 68. 10 06700 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0.000000 70. 00 000000 70. 00000000							
67. 00   06700   OCCUPATI ONAL THERAPY   2, 567, 483   8, 143, 448   0. 315282   67. 00   67. 10   06701   OCCUPATI ONAL THERAPY LIVING CENTER   439, 454   1, 431, 637   0. 306959   67. 10   68. 00   06800   SPEECH PATHOLOGY   1, 507, 624   4, 858, 230   0. 310324   68. 00   68. 10   06801   SPEECH PATHOLOGY   1, 507, 624   4, 858, 230   0. 310324   68. 00   68. 10   06801   SPEECH THERAPY LIVING CENTER   344, 542   1, 214, 185   0. 283764   68. 10   70. 00   07000   ELECTROENCEPHALOGRAPHY   0 0   0 0. 000000   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   31, 712, 266   177, 155, 267   0. 179008   71. 00   72. 00   07200   IMPL DEV. CHARGED TO PATIENTS   44, 578, 884   192, 048, 453   0. 232123   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   56, 006, 776   305, 527, 287   0. 183312   73. 00   74. 00   07400   RENAL DIALYSIS   0 0 0 0. 000000   74. 00   76. 00   03020   CARDI OLOGY   3, 861, 240   29, 109, 848   0. 132644   76. 00   77. 00   07700   ALLOGENEIC STEM CELL ACQUI SITION   0 0 0. 000000   0. 000000   77. 00   00TPATIENT SERVICE COST CENTERS    90. 00   09000   CLINIC   0 0 0. 000000   90. 00   90. 10   09001   FAMILY PRACTICE CLINIC   0 0 0. 000000   90. 10   09001   FAMILY PRACTICE CLINIC   2, 372, 674   1, 616, 149   1. 468103   90. 30   90. 50   09004   SLEEP DI SORDERS CLINIC   1, 165, 846   4, 150, 673   0. 280881   90. 50   91. 00   09100   BERRGENCY   47, 599, 364   92, 114, 453   0. 516742   91. 00   92. 00   09200   OSERVATI ON BEDS (NON-DI STINCT PART)   12, 889, 416   36, 115, 217   0. 356897    102. 00   10200   OPI OID TREATMENT PROGRAM   0 0 0 0. 000000   201. 00   OLDOGODO   DI TREATMENT PROGRAM   0 0 0 0. 000000   201. 00   OSUBOR CENTERS   113. 00   200. 00   Subtotal (sum of lines 50 thru 199)   339, 963, 441   1, 598, 949, 218   200. 00   201. 00   Subtotal (sum of lines 50 thru 199)   339, 963, 441   1, 598, 949, 218   200. 00   201. 00   OSUBOR CENTERS   113. 00   200. 00   200. 000000   201. 0000000000000000000000000000000000							
67. 10			1				
68. 00   06800   SPECH PATHOLOGY   1, 507, 624   4, 858, 230   0. 310324   68. 00   68. 10   06801   SPECH THERAPY LIVING CENTER   344, 542   1, 214, 185   0. 283764   68. 10   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0. 000000   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   31, 712, 266   177, 155, 267   0. 179008   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   44, 578, 884   192, 048, 453   0. 232123   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   56, 006, 776   305, 527, 287   0. 183312   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0.000000   74. 00   76. 00   03020   CARDI OLOGY   3, 861, 240   29, 109, 848   0. 132644   76. 00   77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0   0   0.000000   77. 00   90. 10   09000   CLI NI C   0   0   0.000000   90. 10   90. 10   09000   FAMILLY PRACTICE CLI NI C   0   0   0.000000   90. 10   90. 30   09004   SLEEP DI SORDERS CLI NI C   2, 372, 674   1, 616, 149   1. 468103   90. 30   90. 50   09004   SLEEP DI SORDERS CLI NI C   2, 372, 674   1, 616, 149   1. 468103   90. 30   90. 50   09004   SLEEP DI SORDERS CLI NI C   2, 7599, 364   92, 114, 453   0. 516742   91. 00   91. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   12, 889, 416   36, 115, 217   0. 356897   92. 00   000   000   ODDO   ODDO							
68. 10 06801 SPEECH THERAPY LIVING CENTER 344, 542 1, 214, 185 0. 283764 6 68. 10 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0. 0.000000 70. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 31, 712, 266 177, 155, 267 0. 179008 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 44, 578, 884 192, 048, 453 0. 232123 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 56, 006, 776 305, 527, 287 0. 183312 73. 00 7400 RENAL DIALYSIS 0 0 0. 0000000 74. 00 03020 CARDIOLOGY 3, 861, 240 29, 109, 848 0. 132644 76. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0. 0000000 77. 00 00000 CLINIC 0 0 0. 0000000 77. 00 09000 CLINIC 0 0 0. 0000000 90. 10 09000 ELINIC 0 0 0. 0000000 90. 10 09000 EMERGENCY 47,599, 364 41, 1616, 149 1. 468103 90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC 2, 372, 674 1, 616, 149 1. 468103 90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC 2, 372, 674 1, 616, 149 1. 468103 90. 30 09100 EMERGENCY 47,599, 364 92, 114, 453 0. 516742 91. 00 09100 EMERGENCY 47,599, 364 92, 114, 453 0. 516742 91. 00 09100 EMERGENCY 47,599, 364 92, 114, 453 0. 516742 91. 00 09100 EMERGENCY 47,599, 364 92, 114, 453 0. 516742 91. 00 00 00000 EMERGENCY 47,599, 364 92, 114, 453 0. 516742 91. 00 00000 EMERGENCY 47,599, 364 92, 114, 453 0. 516742 91. 00 00000 EMERGENCY 47,599, 364 92, 114, 453 0. 516742 91. 00 00000 EMERGENCY 47,599, 364 92, 114, 453 0. 516742 91. 00 00000 EMERGENCY 47,599, 364 92, 114, 453 0. 516742 91. 00 00000 EMERGENCY 47,599, 364 92, 114, 453 0. 516742 91. 00 00000 EMERGENCY 47,599, 364 92, 114, 453 0. 516742 91. 00 00000 EMERGENCY 47,599, 364 92, 114, 453 0. 516742 91. 00 000000 EMERGENCY 47,599, 364 92, 114, 453 0. 516742 91. 00 000000 EMERGENCY 47,599, 364 92, 114, 453 0. 516742 91. 00 0000000 EMERGENCY 47,599, 364 92, 114, 453 0. 516742 91. 00 00000000000000000000000000000000							
70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0.0000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.00000000							
71. 00							
72. 00				l ~			l
73. 00							
74. 00							
76. 00							ı
77. 00				ľ			
OUTPATIENT SERVICE COST CENTERS   O			3,001,240	1			
90. 00	77.00				0.00000		77.00
90. 10	00 00				0.00000		00.00
90. 30							
90. 50			2 272 474	1			
91. 00							
92. 00							
OTHER REIMBURSABLE COST CENTERS   102.00   10200   OPI OI D TREATMENT PROGRAM   O   O   0.000000   O.000000   O.0000000   O.0000000   O.0000000   O.0000000   O.0000000   O.00000000   O.000000000   O.000000000   O.000000000   O.0000000000							
102. 00	92.00		12, 889, 416	36, 115, 217	0. 356897		92.00
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   200.00   Subtotal (sum of lines 50 thru 199)   339,963,441   1,598,949,218   200.00   201.00   Less Observation Beds   12,889,416   0   201.00			1			T	
113. 00   200. 00   201. 00   Less Observation Beds   113. 00   339, 963, 441   1, 598, 949, 218   200. 00   201. 00   201. 00   202. 00   203. 00   204. 00   205. 00   206. 00   207. 00   208. 00   209. 00	102.00		0		ր 0.000000		102.00
200. 00     Subtotal (sum of lines 50 thru 199)     339, 963, 441     1, 598, 949, 218     200. 00       201. 00     Less Observation Beds     12, 889, 416     0     201. 00	440.00					1	442.22
201.00 Less Observation Beds 12,889,416 0 201.00			200 0/0 //1	4 500 040 040			
		1 1					
202.00      Total (Tine 200 minus Line 201)   327,074,025  1,598,949,218					<u>'</u>		
	202.00		327, 074, 025	1, 598, 949, 218	5		J202. 00

Health Financial Systems MEMOI	RIAL HOSPITAL O	F SOUTH BEND,	I NC	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co	CN: 15-0058	Peri od: From 01/01/2022	Worksheet D Part I	
				To 12/31/2022	Date/Time Pre 5/31/2023 11:	pared: 28 am
		Title	XVIII	Hospi tal	PPS	20 4
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	11, 149, 229		, ,			
31.00   INTENSIVE CARE UNIT	1, 386, 909		1, 386, 90			
31.01 NEONATAL INTENSIVE CARE UNIT	1, 247, 319		1, 247, 31	9 8, 604		
40. 00   SUBPROVI DER - I PF	0	0		0	0.00	
41. 00 SUBPROVI DER - I RF	530, 341	0	530, 34			
43. 00 NURSERY	196, 242		196, 24			
200.00 Total (lines 30 through 199)	14, 510, 040		14, 510, 04	0 122, 566		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	20, 560		•			30.00
31. 00   INTENSIVE CARE UNIT	1, 758					31.00
31. 01 NEONATAL INTENSIVE CARE UNIT	0	0				31. 01
40. 00 SUBPROVI DER – I PF	0	0				40. 00
41. 00 SUBPROVI DER - I RF	1, 245					41.00
43. 00 NURSERY	0	-				43.00
200.00 Total (lines 30 through 199)	23, 563	2, 815, 842	I			200. 00

Health Financial Systems MEMO	RIAL HOSPITAL C	F SOUTH BEND,	I NC	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Co		Period: From 01/01/2022 To 12/31/2022		pared: 28 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)			4 00		
ANOLILARY REPUBLIC ROOT REVIEWS	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	4 000 000	1 4 4 0 4 0 0 0 4	0.00(77	0 45 404 540	44.4.000	F0 00
50. 00 05000 OPERATING ROOM	4, 392, 238					
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 317, 445				0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 57. 00   05700   CT   SCAN	2, 822, 891				241, 892	
	107, 367					
58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00   05900   CARDI AC CATHETERI ZATI ON	153, 265					58. 00 59. 00
60. 00   06000   LABORATORY	567, 846					60.00
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY	463, 234				00, 587	60.00
65. 00 06500 RESPIRATORY THERAPY	280, 862	-			· · · · · · · · · · · · · · · · · · ·	
66. 00   06600   PHYSI CAL THERAPY	476, 093					
66. 01 06602 PHYSI CAL THERAPY EAST BANK	5, 733				01,539	66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	2, 595				0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	73, 840				_	
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	1, 603				7, 702	67. 10
68. 00   06800  SPEECH PATHOLOGY	19, 112				1, 524	68.00
68. 10 06801 SPEECH THERAPY LIVING CENTER	1, 217				1, 324	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	1,217		0.00000		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	901, 383	1			·	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	643, 909					
73. 00 07300 DRUGS CHARGED TO PATIENTS	807, 264				85, 228	
74. 00 07400 RENAL DIALYSIS	0		l		0	1
76. 00 03020 CARDI OLOGY	126, 757	29, 109, 848			17, 675	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.00000		0	1
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00
90. 10 09001 FAMILY PRACTICE CLINIC	0	0	0.00000	0 0	0	90. 10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	631, 269	1, 616, 149	0. 39060	1 0	0	90. 30
90. 50 09004 SLEEP DISORDERS CLINIC	109, 600	4, 150, 673	0. 02640	5 0	0	90. 50
91. 00   09100   EMERGENCY	3, 226, 826	92, 114, 453	0. 03503	1 5, 641, 492	197, 627	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 120, 168	36, 115, 217	0. 03101	7 0	0	92.00
200.00 Total (lines 50 through 199)	18, 252, 517	1, 598, 949, 218		175, 790, 219	1, 453, 307	200. 00

Health Financial Systems	MEMORIAL HOS	PITAL OF SOUTH BE	ND, INC	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE S	SERVICE OTHER PASS THROU	JGH COSTS   Provid		From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Pre 5/31/2023 11::	
		-	itle XVIII	Hospi tal	PPS	
Cost Center Description	Nurs	sing Nursin	Allied Health	n Allied Health	All Other	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST			From 01/01/2022 To 12/31/2022		
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	,					
30. 00   03000   ADULTS & PEDI ATRI CS	0	0		0	0	30.00
31.00   03100   INTENSIVE CARE UNIT	0	0		0	0	31.00
31.01   02060 NEONATAL INTENSIVE CARE UNIT	0	0		0	0	31. 01
40. 00   04000   SUBPROVI DER - 1 PF	0	0		0	0	40. 00
41. 00   04100   SUBPROVI DER - 1 RF	o	0		0 0	0	41.00
43. 00 04300 NURSERY	O	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	O	0		0 0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
·	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,		Í		
		minus col. 4)				
	4.00	5.00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	·			<u> </u>		
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	97, 93	9 0.00	20, 560	30.00
31. 00 03100 INTENSIVE CARE UNIT		0	7, 14	6 0.00	1, 758	31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT		0	8, 60	4 0.00	0	31. 01
40. 00   04000   SUBPROVI DER - 1 PF	0	0		0.00	0	40.00
41. 00   04100   SUBPROVI DER -     RF	o	0	4, 92			
43. 00   04300   NURSERY		0	3, 95			1
200.00 Total (lines 30 through 199)		0			23, 563	1
Cost Center Description	Inpatient		122,00	<u> </u>	20,000	200.00
555t 5511tG. 555511 pt. 511	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	1.22					
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00 03100 I NTENSI VE CARE UNIT	o					31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	o					31. 01
40. 00   04000   SUBPROVI DER -   PF						40.00
41. 00   04100   SUBPROVI DER -   I RF						41.00
43. 00   04300   NURSERY						43.00
200.00 Total (lines 30 through 199)						200.00
200.00   10tal (111163 30 till ough 177)	١					1200.00

| Peri od: | Worksheet D | From 01/01/2022 | Part IV | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems MEMORIAL HOSPITAL OF APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provi der CCN: 15-0058 THROUGH COSTS

					10 12/31/202	2   Date/lime Pre   5/31/2023 11:	
			Title	XVIII	Hospi tal	PPS	20 4
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Healtl	Allied Health	
	·	Anesthetist	Program	Program	Post-Stepdow	۱	
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS					_	
50.00	05000 OPERATI NG ROOM	0	0		0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	
54.00	05400  RADI OLOGY-DI AGNOSTI C	0	0		0	0 0	54. 00
57. 00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0 0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0 0	
60.00	06000 LABORATORY	0	0		0	0 0	
60. 01	06001 BLOOD LABORATORY	0	0		0	0 0	60. 01
65.00	06500 RESPI RATORY THERAPY	0	0		0	0 0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0 0	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	0	0		0	0 0	66. 01
66. 10	06601 PHYSICAL THERAPY LIVING CENTER	0	0		0	0 0	66. 10
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0 0	67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0		0	0 0	67. 10
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0 0	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	0	0		0	0 0	68. 10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0 0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0 0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0 0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0 0	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0	0 0	74.00
76.00	03020 CARDI OLOGY	0	0		0	0 0	76. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0 0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000  CLI NI C	0	0		0	0 0	90.00
90. 10	09001 FAMILY PRACTICE CLINIC	0	0		0	0 0	90. 10
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	0		0	0 0	70.00
90. 50	09004 SLEEP DI SORDERS CLINIC	0	0		0	0 0	
91. 00	09100 EMERGENCY	0	0		0	0 176, 146	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
200.00	Total (lines 50 through 199)	0	0	l	0	0 176, 146	200. 00

Health Financial Systems	MEMORIAL HOSPITAL OF S	SOUTH BEND, INC	I	In Lieu of Form CMS-2552-10
ADDODEL ONMENT OF LAIDATIENT (OUTD)	TIENT ANGLILADY CEDVICE OTHER DACC	D: -I CON 15 0050	D!I	Wasalia ka a 4 D

Peri od: From 01/01/2022 To 12/31/2022 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0058 Part IV THROUGH COSTS Date/Time Prepared: 5/31/2023 11:28 am Title XVIII Hospi tal Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost Cost (sum of Part I, col. (col. 5 ÷ col 1, 2, 3, and 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 164, 063, 334 0.00000050.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 25, 003, 829 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0000000000000000000000 0 0 172, 601, 486 0.000000 54.00 05700 CT SCAN 0 0 86, 321, 431 57 00 0.000000 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 0 8, 372, 665 0.000000 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 37, 313, 525 0.000000 59.00 181, 731, 929 06000 LABORATORY 0 0 0.000000 60 00 60 00 06001 BLOOD LABORATORY 0 60.01 0 0.000000 60.01 65.00 06500 RESPIRATORY THERAPY 48, 701, 515 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 13, 441, 048 0.000000 66.00 06602 PHYSICAL THERAPY EAST BANK 0 Ω 5, 242, 349 0.000000 66 01 66.01 66.10 06601 PHYSICAL THERAPY LIVING CENTER 0 2, 671, 260 0.000000 66.10 06700 OCCUPATI ONAL THERAPY 8, 143, 448 0.000000 67.00 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 1, 431, 637 0.000000 67.10 67.10 68.00 06800 SPEECH PATHOLOGY Ω 4.858.230 0.000000 68 00 68. 10 06801 SPEECH THERAPY LIVING CENTER 0 1, 214, 185 0.000000 68.10 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 177, 155, 267 0.000000 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 192, 048, 453 72 00 0 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 305, 527, 287 0.000000 73.00 07400 RENAL DIALYSIS 0 74.00 0 0.000000 74.00 03020 CARDI OLOGY 0 76.00 0 29, 109, 848 0.000000 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.00000077.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0.000000 90.00 0 09001 FAMILY PRACTICE CLINIC 0 0.000000 90.10 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 90.30 Ω 0 1, 616, 149 0.000000 90.30 09004 SLEEP DISORDERS CLINIC 0 0 4, 150, 673 0.000000 90.50 91.00 09100 EMERGENCY 176, 146 176, 146 92, 114, 453 0.001912 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 Ω 36, 115, 217 0.000000 200.00 Total (lines 50 through 199) 176, 146 176, 146 1, 598, 949, 218 200.00

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Health Financial Systems	MEMORIAL HOSPITAL OF	SOUTH BEND, INC	In Lie	In Lieu of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0058	Peri od:	Worksheet D	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS   Provider CON: 15-0058   Period: From 01/01/2022   Part Off 12/31/2022   Provider CON: 15-0058   Provider	Health Financial Systems MEMURIAL HOSPITAL OF SOUTH BEND, INC. In Lieu of Form CMS-255.						2552-10	
Title   XVIII   Hospital   Hospital   Hospital   Hospital   Hospital   Hospital   Hospital   Hospital   Program	APPORTI	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS						
Cost Center Description	THROUGH	I COSTS						
Title XVIII   Hospital   PPS   Outpatient   Ratio of Cost   Cost Center Description   Ratio of Cost   Cost   Congress   Cost Center   Cost Center   Cost						To 12/31/2022		
Cost Center Description				T' 11	V0/11 1			
Ratio of Cost   Charges   Col. 6 + col.   Program   Charges		0 1 0 1 0 1 1						
To Charges		Cost Center Description						
Costs (col. 8   X col. 10)   X col. 10)   X col. 12)   X col. 10   X col. 12   X col. 10   X col. 12   X col. 10   X col. 12								
ANCILLARY SERVICE COST CENTERS				unarges				
AMCILLARY SERVICE COST CENTERS			7			8		
ANCILLARY SERVICE COST CENTERS				40.00		10.00		
SOLITION   05000   05000   05000   0   14,846,682   0   50.00   0   0   0   0   0   0   0   0   0		ANOLILARY OFRIGOR COOT OFFITERS	9.00	10.00	11.00	12.00	13. 00	
52.00   05200   05200   05200   05200   05400   05700   058000   058000   058000   058000   058000   058000   058000   058000   058000   058000   058000   058000   058000   058000   058000				45 404 540	ı	al 44 044 400		
54.00         05400 RADIOLOGY-DI AGNOSTIC         0.000000 (14,790,111)         0         26,917,700         0         54.00           57.00         05700 CT SCAN         0.000000 (6,862,637)         0         8.454,806         0         57.00           58.00         05800 (05800) MAGNETIC RESONANCE IMAGING (MRI)         0.000000         1,207,406         0         261,832         0         58.00           59.00         05900 CARDI AC CATHETERI ZATION         0.000000         4,244,414         0         7,042,982         0         59.00           60.01         06000 LABORATORY         0.000000         0 <td></td> <td></td> <td></td> <td></td> <td>1</td> <td></td> <td>_</td> <td></td>					1		_	
57. 00   05700   CT SCAN   0.000000   6,862,637   0   8,454,806   0   57. 00   58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0.000000   1,277,406   0   261.832   0.58.00   59. 00   05900   CARDIAC CATHETERI ZATION   0.000000   4,244,414   0   7,042,982   0.59.00   60. 00   06000   LABORATORY   0.000000   26,122.866   0   8,049,884   0   60.00   65. 00   06500   RESPIRATORY THERAPY   0.000000   0   0   0   0   0   66. 00   06500   RESPIRATORY THERAPY   0.000000   11,617,870   0   399,688   0   65.00   66. 00   06600   PHYSI CAL THERAPY EAST BANK   0.000000   1,455,037   0   1,449,781   0   66.00   66. 10   06602   PHYSI CAL THERAPY EAST BANK   0.000000   0   0   0   34,705   0   66.00   66. 10   06601   PHYSI CAL THERAPY LIVING CENTER   0.000000   0   0   12,541   0   66.10   67. 10   06701   OCCUPATIONAL THERAPY LIVING CENTER   0.000000   0   0   12,541   0   67.10   68. 00   06800   SPECH PATHOLOGY   0.000000   387,484   0   3,464   0   68.00   68. 10   06801   SPECH THERAPY LIVING CENTER   0.000000   0   0   27,011   0   67.10   68. 00   06800   SPECH PATHOLOGY   0.000000   0   0   0   4,952   0   68.00   68. 10   06801   SPECH THERAPY LIVING CENTER   0.000000   0   0   0   0   0   0   71. 00   07000   ELECTROENCEPHALOGRAPHY   0.000000   0   0   0   0   0   0   0			·		1		_	1
58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0.000000   1,207,406   0   261,832   0   58.00   59.00   05900   0   0   0.000000   4,244,414   0   7,042,982   0   59.00   0.000000   0   0   0   0   0   0					l .			1
59. 00   05900   CARDI AC CATHETERIZATION   0.000000   4,244,414   0   7,042,982   0   59.00   60. 00   06000   LABORATORY   0.000000   26,122,866   0   8,049,884   0   60.00   65. 00   06500   RESPIRATORY THERAPY   0.000000   11,617,870   0   399,688   0   65.00   66. 00   06600   PHYSI CAL THERAPY   0.000000   1,455,037   0   1,449,781   0   66.00   66. 01   06601   PHYSI CAL THERAPY EAST BANK   0.000000   0   0   34,705   0   66. 10   06601   PHYSI CAL THERAPY LIVING CENTER   0.000000   0   0   12,541   0   66.10   67. 00   06700   0CCUPATIONAL THERAPY LIVING CENTER   0.000000   0   0   27,011   0   67.10   68. 00   06800   SPEECH PATHOLOGY   0.000000   387,484   0   3,464   0   68.00   68. 00   06800   SPEECH THERAPY LIVING CENTER   0.000000   0   0   2,7011   0   67.10   68. 00   06801   SPEECH THERAPY LIVING CENTER   0.000000   0   0   4,952   0   68.10   69. 00   07100   CLUETRONAL CHERAPY LIVING CENTER   0.000000   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.000000   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.000000   32,258,884   0   46,301,486   0   73.00   74. 00   07400   RENAL DI ALYSIS   0.000000   0   0   0   0   0   75. 00   07300   DRUSC CHARGED TO PATIENTS   0.000000   0   0   0   0   0   76. 00   03020   CARDI OLOGY   0.000000   0   0   0   0   0   77. 00   07400   RENAL DI ALYSIS   0.000000   0   0   0   0   0   77. 00   07400   RENAL DI ALYSIS   0.000000   0   0   0   0   77. 00   07400   CARDINAR CHERAPY   0.000000   0   0   0   0   77. 00   07400   CARDINAR CHERAPY   0.000000   0   0   0   0   77. 00   07400   CARDINAR CHERAPY   0.000000   0   0   0   0   77. 00   07400   CARDINAR CHERAPY   0.000000   0   0   0   0   77. 00   07400   CARDINAR CHERAPY   0.000000   0   0   0   0   77. 00   07400   CARDINAR CHERAPY   0.000000   0   0   0   77. 00   07400   CARDINAR CHERAPY   0.000000   0   0   0   77. 00   07400   CARDINAR CHERAPY   0.000000   0   0   0   77. 00   07400   CARDINAR CHERAPY   0.000000   0   0   0   77. 00	57. 00	05700 CT SCAN		6, 862, 637		0 8, 454, 806	0	57. 00
60. 00   06000   LABORATORY   0. 000000   26, 122, 866   0   8, 049, 884   0   60. 00   60. 01   06001   BLOD LABORATORY   0. 000000   0   0   0   0   0   0   0	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	1, 207, 406		0 261, 832	0	58. 00
60. 01   06001   06001   06001   06001   06001   06001   06001   06001   06001   06001   06001   06001   06001   06000   06001   06000   06000   06000   060000   060000   060000   060000   060000   060000   060000   060000   060000   060000   060000   0600000   06000000   06000000   06000000   06000000   060000000   060000000   0600000000	59.00	05900 CARDIAC CATHETERIZATION	0. 000000	4, 244, 414		0 7, 042, 982	0	59. 00
65. 00   06500   RESPI RATORY THERAPY   0.000000   11, 617, 870   0   399, 688   0   65. 00   66. 00   66. 00   66. 00   66. 00   66. 00   66. 01   66. 01   66. 02   66. 01   66. 02   66. 01   66. 02   66. 01   66. 02   66. 01   66. 02   66. 01   66. 02   66. 01   66. 02   66. 01	60.00	06000 LABORATORY	0. 000000	26, 122, 866		0 8, 049, 884	0	60.00
66. 00   06600   PHYSI CAL THERAPY   0.000000   1,455,037   0   1,449,781   0   66. 00   66. 01   06602   PHYSI CAL THERAPY EAST BANK   0.000000   0   0   34,705   0   66. 01   67. 00   06601   PHYSI CAL THERAPY LIVING CENTER   0.000000   0   0   12,541   0   66. 10   67. 00   06701   0CCUPATI ONAL THERAPY   0.000000   0   0   0   35,749   0   67. 10   67. 10   06701   0CCUPATI ONAL THERAPY LIVING CENTER   0.000000   0   0   27,011   0   67. 10   68. 00   06800   SPEECH PATHOLOGY   0.000000   387,484   0   3,464   0   68. 00   68. 10   06801   SPEECH THERAPY LIVING CENTER   0.000000   0   0   4,952   0   68. 10   70. 00   07000   ELECTROENCEPHALOGRAPHY   0.000000   0   0   0   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.000000   30,485,985   0   14,210,331   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0.000000   32,258,884   0   46,301,486   0   73. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   32,258,884   0   46,301,486   0   73. 00   74. 00   07400   RENAL DI ALYSI S   0.000000   0   0   0   0   0   75. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0.000000   0   0   0   0   00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0.000000   0   0   0   0   00   07000   CHARILOGY ONCOLOGY CLINIC   0.000000   0   0   0   0   00   09000   LERRIGENCY   0.000000   0   0   0   0   00   09000   SEERVATI ON BEDS (NON-DISTINCT PART)   0.000000   0   0   0   0   00   09000   09000   09000   09000   0	60. 01	06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60. 01
66. 00   06600   PHYSI CAL THERAPY   0.000000   1,455,037   0   1,449,781   0   66. 00   66. 01   06602   PHYSI CAL THERAPY EAST BANK   0.000000   0   0   34,705   0   66. 01   67. 00   06601   PHYSI CAL THERAPY LIVING CENTER   0.000000   0   0   12,541   0   66. 10   67. 00   06701   0CCUPATI ONAL THERAPY   0.000000   0   0   0   35,749   0   67. 10   67. 10   06701   0CCUPATI ONAL THERAPY LIVING CENTER   0.000000   0   0   27,011   0   67. 10   68. 00   06800   SPEECH PATHOLOGY   0.000000   387,484   0   3,464   0   68. 00   68. 10   06801   SPEECH THERAPY LIVING CENTER   0.000000   0   0   4,952   0   68. 10   70. 00   07000   ELECTROENCEPHALOGRAPHY   0.000000   0   0   0   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.000000   30,485,985   0   14,210,331   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0.000000   32,258,884   0   46,301,486   0   73. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   32,258,884   0   46,301,486   0   73. 00   74. 00   07400   RENAL DI ALYSI S   0.000000   0   0   0   0   0   75. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0.000000   0   0   0   0   00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0.000000   0   0   0   0   00   07000   CHARILOGY ONCOLOGY CLINIC   0.000000   0   0   0   0   00   09000   LERRIGENCY   0.000000   0   0   0   0   00   09000   SEERVATI ON BEDS (NON-DISTINCT PART)   0.000000   0   0   0   0   00   09000   09000   09000   09000   0	65. 00	06500 RESPIRATORY THERAPY	0. 000000	11, 617, 870		0 399, 688	0	65.00
66. 01 06602 PHYSI CAL THERAPY EAST BANK 0. 000000 0 0 34, 705 0 66. 01 66. 10 06601 PHYSI CAL THERAPY LIVING CENTER 0. 0000000 0 0 12, 541 0 66. 10 67. 00 06700 0CCUPATI ONAL THERAPY LIVING CENTER 0. 000000 1, 078, 839 0 35, 749 0 67. 00 67. 10 06701 0CCUPATI ONAL THERAPY LIVING CENTER 0. 000000 0 0 27, 011 0 67. 10 06701 0CCUPATI ONAL THERAPY LIVING CENTER 0. 000000 0 0 27, 011 0 68. 00 06800 SPEECH PATHOLOGY 0. 000000 0 0 0 4, 952 0 68. 10 06801 SPEECH THERAPY LIVING CENTER 0. 000000 0 0 0 4, 952 0 68. 10 06801 SPEECH THERAPY LIVING CENTER 0. 000000 0 0 0 4, 952 0 68. 10 000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0. 000000	1, 455, 037		0 1, 449, 781	0	66. 00
66. 10 06601 PHYSICAL THERAPY LIVING CENTER 0. 000000 0 12, 541 0 66. 10 67. 00 6700 0CCUPATIONAL THERAPY 0. 000000 1, 078, 839 0 35, 749 0 67. 00 67. 00 68. 00 66. 10 0CCUPATIONAL THERAPY LIVING CENTER 0. 000000 0 0 27, 011 0 67. 10 68. 00 6800 SPECCH PATHOLOGY 0. 000000 387, 484 0 3, 464 0 68. 00 68. 10 06801 SPECCH PATHOLOGY 0. 000000 0 0 0 4, 952 0 68. 10 06801 SPECCH THERAPY LIVING CENTER 0. 000000 0 0 0 4, 952 0 68. 10 07. 00	66. 01	06602 PHYSICAL THERAPY FAST BANK	0. 000000	0			0	66. 01
67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 1, 078, 839 0 35, 749 0 67. 00 67. 10 06701 0CCUPATI ONAL THERAPY LIVING CENTER 0. 000000 0 0 27, 011 0 68. 00 6800 SPEECH PATHOLOGY 0. 000000 387, 484 0 3, 464 0 68. 00 68. 10 06801 SPEECH PATHOLOGY 0. 000000 0 0 0 4, 952 0 68. 10 07. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0			0	
67. 10		I	l I	1 078 839			_	
68. 00	-		l I					
68. 10			1 I	•	l .	•	_	1
70. 00   07000   ELECTROENCEPHALOGRAPHY   0. 000000   0   0   0   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 000000   20, 083, 058   0   14, 210, 331   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 000000   30, 485, 985   0   15, 629, 768   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 000000   32, 258, 884   0   46, 301, 486   0   73. 00   74. 00   07400   RENAL DI ALYSI S   0. 000000   0   0   0   0   0   76. 00   03200   CARDI OLOGY   0. 000000   4, 059, 576   0   3, 470, 615   0   76. 00   77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0. 000000   0   0   0   0   77. 00   09000   CLI NI C   0. 000000   0   0   0   0   0   90. 10   09001   FAMI LY PRACTI CE CLI NI C   0. 000000   0   0   0   0   90. 30   09002   HEMATOLOGY ONCOLOGY CLI NI C   0. 000000   0   0   0   90. 50   09004   SLEEP DI SORDERS CLI NI C   0. 000000   0   0   0   477, 795   0   90. 50   91. 00   09200   DESERVATI ON BEDS (NON-DI STI NCT PART)   0. 000000   0   0   0   1, 265   0   92. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0. 000000   0   0   0   0    71. 00   000000   0   0   0   0   0    72. 00   00000000000000000000000000000000					1		_	
71. 00		1	1 I	0		0 4, 752	_	
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 000000   30, 485, 985   0   15, 629, 768   0   72. 00   73. 00   73. 00   73. 00   74				20 002 050		0 14 210 221	_	1
73. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   32, 258, 884   0   46, 301, 486   0   73. 00   74. 00   07400   RENAL DIALYSIS   0.000000   0   0   0   0   76. 00   03020   CARDIOLOGY   0.000000   0   0   0   0   77. 00   07700   ALLOGENEI C STEM CELL ACQUISITION   0.000000   0   0   0   0    00   00000   CLINIC   0.000000   0   0   0   0    90. 00   09000   CLINIC   0.000000   0   0   0   0    90. 10   09001   FAMILY PRACTICE CLINIC   0.000000   0   0   0    90. 30   09002   HEMATOLOGY ONCOLOGY CLINIC   0.000000   0   0    90. 50   09004   SLEEP DISORDERS CLINIC   0.000000   0   0    91. 00   09100   SMERGENCY   0.001912   5,641,492   10,787   4,877,516   9,326   91.00    92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0.000000   0   0   0    92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0.000000   0   0    94. 00   09200   000000   0   0    95. 00   09200   00000000000000000000000000								
74. 00			·		l .		_	
76. 00				32, 258, 884			_	
77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0.000000   0   0   0   0   0   0   0				0		٥	_	
OUTPATIENT SERVICE COST CENTERS     O		· · · · · · · · · · · · · · · · · · ·	1		1		_	1
90. 00			0. 000000	0		0 0	0	77.00
90. 10					ı		_	
90. 30   09002   HEMATOLOGY ONCOLOGY CLINIC   0. 000000   0   0   0   0   90. 30   90. 50   91. 00   09100   EMERGENCY   0. 000000   0   0   0   0   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0. 000000   0   0   0   0   0   1, 265   0   92. 00   09200   0   0   0   0   0   0   0   0   0			1	0		0	_	1
90. 50   09004   SLEEP DI SORDERS CLINI C				0		0	0	
91. 00   09100   EMERGENCY			·	0		0	0	1
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0. 000000   0   1, 265   0   92. 00				0		•	_	1
	91.00	09100 EMERGENCY		5, 641, 492	10, 78		9, 326	
200.00   Total (Lines 50 through 199)   175, 790, 219   10, 787   152, 510, 553   9, 326 200.00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 1, 265	0	92.00
	200.00	Total (lines 50 through 199)		175, 790, 219	10, 78	152, 510, 553	9, 326	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0058 Peri od: Worksheet D From 01/01/2022 Part V Date/Time Prepared: 12/31/2022 5/31/2023 11:28 am Title XVIII Hospi tal Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 314220 14, 846, 682 4, 665, 124 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.538626 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 26, 917, 700 0 3, 640, 511 54 00 0 135246 54 00 0 0 57.00 05700 CT SCAN 0.034414 8, 454, 806 290, 964 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0. 248716 261, 832 0 65, 122 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.103122 7, 042, 982 0 0 726, 286 59.00 06000 LABORATORY 0 60.00 0.114792 8,049,884 924, 062 60.00 60.01 06001 BLOOD LABORATORY 0.000000 O 60.01 06500 RESPIRATORY THERAPY 0 65.00 0. 179575 399, 688 0 71, 774 65.00 0 06600 PHYSI CAL THERAPY 1, 449, 781 619, 504 66 00 0 427309 66 00 |06602| PHYSI CAL THERAPY EAST BANK 66.01 0.299777 34, 705 10, 404 66.01 06601 PHYSICAL THERAPY LIVING CENTER 0.273935 12, 541 3, 435 66.10 0 0 0 0 0 0 66.10 06700 OCCUPATIONAL THERAPY 0.315282 35, 749 0 11, 271 67.00 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 27, 011 0 67. 10 0.306959 8. 291 67.10 68.00 06800 SPEECH PATHOLOGY 0. 310324 3, 464 0 1,075 68.00 06801 SPEECH THERAPY LIVING CENTER 0. 283764 4, 952 68.10 0 1, 405 68.10 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 14, 210, 331 2, 543, 763 71.00 0.179008 280 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 232123 15, 629, 768 3, 628, 029 72.00 634 07300 DRUGS CHARGED TO PATIENTS 8, 487, 618 73.00 0.183312 46, 301, 486 0 0 73.00 07400 RENAL DIALYSIS 74.00 0.000000 0 74.00 0 03020 CARDI OLOGY 3, 470, 615 O 460, 356 76.00 0.132644 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 90.00 0 09001 FAMILY PRACTICE CLINIC 0 0 90.10 0.000000 C 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 1.468103 90.30 0 0 0 90.30 09004 SLEEP DISORDERS CLINIC 90.50 0. 280881 477, 795 0 134, 204 90.50 09100 EMERGENCY 0 91 00 91 00 0.516742 4, 877, 516 2, 520, 417 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0. 356897 1, 265 0 451 92.00 0 200.00 Subtotal (see instructions) 152, 510, 553 914 28, 814, 066 200.00 Less PBP Clinic Lab. Services-Program 201.00 201. 00 0 Only Charges 202.00 Net Charges (line 200 - line 201) 152, 510, 553 914 28, 814, 066 202. 00

In Lieu of Form CMS-2552-10 Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0058 Peri od: Worksheet D From 01/01/2022 Part V 12/31/2022 Date/Time Prepared: 5/31/2023 11:28 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000000000 0 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54 00 57.00 05700 CT SCAN 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 0 60.00 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06500 RESPIRATORY THERAPY 0 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 66 00 66.01 06602 PHYSI CAL THERAPY EAST BANK 0 66.01 66. 10 06601 PHYSICAL THERAPY LIVING CENTER 0 66. 10 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 0 67. 10 67.10 68.00 06800 SPEECH PATHOLOGY 0 68.00 06801 SPEECH THERAPY LIVING CENTER 68. 10 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 50 0 71.00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 147 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 0 07400 RENAL DIALYSIS 0 74.00 74.00 03020 CARDI OLOGY 76.00 0 76.00 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0000 09001 FAMILY PRACTICE CLINIC 90.10 0 90. 10 09002 HEMATOLOGY ONCOLOGY CLINIC 0 90.30 09004 SLEEP DISORDERS CLINIC 0 90.50 90.50 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 Subtotal (see instructions) 0 200.00 200.00 Less PBP Clinic Lab. Services-Program 201.00 0 201.00

197

0

202.00

Only Charges

Net Charges (line 200 - line 201)

Health Financial Systems MEMOD	RIAL HOSPITAL C	OF SOUTH BEND,	I NC	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C	CN: 15-0058	Peri od:	Worksheet D	
		Component		From 01/01/2022 To 12/31/2022	Part II	narad.
		Component	CCN: 15-T058	To 12/31/2022	Date/Time Pre 5/31/2023 11:	
		Ti tl e	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost (from Wkst. B,	(from Wkst. C, Part I, col.	to Charges (col. 1 ÷ col	Program	(column 3 x column 4)	
	Part II, col.	8)	2)	. Charges	COLUMN 4)	
	26)	0)	2)			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	4, 392, 238	164, 063, 334	0. 02677	2 16, 992	455	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 317, 445	25, 003, 829	0. 05269	0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 822, 891	172, 601, 486	0. 01635	5 24, 354	398	54.00
57. 00  05700 CT SCAN	107, 367	86, 321, 431	0. 00124	4 28, 355	35	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	153, 265	8, 372, 665			32	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	567, 846				0	
60. 00   06000   LABORATORY	463, 234				755	60.00
60. 01   06001   BL00D   LABORATORY	0		0.00000		0	60. 01
65. 00 06500 RESPI RATORY THERAPY	280, 862				762	65. 00
66. 00 06600 PHYSI CAL THERAPY	476, 093		1		19, 782	
66. 01 06602 PHYSI CAL THERAPY EAST BANK	5, 733				0	
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	2, 595				0	66. 10
67.00   06700   OCCUPATI ONAL THERAPY 67.10   06701   OCCUPATI ONAL THERAPY LIVING CENTER	73, 840 1, 603		1		5, 257 0	67. 00 67. 10
68. 00   06800   SPEECH PATHOLOGY	19, 112		1		1, 073	
68. 10 06801 SPEECH THERAPY LIVING CENTER	1, 217	1	1		1,073	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	1	0.00000		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	901, 383	_			27	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	643, 909				8	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	807, 264				1, 811	73. 00
74.00 07400 RENAL DIALYSIS	0			0	0	74. 00
76. 00   03020   CARDI OLOGY	126, 757	29, 109, 848	0. 00435	4 0	0	76. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	O	0.00000	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	,					
90. 00 09000 CLINIC	0	_			0	
90.10 09001 FAMILY PRACTICE CLINIC	0	_			0	
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	631, 269				0	90. 30
90. 50 09004 SLEEP DI SORDERS CLINIC	109, 600				0	90. 50
91. 00 09100 EMERGENCY	3, 226, 826				0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	17 122 240	00//2/	1		20.205	92.00
200.00   Total (lines 50 through 199)	17, 132, 349	1, 598, 949, 218	1	2, 604, 155	30, 395	200. 00

Health Financial Systems MEMC APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	ORIAL HOSPITAL C RVICE OTHER PAS:	S Provider CC Component C	CN: 15-0058 CCN: 15-T058	Fro To	iod: m 01/01/2022 12/31/2022	u of Form CMS-2 Worksheet D Part IV Date/Time Pre 5/31/2023 11:	pared:
		Title	XVIII	Su	bprovi der  - I RF	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Po	ost-Stepdown Adjustments	Allied Health	
	1. 00	2A	2.00		3A	3. 00	
ANCILLARY SERVICE COST CENTERS	Т				_1		
50. 00 05000 OPERATING ROOM	0	-		0	0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C 57. 00   05700   CT   SCAN	0	0		0	0	0	54.00
57. 00   05700 CT SCAN 58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)		0		0	o o	0	57. 00 58. 00
59. 00   05900   MAGNETTC RESONANCE TWAGING (WRT)		0		0	0	0	
60. 00   06000   LABORATORY		0		0	0	0	
60. 01   06001   BLOOD   LABORATORY		0		0	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0	Ö		0	ol	0	1
66. 00   06600   PHYSI CAL THERAPY	0	0		0	ol	0	66.00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0	o		0	ō	0	66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	0	0		0	o	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	0	o		0	o	0	67. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0		0	0	0	67. 10
68. 00   06800   SPEECH PATHOLOGY	0	0		0	0	0	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	0	0		0	0	0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	
74. 00   07400   RENAL DI ALYSI S	0	0		0	0	0	74.00
76. 00   03020   CARDI OLOGY 77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON	0	0		0	0	0	
OUTPATIENT SERVICE COST CENTERS		l o		U	<u> </u>	U	17.00
90. 00 09000 CLINIC	T 0	O		0	ol	0	90.00
90. 10 09001 FAMILY PRACTICE CLINIC		o o		0	0	0	90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	l o	l o		0	ől	0	1
90. 50   09004   SLEEP DI SORDERS CLINIC		l ől		O	ol	0	1
91. 00   09100   EMERGENCY	0	o o		O	o	176, 146	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	آ	0	1
200.00 Total (lines 50 through 199)	0	o		0	o	176, 146	1

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLAR ROUGH COSTS	Y SERVICE OTHER PASS	Component	CCN: 15-T058	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Pre 5/31/2023 11:	pared 28 am
		Titl€	e XVIII	Subprovi der  - I RF	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	The state of the s	Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3, and 4)	8)	7) (see	
			and 4)		instructions)	
	4.00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
0. 00 05000 OPERATING ROOM	0	C		0 164, 063, 334	0.000000	50.0
2. 00 05200 DELIVERY ROOM & LABOR ROOM	0	_	1	0 25, 003, 829		1
I. 00 05400 RADI OLOGY-DI AGNOSTI C	0	Ċ		0 172, 601, 486		
7. 00 05700 CT SCAN	0	Ċ		0 86, 321, 431		
B. 00   05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C		0 8, 372, 665		
P. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 37, 313, 525		•
0. 00   06000   LABORATORY	0	C		0 181, 731, 929	0.000000	60.
0. 01 06001 BLOOD LABORATORY	0	C		0 0	0. 000000	60.
5. 00 06500 RESPIRATORY THERAPY	0	C		0 48, 701, 515	0. 000000	65. (
5. 00 06600 PHYSI CAL THERAPY	0	C	)	0 13, 441, 048	0. 000000	66.
5. 01 06602 PHYSICAL THERAPY EAST BANK	0	C	)	0 5, 242, 349	0. 000000	66.
5. 10 06601 PHYSICAL THERAPY LIVING CENTER	0	C	)	0 2, 671, 260	•	1
7. 00 06700 OCCUPATI ONAL THERAPY	0	C	1	0 8, 143, 448		
7.10  06701 OCCUPATIONAL THERAPY LIVING CENTER	0	C	1	0 1, 431, 637		1
3. 00 06800 SPEECH PATHOLOGY	0	C	•	0 4, 858, 230		
3. 10 06801 SPEECH THERAPY LIVING CENTER	0	C	1	0 1, 214, 185		
0. 00 07000 ELECTROENCEPHALOGRAPHY	0	C	l .	0 0	0. 000000	1
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	15 0		II.	0 177, 155, 267	0.000000	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		l .	0 192, 048, 453	1	1
3. 00 07300 DRUGS CHARGED TO PATIENTS	0		1	0 305, 527, 287	0.000000	
I. 00 07400 RENAL DIALYSIS	0		•	0 0	0.000000	
5.00  03020 CARDIOLOGY 7.00  07700 ALLOGENEIC STEM CELL ACQUISITION	0	-	l	0 29, 109, 848	0. 000000 0. 000000	
OUTPATIENT SERVICE COST CENTERS	0		/	0 0	0.000000	77.
0. 00 09000 CLINIC	0	C		0 0	0.000000	90.
0.10 09001 FAMILY PRACTICE CLINIC	0	C		0 0	0.000000	
0.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	C		0 1, 616, 149	0.000000	90.
0.50 09004 SLEEP DISORDERS CLINIC	0	C		0 4, 150, 673	0.000000	90.
. 00 09100 EMERGENCY	0	176, 146	176, 14	6 92, 114, 453	0. 001912	91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	T) 0			0 36, 115, 217	0. 000000	92.
00.00 Total (lines 50 through 199)	0	176, 146	176.14	6 1, 598, 949, 218		200.

Health Financial Systems MEMO	RIAL HOSPITAL OF	SOUTH BEND,	I NC	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVI CE OTHER PASS	Provi der Co		Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T058	From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre 5/31/2023 11:	
		Title	: XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)	10.00	x col . 10)	10.00	x col . 12)	
ANOLILARY OFFICE OF SOUT OFFICE	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS		4	1			
50. 00   05000   OPERATI NG ROOM	0. 000000	16, 992		0	0	
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	24, 354		0	0	
57. 00 05700 CT SCAN	0. 000000	28, 355		0	0	57. 00
58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI)	0. 000000	1, 756	1	0	0	
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59. 00
60. 00   06000   LABORATORY	0. 000000	296, 270		0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 000000	132, 080	•	0	0	65. 00
66. 00   06600   PHYSI CAL THERAPY	0. 000000	558, 490		0	0	
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0. 000000	0		0	0	66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	0. 000000	0		0	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	579, 811	i	0	0	
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0. 000000	0	1	0	0	67. 10
68. 00 06800 SPEECH PATHOLOGY	0. 000000	272, 739		0	0	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	0. 000000	0		0	0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	5, 270		0	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 400		0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	685, 638	•	0	0	73. 00
74. 00   07400   RENAL DI ALYSI S	0. 000000	0		0	0	
76. 00 03020 CARDI OLOGY	0. 000000	0		0 0	0	76. 00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	0.000000				0	00.00
90. 00   09000   CLI NI C	0. 000000	0		0	0	
90. 10 09001 FAMILY PRACTICE CLINIC	0. 000000	0		0	0	
90. 30   09002   HEMATOLOGY   ONCOLOGY   CLI NI C	0. 000000	0		0	0	90. 30
90. 50 09004 SLEEP DI SORDERS CLINIC	0.000000	0		0 0	0	
91. 00   09100   EMERGENCY	0.001912	0		0 0	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 000000	0 (04 155		0 0	0	
200.00   Total (lines 50 through 199)	1 1	2, 604, 155	I	0 0	0	200. 00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CA	APITAL COSTS	Provi der C		Period: From 01/01/2022 To 12/31/2022		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
·	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	,	Related Cost	•		
	Part II, col.		(col. 1 - col			
	26)		2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	11, 149, 229	0	11, 149, 22	9 97, 939	113. 84	30.00
31.00 INTENSIVE CARE UNIT	1, 386, 909		1, 386, 90	9 7, 146	194. 08	31.00
31.01 NEONATAL INTENSIVE CARE UNIT	1, 247, 319		1, 247, 31	9 8, 604	144. 97	31. 01
40. 00 SUBPROVI DER - I PF	0	0	)	0	0.00	40.00
41. 00 SUBPROVI DER - I RF	530, 341	0	530, 34	1 4, 924	107. 71	41.00
43. 00 NURSERY	196, 242		196, 24	2 3, 953	49. 64	43.00
200.00 Total (lines 30 through 199)	14, 510, 040		14, 510, 04	0 122, 566		200.00
Cost Center Description	Inpatient	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	4, 338					30.00
31.00   INTENSIVE CARE UNIT	90					31.00
31.01 NEONATAL INTENSIVE CARE UNIT	1, 132	164, 106				31. 01
40. 00 SUBPROVI DER - I PF	0	0				40.00
41. 00 SUBPROVI DER - I RF	34	3, 662				41.00
43. 00 NURSERY	350					43.00
200.00 Total (lines 30 through 199)	5, 944	696, 447	1			200.00

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0058 Peri od: Worksheet D From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/31/2023 11:28 am Title XIX Hospi tal **PPS** Capital Costs Cost Center Description Capi tal Total Charges Ratio of Cost Inpati ent (from Wkst. C, to Charges (column 3 x Related Cost Program (from Wkst. B. column 4) Part I, col. (col. 1 ÷ col Charges 2) Part II, col. 8) 26) 2.00 3.00 4.00 5.00 1.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 392, 238 0.026772 37, 823, 488 1, 012, 610 50.00 164, 063, 334 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 317, 445 25, 003, 829 0.052690 14, 144, 114 745, 253 52.00 05400 RADI OLOGY-DI AGNOSTI C 172, 601, 486 0.016355 11, 659, 913 54.00 2, 822, 891 190, 698 54.00 05700 CT SCAN 107, 367 0.001244 9, 032, 753 11, 237 57.00 86, 321, 431 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 153, 265 0.018305 1, 271, 044 58.00 8, 372, 665 23, 266 58.00 59.00 05900 CARDIAC CATHETERIZATION 567, 846 37, 313, 525 0.015218 3, 534, 417 53, 787 59.00 60.00 06000 LABORATORY 463, 234 181, 731, 929 0.002549 30, 326, 537 77, 302 60.00 06001 BLOOD LABORATORY 0.000000 60 01 Ω 60 01 280, 862 06500 RESPIRATORY THERAPY 48, 701, 515 65.00 0.005767 17, 605, 634 101, 532 65.00 66.00 06600 PHYSI CAL THERAPY 476, 093 13, 441, 048 0.035421 1, 869 66 66.00 66.01 06602 PHYSICAL THERAPY EAST BANK 5,733 5, 242, 349 0.001094 0 66.01 0 06601 PHYSICAL THERAPY LIVING CENTER 0.000971 2 595 2, 671, 260 66.10 66 10 0 0 67.00 06700 OCCUPATI ONAL THERAPY 73,840 8, 143, 448 0.009067 258 2 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 67.10 1,603 1, 431, 637 0.001120 0 0 67.10 06800 SPEECH PATHOLOGY 0.003934 68 00 19 112 4 858 230 0 68 00 0 68.10 06801 SPEECH THERAPY LIVING CENTER 1, 217 1, 214, 185 0.001002 258 0 68.10 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 901, 383 177, 155, 267 0.005088 669, 662 3, 407 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 192, 048, 453 643, 909 0.003353 72.00 72 00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 807, 264 305, 527, 287 0.002642 2, 875, 405 7, 597 73.00 07400 RENAL DIALYSIS 0.000000 74.00 0 74.00 76.00 03020 CARDI OLOGY 126, 757 29, 109, 848 0.004354 2, 322, 464 10.112 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 77.00 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 90.00 09000 CLI NI C 0 0 09001 FAMILY PRACTICE CLINIC 0.000000 90.10 0 90.10 0 90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC 631, 269 0.390601 1, 616, 149 48. 134 18, 801 90 30 90. 50 09004 SLEEP DISORDERS CLINIC 109,600 4, 150, 673 0.026405 90.50 0 91. 00 09100 EMERGENCY 0.035031 3, 226, 826 92, 114, 453 5, 481, 772 192, 032 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 120, 168 36, 115, 217 0.031017 92.00 0 200.00 Total (lines 50 through 199) 18, 252, 517 1, 598, 949, 218 136, 797, 722 2, 447, 702 200. 00

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT	ROUTINE SERVICE OTHER PASS THROUGH COSTS   Provider CCN: 15-0058	Peri od: Worksheet D

	RLAL HOSPITAL O		INC	In Lie	eu of Form CMS-2	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	TS Provider Co		eri od:	Worksheet D	
			F	rom 01/01/2022	Part III	
			T	o 12/31/2022		
					5/31/2023 11:	28 am_
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments		.,			
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA.	1.00	Zri	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0	0	30.00
	-	1	1	_	1	
31. 00   03100   INTENSIVE CARE UNIT	0	0	0	0	1	
31.01 02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31. 01
40. 00   04000   SUBPROVI DER - I PF	0	0	)  0	0	0	40. 00
41. 00   04100   SUBPROVI DER - I RF	0	0	) 0	0	0	41.00
43. 00   04300   NURSERY	0	0	ol 0	0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	200.00
oust defiter beschiptron	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
			Days	3 - (01. 0)	Frogram bays	
	Amount (see	1 through 3,				
	instructions)			7.00	0.00	
LAUDATI ENT. DOUTLAGE OFFICE OF CONT. OFFITEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0	0	97, 939			
31.00 03100 INTENSIVE CARE UNIT		0	7, 146			
31.01  02060 NEONATAL INTENSIVE CARE UNIT		0	8, 604	0.00	1, 132	31. 01
40. 00   04000   SUBPROVI DER - 1 PF	0	0	0	0.00	0	40.00
41. 00   04100   SUBPROVI DER - I RF	0	l o	4, 924	0.00	34	41.00
43. 00   04300   NURSERY		0				1
200.00 Total (lines 30 through 199)		٥				200. 00
Cost Center Description	Inpati ent	0	122, 300		J, 744	200.00
cost center bescription						
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	0	l .				31. 01
40. 00   04000   SUBPROVI DER -   PF						40. 00
	0					1
41. 00   04100   SUBPROVI DER -   RF	0	l .				41.00
43. 00   04300   NURSERY	0	l .				43. 00
200.00   Total (lines 30 through 199)	0					200. 00

| Period: | Worksheet D | From 01/01/2022 | Part IV | To | 12/31/2022 | Date/Time | Prepared: Health Financial Systems MEMORIAL HOSPITAL OF APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provi der CCN: 15-0058 THROUGH COSTS

					To 12/31/2022	Date/Time Pre 5/31/2023 11:	
			Ti tl	e XIX	Hospi tal	PPS	20 4
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	·	Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS				_		
50.00	05000 OPERATI NG 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
57. 00	05700  CT SCAN	0	0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
66. 01	06602 PHYSI CAL THERAPY EAST BANK	0	0		0	0	66. 01
66. 10	06601 PHYSI CAL THERAPY LIVING CENTER	0	0		0	0	66. 10
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
67. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0		0	0	67. 10
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
68. 10	06801 SPEECH THERAPY LIVING CENTER	0	0		0	0	68. 10
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0	0	74. 00
76. 00	03020 CARDI OLOGY	0	0		0	0	76. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0	0		0	0	90. 00
90. 10	09001 FAMILY PRACTICE CLINIC	0	0		0	0	90. 10
90. 30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	0		0	0	90. 30
90. 50	09004 SLEEP DISORDERS CLINIC	0	0		0	0	90. 50
91. 00	09100 EMERGENCY	0	0		0	176, 146	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92. 00
200.00	Total (lines 50 through 199)	0	0	l	0 0	176, 146	200. 00

lealth Financial Systems	MEMORIAL HOSPITAL OF S	SOUTH BEND, INC		In Lieu of Form CMS-2552-10
ADDODEL ONMENT OF LABORE FAIT (OUTDAT)	LENT ANGLE ADV CEDVICE OTHER DACC	D	D!I	Wasalia la a a 4 D

He Peri od: From 01/01/2022 To 12/31/2022 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Part IV THROUGH COSTS Date/Time Prepared: 5/31/2023 11:28 am Title XIX Hospi tal Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost Cost (sum of Part I, col. (col. 5 ÷ col 1, 2, 3, and 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 164, 063, 334 0.00000050.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 25, 003, 829 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0000000000000000000000 0 0 172, 601, 486 0.000000 54.00 05700 CT SCAN 0 0 86, 321, 431 57 00 0.000000 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 0 8, 372, 665 0.000000 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 37, 313, 525 0.000000 59.00 181, 731, 929 06000 LABORATORY 0 0 0.000000 60 00 60 00 06001 BLOOD LABORATORY 0 60.01 0 0.000000 60.01 65.00 06500 RESPIRATORY THERAPY 48, 701, 515 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 13, 441, 048 0.000000 66.00 06602 PHYSICAL THERAPY EAST BANK 0 Ω 5, 242, 349 0.000000 66 01 66.01 66.10 06601 PHYSICAL THERAPY LIVING CENTER 0 2, 671, 260 0.000000 66.10 06700 OCCUPATI ONAL THERAPY 8, 143, 448 0.000000 67.00 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 1, 431, 637 0.000000 67.10 67.10 68.00 06800 SPEECH PATHOLOGY Ω 4.858.230 0.000000 68 00 68. 10 06801 SPEECH THERAPY LIVING CENTER 0 1, 214, 185 0.000000 68.10 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 177, 155, 267 0.000000 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 192, 048, 453 72 00 0 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 305, 527, 287 0.000000 73.00 07400 RENAL DIALYSIS 0 74.00 0 0.000000 74.00 03020 CARDI OLOGY 0 76.00 0 29, 109, 848 0.000000 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.00000077.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0.000000 90.00 0 09001 FAMILY PRACTICE CLINIC 0 0.000000 90.10 0 90.10 09002 HEMATOLOGY ONCOLOGY CLINIC 90.30 Ω 0 1, 616, 149 0.000000 90.30 09004 SLEEP DISORDERS CLINIC 0 0 4, 150, 673 0.000000 90.50 91.00 09100 EMERGENCY 176, 146 176, 146 92, 114, 453 0.001912 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 Ω 36, 115, 217 0.000000

176, 146

176, 146 1, 598, 949, 218

200.00

200.00

Total (lines 50 through 199)

Health Financial	Systems	MEMORI AL !	HOSPITAL OF	SOUTH BEND, INC	In Lie	u of Form CMS-2552-10
ADDODEL ONMENT OF	LNDATLENT (QUEDATLENT	ANOLLI ADV. CEDVILOE	OTHER BACC	D ' I OON 45 0050	D	Wasalialaa a # D

Peri od: From 01/01/2022 To 12/31/2022 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Worksheet D Part IV THROUGH COSTS Date/Time Prepared: 5/31/2023 11:28 am Title XIX Hospi tal PPS Cost Center Description Outpati ent Inpatient Inpati ent Outpati ent Outpati ent Program Ratio of Cost Program Program Program Pass-Through to Charges Pass-Through Charges Charges (col. 6 ÷ col Costs (col. 8 Costs (col. x col . 12) 13.00 x col. 10) 7) 9.00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 37, 823, 488 0 0 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.000000 14, 144, 114 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 11, 659, 913 0 54.00 54.00 0 05700 CT SCAN 0.000000 9, 032, 753 0 57.00 57.00 0 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 1, 271, 044 58.00 0 58.00 0 59.00 05900 CARDIAC CATHETERIZATION 0.000000 3, 534, 417 0 59.00 60.00 06000 LABORATORY 0.000000 30, 326, 537 0 0 60.00 0 06001 BLOOD LABORATORY 0.000000 60 01 0 60 01 0 06500 RESPIRATORY THERAPY 17, 605, 634 65.00 0.000000 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 1,869 0 66.00 0 66.01 06602 PHYSICAL THERAPY EAST BANK 0.000000 0 66.01 0 06601 PHYSICAL THERAPY LIVING CENTER 0.000000 0 66.10 66 10 67.00 06700 OCCUPATIONAL THERAPY 0.000000 258 0 67.00 06701 OCCUPATIONAL THERAPY LIVING CENTER 0.000000 0 67.10 C 0 67.10 0 06800 SPEECH PATHOLOGY 68 00 0.000000 0 68 00 0 68.10 06801 SPEECH THERAPY LIVING CENTER 0.000000 258 0 68.10 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 669, 662 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72 00 0.000000 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 2, 875, 405 0 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0 74.00 0 0 76.00 03020 CARDI OLOGY 0.000000 2, 322, 464 0 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0 0 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 0 90.00 0 09001 FAMILY PRACTICE CLINIC 0.000000 0 0 0 90. 10 90.10 0 0 90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC 90. 30 0.000000 0 48, 134 0 90.50 09004 SLEEP DISORDERS CLINIC 0.000000 0 0 90.50 91. 00 09100 EMERGENCY 91.00 0.001912 5, 481, 772 10, 481 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 92.00 C

136, 797, 722

10.481

0

0 200. 00

200.00

Total (lines 50 through 199)

Health Financial Systems MEMOD	RIAL HOSPITAL C	OF SOUTH BEND,	I NC	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C	CN: 15-0058	Peri od:	Worksheet D	
		Component		From 01/01/2022 To 12/31/2022	Part II	narad.
		Component	CCN: 15-T058	To 12/31/2022	Date/Time Pre 5/31/2023 11:	
		Ti tl	e XIX	Subprovi der -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost (from Wkst. B,	(from Wkst. C, Part I, col.	to Charges (col. 1 ÷ col	Program	(column 3 x column 4)	
	Part II, col.	8)	2)	. Charges	COTUINIT 4)	
	26)	0)	2)			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	4, 392, 238	164, 063, 334	0. 02677	2 6, 129	164	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 317, 445	25, 003, 829	0. 05269	0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 822, 891	172, 601, 486	0. 01635	5 28, 969	474	54.00
57. 00  05700 CT SCAN	107, 367	86, 321, 431	0. 00124		18	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	153, 265	8, 372, 665			216	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	567, 846				0	59. 00
60. 00   06000   LABORATORY	463, 234				492	60.00
60. 01   06001   BL00D   LABORATORY	0		0.00000		0	60. 01
65. 00 06500 RESPI RATORY THERAPY	280, 862				90	65. 00
66. 00   06600   PHYSI CAL THERAPY	476, 093		1		14, 837	66.00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	5, 733				0	66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	2, 595				0	66. 10
67. 00   06700   OCCUPATI ONAL THERAPY 67. 10   06701   OCCUPATI ONAL THERAPY LIVING CENTER	73, 840 1, 603		1		3, 499 0	67. 00 67. 10
68. 00   06800   SPEECH PATHOLOGY	19, 112		1		840	1
68. 10   06801   SPEECH THERAPY LIVING CENTER	1, 217		1		040	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		1		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	901, 383	_			24	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	643, 909				0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	807, 264				1, 547	73. 00
74.00 07400 RENAL DIALYSIS	0			0	0	74. 00
76. 00   03020   CARDI OLOGY	126, 757	29, 109, 848	0. 00435	3, 099	13	76. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	O	0.00000	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	,					
90. 00 09000 CLINIC	0				0	
90.10 09001 FAMILY PRACTICE CLINIC	0	_			0	
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	631, 269				0	90. 30
90. 50 09004 SLEEP DI SORDERS CLINIC	109, 600				0	90. 50
91. 00 09100 EMERGENCY	3, 226, 826				0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	17 122 240	00//2/	1		0	92.00
200.00   Total (lines 50 through 199)	17, 132, 349	1, 598, 949, 218	1	1, 881, 627	22, 214	200. 00

Health Financial Systems MEMO APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RIAL HOSPITAL ORVICE OTHER PASS		CN: 15-0058		riod: om 01/01/2022	u of Form CMS-2 Worksheet D Part IV Date/Time Pre	
		· ·	e XIX		ubprovi der -	5/31/2023 11: PPS	28 am
					I RF		
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	F	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2. 00		3A	3. 00	
ANCILLARY SERVICE COST CENTERS	11.00		2.00		<u> </u>	0.00	
50. 00 05000 OPERATING ROOM	0	0		0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	o		0	o	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	О		0	o	0	54. 00
57. 00  05700 CT SCAN	0	o		0	o	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59. 00
60. 00  06000   LABORATORY	0	0		0	0	0	60.00
60. 01  06001  BLOOD LABORATORY	0	0		0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66. 00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0	0		0	0	0	66. 01
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	0	0		0	0	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
67. 10   06701   0CCUPATIONAL THERAPY LIVING CENTER 68. 00   06800   SPEECH PATHOLOGY	0	0		0	U O	0	67. 10 68. 00
68. 10   06800   SPEECH PATHOLOGY   68. 10   06801   SPEECH THERAPY LIVING CENTER	0	0		0	o O	0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	ol Ol	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	Ö		0	ol	0	
74. 00 07400 RENAL DIALYSIS	0	o		0	ol	0	74. 00
76. 00 03020 CARDI OLOGY	0	o		0	o	0	76. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	o		0	o	0	77. 00
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	0	0		0	0	0	90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	0		0	0	0	90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0		0	0	0	90. 30
90. 50 09004 SLEEP DISORDERS CLINIC	0	0		0	0	0	90. 50
91. 00   09100   EMERGENCY	0	0		0	0	176, 146	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	_	0	
200.00   Total (lines 50 through 199)	0	0		0	0	176, 146	J200. 00

	RIAL HOSPITAL O		I NC	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEITHROUGH COSTS	RVICE OTHER PASS			Peri od: From 01/01/2022	Worksheet D Part IV	
		Component	CCN: 15-T058	To 12/31/2022	Date/Time Pre 5/31/2023 11:	
			e XIX	Subprovi der - I RF	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	F 00	4 00	7. 00	instructions)	
ANCILLADY CEDVICE COCT CENTERS	4. 00	5. 00	6. 00	7.00	8. 00	
ANCI LLARY SERVI CE COST CENTERS  50. 00 05000 OPERATI NG ROOM	0	0		0 164, 063, 334	0. 000000	50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0		1	0 25, 003, 829	0.000000	
	0					
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0			0 172, 601, 486		1
57. 00   05700   CT SCAN	0			0 86, 321, 431	0.000000	
58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI)	0	0		0 8, 372, 665	0.000000	1
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0		0 37, 313, 525	0.000000	
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY	0			0 181, 731, 929	0.000000	
	0			٦	0.000000	1
65. 00 06500 RESPIRATORY THERAPY	0			0 48, 701, 515	0.000000	
66. 00 06600 PHYSI CAL THERAPY	0			0 13, 441, 048 0 5 242 349	0.000000	1
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0	0		0,2.2,0.7	0.000000	
66. 10 06601 PHYSI CAL THERAPY LIVING CENTER	0	0		0 2, 671, 260	0.000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 8, 143, 448	0.000000	
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0		0 1, 431, 637	0.000000	
68. 00 06800 SPEECH PATHOLOGY	0	0		0 4, 858, 230		
68. 10   06801   SPEECH THERAPY LIVING CENTER	0	0		0 1, 214, 185	0.000000	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 177, 155, 267	0.000000	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 192, 048, 453	0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 305, 527, 287	0.000000	
74. 00 07400 RENAL DI ALYSI S	0	0		0 0	0. 000000	1
76. 00 03020 CARDI OLOGY	0	-		0 29, 109, 848	0.000000	
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0. 000000	77. 00
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC	0	0	1	0 0	0.000000	00.00
		-	•	-	0.000000	
90. 10   09001   FAMILY PRACTICE CLINIC	0	0		0	0.000000	
90. 30   09002   HEMATOLOGY ONCOLOGY CLINIC	0	0		0 1, 616, 149		
90. 50   09004   SLEEP DI SORDERS CLINIC	0	17/ 14/	17/ 1	0 4, 150, 673		
91. 00   09100   EMERGENCY	0	176, 146	176, 14			
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART) 200.00   Total (lines 50 through 199)	0	174 144	17/ 1/	0 36, 115, 217	0. 000000	200.00
200.00   Total (Titles 50 through 199)	0	176, 146	1 1/6, 14	16 1, 598, 949, 218		J200. 00

Health Financial Systems MEMOR	RIAL HOSPITAL OF	SOUTH BEND,	I NC	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der CO	CN: 15-0058	Peri od:	Worksheet D	
THROUGH COSTS		Component (	CCN: 15-T058	From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre 5/31/2023 11:	
		Ti tl	e XIX	Subprovi der – I RF	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						1
50. 00   05000   OPERATI NG ROOM	0. 000000	6, 129		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	28, 969		0	0	54.00
57.00  05700 CT SCAN	0. 000000	14, 530		0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	11, 799		0 0	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59. 00
60. 00   06000   LABORATORY	0. 000000	193, 059		0 0	0	60.00
60. 01   06001   BL00D   LABORATORY	0. 000000	0		0 0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 000000	15, 583		0 0	0	65.00
66. 00   06600   PHYSI CAL THERAPY	0. 000000	418, 880		0 0	0	66.00
66. 01 06602 PHYSI CAL THERAPY EAST BANK	0. 000000	0		0	0	66. 01
66. 10 06601 PHYSICAL THERAPY LIVING CENTER	0. 000000	0		0 0	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	385, 877		0 0	0	67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0. 000000	0		0 0	0	67. 10
68.00 06800 SPEECH PATHOLOGY	0. 000000	213, 428		0 0	0	68. 00
68. 10 06801 SPEECH THERAPY LIVING CENTER	0. 000000	0		0 0	0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	4, 719		0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	585, 555		0 0	0	73.00
74. 00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
76. 00 03020 CARDI OLOGY	0. 000000	3, 099		0 0	0	76. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		o o	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 10 09001 FAMILY PRACTICE CLINIC	0. 000000	0		0 0	0	90. 10
90. 30 09002 HEMATOLOGY ONCOLOGY CLINIC	0. 000000	0		0 0	0	90. 30
90. 50   09004   SLEEP DI SORDERS   CLINIC	0. 000000	0		0 0	0	
91. 00   09100   EMERGENCY	0. 001912	0		0 0	0	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		1, 881, 627	I	0 0	-	200. 00

Health Financial Systems	MEMORIAL HOSPITAL OF S	SOUTH BEND, INC	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058	Peri od: From 01/01/2022	Worksheet D-1	
			To 12/31/2022	Date/Time Pre 5/31/2023 11:	
		Title XVIII	Hospi tal	PPS	
0 1 0 1 D 1 11					

		Title XVIII	Hospi tal	5/31/2023 11:: PPS	28 am_
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b	s, excluding newborn)		97, 939	1.00
2. 00 3. 00	Private room days (excluding swing-bed and observation bed day		vate room days,	97, 939 0	2. 00 3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		88, 099	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roof reporting period		31 of the cost	00,077	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	0	6. 00		
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swing-bed and	20, 560	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nly (including private ro	oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period		e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13. 00
14.00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	0. 00	18. 00		
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	0. 00	19. 00		
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	ne cost	0. 00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng period (line	128, 290, 453 0	21. 00 22. 00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)		, , ,	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	·		0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December $(x,y)$	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		0 128, 290, 453	26. 00 27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	1 and observation had ab-	argos)	0	28. 00
29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	a and observation bed cha	arges)	0	28.00
30. 00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 -	: line 28)		0. 000000	31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0. 00	34. 00
35. 00	Average per diem private room cost differential (line 34 x line)	ne 31)		0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)		66	120, 200, 452	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	rrerential (line	128, 290, 453	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		T	1 200 00	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 309. 90 26, 931, 544	38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Progra	•		20, 731, 344	40.00
41. 00	1			26, 931, 544	

COMPUTA	Financial Systems MEMOR ATION OF INPATIENT OPERATING COST		Provider Co	CN: 15-0058 P	eri od:	u of Form CMS-2 Worksheet D-1		
				F T	rom 01/01/2022 o 12/31/2022	Date/Time Pre		
-			Title	e XVIII	Hospi tal	5/31/2023 11: PPS	28 am_	
	Cost Center Description	Total Inpatient Cost	Total	Average Per Diem (col. 1 ÷	Program Days	Program Cost (col. 3 x col.		
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00		
42. 00	NURSERY (title V & XIX only)	0	0				42. 00	
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	21, 941, 850	7, 146	3, 070. 51	1, 758	5, 397, 957	43. 00	
	NEONATAL INTENSIVE CARE UNIT	15, 431, 987	8, 604			0, 397, 937	43. 00	
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00	
	SURGICAL INTENSIVE CARE UNIT						46. 00	
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00	
	Cost Center Description					1. 00		
	Program inpatient ancillary service cost (Wk	·	. ,	111 1: 10	1 1)	34, 048, 919		
	Program inpatient cellular therapy acquisition Total Program inpatient costs (sum of lines of the costs)				corumn 1)	0 66, 378, 420		
	PASS THROUGH COST ADJUSTMENTS	ationt mouting	and on (from	Wkat D sum	of Donto L and	2 (01 742	FO 00	
50. 00	Pass through costs applicable to Program inpa	atrent routine	services (iron	I WKSt. D, Sum (	or Parts r and	2, 681, 743	50. 00	
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillar	y services (fr	om Wkst. D, su	m of Parts II	1, 464, 094	51. 00	
	Total Program excludable cost (sum of lines		lated non phy	rci ci an anastha	tict and	4, 145, 837		
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line !		rated, non-pny	rsi ci ani anestne	trst, and	62, 232, 583	53. 00	
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION							
	Target amount per discharge		0 0. 00	54. 00 55. 00				
	Permanent adjustment amount per discharge	ico only)				0. 00 0. 00		
	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55	0.00	56.00					
	Difference between adjusted inpatient operat	ng cost and ta	rget amount (I	ine 56 minus I	ine 53)	0	57. 00	
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	0 0. 00	58. 00 59. 00					
40.00	updated and compounded by the market basket)			0 .	3	0.00	40.00	
	Expected costs (lesser of line 53 ÷ line 54, market basket)				, and the second	0. 00	60.00	
61. 00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less					0	61. 00	
	53) are less than expected costs (lines 54 $\times$							
62 00	enter zero. (see instructions) Relief payment (see instructions)					0	62. 00	
63. 00	Allowable Inpatient cost plus incentive payments	ent (see instru	ctions)			0		
	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporting	neriod (See	0	64. 00	
	instructions)(title XVIII only)	Ü						
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the c	cost reporting	period (See	0	65. 00	
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVIII	only); for	0	66. 00	
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	of the cost rep	orting period	0	67. 00	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repor	ting period	0	68. 00	
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient :	routine costs (	line 67 + line	e 68)		0	69. 00	
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70. 00	
	Adjusted general inpatient routine service of	,		, ,			71.00	
	Program routine service cost (line 9 x line Medically necessary private room cost applications)		(line 14 v li	ne 35)			72. 00 73. 00	
	Total Program general inpatient routine services		•	,			74.00	
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from W	lorksheet B, Pa	rt II, column		75. 00	
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00	
	Program capital -related costs (line 9 x line						77. 00 78. 00	
	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der record	ls)			78.00	
80. 00	Total Program routine service costs for companient routine service cost per diem limit		ost limitation	ı (line 78 minu	s line 79)		80. 00 81. 00	
81. 00								

83.00

84.00 85.00

86.00

9, 840 87. 00 1, 309. 90 88. 00

84.00

85.00

86.00

Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions)

Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

Program inpatient ancillary services (see instructions)

87.00 Total observation bed days (see instructions)

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu						2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		1		From 01/01/2022		
				To 12/31/2022		pared:
			\0.01.1.1		5/31/2023 11:	28 am_
		litle	XVIII	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				12, 889, 416	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
		·		Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
				The state of the s	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	11, 149, 229	128, 290, 453	0. 08690	6 12, 889, 416	1, 120, 168	90.00
91.00 Nursing Program cost	0	128, 290, 453	0. 00000	0 12, 889, 416	0	91.00
92.00 Allied health cost	0	128, 290, 453	0. 00000	0 12, 889, 416	0	92.00
93.00 All other Medical Education	0	128, 290, 453	0. 00000	0 12, 889, 416	0	93.00

Health Financial Systems	MEMORIAL HOSPITAL OF S	SOUTH BEND, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058	Peri od: From 01/01/2022	Worksheet D-1
		Component CCN: 15-T058	To 12/31/2022	Date/Time Prepared: 5/31/2023 11:28 am
		Title XVIII	Subprovider -	PPS

		litie XVIII	Supprovider -	PPS	
	Cost Center Description		TIM		
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s excluding newborn)	T	4, 924	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			4, 924	2. 00
3.00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be		. 21 -6 -1	4, 924	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roof reporting period	om days) through becembe	1 31 01 the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om 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	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceiibei 3	i oi the cost	U	8.00
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	1, 245	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruc-	nly (including private r	oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	ulv (including private r	oom days) after	0	11. 00
00	December 31 of the cost reporting period (if calendar year, en		days, ares.	· ·	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	/! (!!		0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar years)			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	3 - 3 - 3	,	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT		6.11	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	r the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20. 00
20.00	reporting period	s arter becember 51 or t	THE COST	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			6, 455, 984	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17)   Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6	0	23. 00
23.00	x line 18)	31 of the cost reportin	g perrod (Trile o	O	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)				05.00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 455, 984	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed ch	arges)	0	28. 00
29. 00 30. 00	Semi - pri vate room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mil		tions)	0. 00 0. 00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ie 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	6, 455, 984	37. 00
	27 minus line 36)		<u> </u>		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTO			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see		I	1 211 12	20 00
38. 00 39. 00	Program general inpatient routine service cost per diem (see			1, 311. 13 1, 632, 357	
40. 00	Medically necessary private room cost applicable to the Progra			0	
	Total Program general inpatient routine service cost (line 39			1, 632, 357	

Intensive Care Type Inpatt ent Hospit al Units			RIAL HOSPITAL C				eu of Form CMS-	
Construction   Cons	OMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0058			
Title XVII   Subprovider   PPS   Record   PROGRAM   PR				Component	CCN: 15-T058		Date/Time Pre	
Total   Average Fed   Program Days   Coci   3 x col   4.00   5.00   1.00   2.00   3.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   5.00   4.00   6.				Ti tl e	e XVIII	Subprovi der -		28 aiii
Impatient Cost   Days			T	T	I 4 B			
MIRSERY (TITLE V.S.XIX.only)		Cost Center Description				9		
December			Impatrent oost	impatront bays				
Intensive Care Type Inpatient Hospital Units		NURSERY (III III A VIV.						10.
On   INTERSIVE CARE UNIT	2. 00		0	<u> </u>	0.	DO  C	0	42.0
00 CORNARY CARE UNIT 00 SURGICAL INTERSIVE CARE UNIT 00 THER NETERSIVE CARE UNIT 00 THER NETERSIVE CARE UNIT 01 OTHER SPECIAL CARE (SPECIFY)  Cost Center Description 1.00  1.	3. 00		Ιο	C	0.	00 0	0	43. (
00 BURN INTERSIVE CARE UNIT 00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description  1.00  OTHER SPECIAL CARE (SPECIFY) Cost Center Description  1.00  OTHER SPECIAL CARE (SPECIFY) Cost Center Description  Program inpatient cacits (you of lines 41 through 48.01) (see instructions)  OTHER SPECIAL CARE (SPECIFY) Cost Center Description  OTHER SPECIAL CARE (SPECIAL			0	C	1			
On SURGICAL INTENSIVE CARE UNIT 4.00 OTHER SPECIAL CARE (SPECIAL)								44. (
Cost Center Description    Cost Center Description   1.00								45. (
Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Program inpatient cost (livist. D-3, col. 3, line 200) Program inpatient cost (sum of lines 41 through 48, 01) (see instructions) Pass Through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III) Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and III) Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and III) Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and III) Program excludable cost (sum of lines 50 and 51) Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 2, 166,911 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 2, 166,911 Target amount per discharge 0,00 Program discharges 0,00 Target amount per discharge 0,00 Deman payment (see instructions) 0,00 Target amount (line 54 x sum of line 55, 5.01, and 55.02) Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0,57 Deman payment (see instructions) 0,58 Target amount (line 53 x line 53 x line 54, or line 55 from the cost reporting period ending 1996, 0,58 Target								1
Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) PASS THROUGH COST ADJUSTMENTS PASS THROUGH COST	7.00							47.0
Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)		oost outter boson per on					1.00	
total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)  Pass Through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts I and 134,099 50.111)  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts I and 134,099 50.111)  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts I and 134,099 50.111)  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts I and 134,099 50.111)  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts I and 134,099 50.111)  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts I and 134,099 50.111)  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts I and 134,099 50.111)  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts I and 2,095 50.111)  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts I and 2,095 50.111)  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts I and 2,095 50.111)  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts I and 2,095 50.111)  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts I and 2,095 50.111)  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts I and 2,095 50.111)  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts I and 2,095 50.111)  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts I and 2,095 50.111)  Pass through costs applicable to Program (line 14 x line 35)  Pass through costs applicable to Program (line 14 x line 35)  Pass through costs applicable to Program (li	3. 00						701, 048	1
PASS THROUGH COST ADJUSTNENTS  Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and I 34,099 so III)  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)  Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)  Total Program excludable cost (sum of lines 50 and 51)  Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and education costs (line 49 minus line 52)  TARGET ANDUNT AND LIMIT COMPUTATION  Program discharges  O 54.  Target amount per discharge  O 0 75.  Adjustment adjustment amount per discharge (contractor use only)  Adjustment adjustment adjustment inless 55, 501, and 55.02  Adjustment amount (line 54 x sum of lines 55, 501, and 55.02)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 58)  Difference between adjusted inpatient for line 55 from prior year cost report, updated by the market basket)  Difference between adjusted inpatient for line 55 from prior year cost report, updated by the market basket)  Difference between adjusted by the market basket of the baske						column 1)		
134,099   50.	0. 00		41 through 48.(	01)(see instruc	ctions)		2, 333, 405	49.
111   11   11   11   11   11   12   13   13			ationt routine	services (from	n Wket D su	m of Darte L and	13/ 000	50
Sease through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)   30,395   51.	. 00		attent routine	services (ITOII	ii wkst. D, Sui	ii or raits r and	134, 077	30.
Total Program excludable cost (sum of lines 50 and 51)  Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and modical education costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION  Program discharges  TARGET AMOUNT AND LIMIT COMPUTATION  Degramment adjustment amount per discharge  Difference between adjustment amount per discharge (contractor use only)  Target amount (line 54 x sum of lines 55, 55.01, and 55.02)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  Difference between adjusted inpatient 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)  Difference costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)  Difference costs (lesser of line 53 + line 54 is less than the lowest of lines 55 plus on line 53, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53.0) are less than expected costs (line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53.0) are less than expected costs (line 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only):  Dital Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Medicare swing	. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (fr	om Wkst. D,	sum of Parts II	30, 395	51. (
Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)  Target amount per discharge  Oncolor Program discharges  Target amount per discharge  Adjustment amount per discharge  Adjustment amount per discharge (contractor use only)  Target amount (line 54 x sum of lines 55, 55.01, and 55.02)  Target amount (line 54 x sum of lines 55, 55.01, and 55.02)  Target amount (line 54 x sum of lines 55, 55.01, and 55.02)  Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)  Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)  Expected costs (lesser of line 54 + or line 55 from prior year cost report, updated by the market basket)  Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 50.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)  Relief payment (see instructions)  Relief payment (see instructions)  Allowable Inpatient cost plus incentive payment (see instructions)  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tine 100 x 100	. 00		50 and 51)				164. 494	52.
TARREET MOUNT AND LIMIT COMPUTATION  Program discharges  0 0 54.  Target amount per discharge  0 0 0 55.  Adjustment amount per discharge (contractor use only)  1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		•	,	elated, non-phy	sician anestl	netist, and		1
0 Program discharges 0 5 54. 0 Target amount per discharge 0.00 55. 01 Permanent adjustment amount per discharge 0.00 55. 01 Permanent adjustment amount per discharge 0.00 55. 02 Adjustment amount per discharge (contractor use only) 0.00 55. 03 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 0.00 10 Irference between adjusted inpatitent operating cost and target amount (line 56 minus line 53) 0.57. 04 Bonus payment (see instructions) 0.58. 05 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 0.00 Expected costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 0.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 0.62. 04 All Owable Inpatient cost plus incentive payment (see instructions) 0.63. 05 All Owable Inpatient cost plus incentive payment (see instructions) 0.64. 06 All Owable Inpatient cost plus incentive payment (see instructions) 0.65. 07 All Owable Inpatient cost plus incentive payment (see instructions) 0.65. 08 All Owable Inpatient cost plus incentive payment (see instructions) 0.65. 09 All Owable Inpatient cost plus incentive payment (see instructions) 0.65. 00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (tille XVIII only); for 0.66. 06 All Owable Inpatient in a XIII only 0.66. 07 All owable Inpatient in All owable 0.67. 08 All owable 0.68 Instructions 0.68. 09 All owable 0.68 Instructions 0.69. 09 All owable 0.68		medical education costs (line 49 minus line						
1 Permanent adjustment amount per discharge   0.00   55.   2 Permanent adjustment amount per discharge (contractor use only)   0.00   55.   3 Adjustment amount per discharge (contractor use only)   0.00   55.   3 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)   0.50   3 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)   0.50   3 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0.50   4 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0.50   5 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0.50   5 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0.50   6 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0.50   6 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0.50   6 Difference between adjusted inpatient post between the cost reporting period ending 1996, updated and compounded by the market basket)   0.00   7 Difference cost (line 53 + line 54, or line 55 from the cost report, updated by the market basket)   0.00   8 Difference cost of lines 53 + line 54, or line 55 from prior year cost report, updated by the market basket)   0.00   9 Difference cost (line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)   0.00   0.00   9 Difference cost (line 53 + line 54, or line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 53 + line 54, or line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 53 + line 54, or line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 59, or line 53 + line 54, or line 59 from prior year cost reporting period (see instructions)   0.00   9 Difference swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions)   0.00   9 Difference swing-bed							1	
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55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)  Relief payment (see instructions)  Relief payment (see instructions)  Relief payment (see instructions)  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions  Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  Adjusted general inpatient routine service cost (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID DNLY  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 + line 2)  Program routine service cost (line 9 x line 71)  Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (line 72 + line 73)  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  Per diem capital-related costs (line 9 x line 76)	. 00		e 53 ÷ line 54	is less than t	the lowest of	lines 55 plus	0	61. (
enter zero. (see instructions)  Relief payment (see instructions)  Allowable Inpatient cost plus incentive payment (see instructions)  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions  Title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions  Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 + line 2)  Program routine service cost (line 9 x line 71)  Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  Per diem capital-related costs (line 75 + line 2)  Program capital-related costs (line 9 x line 76)  76.								
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Allowable Inpatient cost plus incentive payment (see instructions)  PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions  Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (67. (line 12 x line 19))  Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 + line 2)  Program routine service cost (line 9 x line 71)  Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  Per diem capital -related costs (line 75 + line 2)  Program capital -related costs (line 9 x line 76)								42
PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions  Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 + line 2)  Program routine service cost (line 9 x line 71)  Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (line 72 + line 73)  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  Per diem capital-related costs (line 9 x line 76)			ent (see instr	ictions)				1
instructions) (title XVIII only)  Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions  Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  Program routine service cost (line 9 x line 71)  Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  O Per diem capital-related costs (line 75 ÷ line 2)  Program capital-related costs (line 9 x line 76)  75.			0.11 (000 111011	201101101				1
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instructions)(title XVIII only)  Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions  Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  Program routine service cost (line 9 x line 71)  Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (line 72 + line 73)  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  Per diem capital-related costs (line 75 ÷ line 2)  Program capital-related costs (line 9 x line 76)								
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CAH, see instructions  Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  Program routine service cost (line 9 x line 71)  Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (line 72 + line 73)  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  Per diem capital-related costs (line 75 ÷ line 2)  Program capital-related costs (line 9 x line 76)	5 00		na costs (lina	64 nlus line A	55)(+i+l_ YVI	II only): for	0	66
Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  Program routine service cost (line 9 x line 71)  Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (line 72 + line 73)  Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  Per diem capital -related costs (line 9 x line 76)  75.	J. 00	9 1	110 00313 (11110	of prus trile c	os) (ti ti e xvi	11 Only), 101		00.
Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 + line 2)  Program routine service cost (line 9 x line 71)  Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (line 72 + line 73)  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  Per diem capital-related costs (line 75 + line 2)  Program capital-related costs (line 9 x line 76)	7. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	n December 31 d	of the cost re	eporting period	0	67. (
(line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 + line 2)  Program routine service cost (line 9 x line 71)  Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (line 72 + line 73)  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  Per diem capital-related costs (line 75 + line 2)  Program capital-related costs (line 9 x line 76)								
Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  Program routine service cost (line 9 x line 71)  Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (line 72 + line 73)  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  Per diem capital-related costs (line 75 ÷ line 2)  Program capital-related costs (line 9 x line 76)  71.	. 00		e costs after [	December 31 of	the cost rep	orting period	0	68. (
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  Program routine service cost (line 9 x line 71)  Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (line 72 + line 73)  Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  Per diem capital -related costs (line 75 ÷ line 2)  Program capital -related costs (line 9 x line 76)  71.	00	· ·	routine costs (	(line 67 + line	68)		0	69
ON Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  Program routine service cost (line 9 x line 71)  Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (line 72 + line 73)  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  Per diem capital-related costs (line 75 ÷ line 2)  Program capital-related costs (line 9 x line 76)  70.								37.
Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  Program routine service cost (line 9 x line 71)  Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (line 72 + line 73)  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  Per diem capital-related costs (line 75 ÷ line 2)  Program capital-related costs (line 9 x line 76)  71.  72.  73.  74.  75.  76.  77.						)		70.
00 Medically necessary private room cost applicable to Program (line 14 x line 35) 100 Total Program general inpatient routine service costs (line 72 + line 73) 100 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 100 Per diem capital-related costs (line 75 ÷ line 2) 100 Program capital-related costs (line 9 x line 76) 172 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 75.		9	-					71.
Total Program general inpatient routine service costs (line 72 + line 73)  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  Per diem capital-related costs (line 75 ÷ line 2)  Program capital-related costs (line 9 x line 76)  74.  75.  76.  77.		Program routine service cost (line 9 x line	71)					72.
OD Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) OD Per diem capital-related costs (line 75 ÷ line 2) OD Program capital-related costs (line 9 x line 76) 77.	. 00	3		•	,			73.
26, line 45)  00 Per diem capital-related costs (line 75 ÷ line 2)  00 Program capital-related costs (line 9 x line 76)  76.	. 00	· ·	•					74.
00 Per diem capital-related costs (line 75 ÷ line 2) 00 Program capital-related costs (line 9 x line 76) 76.	. 00	•	routine service	e costs (from V	Worksheet B, I	Part II, column		75.
00 Program capital-related costs (line 9 x line 76)	, 00		ne 2)					76
	. 00							77.
00  Inpatient routine service cost (line 74 minus line 77)   78.		•					i	1

78.00 | Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 81.00 Inpatient routine service cost per diem limitation 81.00 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) 83.00 83. 00 84.00 84.00 85.00 85.00 Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 86.00 86.00 87.00 Total observation bed days (see instructions) 0 87.00 MCRI F32 - 19. 1. 175. 2

Health Financial Systems MEMOI	RIAL HOSPITAL O	F SOUTH BEND,	In Lie	u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (		From 01/01/2022 To 12/31/2022		
		Title XVIII Subprovider -		PPS	PPS	
Cost Center Description						
					1.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88. 00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital -related cost	530, 341	6, 455, 984	0. 08214	7 0	0	90.00
91.00 Nursing Program cost	0	6, 455, 984	0.00000	0	0	91.00
92.00 Allied health cost	0	6, 455, 984	0.00000	0	0	92.00
93.00 All other Medical Education	0	6, 455, 984	0.00000	0	0	93. 00

Health Financial Systems	MEMORIAL HOSPITAL OF S	SOUTH BEND, INC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Prep 5/31/2023 11:	
		Title XIX	Hospi tal	PPS	20 alli
Cost Center Description					

				5/31/2023 11:	28 am
		Title XIX	Hospi tal	PPS	
	Cost Center Description				
	'			1.00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				1
1.00	Inpatient days (including private room days and swing-bed days	s. excluding newborn)		97, 939	1.00
2.00	Inpatient days (including private room days, excluding swing-			97, 939	2. 00
3.00	Private room days (excluding swing-bed and observation bed day		vate room days	0	3. 00
0.00	do not complete this line.	ys). It you have omly pri	vate room days,		0.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		88, 099	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	00,077	5. 00
5.00	reporting period	on days) through becember	31 Of the Cost	l o	3.00
6. 00	Teportring period  Total swing-bed SNF type inpatient days (including private roo	om days) after December (	21 of the cost	0	4 00
6.00		om days) after becember .	31 OF the Cost	ال	6. 00
7 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roor	n daya) thraugh Dagambar	21 of the cost	0	7 00
7. 00		ii days) through beceiiber	31 Of the Cost	ال	7. 00
0.00	reporting period		1 6 11		0.00
8. 00	Total swing-bed NF type inpatient days (including private roor	m days) arter becember 3	or the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	5			
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	4, 338	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
	through December 31 of the cost reporting period (see instruc-				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er				
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)	K only (including private	e room days)	0	12. 00
	through December 31 of the cost reporting period				
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this line	e)		
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	14.00
15.00	Total nursery days (title V or XIX only)		-	3, 953	15. 00
16.00	Nursery days (title V or XIX only)			350	16. 00
	SWING BED ADJUSTMENT				İ
17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period				
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
. ,	reporting period	s in ough becomes of or	11.0 0001		171.00
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00
20.00	reporting period	3 4. 10. 200020. 0. 0. 1.			20.00
21. 00	Total general inpatient routine service cost (see instructions	3)		128, 290, 453	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line		22. 00
22.00	5 x line 17)	or or the cost reporti	ing period (inic		22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	n nariod (line 6	o	23. 00
23.00	x line 18)	of the cost reporting	g period (iiile o		25.00
24. 00	Swing-bed cost applicable to NF type services through December	21 of the cost reportion	na poriod (line	0	24. 00
24.00	7 x line 19)	31 of the cost reportin	ig period (Title	l o	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	21 of the cost reporting	poriod (line 0	0	25. 00
25.00	x line 20)	of the cost reporting	perrou (Trile o	l o	25.00
26. 00	Total swing-bed cost (see instructions)			o	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 24)		128, 290, 453	•
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TITIE 21 IIITIUS TITIE 26)		120, 290, 433	27.00
00 00			`		00.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	•
29. 00	Private room charges (excluding swing-bed charges)			0	1
30.00	Semi-private room charges (excluding swing-bed charges)			0	
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	1
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 min		tions)	0.00	34. 00
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37.00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	128, 290, 453	37. 00
	27 minus line 36)	-	•	<u> </u>	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			1
38.00	Adjusted general inpatient routine service cost per diem (see			1, 309. 90	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	*		5, 682, 346	1
	Medically necessary private room cost applicable to the Progra	-		0	40.00
	Total Program general inpatient routine service cost (line 39	,		5, 682, 346	1
	J . J	/		.,,	

	Financial Systems MEMOF ATION OF INPATIENT OPERATING COST	RIAL HOSPITAL O			Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2022 To 12/31/2022	Date/Time Prep 5/31/2023 11:3	
			Ti tl	e XIX	Hospi tal	PPS	20 alli
	Cost Center Description	Total	Total	Average Per		Program Cost	
		inpatient cost	Inpatient Days	col. 2)	÷	(col. 3 x col. 4)	
42.00	NUDCEDY (+; +Lo V & VIV only)	1.00	2.00	3.00	4. 00	5. 00	42.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	3, 389, 485	3, 953	857. 4	350	300, 108	42. 00
43.00	INTENSIVE CARE UNIT	21, 941, 850		•			43. 00
	NEONATAL INTENSIVE CARE UNIT	15, 431, 987	8, 604	1, 793. 5	1, 132	2, 030, 333	43. 01
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)			<u> </u>			47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	, line 200)			32, 573, 788	48. 00
48. 01	Program inpatient cellular therapy acquisition				column 1)	0	48. 01
	Total Program inpatient costs (sum of lines A PASS THROUGH COST ADJUSTMENTS	41 through 48.0	1)(see instruc	ctions)		40, 862, 921	49. 00
50.00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sum	of Parts I and	692, 785	50. 00
E1 00	)	ationt andillon	v comileos (fr	som Wko+ D. o	um of Dorsto II	2 450 102	F1 00
51. 00	Pass through costs applicable to Program inpa and IV)	atient anciliar	y services (fr	OM WKSt. D, S	sum of Parts II	2, 458, 183	51. 00
	Total Program excludable cost (sum of lines!					3, 150, 968	•
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !		lated, non-phy	sician anesth	etist, and	37, 711, 953	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
54.00	Program di scharges						54. 00
55. 00							55. 00
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor u	ise only)					55. 01 55. 02
	Target amount (line 54 x sum of lines 55, 55.					0.00	56. 00
	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54, o	or line EE from	the cost rone	eting ported	anding 1004	0 0. 00	58. 00 59. 00
39.00	updated and compounded by the market basket)	or title 55 from	the cost repo	n tring perrou	ending 1996,	0.00	39.00
60.00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior year o	ost report, u	pdated by the	0. 00	60. 00
61. 00	<pre>market basket) Continuous improvement bonus payment (if line</pre>	- 53 ÷ line 54	is less than t	he lowest of	lines 55 nlus	0	61. 00
01.00	55.01, or line 59, or line 60, enter the less						01.00
	53) are less than expected costs (lines 54 $\ensuremath{\text{x}}$	60), or 1 % of	the target an	nount (line 56	), otherwise		
62 00	enter zero. (see instructions) Relief payment (see instructions)					0	62. 00
	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	1
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	cost reporting	period (See	0	65. 00
// 00	instructions)(title XVIII only)	+- (1:	/	E) (+: +1 - )(/// 1			
66. 00	Total Medicare swing-bed SNF inpatient routin CAH, see instructions	ne costs (iine	64 prus rine 6	ob)(title XVII	i only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	of the cost re	porting period	0	67. 00
40.00	(line 12 x line 19)	a acata aftan D	acamban 21 af	the cost mana	unting paried	0	40.00
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after b	ecember 31 01	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU						70.00
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of						70. 00 71. 00
	Program routine service cost (line 9 x line			,			72.00
	Medically necessary private room cost applications						73. 00
74.00	Total Program general inpatient routine servi	•			ert II column		74.00
75. 00	Capital-related cost allocated to inpatient (26, line 45)	outine Service	COSIS (IIOII W	IOIKSHEEL B, F	art II, COLUMN		75. 00
		20 2)					76. 00
	Per diem capital-related costs (line 75 ÷ li						1
	Program capital-related costs (line 73 - line Inpatient routine service cost (line 74 minus	76)					77. 00 78. 00

79.00

80.00

81.00

82.00

83.00

84. 00 85. 00

86.00

9, 840 87. 00 1, 309. 90 88. 00

80.00

82.00

84.00

85.00

86.00

79.00 Aggregate charges to beneficiaries for excess costs (from provider records)

Inpatient routine service cost limitation (line 9 x line 81)

Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)

83.00 Reasonable inpatient routine service costs (see instructions)

Program inpatient ancillary services (see instructions)

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

81.00 | Inpatient routine service cost per diem limitation

87.00 Total observation bed days (see instructions)

Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC			In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Prepared: 5/31/2023 11:28 am	
		Title XIX		Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				12, 889, 416	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital -related cost	11, 149, 229	128, 290, 453	0. 08690	6 12, 889, 416	1, 120, 168	90.00
91.00 Nursing Program cost	0	128, 290, 453	0.00000	0 12, 889, 416	0	91.00
92.00 Allied health cost	0	128, 290, 453	0.00000	0 12, 889, 416	0	92.00
93.00 All other Medical Education	o	128, 290, 453	0. 00000	0 12, 889, 416	0	93. 00

Health Financial Systems	MEMORIAL HOSPITAL OF S	SOUTH BEND, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0058	Peri od: From 01/01/2022	Worksheet D-1
		Component CCN: 15-T058	To 12/31/2022	Date/Time Prepared: 5/31/2023 11:28 am
		Title XIX	Subprovi der -	PPS

		II the XIX	I RF	FF3	
	Cost Center Description				
	DADT I ALL DDOVIDED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		4, 924	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			4, 924 0	2. 00
3. 00					3. 00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		4, 924	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period				, 00
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	or the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
	reporting period			_	
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	34	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		om days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		om davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	( only (including private	room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	(only (including private	room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			O	13.00
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed d	ays)	0	14. 00
15.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)				15.00
16. 00	SWING BED ADJUSTMENT			350	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
40.00	reporting period			0.00	40.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of t	he cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
	reporting period	<u> </u>			
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	e cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	s)		6, 455, 984	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
22.00	5 x line 17)	21 of the cost reporting	noried (line (	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (iine 6	U	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	g period (line	0	24. 00
05.00	7 x line 19)				05 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	or the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		6, 455, 984	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation had cha	raes)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed cha	i ges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	ions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin		/	0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost dif	ferential (line	6, 455, 984	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38.00	Adjusted general inpatient routine service cost per diem (see			1, 311. 13	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	-		44, 578 0	
	Total Program general inpatient routine service cost (line 39	•		44, 578	
		,	'		

		RIAL HOSPITAL C				eu of Form CMS-:	
OMPUT.	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0058	Period: From 01/01/2022	Worksheet D-1	
			Component	CCN: 15-T058	To 12/31/2022	Date/Time Pre	
			Ti tl	e XIX	Subprovi der -	5/31/2023 11: PPS	28 alli
		T	T		IRF		
	Cost Center Description	Total	Total Inpatient Days	Average Per		Program Cost (col. 3 x col.	
		impatront oost	impatront bays	col . 2)		4)	
	NUPOEDY (III II I	1.00	2. 00	3.00	4. 00	5.00	
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.	00 0	0	42. 0
3. 00	INTENSIVE CARE UNIT	1 0	C	0.	00 0	0	43. (
	NEONATAL INTENSIVE CARE UNIT	0	C			o	43. (
	CORONARY CARE UNIT						44. (
	BURN INTENSIVE CARE UNIT						45. (
	SURGICAL INTENSIVE CARE UNIT						46. (
7.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.
	oost denter boschiptron					1. 00	
3. 00	Program inpatient ancillary service cost (Wk					509, 717	1
	Program inpatient cellular therapy acquisiti				column 1)	0	
0. 00	Total Program inpatient costs (sum of lines	41 through 48.(	01)(see instruc	ctions)		554, 295	49.
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routine	services (from	Wket D su	m of Darte L and	3, 662	50.
, 00	III)	atrent routine	SCIVICCS (ITOI	i wkst. b, sui	ii or raits r and	3,002	30.
. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	ry services (fr	om Wkst. D,	sum of Parts II	22, 214	51.
. 00	Total Program excludable cost (sum of lines	50 and 51)				25, 876	52.
3. 00	Total Program inpatient operating cost exclu		elated, non-phy	sician anestl	netist, and	528, 419	53.
	medical education costs (line 49 minus line	52)					
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					T 0	54.
	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge					0.00	1
	Adjustment amount per discharge (contractor	use only)				0.00	1
. 00	Target amount (line 54 x sum of lines 55, 55	. 01, and 55. 02)	)			0	56.
	Difference between adjusted inpatient operat	ing cost and ta	arget amount (I	ine 56 minus	line 53)	0	1
3. 00	Bonus payment (see instructions)	I: FF 6	. 464			0	
9. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)	or line 55 from	n the cost repo	orting period	ending 1996,	0.00	59.
. 00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior year o	cost report,	updated by the	0.00	60.
. 00	<pre>market basket) Continuous improvement bonus payment (if lin</pre>	e 53 ÷ line 54	is less than t	he lowest of	lines 55 nlus	0	61.
. 00	55.01, or line 59, or line 60, enter the les						01.
	53) are less than expected costs (lines 54 $\times$	60), or 1 % of	f the target an	nount (line 5	6), otherwise		
	enter zero. (see instructions)						
	Relief payment (see instructions)	ent (see instr	ictions)			0 0	
. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see Histit	actions)				1 03.
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost report	ng period (See	0	64.
	instructions)(title XVIII only)	-					
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the d	cost reportin	g period (See	0	65.
. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 plus line 4	5)(+i+lo V//	II only): for	0	66.
5. 00	CAH, see instructions	ne costs (Title	04 prus rine c	os)(title xvi	i i oniy), roi		00.
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31 d	of the cost re	eporting period	0	67.
	(line 12 x line 19)						
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after [	December 31 of	the cost rep	orting period	0	68.
00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (	Cline 67 + line	. 68)		0	69.
- 0	PART III - SKILLED NURSING FACILITY, OTHER N					·	1
. 00	Skilled nursing facility/other nursing facil				)		70.
. 00	Adjusted general inpatient routine service c	ost per diem (I	ine 70 ÷ line	2)			71.
	Program routine service cost (line 9 x line						72.
. 00	Medically necessary private room cost applic		•				73.
. 00	Total Program general inpatient routine serv				Dont III		74.
6. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from V	worksneet B, I	rant II, column		75.
. 00	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					1	78.
UU	The 74 minu	3 11116 11)					/ 0.

78.00 | Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 81.00 Inpatient routine service cost per diem limitation 81.00 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) 83.00 83. 00 84.00 84.00 85.00 85.00 Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 86.00 86.00 87.00 Total observation bed days (see instructions) 0 87.00 MCRI F32 - 19. 1. 175. 2

Health Financial Systems MEMOF	RIAL HOSPITAL O	F SOUTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (		From 01/01/2022 To 12/31/2022		
		Ti tl	e XIX	Subprovi der - I RF	PPS	
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0.00	88. 00
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	530, 341	6, 455, 984	0. 08214	7 0	0	90.00
91.00 Nursing Program cost	0	6, 455, 984	0.00000	0 (C	0	91. 00
92.00 Allied health cost	0	6, 455, 984	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	6, 455, 984	0.00000	0 0	0	93.00

Health Financial Systems	MEMORIAL HOSPITAL OF SOUTH BEND, INC	In Li	eu of Form CMS-2552-10
INDATIENT ANGLI LADV CEDVI CE COCT ADDODT	ONMENT Describes CON 15 0050	D!!	WI D 2

Health Financial Systems MEMORIAL HOSPITAL OF S	OUTH BEND,	INC	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider Co	CN: 15-0058	Peri od:	Worksheet D-3	
			From 01/01/2022		
			To 12/31/2022	Date/Time Pre	
	T: +1 o		Hooni tol	5/31/2023 11:	28 am_
Ct Ct Pinti	IIIII	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INDATIONE DOUBLING CODYLOG COST CONTEDS		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS  30. 00 03000 ADULTS & PEDIATRICS		1	42 O2E 240		20 00
			63, 035, 248		30.00
31. 00   03100   INTENSIVE CARE UNIT			9, 108, 420		31.00
31. 01   02060   NEONATAL INTENSIVE CARE UNIT			0		31. 01
40. 00   04000   SUBPROVI DER -   PF			0		40.00
41. 00   04100   SUBPROVI DER - I RF			0		41.00
43. 00   04300  NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS		1 004400	ol 45 404 540		
50. 00   05000   OPERATING ROOM		0. 31422		4, 868, 701	50. 00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 53862		0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 13524		2, 000, 303	54. 00
57. 00   05700   CT   SCAN		0. 03441		236, 171	57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)		0. 24871		300, 301	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0. 10312	2 4, 244, 414	437, 692	59. 00
60. 00   06000   LABORATORY		0. 11479	2 26, 122, 866	2, 998, 696	60.00
60. 01   06001   BL00D   LABORATORY		0.00000	0 0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY		0. 17957	5 11, 617, 870	2, 086, 279	65. 00
66. 00   06600 PHYSI CAL THERAPY		0. 42730	9 1, 455, 037	621, 750	66.00
66. 01 06602 PHYSI CAL THERAPY EAST BANK		0. 29977	7 0	0	66. 01
66. 10 06601 PHYSICAL THERAPY LIVING CENTER		0. 27393	5 0	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY		0. 31528		340, 139	67. 00
67. 10 06701 OCCUPATIONAL THERAPY LIVING CENTER		0. 30695		0	67. 10
68. 00 06800 SPEECH PATHOLOGY		0. 31032		120, 246	68. 00
68. 10   06801   SPEECH THERAPY LIVING CENTER		0. 28376		0	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 00000		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 17900		3, 595, 028	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 23212		7, 076, 498	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 18331		5, 913, 441	73. 00
74. 00   07400   RENAL DI ALYSI S		0. 00000		0, 713, 441	74.00
76. 00   03020   CARDI OLOGY		0. 13264		538, 478	76.00
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON		0. 00000		0 0	77. 00
OUTPATIENT SERVICE COST CENTERS		0.00000	U U	U	77.00
90. 00   09000   CLINI C		0.00000		0	90.00
		0.00000		0	90.00
		0.00000		0	
90. 30   09002   HEMATOLOGY ONCOLOGY CLINIC		1. 46810		_	90. 30
90. 50   09004   SLEEP DI SORDERS CLINIC		0. 28088		0	90. 50
91. 00   09100   EMERGENCY		0. 51674		2, 915, 196	91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)		0. 35689		0	92.00
Total (sum of lines 50 through 94 and 96 through 98)	(1)		175, 790, 219	34, 048, 919	•
201.00 Less PBP Clinic Laboratory Services-Program only charges	(IINE 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)		I	175, 790, 219		202. 00

I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0058 CCN: 15-T058	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Pre 5/31/2023 11:	pare
		Ti tl d	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	,	Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00	03000 ADULTS & PEDI ATRI CS					30.
31. 00	03100 I NTENSI VE CARE UNI T					31.
31. 01	02060 NEONATAL INTENSIVE CARE UNIT					31.
10.00	04000 SUBPROVI DER - I PF					40.
1.00	04100 SUBPROVI DER - I RF			4, 055, 195		41.
3. 00	04300 NURSERY					43.
	ANCILLARY SERVICE COST CENTERS					
0. 00	05000 OPERATING ROOM		0. 3142		5, 339	1
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 5386		0	52
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1352		3, 294	
7. 00	05700 CT SCAN		0. 0344		976	
8. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 2487		437	58
9. 00	05900 CARDI AC CATHETERI ZATI ON		0. 1031		0	59
0.00	06000 LABORATORY		0. 1147			
0. 01 5. 00	06001 BL00D LABORATORY 06500 RESPI RATORY THERAPY		0.0000		0	60 65
5. 00	06600 PHYSI CAL THERAPY		0. 1795 0. 4273		23, 718 238, 648	
6. 01	06602 PHYSICAL THERAPY EAST BANK		0. 4273		230, 040	66
6. 10	06601 PHYSI CAL THERAPY LIVING CENTER		0. 2739		0	66
7. 00	06700 OCCUPATI ONAL THERAPY		0. 3152		182, 804	67
7. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER		0. 3069		0	67
8. 00	06800 SPEECH PATHOLOGY		0. 3103		84, 637	68
8. 10	06801 SPEECH THERAPY LIVING CENTER		0. 2837		0	68
0. 00	07000 ELECTROENCEPHALOGRAPHY		0.0000	00 0	0	70
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1790	08 5, 270	943	71
2. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 2321	23 2, 400	557	72
3. 00	07300 DRUGS CHARGED TO PATIENTS		0. 1833	12 685, 638	125, 686	73
4. 00	07400 RENAL DI ALYSI S		0.0000	00	0	74.
5. 00	03020 CARDI OLOGY		0. 1326		0	76.
7. 00	07700 ALLOGENEIC STEM CELL ACQUISITION		0.0000	00 0	0	77.
	OUTPATIENT SERVICE COST CENTERS					
0. 00	09000 CLI NI C		0.0000		0	
0. 10	09001 FAMILY PRACTICE CLINIC		0.0000		0	90.
0. 30	09002 HEMATOLOGY ONCOLOGY CLINIC		1. 4681		0	90
	09004 SLEEP DI SORDERS CLINIC		0. 2808		0	

0.516742

0. 356897

2, 604, 155

91.00

0 92.00

701, 048 200. 00 201. 00 202. 00

91.00

201.00

202.00

09100 EMERGENCY

92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART)
200. 00 | Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

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

Health Financial Systems	MEMORIAL HOSPITAL OF S	OUTH BEND,	INC	In Lie	u of Form CMS-2552-10

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND	, INC	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider	CCN: 15-0058	Peri od:	Worksheet D-3	
		From 01/01/2022		
		To 12/31/2022		
Ti-	tle XIX	Hospi tal	5/31/2023 11: PPS	28 am_
Cost Center Description	Ratio of Cos		Inpati ent	
cost center bescription	To Charges	Program	Program Costs	
	10 Charges	Charges	(col. 1 x col.	
		onal ges	2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS		53, 738, 294		30.00
31.00 O3100 INTENSIVE CARE UNIT		16, 993, 135		31. 00
31.01 02060 NEONATAL INTENSIVE CARE UNIT		19, 973, 465		31. 01
40. 00   04000   SUBPROVI DER - 1 PF		0		40.00
41. 00   04100   SUBPROVI DER -   RF		113, 976		41.00
43. 00 04300 NURSERY		2, 037, 654		43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 O5000 OPERATING ROOM	0. 31422	20 37, 823, 488	11, 884, 896	50.00
52. OO O5200 DELIVERY ROOM & LABOR ROOM	0. 53862	26 14, 144, 114	7, 618, 388	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 13524	16 11, 659, 913	1, 576, 957	54.00
57. 00   05700   CT SCAN	0. 0344	9, 032, 753	310, 853	57. 00
58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)	0. 2487	1, 271, 044	316, 129	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 10312	22 3, 534, 417	364, 476	59. 00
60. 00   06000   LABORATORY	0. 11479	30, 326, 537	3, 481, 244	60.00
60. 01   06001 BLOOD LABORATORY	0.00000		0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 1795	75 17, 605, 634	3, 161, 532	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 42730	1, 869	799	66. 00
66. 01 06602 PHYSICAL THERAPY EAST BANK	0. 2997	77 0	0	66. 01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0. 27393	35 0	0	66. 10
67. 00 06700 OCCUPATI ONAL THERAPY	0. 31528	32 258	81	67. 00
67. 10   06701 OCCUPATIONAL THERAPY LIVING CENTER	0. 30695	59 0	0	67. 10
68. 00   06800   SPEECH PATHOLOGY	0. 31032	24 0	0	68. 00
68. 10   06801   SPEECH THERAPY LIVING CENTER	0. 28376	258	73	68. 10
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.00000	00 0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 17900	08 669, 662	119, 875	71. 00
72.00 07200 MPL. DEV. CHARGED TO PATLENTS	0. 23212	23 0	0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 1833	2, 875, 405	527, 096	73. 00
74. 00   07400   RENAL DI ALYSI S	0. 00000	00	0	74. 00
76. 00   03020   CARDI OLOGY	0. 13264	14 2, 322, 464	308, 061	76. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 00000	00	0	77. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0.00000	00	0	90.00
90. 10   09001   FAMILY PRACTICE CLINIC	0. 00000	00	0	90. 10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	1. 46810	134 48, 134	70, 666	90. 30
90. 50 09004 SLEEP DI SORDERS CLINIC	0. 28088	31 0	0	90. 50
91. 00   09100   EMERGENCY	0. 51674	5, 481, 772	2, 832, 662	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 35689	97 0	0	92. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		136, 797, 722	32, 573, 788	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)	)	0		201. 00
202.00 Net charges (line 200 minus line 201)	[	136, 797, 722		202. 00

I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 15-0058 CCN: 15-T058	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Pre 5/31/2023 11:	pared
		Ti t	le XIX	Subprovi der - I RF	PPS	
	Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00	03000 ADULTS & PEDIATRICS		I			30.0
31. 00	03100   NTENSI VE CARE UNI T					31.
31. 01	02060 NEONATAL INTENSIVE CARE UNIT					31. (
40. 00	04000 SUBPROVI DER - I PF					40. (
41. 00	04100 SUBPROVI DER – I RF			3, 078, 881		41. (
43. 00	04300 NURSERY					43.
	ANCILLARY SERVICE COST CENTERS					
0.00	05000 OPERATING ROOM		0. 31422		1, 926	
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 53862		0	
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1352		3, 918	1
7.00	05700 CT SCAN		0. 0344		500	
8.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2487		2, 935	
9.00	05900 CARDI AC CATHETERI ZATI ON		0. 10312		0	
0.00	06000  LABORATORY   06001  BLOOD LABORATORY		0. 11479		22, 162 0	1
5. 00	06500 RESPI RATORY THERAPY		0. 00000		2, 798	1
6. 00	06600 PHYSI CAL THERAPY		0. 42730		178, 991	66.
6. 01	06602 PHYSI CAL THERAPY EAST BANK		0. 2997		170, 771	66.
6. 10	06601 PHYSI CAL THERAPY LIVING CENTER		0. 27393		0	66.
7. 00	06700 OCCUPATI ONAL THERAPY		0. 31528		121, 660	
7. 10	06701 OCCUPATIONAL THERAPY LIVING CENTER		0. 30695		0	67.
8. 00	06800 SPEECH PATHOLOGY		0. 31032	24 213, 428	66, 232	68.
8. 10	06801 SPEECH THERAPY LIVING CENTER		0. 28376	54 0	0	68.
0. 00	07000 ELECTROENCEPHALOGRAPHY		0.00000	00	0	70.
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 17900		845	
2. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 23212		0	1
3. 00	07300 DRUGS CHARGED TO PATIENTS		0. 1833	· ·	107, 339	1
4. 00	07400 RENAL DI ALYSI S		0.00000		0	
6.00	03020 CARDI OLOGY		0. 13264		411	1
7.00	07700 ALLOGENEI C STEM CELL ACQUISITION		0.00000	00 0	0	77.
00 00	OUTPATIENT SERVICE COST CENTERS    O9000   CLINIC		0.00000	00 0	0	00
90. 00	09001 FAMILY PRACTICE CLINIC					
90. 10	09002 HEMATOLOGY ONCOLOGY CLINIC		0. 00000 1. 46810		0	
	09004 SLEEP DI SORDERS CLINIC		0. 28088		0	
	109100 FMERGENCY		0. 2000			

91.00

201. 00

202. 00

0 92.00

509, 717 200. 00

0.516742

0. 356897

1, 881, 627

1, 881, 627

91.00

201.00

202.00

09100 EMERGENCY

92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART)
200. 00 | Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

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

	Title XVIII Hospital	5/31/2023 11: 2 PPS	<u> 28 am</u>
		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see	0 33, 224, 301	
1. 02	<pre>instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)</pre>	11, 307, 253	1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to Octobe 1 (see instructions)	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount	0	2. 00 2. 01
2. 02 2. 03	Outlier payment for discharges for Model 4 BPCI (see instructions)	0 1, 600, 750	
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)	243, 974	
3.00	Managed Care Simulated Payments	41, 170, 566	1
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions)  Indirect Medical Education Adjustment	410.00	4.00
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending of or before 12/31/1996. (see instructions)	16. 76	5. 00
5. 01 6. 00	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap fo	0. 00 0. 00	5. 01 6. 00
6. 26	new programs in accordance with 42 CFR 413.79(e) Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of	0.00	6. 26
7. 00 7. 01	the CAA 2021 (see instructions) MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the	0. 00 0. 00	7. 00 7. 01
7. 02	cost report straddles July 1, 2011 then see instructions.  Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b)	0.00	7. 02
8.00	and 87 FR 49075 (August 10, 2022) (see instructions)  Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,	0.00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cos report straddles July 1, 2011, see instructions.	3.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital lunder § 5506 of ACA. (see instructions)	0.00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	19. 76	9. 00
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the current year from your records FTE count for residents in dental and podiatric programs.	27. 25 0. 00	
12. 00	Current year allowable FTE (see instructions)		12. 00
13.00	Total allowable FTE count for the prior year.	19. 76	
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997 otherwise enter zero.	19. 76	14. 00
15. 00		19. 76	15. 00
	Adjustment for residents in initial years of the program (see instructions)		16. 00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count	0. 00 19. 76	17. 00 18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).	0. 048195	
20.00	Prior year resident to bed ratio (see instructions)	0. 049874	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0. 048195	1
22. 00 22. 01	IME payment adjustment (see instructions)  IME payment adjustment - Managed Care (see instructions)  Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA	1, 157, 019 1, 069, 694	1
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  (f)(1)(iv)(C).	0.00	23. 00
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see	7. 49 0. 00	
26. 00	instructions) Resident to bed ratio (divide line 25 by line 4)	0. 000000	
27. 00 28. 00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)	0.000000	1
28. 01	IME add-on adjustment amount - Managed Care (see instructions)	0	28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)	1, 157, 019	
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment	1, 069, 694	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	6. 07	30.00
31.00	Percentage of Medicaid patient days (see instructions)	37. 28	31.00
32.00	Sum of lines 30 and 31	43. 35	
33. 00 34. 00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)	24. 98 2, 780, 996	
	1	2,730,770	

Heal th	Financial Systems MEMORIAL HOSPITAL OF S	OUTH BEND, INC	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Pre	
		Title XVIII	Hospi tal	5/31/2023 11: PPS	28 am
		in the Arriva	Prior to 10/1		
			1. 00	2. 00	
	Uncompensated Care Payment Adjustment				
35.00	Total uncompensated care amount (see instructions)		7, 192, 008, 710	6, 874, 403, 459	35. 00
35. 01	Factor 3 (see instructions)		0. 000401192	0. 000482706	35. 01
35. 02	Hospital UCP, including supplemental UCP (If line 34 is zero,	enter zero on this line)	2, 885, 376	3, 318, 316	35. 02
	(see instructions)				
35. 03	Pro rata share of the hospital UCP, including supplemental UCF	(see instructions)	2, 158, 103	836, 398	
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	(1: 40 th	2, 994, 501		36. 00
40. 00	Additional payment for high percentage of ESRD beneficiary dis Total Medicare discharges (see instructions)	charges (Tines 40 throug	n 46)		40.00
41. 00	Total ESRD Medicare discharges (see instructions)		0		41. 00
41. 00	Total ESRD Medicare covered and paid discharges (see instructi	one)	0		41. 01
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qualif	•	0.00		42. 00
43. 00	Total Medicare ESRD inpatient days (see instructions)	y ron adjustment)	0.00		43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided by	by line 41 divided by 7	0. 000000		44. 00
11.00	days)	y Time II di vided by 7	0.00000		11.00
45.00	Average weekly cost for dialysis treatments (see instructions)	ı	0.00		45. 00
46.00	Total additional payment (line 45 times line 44 times line 41.		0		46. 00
47.00	Subtotal (see instructions)		53, 308, 794		47. 00
48.00	Hospital specific payments (to be completed by SCH and MDH, sm	nall rural hospitals	0		48. 00
	only. (see instructions)				
				Amount	
10.00				1. 00	10.00
49. 00	Total payment for inpatient operating costs (see instructions)			54, 378, 488	1
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			3, 990, 592 0	ł
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, lir			892, 904	51. 00 52. 00
	Nursing and Allied Health Managed Care payment	le 49 see l'istructions).		15, 234	
54. 00	Special add-on payments for new technologies			427, 274	ł
	Islet isolation add-on payment			427, 274	ł
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69	9)		0	55.00
55. 01	Cellular therapy acquisition cost (see instructions)			0	55. 01
56. 00	Cost of physicians' services in a teaching hospital (see intru	ıcti ons)		0	56.00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. II	,	rough 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. I		<i>y</i> ,	10, 787	58. 00
59.00	Total (sum of amounts on lines 49 through 58)			59, 715, 279	59.00
60.00	Primary payer payments			52, 532	60.00
61. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		59, 662, 747	
62.00	Deductibles billed to program beneficiaries			4, 544, 372	62. 00
63.00	Coinsurance billed to program beneficiaries			253, 301	63. 00
64.00	Allowable bad debts (see instructions)			144, 169	
65. 00	Adjusted reimbursable bad debts (see instructions)			93, 710	
66.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		69, 836	
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			54, 958, 784	67. 00

68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)

Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)

69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)

OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)

70.92 Bundled Model 1 discount amount (see instructions)
70.93 HVBP payment adjustment amount (see instructions)

70.94 HRR adjustment amount (see instructions)

70.95 Recovery of accelerated depreciation

70.75 N95 respirator payment adjustment amount (see instructions)

Demonstration payment adjustment amount before sequestration

Pioneer ACO demonstration payment adjustment amount (see instructions)

SCH or MDH volume decrease adjustment (contractor use only)

HSP bonus payment HVBP adjustment amount (see instructions)

HSP bonus payment HRR adjustment amount (see instructions)

0 68.00

0 70.00

-100, 986

69.00

0 70.50

70.75

70.87

70.88

70.89

70. 90

70. 91

0 70. 92 0 70. 93

70. 94

0 70.95

70.00

70.50

70.88

70.89

Health Financial Systems	MEMORIAL HOSPITAL OF S	OUTH BEND, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF DELMBURGEMENT CETTLEMENT		Dravidar CCN, 1E OOEO	Doni od.	Washabaat F

	Financial Systems MEMORIAL HOSPITAL OF S					2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0058	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Pre	
		T: +1 a	. VI/I I I	Hooni tol	5/31/2023 11: 3	28 alli
		II LIE	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
70.0/	Low values adjustment for foderal figure voor (vana) (Enter in	- aalmn 0		0	1. 00	70. 96
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	1 COLUMN O		0	U	70.96
70. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column O		0	0	70. 97
, 0. , ,	the corresponding federal year for the period ending on or aft			Ü	Ü	' ' ' ' '
70. 98	Low Volume Payment-3	ŕ			0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	59 & 70)			54, 857, 798	71. 00
71. 01	Sequestration adjustment (see instructions)				691, 208	71. 01
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM or CHART pass-throughs					71. 03
72. 00	Interim payments				53, 672, 010	72. 00
72. 01	Interim payments-PARHM or CHART					72. 01
73. 00	Tentative settlement (for contractor use only)				0	
73. 01	Tentative settlement-PARHM or CHART (for contractor use only)					73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2, 72, and			494, 580	74. 00
74 01	73)					74 01
74. 01 75. 00	Balance due provider/program-PARHM or CHART (see instructions) Protested amounts (nonallowable cost report items) in accordance				1 017 250	74. 01 75. 00
75.00	CMS Pub. 15-2, chapter 1, §115.2	ice with			1, 017, 258	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	of 2 03			0	90.00
70.00	plus 2.04 (see instructions)	2.00			o o	70.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instru	uctions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruct	tions)			0	93. 00
94.00	The rate used to calculate the time value of money (see instru				0.00	94. 00
95.00	Time value of money for operating expenses (see instructions)				0	95. 00
96.00	Time value of money for capital related expenses (see instruct	tions)			0	96.00
						70.00
		,	1	Prior to 10/1		70.00
		,		Prior to 10/1 1.00		70.00
	HSP Bonus Payment Amount	,		1. 00	0n/After 10/1 2.00	
100.00	HSP bonus amount (see instructions)				0n/After 10/1 2.00	100.00
	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment	,		1.00	0n/After 10/1 2.00	100. 00
101. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0. 0000000000	0n/After 10/1 2.00 0 0.0000000000	100.00
101. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions			1.00	0n/After 10/1 2.00 0 0.0000000000	100. 00
101. 00 102. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment			0.0000000000000000000000000000000000000	0n/After 10/1 2.00 0 0.00000000000000000000000000000	100. 00 101. 00 102. 00
101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)	5)		1.00 0.0000000000 0.0000	0n/After 10/1 2.00 0 0.0000000000 0	100. 00 101. 00 102. 00 103. 00
101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	5)	istment	0.0000000000000000000000000000000000000	0n/After 10/1 2.00 0 0.0000000000 0	100. 00 101. 00 102. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr	s) Tation) Adju		1.00 0.0000000000 0.0000	0n/After 10/1 2.00 0 0.0000000000 0 0.0000 0	100. 00 101. 00 102. 00 103. 00 104. 00
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101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr	s) Tation) Adju		1.00 0.0000000000 0.0000	0n/After 10/1 2.00 0 0.0000000000 0 0.0000 0	100. 00 101. 00 102. 00 103. 00 104. 00
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101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	s) ration) Adju riod under t		1.00 0.0000000000 0.0000	0n/After 10/1 2.00 0 0.00000000000 0 0.0000	100. 00 101. 00 102. 00 103. 00 104. 00 200. 00
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101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	ration) Adjuriod under t	he 21st	0.0000000000 0.0000000000000 0	0n/After 10/1 2.00 0.00000000000 0.0000 0.0000 0	100. 00 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	ration) Adjuriod under t	he 21st	0.0000000000 0.0000000000000 0	0n/After 10/1 2.00 0 0.0000000000 0 0.0000 0	100. 00 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
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101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	first year	he 21st	0.0000000000 0.0000000000000 0	0n/After 10/1 2.00 0.00000000000 0.0000000000 0.ration	100. 00 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	first year	he 21st	0.0000000000 0.0000000000000 0	0n/After 10/1 2.00 0.00000000000 0.0000 0.0000 0	100. 00 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	first year	he 21st	0.0000000000 0.0000000000000 0	0n/After 10/1 2.00 0 0.00000000000 0 0.0000 0	100. 00 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRBR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use	first year	he 21st	0.0000000000 0.0000000000000 0	0n/After 10/1 2.00 0.00000000000000 0.00000000000000	100. 00 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
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101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 213. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRBR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 205)	first year  ructions) Line 59)	of the curre	0.0000000000 0.0000000000000 0	0n/After 10/1 2.00 0.00000000000 0.0000 0.ration	100. 00 101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
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Health Financial Systems	MEMORIAL HOSPITAL OF S	SOUTH BEND, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0058	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/31/2023 11: 28 am
		T: +1 - \/\/	11: 4-1	DDC

			Title XVIII	Hospi tal	5/31/2023 11: PPS	28 am
Most File   Ministration   Ministr			II tie xviii	поѕрі таі	PPS	
More					1. 00	
Medical and other services reinturesd under PPPS (see instructions)   28, 804 AP, 2 0.0	1 00				107	1 00
20.00   OPPS pagements   22, 349, 1842   3.00   College   Colleg		· · · · · · · · · · · · · · · · · · ·	)			
0.00   0.00			,			
Enter the hospit full specific payment to cost ratio (see instructions)	4.00	Outlier payment (see instructions)			208, 507	4. 00
Line 2 Times   Line 5		· · · · · · · · · · · · · · · · · · ·				
Sam of Tines 3. 4, and 4.01, divided by line 6   0.00   7.80			s)			
Transitional corridor payment (see instructions)   0.0   8.00   0.0   0.00					-	
Ancillary service other pass through costs from West. D. Pt. IV, col. 13, line 200   9, 326   9, 00						
1.00   Total cost (sun of lines 1 and 10) (see Instructions)   10.0   10.0			ol. 13, line 200		9, 326	
COMPUTATION OF ITSSER OF COST OR CHARGES   Substitution   Substi	10.00					10.00
Reasonable charges   12.00   Ancil Tary service charges   13.00   Organ acquisit on charges (from Wist. D.4, Pt. 111, col. 4, line 69)   13.00   13.	11. 00				197	11. 00
12.00						
3.00   organ acquisition charges (from Wist. D-4, Pt. III. col. 4, line 69)	12 00				914	12 00
14.00			9)			
15.00   Aggregate amount actually collected from patients Hable for payment for services on a charge basis   0   15.00	14.00		<u> </u>		914	14. 00
16.00   Amounts that would have been reallized from patients liable for payment for services on a chargebasis   0   10.00   Nature payment been made in accordance with 42 CFR \$413.13(e)   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.00000   17.00   0.00000   17.00   0.00000   17.00   0.00000   17.00   0.00000   17.00   0.00000   17.00   0.00000   17.00   0.00000   17.00   0.00000   17.00   0.00000   17.00   0.00000   17.00   0.00000   17.00   0.00000   17.00   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.00000000						
had such payment been made in accordance with 42 CFR \$413.13(e)						
17.00   Ratio of line 15 to line 16 (not to exceed 1.000000)   17.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00	16.00		ment for services on	i a chargebasis	0	16.00
18.00   Total customery charges (see instructions)   914   18.00   19.00   Excess of customery charges (complete only if line 18 exceeds line 11) (see   717   19.00   19.00   Excess of customery charges (complete only if line 11 exceeds line 18) (see   19.00	17. 00				0. 000000	17. 00
Instructions						
20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0.20.00   Instructions)   197   21.00   21.00   22.00   2	19. 00	Excess of customary charges over reasonable cost (complete only if	line 18 exceeds lin	ne 11) (see	717	19. 00
Instructions    197   21.00   22.00   1nterns and residents (see instructions)   197   21.00   22.00   1nterns and residents (see instructions)   0.22.00   22.00   23.00	00.00			10) (		00.00
1.00   Lesser of cost or charges (see instructions)   197   21.00   22.00   Cost of physicians' services in a teaching hospital (see instructions)   0.22.00   23.00   Cost of physicians' services in a teaching hospital (see instructions)   28,567,675   24.00   CoMPUTATION OF RELIBEURSEMENT SETTLEMENT   28,500   Deductibles and coinsurance amounts (for CAH, see instructions)   128   25.00   Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   4,682,529   26.00   Eductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   23,885,215   20,00   Instructions   23,885,215   20,00   Instructions   24,000   Defect graduate medical education payments (from Wkst. E-4, line 50)   374,544   28.00   Detect graduate medical education costs (from Wkst. E-4, line 36)   0.24,259,759   30.00   24,	20.00		line 11 exceeds lin	ne 18) (see	0	20.00
22 00   Interns and residents (see instructions)   0 22 00	21. 00				197	21. 00
24.00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   28,567,675   24.00						
COMPUTATION OF RELIMBURSCHENT SETTLEMENT   1,25.00   25.00   Deductible sand coinsurance amounts (for CAH, see instructions)   1,28.25.00   Deductible sand coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   4,882,529   26.00   Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   23,885,215   27.00   27.00   ESRD direct medical education payments (from Wkst. E-4, line 50)   374,544   28.00   29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   0,09   29.00   24,259,759   30.00   29.00			ons)			
25.00   Deductible sand coinsurance amounts (For CAH, see instructions)   1.28   25.00   26.00   Deductible sand Coinsurance amounts of line 24 (for CAH, see instructions)   4.682,529   26.00   27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see   23,885,215   27.00   27.00   28.00   29.00   29.00   29.00   29.00   28.00   25.00   29.00	24. 00				28, 567, 675	24. 00
26.00   Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   23,885,215   27.00	25 00				120	25 00
27.00   Subtotal   ((I ines 21 and 24 minus the sum of I ines 25 and 26) plus the sum of I ines 22 and 23] (see   33,885,215   27.00			(for CAH see instru	ıctions)		
Instructions			•	'		
29.00   ESRO direct medical education costs (from Wkst. E-4, line 36)   24, 259, 759   30.00   30.00   Subtotal (sum of lines 27 through 29)   30.00   71.3, 925   31.00   32.00   3						
Subtotal (sum of lines 27 through 29)   24, 259, 759   30, 00   24, 259, 759   31, 00   30, 00   24, 259, 759   31, 00   32, 00   32, 00   32, 00   33, 00   34, 00			0)			
31.00   Primary payer payments   13.925   31.00   Subtotal (line 30 minus line 31)   24.245,834   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (From Wkst. I - 5, line 11)   0.33.00   33.00   33.00   34.00   Allowable bad debts (see instructions)   176, 818   34.00   35.00   Adjusted relmbursable bad debts (see instructions)   114, 932   35.00   36.00   Allowable bad debts (see instructions)   141, 973   36.00   37.00   Subtotal (see instructions)   24, 360, 766   37.00   38.00   MSP-LCC reconciliation amount from PS&R   -3.362   38.00   MSP-LCC reconciliation amount from PS&R   -3.362   38.00   39.50   From the ACO demonstration payment adjustment (see instructions)   29.55   99.55   90.5						
Subtotal (line 30 minus line 31)						
ALLOWABLE RAD DEBTS (EXCLUDE RAD DEBTS FOR PROFESSIONAL SERVICES)   Composite rate ESRD (from Wkst. I - 5, line 11)   0   33, 00   34, 00   All owable bad debts (see instructions)   176, 818   34, 00   35, 00   Adjusted reimbursable bad debts (see instructions)   114, 932   35, 00   36, 00   All lowable bad debts (see instructions)   141, 997   36, 00   37, 00   Subtotal (see instructions)   24, 360, 766   37, 00   Subtotal (see instructions)   24, 360, 766   37, 00   Subtotal (see instructions)   24, 360, 766   37, 00   39, 00   MSP-LCC reconciliation amount from PS&R   -3, 362   38, 00   39, 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39, 00   39, 50   Pioneer ACO demonstration payment adjustment amount (see instructions)   0   39, 50   99, 50   Pioneer ACO demonstration payment adjustment amount (see instructions)   0   39, 97   99, 97   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39, 97   99, 97   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39, 99   40, 00   Subtotal (see instructions)   0   39, 99   40, 00   Subtotal (see instructions)   24, 364, 128   40, 00   40, 01   Sequestration adjustment (see instructions)   30, 98   40, 01   Sequestration payment adjustment amount after sequestration   24, 364, 128   40, 00   40, 02   40, 03   40, 0						
34. 00		ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			.,,	
35.00   Adjusted reimbursablè bad debts (see instructions)   114,932   35.00   36.00   Adjusted reimbursablè bad debts for dual eligible beneficiaries (see instructions)   141,977   36.00   37.00   Subtotal (see instructions)   24,360,766   37.00   38.00   MSP-LCC reconciliation amount from PS&R   -3,362   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   -3,362   38.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.57   97.50   97.5						
36. 00		· · · · · · · · · · · · · · · · · · ·				
37.00   Subtotal (see instructions)   24,360,766   37.00   38.00   MSP-LCC reconciliation amount from PS&R   -3,362   38.00   39.00   MSP-LCC reconciliation amount from PS&R   -3,362   38.00   39.00   39.50   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0.39.00   39.50			one)			
38.00   MSP-LCC reconciliation amount from PS&R   -3, 362   38.00   0   O   O   O   O   O   O   O   O			3115)			
39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.50   Pi oneer ACO demonstration payment adjustment (see instructions)   39.50   39.50   39.57   N95 respirator payment adjustment amount (see instructions)   39.57   39.97   Demonstration payment adjustment amount before sequestration   39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   39.98   24.364, 128   40.00   40.01   Sequestration adjustment (see instructions)   24.364, 128   40.00   40.01   Sequestration adjustment (see instructions)   306, 988   40.01   40.02   40.03   40.00   40						
39. 75       N95 respirator payment adjustment amount (see instructions)       0       39. 75         39. 97       Demonstration payment adjustment amount before sequestration       0       39. 98         39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       24, 364, 128       40. 00         40. 01       Demonstration adjustment (see instructions)       306, 988       40. 01         40. 02       Sequestration adjustment amount after sequestration       0       40. 02         40. 03       Sequestration adjustment-PARHM or CHART pass-throughs       40. 03         41. 01       Interim payments       24, 149, 106       41. 00         41. 01       Interim payments -PARHM or CHART       41. 01       41. 01         42. 01       Tentative settlement (for contractors use only)       0       42. 00         43. 00       Bal ance due provider/program (see instructions)       -91, 966       43. 00         44. 00       Balance due provider/program-PARHM (see instructions)       -91, 966       43. 01         44. 00       Be COMPLETED BY CONTRACTOR       0       90. 00 <t< td=""><td></td><td>OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</td><td></td><td></td><td>0</td><td>39. 00</td></t<>		OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 97 39. 98 39. 98 39. 98 39. 99 39. 98 39. 90 39. 98 39. 90 30. 90 30						
39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       24, 364, 128       40. 00         40. 01       Sequestration adjustment (see instructions)       306, 988       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         40. 03       Sequestration adjustment-PARHM or CHART pass-throughs       40. 03         41. 01       Interim payments       24, 149, 106       41. 00         41. 01       Interim payments-PARHM or CHART       41. 01       41. 01         42. 01       Tentative settlement (for contractors use only)       0       42. 00         43. 00       Bal ance due provider/program (see instructions)       -91, 966       43. 00         43. 01       Bal ance due provider/program (see instructions)       43. 01         44. 00       Fortested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,       0       44. 00         90. 00       Original outlier amount (see instructions)       0       90. 00         91. 00       The rate used to calculate the Time Value of Money       0. 00       92. 00						
39. 99 40. 00 50			avicas (saa instruct	ione)		
40.00       Subtotal (see instructions)       24, 364, 128       40.00         40.01       Sequestration adj ustment (see instructions)       306, 988       40.01         40.02       Demonstration payment adj ustment amount after sequestration       0 40.02         40.03       Sequestration adj ustment-PARHM or CHART pass-throughs       24, 149, 106       41.00         41.01       Interim payments       24, 149, 106       41.01         41.01       Tentative settlement (for contractors use only)       0 42.00         42.01       Tentative settlement (For contractor use only)       42.01         43.00       Balance due provider/program (see instructions)       -91,966       43.00         43.01       Balance due provider/program-PARHM (see instructions)       43.01         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00       44.00         5115.2       To BE COMPLETED BY CONTRACTOR       90.00         90.00       Original outlier amount (see instructions)       0 90.00         91.00       The rate used to calculate the Time Value of Money (see instructions)       0 91.00         92.00       Time Value of Money (see instructions)       0 93.00			evices (see instruct	.1 0113)		
40.02 Demonstration payment adjustment amount after sequestration  Sequestration adjustment-PARHM or CHART pass-throughs  1. Interim payments 1. Interim payments 1. Interim payments-PARHM or CHART 1. On Tentative settlement (for contractors use only) 1. Tentative settlement (for contractor use only) 1. Tentative settlement-PARHM or CHART (for contractor use only) 1. Tentative settlement-PARHM (see instructions) 1. Salance due provider/program (see instructions) 1. Salance due provider/program-PARHM (see instructions) 1. To Be COMPLETED BY CONTRACTOR 1. Oniginal outlier amount (see instructions) 2. Oniginal outlier amount (see instructions) 3. On						
40.03 Sequestration adjustment-PARHM or CHART pass-throughs  41.00 Interim payments  41.01 Interim payments-PARHM or CHART  42.00 Tentative settlement (for contractors use only)  42.01 Tentative settlement-PARHM or CHART (for contractor use only)  43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  5115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Og Time Value of Money (see instructions)  94.00 Og Time Value of Money (see instructions)  95.00 Og Time Value of Money (see instructions)  96.00 Og Time Value of Money (see instructions)  97.00 Og Time Value of Money (see instructions)  98.00 Og Time Value of Money (see instructions)	40. 01	Sequestration adjustment (see instructions)			306, 988	40. 01
41.00					0	
41.01					24 140 104	
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM or CHART (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 42.00 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 43.00 43.01 44.00 91.01 91.02 91.02 91.03 92.04 93.00					24, 149, 106	
42.01 Tentative settlement-PARHM or CHART (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 Utilier reconciliation adjustment amount (see instructions) 0 Utilier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00					0	
43.01  44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  Protested amounts (nonallowable cost					_	
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{\f	43.00	Balance due provider/program (see instructions)			-91, 966	
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 utlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0 1 Time Value of Money (see instructions) 0 93.00						
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  10 90.00  91.00  92.00  93.00 Time Value of Money (see instructions)  10 90.00  92.00  93.00	44. 00		rtn CMS Pub. 15-2, c	cnapter 1,	0	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00  92.00  93.00	90. 00				0	90.00
93.00 Time Value of Money (see instructions) 0 93.00					0	91. 00
		· · · · · · · · · · · · · · · · · · ·				
74. 00   10 tai (Suiii 01 11 1185 91 aliu 93)						
	74. UU	Tiotai (Suiii Oi Titles 71 allu 73)		ı	Ü	74.00

Health Financial Systems	MEMORI AL	HOSPITAL OF	SOUTH BEND, INC	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Provider CCN: 15-0058	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Pre	nared:
				10 12/01/2022	5/31/2023 11:	
			Title XVIII	Hospi tal	PPS	
					1. 00	
MEDICARE PART B ANCILLARY COSTS						
200.00 Part B Combined Billed Days					C	200. 00

Contractor

Number

1 00

0

NPR Date (Mo/Day/Yr)

2 00

8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0058 Peri od: Worksheet E-1 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/31/2023 11:28 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 53, 672, 010 24, 149, 106 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 0 3.02 0 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 0 3.51 0 0 3.52 3.52 0 3.53 0 3.53 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 Ω 3.99 3.50-3.98) 53, 672, 010 24, 149, 106 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5. 99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 494, 580 0 6.01 6 02 SETTLEMENT TO PROGRAM 91, 966 6.02 7.00 Total Medicare program liability (see instructions) 54, 166, 590 24, 057, 140 7.00

8.00 Name of Contractor

Provider CCN: 15-0058 Component CCN: 15-T058 Title XVIII

		Title	XVIII	Subprovi der - I RF	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2, 564, 705 C		0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3. 00
3.01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3.02			C	)	0	3. 02
3.03			C	)	0	3. 03
3.04			C		0	3. 04
3.05			C		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51			C		0	3. 51
3. 52			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) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		2, 564, 705		0	4. 00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
F 04	Program to Provider					F 04
5. 01	TENTATI VE TO PROVI DER		O		0	5. 01
5. 02 5. 03			C   C			5. 02 5. 03
5.03	Provider to Program				0	3.03
5. 50	TENTATI VE TO PROGRAM		C	1	0	5. 50
5. 51	TENTITIVE TO TROOTOUM		Ö		0	5. 51
5. 52			ď			5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		C		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		37, 131		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		C		Ö	6. 02
7. 00	Total Medicare program liability (see instructions)		2, 601, 836	,	Ö	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Heal t	h Financial Systems MEMORIAL HOSPITAL OF	SOUTH BEND INC	In lie	u of Form CMS-	2552-10
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 15-0058   Period:   Work: From 01/01/2022   Part   To 12/31/2022   Date.				
				5/31/2023 11:	<u>28 am</u>
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	14		1.00
2.00	2.00   Medicare days (see instructions)				
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of c		Wkst S-2 Pt I		7. 00
,, 00	line 168	or triviour in recommenegy			/
8. 00	Calculation of the HIT incentive payment (see instructions)				8.00
9. 00	Sequestration adjustment amount (see instructions)				9. 00
10. 00	, ,	(soo instructions)			10.00
10.00		(See This true (10hs)			10.00
00.0	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31. 00
	Nalanas dus providor (lips O (ar lips 10) minus lips 20 and l				1 22 00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

Health Financial Systems	MEMORIAL HOSPITAL OF S	SOUTH BEND, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0058	Peri od: From 01/01/2022	Worksheet E-3
		Component CCN: 15-T058		
		Title XVIII	Subprovi der -	PPS

		I RF		
			1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			Т
О	Net Federal PPS Payment (see instructions)		2, 380, 113	1
C	Medicare SSI ratio (IRF PPS only) (see instructions)		0. 0353	
0	Inpatient Rehabilitation LIP Payments (see instructions)		193, 741	
0	Outlier Payments		78, 719	
0	Unweighted intern and resident FTE count in the most recent cost reporting period ending to November 15, 2004 (see instructions)	on or prior	0. 00	
)1	Cap increases for the unweighted intern and resident FTE count for residents that were diprogram or hospital closure, that would not be counted without a temporary cap adjustment CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0. 00	
0	New Teaching program adjustment. (see instructions)		0. 00	
0	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period teaching program" (see instructions)	od of a "new	0. 00	
0	Current year's unweighted L&R FTE count for residents within the new program growth period teaching program" (see instructions)	od of a "new	0.00	
0	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0. 00	
00	Average Daily Census (see instructions)		13. 490411	
00	Teaching Adjustment Factor (see instructions)		0.000000	
00	Teaching Adjustment (see instructions)		0	
00	Total PPS Payment (see instructions)		2, 652, 573	1
00	Nursing and Allied Health Managed Care payments (see instruction)		0	1
00	Organ acquisition (DO NOT USE THIS LINE)			1
00	Cost of physicians' services in a teaching hospital (see instructions)		0	1
00	Subtotal (see instructions)		2, 652, 573	1
00	Primary payer payments		0	1
00	Subtotal (line 17 less line 18).		2, 652, 573	1
00	Deducti bl es		9, 366	
00	· ·		2, 643, 207	
00			8, 169	
00			2, 635, 038	
00			0	
00	, ,		0	
00			0	
00	Subtotal (sum of lines 23 and 25)		2, 635, 038	
00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	
00	Other pass through costs (see instructions)		0	
00	Outlier payments reconciliation		0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	
50	Pioneer ACO demonstration payment adjustment (see instructions)		0	
98 99	Recovery of accelerated depreciation.  Demonstration payment adjustment amount before sequestration		0	
00	Total amount payable to the provider (see instructions)		2, 635, 038	
01	Sequestration adjustment (see instructions)		33, 202	
02			33, 202	
00			2, 564, 705	
00			2, 304, 703	
00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		37, 131	
00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chap	iter 1	07, 131	
	§115. 2			`
00	TO BE COMPLETED BY CONTRACTOR		70 710	۱,
00	Original outlier amount from Wkst. E-3, Pt. III, line 4		78, 719	
00	Outlier reconciliation adjustment amount (see instructions)		0	
00	The rate used to calculate the Time Value of Money		0.00	
00	Time Value of Money (see instructions)	THE COVED 10	0	5
00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF		0. 000000	٦,
	Teaching Adjustment Factor for the cost reporting period immediately preceding February 2	7, ZUZU.	( ) ( ) ( ) ( ) ( ) ( )	ıУ

	Financial Systems MEMORIAL HOSPITAL OF S				u of Form CMS-2	2552-10	
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CC	CN: 15-0058	Peri od: From 01/01/2022	Worksheet E-4		
	To 12/31/2022				Date/Time Prep 5/31/2023 11:3		
	Title XVIII Hospital						
					1. 00		
1 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT	6			24.7/	1.00	
1. 00	Unweighted resident FTE count for allopathic and osteopathic pending on or before December 31, 1996.	orograms for	cost reporti	ng perioas	24. 76	1. 00	
1. 01	FTE cap adjustment under §131 of the CAA 2021 (see instruction		1) (000 i notr	uati ana)	0.00	1. 01	
2. 00 2. 26	Unweighted FTE resident cap add-on for new programs per 42 CFI Rural track program FTE cap limitation adjustment after the ca				0.00	2. 00 2. 26	
2 00	the CAA 2021 (see instructions) Amount of reduction to Direct GME cap under section 422 of MM.	۸			0.00	2 00	
3. 00 3. 01	Direct GME cap reduction amount under ACA §5503 in accordance		§413.79 (m).	(see	0. 00 0. 00	3. 00 3. 01	
3. 02	instructions for cost reporting periods straddling 7/1/2011) Adjustment (increase or decrease) to the hospital's rural trad	ak ETE limi+	ation(s) for	rural track		3. 02	
3.02	programs with a rural track Medicare GME affiliation agreemen					3. 02	
4. 00	49075 (August 10, 2022) (see instructions) Adjustment (plus or minus) to the FTE cap for allopathic and	ostoonathi c	programe duo	to a Modicaro	0. 00	4. 00	
4.00	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)	)			0.00	4.00	
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instistraddling 7/1/2011)	ructions for	cost reporti	ng periods	0. 00	4. 01	
4. 02	ACA Section 5506 number of additional direct GME FTE cap slots	s (see inst	ructions for	cost reporting	3. 00	4. 02	
4. 21	periods straddling 7/1/2011) The amount of increase if the hospital was awarded FTE cap slo	nts under 81	26 of the CA4	1 2021 (SEE		4. 21	
	instructions)			•			
5. 00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus line 3.01, plus or minus line 3.02, plus or minus line 4, plus line			nus lines 3 and	27. 76	5. 00	
6. 00	Unweighted resident FTE count for allopathic and osteopathic			year from your	27. 25	6. 00	
7. 00	records (see instructions) 00 Enter the lesser of line 5 or line 6					7. 00	
7.00	the reason of this or this or		Primary Care		27. 25 Total	7.00	
8. 00	Weighted FTE count for physicians in an allopathic and osteopa	athi c	1. 00 27. 2	2. 00 25 0. 00	3. 00 27. 25	8. 00	
	program for the current year.						
9. 00	If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amount		27. 2	0.00	27. 25	9. 00	
	6. For cost reporting periods beginning on or after October 1,						
10. 00	if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curre	ent vear		0.00		10. 00	
10. 01	Unweighted dental and podiatric resident FTE count for the cur			0.00		10. 01	
11. 00 12. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting	n vear (see	27. 2 27. 2			11. 00 12. 00	
	instructions)						
13. 00	Total weighted resident FTE count for the penultimate cost repear (see instructions)	porting	27. 2	0.00		13. 00	
14. 00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	27. 2			14. 00	
15. 00 15. 01	Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs	roarams	0. ( 0. (			15. 00 15. 01	
	Adjustment for residents displaced by program or hospital clos		0. (			16. 00	
16. 01	Unweighted adjustment for residents displaced by program or holds	ospi tal	0.0	0.00		16. 01	
17. 00	Adjusted rolling average FTE count		27. 2			17. 00	
18. 00 18. 01			119, 314. (	0.00		18. 00 18. 01	
	Approved amount for resident costs		3, 247, 72	27 0	3, 247, 727	19. 00	
					1. 00		
20. 00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots red	cei ved under 42		20. 00	
21. 00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruc	rtions)			0.00	21. 00	
22. 00	Allowable additional direct GME FTE Resident Count (see instru					22. 00	
23.00	Enter the locality adjustment national average per resident an Multiply line 22 time line 23	mount (see i	nstructions)			23. 00 24. 00	
	Total direct GME amount (sum of lines 19 and 24)				0 3, 247, 727		
	7 0,211,721,251						

Heal th	n Financial Systems MEMORIAL HOSPITAL OF S	SOUTH BEND.	INC	In Lie	u of Form CMS-2	2552-10
	T GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der C		Peri od:	Worksheet E-4	
MEDI C	AL EDUCATION COSTS			From 01/01/2022	D-+- /T: D	
				To 12/31/2022	Date/Time Prep 5/31/2023 11:	
		Title	xVIII	Hospi tal	PPS	
			Inpatient Par	t Managed Care	Total	
			A			
	COMPUTATION OF PROCESM DATIFAT LOAD		1.00	2. 00	3. 00	
26. 00	COMPUTATION OF PROGRAM PATIENT LOAD  Inpatient Days (see instructions) (Title XIX - see S-2 Part I)	Y line	23, 56	22, 101		26. 00
20.00	3. 02, column 2)	X, TITIE	23, 30	22, 101		20.00
27. 00			109, 00	109, 008		27. 00
28. 00	1		0. 21615	•		28. 00
29. 00	Program di rect GME amount		702, 02	22 658, 467	1, 360, 489	29.00
29. 01						29. 01
	Reduction for direct GME payments for Medicare Advantage			93, 041	93, 041	30.00
31. 00	Net Program direct GME amount				1, 267, 448	31. 00
					4 00	
	DIDECT MEDICAL EDUCATION COSTS FOR FERR COMPOSITE DATE. TITLE	- VVIII ONIV	/ (NUIDCLNC DDC	CDAM AND DADAMER	1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)					
32. 00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)					32. 00
33. 00						33. 00
34. 00				1 4114 717	0. 000000	
35. 00	9 ,		,		0	35. 00
36. 00	Medicare outpatient ESRD direct medical education costs (line	34 x line 3	35)		0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY				
	Part A Reasonable Cost					
37. 00					68, 711, 825	
38. 00					0	38. 00
39. 00 40. 00		ructions)			0 52, 532	39. 00 40. 00
	Total Part A reasonable cost (sum of lines 37 through 39 minus	s lino 40)			68, 659, 293	
41.00	Part B Reasonable Cost	5 TTHE 40)			00, 007, 273	41.00
42. 00					28, 814, 263	42. 00
43. 00					13, 925	
44. 00					28, 800, 338	
45. 00					97, 459, 631	45. 00
46. 00	Ratio of Part A reasonable cost to total reasonable cost (line	e 41 ÷ line	45)		0. 704490	46.00
47. 00	Ratio of Part B reasonable cost to total reasonable cost (line		45)		0. 295510	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR	RT B				
	Total program GME payment (line 31)				1, 267, 448	
49. 00	7,				892, 904	
50. 00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see Instru	ictions)		374, 544	50.00

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu					u of Form CMS-2	2552-10
OUTLI E	OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT Provider CCN: 15-0058 Period: W					
				From 01/01/2022 To 12/31/2022	Date/Time Prep 5/31/2023 11:2	
			Title XVIII		PPS	
	·					
					1. 00	
	TO BE COMPLETED BY CONTRACTOR					
1.00	Operating outlier amount from Wkst. E, Pt. /	A, line 2, or sum o	of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2				0	2.00
3.00	Operating outlier reconciliation adjustment	amount (see instru	ucti ons)		0	3.00
4.00	Capital outlier reconciliation adjustment ar	mount (see instruct	ti ons)		0	4.00
5.00 The rate used to calculate the time value of money (see instructions)					0.00	5.00
6.00	Time value of money for operating expenses	(see instructions)			0	6.00
7.00	Time value of money for capital related expe	enses (see instruct	tions)		o	7. 00

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

Provider CCN: 15-0058

Peri od: Worksheet G From 01/01/2022 To 12/31/2022 Date/Time Prepared:

onl y)			'	0 12/31/2022	5/31/2023 11:	
		General Fund	Speci fi c	Endowment Fund		
		1. 00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	21, 953, 000		0	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	15, 941, 000		-	0	2. 00 3. 00
4. 00	Accounts receivable	269, 370, 000	1	0	0	4.00
5. 00	Other recei vabl e	0		Ö	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-152, 375, 000	0	0	0	6. 00
7.00	Inventory	18, 016, 000	0	0	0	7. 00
8.00	Prepai d expenses	963, 000		0	0	8. 00
9. 00 10. 00	Other current assets Due from other funds	42, 055, 000	9, 353, 000	0	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	215, 923, 000			0	11.00
11.00	FIXED ASSETS	210, 720, 000	7, 000, 000	<u> </u>		11.00
12.00	Land	26, 982, 000	) C	0	0	12. 00
13. 00	Land improvements	0	0		0	13. 00
14. 00	Accumulated depreciation	0		0	0	14.00
15. 00 16. 00	Buildings Accumulated depreciation	530, 738, 000 -476, 619, 000	1	0	0	15. 00 16. 00
17. 00	Leasehold improvements	-470,019,000 0		0	0	17. 00
18. 00	Accumulated depreciation	0		0	0	18. 00
19. 00	Fi xed equipment	255, 015, 000	) c	0	0	19. 00
20. 00	Accumulated depreciation	0	0	0	0	20. 00
21. 00	Automobiles and trucks	0		0	0	21.00
22. 00 23. 00	Accumulated depreciation  Major movable equipment	0		0	0	22. 00 23. 00
24. 00	Accumul ated depreciation	0		0	0	24.00
25. 00	Mi nor equipment depreciable	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	Accumulated depreciation	0		0	0	28. 00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	336, 116, 000		-	0	29. 00 30. 00
30.00	OTHER ASSETS	330, 110, 000	ή	9	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 35. 00	Other assets Total other assets (sum of Lines 21 24)	30, 484, 000		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)	30, 484, 000 582, 523, 000	1	١	0	36.00
00.00	CURRENT LI ABILITIES	002, 020, 000	7, 000, 000	<u> </u>		00.00
37.00	Accounts payable	50, 943, 000	) C	0	0	37. 00
38. 00	Salaries, wages, and fees payable	0	0	0	0	38. 00
39. 00	Payroll taxes payable	0		0	0	39.00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	5, 320, 000		0	0	40. 00 41. 00
42.00	Accel erated payments	0		U	U	42.00
43. 00	Due to other funds	0	O	0	0	43. 00
44.00	Other current liabilities	2, 980, 000			0	44. 00
45.00	Total current liabilities (sum of lines 37 thru 44)	59, 243, 000	) C	0	0	45. 00
47,00	LONG TERM LIABILITIES	0			0	1/ 00
46. 00 47. 00	Mortgage payable Notes payable	0		-	0	46. 00 47. 00
48. 00	Unsecured Loans	0			0	48. 00
49. 00	Other long term liabilities	173, 397, 000	Ö	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	173, 397, 000		0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	232, 640, 000	) <u> </u>	0	0	51.00
F2 00	CAPITAL ACCOUNTS	240, 002, 000				
52. 00 53. 00	General fund balance Specific purpose fund	349, 883, 000	9, 353, 000			52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted		7, 333, 000	0		54.00
55. 00	Donor created - endowment fund balance - unrestricted		1	0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	349, 883, 000	9, 353, 000	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	582, 523, 000			0	60.00
	59)		1			

Health Financial Systems MEMORIAL HOSPITAL OF SOUTH BEND, INC In Lieu of Form CMS-2552-10

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0058
Period:
From 01/01/2022
To 12/31/2022 To 12/31/2023 11: 28 am

General Fund Special Purpose Fund Endowment Fund

					0 12/31/2022	5/31/2023 11:2	
		General	Fund	Special Pu	urpose Fund	Endowment Fund	20 4111
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period	1.00	303, 747, 000		9, 395, 000	5.00	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		103, 716, 868		7, 373, 000		2. 00
3.00	Total (sum of line 1 and line 2)		407, 463, 868		9, 395, 000		3. 00
4. 00	NET ASSETS RELEASED FROM RESTRICTION	1, 390, 000	1077 1007 000	(	) // 0/0/000	0	4. 00
5. 00	CHANGE IN INTEREST IN RECIPIENT ORG	0		-42, 000		ő	5. 00
6.00				,		ol	6. 00
7.00		o				0	7. 00
8.00		0				0	8. 00
9.00		0		(		o	9. 00
10.00	Total additions (sum of line 4-9)		1, 390, 000		-42, 000		10.00
11.00	Subtotal (line 3 plus line 10)		408, 853, 868		9, 353, 000		11.00
12.00	NET ASSETS RELEASED AND TRANSFERRED	59, 054, 867		(		ol	12.00
13.00		0		(		0	13.00
14.00		o		(		o	14.00
15.00		0		(		0	15.00
16.00		0		(		0	16.00
17. 00		0		(		0	17.00
18. 00	Total deductions (sum of lines 12-17)		59, 054, 867		0		18.00
19. 00	Fund balance at end of period per balance		349, 799, 001		9, 353, 000		19. 00
	sheet (line 11 minus line 18)		51	L			
		Endowment Fund	PI ant	Funa	_		
		6. 00	7. 00	8. 00	_		
1. 00	Fund balances at beginning of period	0		(			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)	1					2.00
3.00	Total (sum of line 1 and line 2)	0		(			3.00
4.00	NET ASSETS RELEASED FROM RESTRICTION		0				4.00
5.00	CHANGE IN INTEREST IN RECIPIENT ORG		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8. 00
9.00			0				9. 00
10.00	Total additions (sum of line 4-9)	0		(			10.00
11. 00	Subtotal (line 3 plus line 10)	0		(			11. 00
12. 00	NET ASSETS RELEASED AND TRANSFERRED		0				12. 00
13.00			0				13.00
14.00			0				14.00
15.00			0				15. 00
16. 00 17. 00			0				16. 00 17. 00
17.00	Total deductions (sum of lines 12 17)		U	,			17.00
19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance			(	(		19. 00
17.00	sheet (line 11 minus line 18)				΄		17.00
	Tancot (Time II milius IIIIe 10)	ı I		1	T		

Health Financial Systems MEMORIA STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0058

		Т	o 12/31/2022	Date/Time Pre 5/31/2023 11:	
	Cost Center Description	Inpatient	Outpati ent	Total	20 alli
	obst dontor boost per on	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	•			
	General Inpatient Routine Services				
1.00	Hospi tal	280, 738, 216		280, 738, 216	1.00
2.00	SUBPROVI DER - I PF	C		0	2.00
3.00	SUBPROVI DER - I RF	15, 243, 763		15, 243, 763	3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	C		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)	295, 981, 979		295, 981, 979	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	48, 090, 575		48, 090, 575	11. 00
11. 01	NEONATAL INTENSIVE CARE UNIT	29, 808, 678		29, 808, 678	11. 01
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL 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	77, 899, 253		77, 899, 253	16.00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	373, 881, 232		373, 881, 232	17. 00
18. 00	Ancillary services	766, 172, 757			18. 00
19. 00	Outpati ent servi ces	22, 075, 941	111, 920, 551	133, 996, 492	19. 00
20. 00	RURAL HEALTH CLINIC	0	0	0	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	NURSERY	5, 804, 230		5, 804, 230	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	1, 167, 934, 160	810, 700, 520	1, 978, 634, 680	28. 00
	G-3, line 1)				
00.00	PART II - OPERATING EXPENSES		F70 000 040		00.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		570, 038, 249		29. 00
30.00	ADD (SPECIFY)	C			30.00
31. 00		C			31. 00
32. 00		0			32. 00
33. 00		C			33. 00
34. 00		C			34. 00
35. 00	Total additions (sum of Lines 20 25)				35. 00
36. 00 37. 00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)		0		36. 00 37. 00
38. 00	DEDUCT (SPECIFY)				
		~			38. 00
39. 00 40. 00		0			39. 00 40. 00
40.00					40.00
41.00	Total deductions (sum of lines 37-41)				41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		570, 038, 249		42.00
43.00	to Wkst. G-3, line 4)		370, 030, 249		43.00
	10 most. 0 0, 11me 4)	I	1		1

Health Financial Systems	MEMORIAL HOSPITAL OF SC	OUTH BEND, INC	In Lie	u of Form CMS-2552-10
STATEMENT OF REVENUES AND EXPENSES		Provi der CCN: 15-0058	Peri od:	Worksheet G-3

Heal th	Financial Systems MEMORIAL HOSPITAL O	F SOUTH BEND, INC	In Lie	u of Form CMS-2	2552-10
STATE	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0058 Period:		Worksheet G-3		
			From 01/01/2022 To 12/31/2022	Date/Time Pre	nared·
			12,01,2022	5/31/2023 11:	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, I			1, 978, 634, 680	
2.00	Less contractual allowances and discounts on patients' accounts			1, 347, 165, 132	1
3.00	Net patient revenues (line 1 minus line 2)	>		631, 469, 548	
4.00	Less total operating expenses (from Wkst. G-2, Part II, lin	e 43)		570, 038, 249	1
5.00	Net income from service to patients (line 3 minus line 4)			61, 431, 299	5.00
6. 00	OTHER INCOME Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			115, 407	7. 00
8.00	Revenues from telephone and other miscellaneous communicati	on sarvices		113, 407	1
9. 00	Revenue from television and radio service	on services		0	1
10. 00				0	10.00
	Rebates and refunds of expenses			0	1
	Parking lot receipts			470, 168	
	Revenue from Laundry and Linen service			470, 100	1
	Revenue from meals sold to employees and guests			1, 843, 235	
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to other	than patients		0	16. 00
	Revenue from sale of drugs to other than patients			0	17. 00
18. 00				0	18. 00
19. 00				0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
	Rental of vending machines			0	21. 00
	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			5, 234, 888	23. 00
	ALL OTHER INCOME			16, 945, 368	1
24. 01	UNREALIZED GAINS ON SWAPS, NET			5, 852, 705	24. 01
24. 02	OTHER (SPECIFY)			0	24. 02
24. 50	COVI D-19 PHE Funding			11, 823, 798	24. 50
25.00	Total other income (sum of lines 6-24)			42, 285, 569	25. 00
26.00	Total (line 5 plus line 25)			103, 716, 868	26. 00
27.00	OTHER EXPENSES (SPECIFY)			0	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29.00	Net income (or loss) for the period (line 26 minus line 28)			103, 716, 868	29. 00

	Financial Systems MEMORIAL HOSPITAL OF			u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0058	Peri od: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Pre 5/31/2023 11:	pared:
		Title XVIII	Hospi tal	PPS	20 ан
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			3, 370, 915	
1.01	Model 4 BPCI Capital DRG other than outlier			219, 038	1. 01
2.00	Capital DRG outlier payments			0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3. 00 4. 00	Total inpatient days divided by number of days in the cost re Number of interns & residents (see instructions)	porting period (see insi	ructions)	285. 16 19. 76	3. 00 4. 00
5. 00	Indirect medical education percentage (see instructions)			19. 76	
6. 00	Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and			71, 081	
0.00	1.01) (see instructions)			71,001	8.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)			6. 07	7. 00
8.00	Percentage of Medicaid patient days to total days (see instructions)			37. 28	8. 00
9.00	Sum of lines 7 and 8			43. 35	
				9. 18	
				329, 558	
12. 00	Total prospective capital payments (see instructions)			3, 990, 592	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00
4.00	Capital cost payment factor (see instructions)			0	4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)			0	
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3. 00

0.00

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11.00

12.00

13.00

14.00

Applicable exception percentage (see instructions)

Capital minimum payment level (line 5 plus line 7)

Worksheet L, Part III, line 14)

Capital cost for comparison to payments (line  $3 \times 1$  line 4)

(if line 12 is negative, enter the amount on this line)

16.00 Current year operating and capital costs (see instructions)

17.00 | Current year exception offset amount (see instructions)

Percentage adjustment for extraordinary circumstances (see instructions)

Current year capital payments (from Part I, line 12, as applicable)

Current year allowable operating and capital payment (see instructions)

Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)

Carryover of accumulated capital minimum payment level over capital payment (from prior year

Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

Current year exception payment (if line 12 is positive, enter the amount on this line)

Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)

Carryover of accumulated capital minimum payment level over capital payment for the following period