This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0115 Worksheet S Peri od: From 07/01/2021 Parts I-III AND SETTLEMENT SUMMARY 06/30/2022 Date/Time Prepared: 11/29/2022 11:30 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 11/29/2022 Time: 11:30 am ] Manually prepared cost report use only ] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended

## 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 HOSP & HEALTH CARE CTR (15-0115) for the cost reporting period beginning 07/01/2021 and ending 06/30/2022 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 ADMINISTRATOR	CHECKBOX		
	1	2	SI GNATURE STATEMENT	
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	1, 207, 284	-72, 142	0	0	1.00
2.00	Subprovider - IPF	0	12, 776	0		0	2.00
3.00	Subprovider - IRF	0	-22, 654	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	-1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		13, 131		0	10.00
10. 01	RURAL HEALTH CLINIC II	0		16, 123		0	10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	1, 197, 406	-42, 889	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 valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0115 Peri od: Worksheet S-2 From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/29/2022 11:30 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 800 WEST 9TH STREET 1.00 PO Box: 1.00 State: IN Zi p Code: 47546 2.00 City: JASPER County: DUBOIS 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal MEMORIAL HOSP & HEALTH 150115 99915 07/01/1966 Ν Р 0 3.00 1 CARE CTR MEMORIAL HOSP & HCC 4.00 Subprovi der - IPF 15S115 99915 4 07/01/1985 Ν Ρ 0 4.00 (PSYCH) 5.00 Subprovi der - IRF MEMORIAL HOSP & HCC 15T115 99915 07/01/2005 Р 0 5.00 (REHAB) Subprovider - (Other) Swing Beds - SNF 6.00 6 00 7.00 7.00 8.00 Swing Beds - NF 8.00 Hospital-Based SNF MEMORIAL HOSP & HEALTH 155305 99915 08/04/1987 Р 0 9.00 9.00 Ν CARE CTR 10.00 Hospital-Based NF 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA MEMORIAL HOSP & HEALTH 157222 99915 08/28/1991 Ν Ρ Ν 12.00 CARE CTR 13.00 Separately Certified ASC 13 00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital -Based Health Clinic - RHC FRENCH LICK FAMILY 158507 99915 06/19/2009 0 N 15.00 MEDICINE Hospital-Based Health Clinic - RHC LOOGOOTEE FAMILY 158508 99915 15.01 15.01 12/14/2009 N 0 N MEDICINE 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From 1.00 2.00 07/01/2021 06/30/2022 20.00 Cost Reporting Period (mm/dd/yyyy) 20.00 21.00 Type of Control (see instructions) 21.00 1 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ Ν 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. 22.01 Did this hospital receive interim uncompensated care payments for this Υ Υ 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν Ν 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to Ν Ν N 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no

Prof.   Prof	Heal th Financi		HOSP & HEAL				In Lieu			
11/29/2022   11/30 c	HOSPITAL AND H	IOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	DATA	Provi der CC	CN: 15-0115	Period: From 07/	01/2021		eet S-2	
23.00 which nethod is used to determine Medicald days on lines 24 and/or 25 bellow? 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 different from the method used in the prior cost reporting period. The referent from the method used in the prior cost reporting period different from the method used in the prior cost.    The prior of the prior of the prior of the prior cost in the prior cost in the prior cost reporting period. The prior of the prior o						To 06/	30/2022			
23.00 which nethod is used to determine Medicald days on lines 24 and/or 25 bellow? 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 different from the method used in the prior cost reporting period. The referent from the method used in the prior cost reporting period different from the method used in the prior cost.    The prior of the prior of the prior of the prior cost in the prior cost in the prior cost reporting period. The prior of the prior o					1 00	2	00	3 (	20	
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24.00   If this provider is an IPPS hospital, enter the in-state Wedical deligible unpaid days in column 2, out-of-state Wedicald paid days in column 3, out-of-state Wedicald paid days in column 3, out-of-state Wedicald paid days in column 4, Wedicald W			Medi cai d	Medi cai d el i gi bl e unpai d	State Medi cai d	State Medicaid eligible		ys Med	di cai d	
In-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible burghald days in column 4, Medicaid HMD paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.    Storow	04.00 1.6 11.1	I DDC I was to the								24.00
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "" for urban or "2" for rural.  27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter "" for urban or "2" for rural. If applicable, enter the effective date of the geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.  35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.  8 Beginning: Ending: 1.00 2.00 35.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.  37.01 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.  37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see Instructions)  38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.  37.01 Is this hospital subject to the HAC program reduction adjustment for low volume hospitals in accordance with 42 CFR \$412.101(b)(2)(i), (ii), or (iii)? Enter in column 1, "Y" for yes or "N" for no. Does the facility meet the mil leage requirements in accordance with 42 CFR \$412.101(b)(2)(i), (ii), or (iii)? Enter in column 2, "Y" for yes or "N" for no clumn 1, for discharges prior to October 1. Enter "Y" for yes or "N" for yes or "N" for no clumn 1, for discharges prior to October 1. Enter "Y" for yes or "N" for yes or "N" for no in column 2, for discharges prior to October 1. Enter "Y" for yes or "N" for yes or "N" for no in col	i n-state Medicai out-of-s out-of-s 4, Medic column ! 25.00 If this Medicai Medicai out-of-s Medicai Medicai	e Medicaid paid days in column 1, in-state deligible unpaid days in column 2, state Medicaid paid days in column 3, state Medicaid eligible unpaid days in column 3, state Medicaid eligible but unpaid days in column 6, and other Medicaid days in column 6, provider is an IRF, enter the in-state depaid days in column 1, the in-state deligible unpaid days in column 2, state Medicaid days in column 3, out-of-state deligible unpaid days in column 4, Medicaid	n n						176	25. 00
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.  27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.  36.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.  36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.  37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.  37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)  38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.  47.00 VAN VAN 1.00 2.00  39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR \$412.101(b)(2)(1), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. (see instructions)  40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "V" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "V" for yes or "N" for no in column 2, for discharges prior to October 1. Enter "V" for yes or "N" for no be the facility qualify and receive Capital payment for disproportionate share in accordance N N N N 45.00	HMO paid	d and eligible but unpaid days in column 5.				Urban/	Rural S	Date of	Geogr	
cost réporting period. Enter "1" for urban or "2" for cural.  27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.  35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	24.22 5					1.				
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effect in the cost reporting period.    Beginning:   Ending:	27.00 Enter your reporting enter the	our standard geographic classification (not w ng period. Enter in column 1, "1" for urban o ne effective date of the geographic reclassif	wage) statu: or "2" for fication in	rural. If a column 2.	ippl i cabl e,		2			27. 00
36. 00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.  37. 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.  37. 01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)  38. 00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.  97/N 97/N 1.00 2.00  39. 00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR \$412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)  40. 00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)  9 Prospective Payment System (PPS)-Capital  45. 00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N N 45.6			ne number o	f periods S 	SCH status i	n	0			35. 00
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.  37.01 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.  37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)  38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.  45.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR \$412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR \$412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)  40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)  45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N N 45.0										
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38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.    Y/N	37.01 Is this accordar	hospital a former MDH that is eligible for 1 nce with FY 2016 OPPS final rule? Enter "Y" f								37. 01
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR \$412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)  40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)  Prospective Payment System (PPS)-Capital  45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N N A 45.0	38.00 If line greater	37 is 1, enter the beginning and ending date than 1, subscript this line for the number of								38. 00
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR \$412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR \$412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)  40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)  Prospective Payment System (PPS)-Capital  45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N N A 5.00										-
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)    V   XVIII   XIX   1.00   2.00   3.00	hospi tal 1 "Y" fo accordar	Is in accordance with 42 CFR §412.101(b)(2)(i or yes or "N" for no. Does the facility meet nce with 42 CFR 412.101(b)(2)(i), (ii), or (i	i), (ii), o the mileag	r (iii)? En e requireme	nter in colu ents in	ume ımn				39.00
Prospective Payment System (PPS)-Capital  45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N 45.00	40.00 Is this "N" for	hospital subject to the HAC program reduction oin column 1, for discharges prior to Octo	ober 1. Ent	er "Y" for			N	Y		40.00
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N 45.0	ļ.,0 ; ; ; ; ;	y amil 27 you are sorid, good on the area. Society	(000 / 110	40 (. 0.10)		<u> </u>				
			ant for di-	nronort! oz-	to chara !	00000000				45.00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances N N N 46.0	with 42	CFR Section §412.320? (see instructions)		•						46.00
pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	Pt. III.					Ü				47.00
	48.00 Is the	facility electing full federal capital paymer	•		-				1	47.00 48.00
	56.00 Is this "N" for was invo year, an	a hospital involved in training residents in no in column 1. For column 2, if the respons olved in training residents in approved GME p nd are you are impacted by CR 11642 (or appli	se to colum programs in icable CRs)	n 1 is "Y", the prior	or if this year or per	hospital nultimate		Y		56.00
	57.00 If line GME prog is "Y" o for yes	56 is yes, is this the first cost reporting grams trained at this facility? Enter "Y" fo did residents start training in the first mor or "N" for no in column 2. If column 2 is "	period dur or yes or "I nth of this "Y", comple	N" for no i cost repor te Workshee	n column 1. ting period	If column  ? Enter "	1 Y"	Y		57.00

3, the IME FTE unweighted count. Enter in column 4,	ŀ	
the direct GME FTE unweighted count.		
	1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which	0. 00	62.00
your hospital received HRSA PCRE funding (see instructions)	l	
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital	0.00	62.01
during in this cost reporting period of HRSA THC program. (see instructions)		
Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter	Y	63.00
"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	l	

Enter in column 2, the program code. Enter in column

Hool th E	i papai al Systams	MEMODIAL L	JOSE & HEALTH CARE CTE	•	In Lie	u of Form CMS-2	DEE2 10
	inancial Systems _ AND HOSPITAL HEALTH CARE COMP		HOSP & HEALTH CARE CTR ATA Provider CC	CN: 15-0115 Pe	eriod: rom 07/01/2021	Worksheet S-2 Part I	pared:
			'	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	. 00 um
				1. 00	2. 00	3. 00	
Se	ection 5504 of the ACA Base Yea	ar FTE Residents in N	Nonprovider Settings	This base year	is your cost	reporti ng	
64. 00 Er i r re	eriod that begins on or after shrer in column 1, if line 63 is not the base year period, the numes dent FTEs attributable to rote things. Enter in column 2 the esident FTEs that trained in you	s yes, or your facili nber of unweighted no otations occurring in e number of unweighte	ty trained residents on-primary care on all nonprovider ed non-primary care	0.00	0.00	0. 000000	64.00
	f (column 1 divided by (column						
	Ceordina - drvided by Ceordina	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1. 00	2. 00	3. 00	4. 00	5. 00	
isti yv as Fr pp re ti cc un re cc un re sc di	nter in column 1, if line 63 is yes, or your facility rained residents in the base ear period, the program name issociated with primary care its for each primary care rogram in which you trained esidents. Enter in column 2, he program code. Enter in column 3, the number of nweighted primary care FTE esidents attributable to obtations occurring in all con-provider settings. Enter in column 4, the number of nweighted primary care esidents attributable to obtations occurring in all con-provider settings. Enter in column 4, the number of nweighted primary care esident FTEs that trained in our hospital. Enter in column 1, the ratio of (column 3 ivided by (column 3 + column 1). (see instructions)			0.00	0.00		65.00
				Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs Nonprovi der Si te	FTEs in Hospital	1/ (col . 1 + col . 2))	
C	ection 5504 of the ACA Current	Voor FTF Dool donto	n Nonneoui don Cottino	1.00	2.00	3.00	
	ection 5504 of the ACA current eginning on or after July 1, 20		n Nonprovider Setting	JSEITECTIVE I	or cost report	ing perrous	
66. 00 Er F <sup>-</sup> Er	nter in column 1 the number of TEs attributable to rotations on the rin column 2 the number of TEs that trained in your hospiticolumn 1 divided by (column 1	unweighted non-prima occurring in all nonp unweighted non-prima tal. Enter in column column 2)). (see in	provider settings. ary care resident 3 the ratio of astructions)	0.00			66.00
		Program Name	Program Code	Unweighted	Unweighted FTEs in	Ratio (col.	
				FTEs Nonprovi der	Hospi tal	3/ (col. 3 + col. 4))	
				Si te			
		1. 00	2. 00	3. 00	4. 00	5. 00	
na yo wh Er co co to no co un ro 5, di	nter in column 1, the program ame associated with each of our primary care programs in hich you trained residents. Inter in column 2, the program ode. Enter in column 3, the umber of unweighted primary are FTE residents attributable or otations occurring in all on-provider settings. Enter in column 4, the number of nweighted primary care esident FTEs that trained in our hospital. Enter in column 1, the ratio of (column 3 ivided by (column 3 + column 1). (see instructions)	FAMILY MEDICINE	1350	2. 38	6. 85	0. 257855	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0115 Peri od: Worksheet S-2 From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/29/2022 11:30 am 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 | Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν 71.00 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75 00 Υ subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 80.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00  $\S413.40(f)(1)(ii)$ ? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. V XIX 1. 00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90 00 Ν yes or "N" for no in the applicable column. is this hospital reimbursed for title V and/or XIX through the cost report either in Ν Υ 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Ν 92.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 93.00 Ν N 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν Ν 94.00 applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν N 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 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Υ 98.00 stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 98.01 98.01 C,Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V,and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation 98.02 bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and N N 98.04 in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on 98.05 Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? 105 00 N 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) 107.00 Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)

Health Financial Systems MEMORIAL HOSP & HE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	ALTH CARE CTF	₹	In Lie	eu of Form CMS	S-2552-10
	Provi der Co	CN: 15-0115 F	Period: From 07/01/2021 To 06/30/2022		repared:
	<b>'</b>	<u> </u>	V	XIX	
108.00 Is this a rural hospital qualifying for an exception to the	CRNA fee sche	edul e? See 42	1. 00 N	2. 00	108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	/
100 00 f this best tal qualifies as a CAU as a cost provider, are	1. 00	2. 00	3. 00	4.00	109.00
109.00 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.					109.00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "'complete Worksheet E, Part A, lines 200 through 218, and Worlapplicable.	Y" for yes or	"N" for no.	lf yes,	N	110.00
111 00 6 this facility, malificates and CMU did it grantisticate in the	h- F+: (	\	1.00	2. 00	111 00
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cossumers of the FCHIP demonstration for this cossintegration prong of the FCHIP demonstration that apply: "A" for Ambulance services; "B" for additional for tele-health services.	st reporting Iumn 1 is Y, ticipating ir	period? Enter enter the n column 2.	N		111.00
		1.00	2.00	3.00	
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting participation of the current cost reporting participation of the current cost reporting participation of the demonstration of the dem	peri od? "Y", enter e	N			112.00
115.00 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 (ipsychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub. 15-1, chapter 22, §2208.1.	, or E only) 3" percent includes	N			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" in "N" for no.	for yes or	Y			116. 00
117.00 s this facility legally-required to carry malpractice insura	ance? Enter	Υ			117. 00
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence poli			1		118. 00
if the policy is claim-made. Enter 2 if the policy is occurre	ence.	Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 1, 235, 75	2.00	3.00	0118.01
The organisation of marpraetice premiums and para rosses.		1, 233, 73			0110.01
118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein.			1. 00 N	2.00	118. 02
119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Harmless provision in ACA §3121 and applicable amendments.	column 1, "Y alifies for t	/" for yes or the Outpatient		N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implant the cost in the cost implant the cost in the	ntable device	es charged to	Υ		121.00
patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.					122. 00
Transplant Center Information	r yes and "N"	for no. If	N		125. 00
125.00 Does this facility operate a transplant center? Enter "Y" for					126. 00
125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, en	ter the certi	fication date			
yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, enin column 1 and termination date, if applicable, in column 2.					
yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.  127.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certif	ication date			127. 00
yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.  127.00 If this is a Medicare certified heart transplant center, enter	er the certif er the certif	ication date			

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	MEMORIAL HOSP & IDENTIFICATION DATA	Provi der CC	CN: 15-0115	In Lie Period: From 07/01/202 To 06/30/2022		-2 repared:
				1 00	2.00	
130.00 If this is a Medicare certified pan	creas transplant center	, enter the cer	ti fi cati on	1. 00	2.00	130.00
date in column 1 and termination da 131.00 If this is a Medicare certified int	te, if applicable, in c estinal transplant cent	olumn 2. er, enter the c				131. 00
date in column 1 and termination da 132.00 If this is a Medicare certified isl in column 1 and termination date, i	et transplant center, e	nter the certif	ication date			132. 00
133.00 Removed and reserved 134.00 If this is an organ procurement organ termination date, if applicable		the OPO number	in column 1			133. 00 134. 00
All Providers  140.00 Are there any related organization chapter 10? Enter "Y" for yes or "N are claimed, enter in column 2 the	" for no in column 1. I	f yes, and home	office costs	y Y		140. 00
1.00  If this facility is part of a chair	2.0			3. 00	s of the home	
office and enter the home office co			Jugii 143 the i	ialle and addres	is of the nome	
141.00 Name: MEMORIAL HOSPITAL AND HEALTH CENTER		PS	Contracto	or's Number: 081	01	141. 00
142.00 Street: 800 W 9TH STREET 143.00 City: JASPER	PO Box: State:	V	Zi p Code:	475	546	142. 00 143. 00
	12.22.22		1 1 2 2 2 2 2			
144.00 Are provider based physicians' cost	s included in Worksheet	Δ?			1.00 Y	144. 00
144. Ooki e provi der based priysrerans eost	3 Theraded Th Worksheet	A:				144.00
145.00 of costs for renal services are cla	: Wi A 1: 7	4	- 6	1. 00	2.00	145.00
<pre>inpatient services only? Enter "Y" no, does the dialysis facility incl period? Enter "Y" for yes or "N" f</pre>	for yes or "N" for no inude Medicare utilization or no in column 2.	n column 1. If n for this cost	column 1 is reporting			145. 00
146.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/dd	column 1. (See CMS Pub.	ously filed cos 15-2, chapter	t report? 40, §4020) If	- N		146. 00
					1.00	
147.00Was there a change in the statistic 148.00Was there a change in the order of 149.00Was there a change to the simplifie	allocation? Enter "Y" f	or yes or "N" f	or no.	- no	N N N	147. 00 148. 00 149. 00
147. 00 was there a change to the shiphing	a cost finding method:	Part A	Part B	Title V	Title XIX	_
		1.00	2. 00	3. 00	4.00	
Does this facility contain a providor charges? Enter "Y" for yes or "N						
155. 00 Hospi tal	Tot no tot cach compo	N N	N N	N N	N N	155. 00
156.00 Subprovi der - IPF		N	N	N	N	156. 00
157. 00 Subprovi der - I RF 158. 00 SUBPROVI DER		N	N N	N	N	157. 00 158. 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	N	161. 00
					1. 00	
Multicampus 165.00 s this hospital part of a Multicam	pus hospital that has o	ne or more camp	uses in diffe	erent CBSAs?	N	165. 00
Enter "Y" for yes or "N" for no.		<u> </u>				
	Name 0	County 1.00		Code CBSA 4. 00	FTE/Campus 5.00	
166.00 If line 165 is yes, for each	0	1.00	2.00	3.00 4.00		00 166. 00
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						
					1.00	
Health Information Technology (HIT)	incentive in the Ameri	can Recovery ar	nd Reinvestmer	nt Act	1.00	
167.00 s this provider a meaningful user 168.00 If this provider is a CAH (line 105	is "Y") and is a meani	ngful user (lin		, enter the	Y	167. 00 168. 00
reasonable cost incurred for the HI 168.01 If this provider is a CAH and is no	t a meaningful user, do	es this provide				168. 01
exception under §413.70(a)(6)(ii)?	Enter "Y" for yes or "N	" for no. (see	instructions)	•		
169.00   If this provider is a meaningful us transition factor. (see instruction		d is not a CAH	(line 105 is	ีเง"), enter th	e 9.	99169. 00

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR				u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	ENTIFICATION DATA	Provider CCN: 15-0115	Peri od:	Worksheet S-2	
			From 07/01/2021		
			To 06/30/2022	Date/Time Pre	
				11/29/2022 11	:30 am
			Begi nni ng	Endi ng	
	1. 00	2. 00			
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting					170. 00
period respectively (mm/dd/yyyy)					
	1. 00	2. 00			
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in			N	0	171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter					
"Y" for yes and "N" for no in column 1	. If column 1 is yes, e	nter the number of secti	on		
1876 Medicare days in column 2. (see i	nstructions)				

	n Financial Systems MEMORIAL HOSP & HEALTH CATE REIMBURSEMENT QUESTIONNAIRE Provi	ider C		Peri od: From 07/01/2021	Worksheet S-2 Part II	2
			,	To 06/30/2022	11/29/2022 11	epared: 1:30 ar
				Y/N	Date	
	Constant I was the Constant of	. NO :	F-+	1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N for all mm/dd/yyyy format.	NO re	esponses. Ent	er all dates in	tne	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
1. 00	Has the provider changed ownership immediately prior to the beginni			N		1.00
	reporting period? If yes, enter the date of the change in column 2.	. (see			V//I	
			1. 00	2. 00	V/I 3. 00	
2. 00	Has the provider terminated participation in the Medicare Program?	lf	1.00 N	2.00	3.00	2.00
2. 00	yes, enter in column 2 the date of termination and in column 3, "V' voluntary or "I" for involuntary.					2.00
3. 00	Is the provider involved in business transactions, including manage		N			3.00
	contracts, with individuals or entities (e.g., chain home offices, or medical supply companies) that are related to the provider or in					
	officers, medical staff, management personnel, or members of the bo					
	of directors through ownership, control, or family and other similar					
	relationships? (see instructions)					
			Y/N	Type	Date	
	Financial Data and Reports		1. 00	2. 00	3. 00	
4. 00	Column 1: Were the financial statements prepared by a Certified Po	ublic	Υ	A		4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compi					
	or "R" for Reviewed. Submit complete copy or enter date available i	i n				
	column 3. (see instructions) If no, see instructions.					
5. 00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliations		N			5.00
	those on the fired financial statements: If yes, submit reconcilla	ti on.		Y/N	Legal Oper.	
				1. 00	2. 00	
,	Approved Educational Activities			1		
5. 00	Column 1: Are costs claimed for a nursing program? Column 2: If y is the legal operator of the program?	yes, is	s the provide	r N		6.00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see instruction	ons		N		7.00
8. 00	Were nursing programs and/or allied health programs approved and/or		wed during th			8.00
	cost reporting period? If yes, see instructions.		3			
9. 00	Are costs claimed for Interns and Residents in an approved graduate	e medio	cal education	N		9. 00
10. 00	program in the current cost report? If yes, see instructions.  Was an approved Intern and Resident GME program initiated or renewe	od in :	the current	N		10.00
10.00	cost reporting period? If yes, see instructions.	eu iii	the current	IN		10.00
11. 00	Are GME cost directly assigned to cost centers other than I & R in	an App	proved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
	Bad Debts				1. 00	
	Is the provider seeking reimbursement for bad debts? If yes, see in	nstruc	tions.		Υ	12.00
12. 00	The first of the provider seeking remindration semicing for body depts: in yes, see in			ost reporting	N	13.00
12. 00 13. 00	If line 12 is yes, did the provider's bad debt collection policy of					
13. 00	If line 12 is yes, did the provider's bad debt collection policy cl period? If yes, submit copy.	Ü				1
13. 00	If line 12 is yes, did the provider's bad debt collection policy cheriod? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payments wait.	Ü	fyes, see in:	structions.	N	14.00
13. 00 14. 00	If line 12 is yes, did the provider's bad debt collection policy cheriod? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payments waiv  Bed Complement	ved? I	•			
13. 00 14. 00	If line 12 is yes, did the provider's bad debt collection policy cheriod? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payments wait.	ved? It	yes, see ins	tructions.	N	
13. 00 14. 00	If line 12 is yes, did the provider's bad debt collection policy cheriod? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payments waiv  Bed Complement	ved? Ii od? If Par	•	tructions.		
13. 00 14. 00	If line 12 is yes, did the provider's bad debt collection policy cheriod? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payments waive Bed Complement  Did total beds available change from the prior cost reporting period   Y/N  1.0	ved? Ii od? If Par	yes, see ins	tructi ons. Par	N t B	14.00
13. 00 14. 00 15. 00	If line 12 is yes, did the provider's bad debt collection policy cheriod? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payments waive Bed Complement  Did total beds available change from the prior cost reporting period   Y/N  1.0  PS&R Data	ved? If od? If Par	yes, see ins t A Date 2.00	tructions. Par Y/N 3.00	N t B Date 4.00	15. 00
13. 00 14. 00 15. 00	If line 12 is yes, did the provider's bad debt collection policy cheriod? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payments waive Bed Complement  Did total beds available change from the prior cost reporting period  Y/N  1.0  PS&R Data  Was the cost report prepared using the PS&R Report only?  Y	ved? If od? If Par	yes, see ins	tructions. Par	N t B Date	
13. 00 14. 00	If line 12 is yes, did the provider's bad debt collection policy cheriod? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payments waive Bed Complement  Did total beds available change from the prior cost reporting period   Y/N  1.0  PS&R Data	ved? If od? If Par	yes, see ins t A Date 2.00	tructions. Par Y/N 3.00	N t B Date 4.00	15.00

Ν

Ν

Ν

Ν

17.00

18.00

19.00

instructions)

17.00 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If

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

cost report? If yes, see instructions.

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

Report data for corrections of other PS&R Report information? If yes, see instructions.

in columns 2 and 4. (see instructions)

either column 1 or 3 is yes, enter the paid-through date

Report data for additional claims that have been billed but are not included on the PS&R Report used to file this

Health Financial Systems MEMORIAL HOSP & H	HEALTH CARE CT	R	In Lie	u of Form CM:	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-0115	Peri od: From 07/01/2021 To 06/30/2022	Worksheet S Part II Date/Time P 11/29/2022	repared:
		iption	Y/N	Y/N	
20.00 If line 16 or 17 is yes, were adjustments made to PS&R		0	1.00 N	3. 00 N	20.00
Report data for Other? Describe the other adjustments:			IN	IN	20.00
	Y/N	Date	Y/N	Date	
	1. 00	2.00	3. 00	4. 00	
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
				1. 00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS	HOSPI TALS)			
Capital Related Cost					
22.00 Have assets been relifed for Medicare purposes? If yes, see 23.00 Have changes occurred in the Medicare depreciation expense			ring the cost		22. 00 23. 00
reporting period? If yes, see instructions.	due to apprai	sais made du	ring the cost		23.00
24.00 Were new leases and/or amendments to existing leases entered lf yes, see instructions	ed into during	this cost r	eporting period?		24. 00
25.00 Have there been new capitalized leases entered into during	the cost repo	orting period	? If yes, see		25. 00
instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during th	he cost renort	ing period?	lf ves see		26.00
instructions.	•	0 .			25.50
27.00 Has the provider's capitalization policy changed during the	e cost reporti	ng period? I	f yes, submit		27. 00
copy. Interest Expense					
28.00 Were new Loans, mortgage agreements or letters of credit er	ere new Loans, mortgage agreements or letters of credit entered into during the cost reporting				28. 00
period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or	and/or bond funds (Debt Service Reserve Fund)				29. 00
treated as a funded depreciation account? If yes, see instr	e instructions				27.00
30.00 Has existing debt been replaced prior to its scheduled maturination.	urity with new		30.00		
	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see				
instructions.					
Purchased Services  32.00 Have changes or new agreements occurred in patient care ser	rvices furnish	ed through c	ontractual		32.00
arrangements with suppliers of services? If yes, see instru	ucti ons.	· ·			
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 app	plied pertaini	ng to compet	itive bidding? If		33.00
no, see instructions. Provider-Based Physicians					
34.00 Are services furnished at the provider facility under an ar	rrangement wit	h provider-b	ased physicians?		34.00
If yes, see instructions.					25.00
35.00 If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		ents with the	provider-based		35.00
			Y/N	Date	
Home Office Costs			1. 00	2. 00	
36.00 Were home office costs claimed on the cost report?					36.00
37.00 If line 36 is yes, has a home office cost statement been pr	repared by the	home office	?		37. 00
If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home off	fico difforent	from that a	.f		38.00
the provider? If yes, enter in column 2 the fiscal year end			"		30.00
39.00 If line 36 is yes, did the provider render services to other	er chain compo	nents? If ye	S,		39. 00
see instructions. 40.00 If line 36 is yes, did the provider render services to the	home office?	If ves. see			40.00
instructions.					1 2 2 2 3
	1.00 2.			00	
Cost Report Preparer Contact Information	1.		Ζ.		
41.00 Enter the first name, last name and the title/position	KERRY		BEJARANO		41.00
held by the cost report preparer in columns 1, 2, and 3, respectively.					
	BKD, LLP				42.00
preparer.	(217) 202 400	2	NDE INDANOSDIO	COM	42.00
43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(317) 383-4000	J	KBEJARANO@BKD.	CON	43.00

Health Financial Systems MEMORIAL HOSP &	HEALTH CARE CTR	In Lieu of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Peri od: Worksheet S- From 07/01/2021 Part II To 06/30/2022 Date/Time Pr 11/29/2022 1	epared:
	3. 00		
Cost Report Preparer Contact Information			
41.00 Enter the first name, last name and the title/position	DI RECTOR		41.00
held by the cost report preparer in columns 1, 2, and 3,			
respectively.			
42.00 Enter the employer/company name of the cost report			42.00
preparer.			
43.00 Enter the telephone number and email address of the cost			43.00
report preparer in columns 1 and 2, respectively.			

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

						I/P Days /	
						0/P Visits /	
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
1 00		1. 00	2.00	3. 00	4. 00	5. 00	1.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	70	25, 550	0. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)						2.00
2. 00 3. 00	HMO and other (see instructions)						3.00
4. 00	HMO IPF Subprovider 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		70	25, 550	0. 00	0	7.00
7.00	beds) (see instructions)		70	25, 550	0.00	U	7.00
8. 00	INTENSIVE CARE UNIT	31. 00	26	9, 490	0. 00	0	8.00
9. 00	CORONARY CARE UNIT	31.00	20	7, 470	0.00	U	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)	10.00	96	35, 040	0. 00	Ö	14.00
15. 00	CAH visits			22, 2		0	15. 00
16. 00	SUBPROVI DER - I PF	40.00	10	3, 650		0	16.00
17.00	SUBPROVIDER - IRF	41.00	1	2, 920		0	17. 00
18. 00	SUBPROVI DER			•			18. 00
19.00	SKILLED NURSING FACILITY	44.00	14	5, 110		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	116. 00	0	0			24.00
24. 10	HOSPICE (non-distinct part)	30.00					24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	88. 00				0	26. 00
26. 01	RURAL HEALTH CLINIC II	88. 01				0	26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27.00	Total (sum of lines 14-26)		128				27. 00
28. 00	Observation Bed Days					0	
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days						33. 00 33. 01
JJ. U1	LTCH site neutral days and discharges		I			l	33.01

Health Financial SystemsMEMORIAL HOHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0115

Peri od: Worksheet S-3 From 07/01/2021 Part I To 06/30/2022 Date/Time Prepared:

				'		11/29/2022 11	: 30 am
	·	I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
				•		'	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	3, 556	103	8, 871			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)	1, 878	2, 021				2.00
3.00	HMO IPF Subprovider	8	0				3.00
4.00	HMO IRF Subprovider	0	32				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation	3, 556	103	8, 871			7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	1, 641	129	4, 472			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		55	1, 600			13.00
14.00	Total (see instructions)	5, 197	287	14, 943		946. 57	
15. 00	CAH visits	o	0	0			15.00
16.00	SUBPROVIDER - IPF	290	531	1, 337	0. 19	14. 13	16.00
17.00	SUBPROVI DER - I RF	559	o	958			1
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY	3, 138	38	4, 350	0.00	19. 93	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	10, 304	0	17, 408	0.00	30. 89	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	o	0	0	0.00	0.00	24.00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1, 171	0	3, 532	0.00	4. 74	26.00
26. 01	RURAL HEALTH CLINIC II	1, 657	0	5, 152	0.00	6. 78	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	ol	o	. 0		0.00	26. 25
27. 00	Total (sum of lines 14-26)				14. 72	1, 030. 56	
28. 00	Observation Bed Days		560	3, 442		,	28. 00
29. 00	Ambul ance Trips	0		-,			29.00
30. 00	Employee discount days (see instruction)			0			30.00
31. 00	Employee discount days - IRF			0			31.00
32. 00	Labor & delivery days (see instructions)	0	176	423			32.00
32. 01	Total ancillary labor & delivery room	١	.,,	0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	o					33.00
	LTCH site neutral days and discharges	Ö					33. 01
	, J	1	'	•	1	•	•

Health Financial SystemsMEMORIAL HOHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0115

| Peri od: | Worksheet S-3 | From 07/01/2021 | Part I | To 06/30/2022 | Date/Time Prepared:

				10	06/30/2022	11/29/2022 11	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 641	245	3, 238	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)			_	_		
2. 00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovi der				0		3.00
4.00	HMO IRF Subprovi der				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
8. 00	beds) (see instructions)						8. 00
9. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	1, 641	245	3, 238	
15. 00	CAH visits	0.00	ď	1, 041	243	3, 230	15.00
16. 00	SUBPROVI DER - I PF	0.00	0	36	309	656	16.00
17. 00	SUBPROVIDER - I RF	0.00	0	44	0	83	17. 00
18. 00	SUBPROVI DER	0.00	Ĭ		Ĭ	00	18.00
19. 00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	0.00					24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	0.00					26. 00
26. 01	RURAL HEALTH CLINIC II	0.00					26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges	I I	ı	0			33. 01

| Peri od: | Worksheet S-3 | From 07/01/2021 | Part II | To 06/30/2022 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0115

PART II - WAGE DATA   SALARIES	6. 00	Related to Salaries in	Sal ari es					
PART II - WAGE DATA   SALARIES   1.00   2.00   3.00   4.00   5.00	(col. 4 ÷ col. 5)	Salaries in		I on or	Reported	Number		
PART II - WAGE DATA   SALARIES	6.00		(COL. 2 ± COL.	Sal ari es	·			
PART II - WAGE DATA   SALARIES		COI. 4	3)					
PART II - WAGE DATA		5. 00	4. 00		2. 00	1. 00		
Total salaries (see   200.00   99,882,027   -1,417,009   98,465,018   2,101,563.6   1,100   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000   1,000	00 46.85 1.							
Instructions		2 101 563 00	98 465 018	-1 417 009	99 882 027	200 00		1 00
A						2001.00	instructions)	
8	0.00 2.	0. 00	0	0	0		Non-physician anesthetist Part	2. 00
Administrative	55 111. 29 3.	31, 428. 65	3, 497, 621	0	3, 497, 621		Non-physician anesthetist Part	3.00
4.01	307. 60 4.	542. 00	166, 721	0	166, 721			4. 00
Physician-Part B	144. 92 4.	8, 023. 35	1, 162, 735	0	1, 162, 735			4. 01
6.00 Non-physician-Part B for hospital-based RHC and FOHC services 7.00 Interns & residents (in an approved program) 7.01 Contracted interns and residents (in an approved programs) 8.00 Home office and/or related organization personnel 9.00 SNF	312. 37 5.	33, 341. 41	10, 414, 977	0	10, 414, 977			5. 00
1.00	38. 36 6.	15, 825. 63	607, 028	0	607, 028		Non-physician-Part B for hospital-based RHC and FQHC	6. 00
Approved program	0.00 7.	0. 00	0	0	0	21. 00		7. 00
residents (in an approved programs) 8.00   Mome office and/or related organization personnel   44.00   1,399,390   -26,913   1,372,477   39,881.0   9.00   SNF   44.00   1,399,390   -26,913   1,372,477   39,881.0   10.00   Excluded area salaries (see   38,396,551   -302,324   38,094,227   736,079.0   10.00   Excluded area salaries (see   38,396,551   -302,324   38,094,227   736,079.0   10.00   Contract labor: Direct Patient   1,830,244   0   1,830,244   59,147.4   10.00   Contract labor: Top level   0   0   0   0   10.00   Management and other   management and administrative   13.00   Contract labor: Physician-Part   109,172   0   109,172   937.5   14.01   Home office and/or related   0   0   0   0   14.02   Related costs   19,635,170   0   19,635,170   476,247.4   14.03   Related organization salaries   0   0   0   0   14.04   Home office: Physician Part A   0   0   0   0   15.00   Home office and Contract   0   0   0   0   16.01   Home office hysicians Part A   - Teaching   Home office contract   0   0   0   0   16.02   Home office contract   0   0   0   0   16.03   Home office contract   0   0   0   0   16.04   Home office contract   0   0   0   0   16.05   Home office contract   0   0   0   0   16.06   Home office contract   0   0   0   0   16.07   Home office contract   0   0   0   0   16.08   Home office contract   0   0   0   0   16.09   Home office contract   0   0   0   0   16.00   Home office contract   0   0   0   0   16.01   Home office contract   0   0   0   0   16.02   Home office contract   0   0   0   0   16.03   Home office contract   0   0   0   0   17.04   0   0   0   0   18.04   0   0   0   0   18.05   0   0   0   0   19.06   0   0   0   19.07   0   0   19.08   0   0   0   19.08   0   0   19.08   0   0   19.08   0   0   19.08   0   0   19.08   0   0   19.08   0   0   19.08   0   0   19.08   0   0   19.08   0   0   19.08   0   0   19.08   0   0   19.08   0   0   19.08   0   0   19.08   0   0   19.08   0   0   19.08   0   0   19.08   0   0   19.08   0   0   19.08   0   0   19.08   0   0   19.08							approved program)	
Home office and/or related organization personnel   SNF	58. 07 7.	19, 822. 00	1, 151, 155	0	1, 151, 155		residents (in an approved	7. 01
9.00 SNF	0.00 8.	0. 00	0	0	0			8. 00
Instructions   OTHER WAGES & RELATED COSTS	34. 41 9.	39, 881. 00	1, 372, 477	-26, 913	1, 399, 390	44. 00	SNF	9. 00
11. 00   Contract Labor: Direct Patient Care   1,830,244   0   1,830,244   59,147.4   12. 00   Contract Labor: Top Level management and other management and administrative services   13. 00   Contract Labor: Physician-Part A - Administrative   14. 00   Home office and/or related organization salaries and wage-related costs   14. 01   Home office salaries   19,635,170   0   19,635,170   476,247.4   14. 02   Related organization salaries   0   0   0   0   0   15. 00   Home office: Physician Part A   0   0   0   0   0   16. 01   Home office Physicians Part A - Teaching   16. 02   Home office contract   0   0   0   0   16. 02   Home office contract   0   0   0   0   17,830,244   59,147.4   59,147.4   18,30,244   0   1,830,244   59,147.4   19,635,170   0   109,172   937.5   109,172   0   109,172   937.5   109,172   0   109,172   937.5   109,172   0   109,172   937.5   109,172   0   109,172   937.5   109,172   0   109,172   937.5   109,172   0   109,172   937.5   109,172   0   109,172   937.5   109,172   0   109,172   937.5   109,172   0   109,172   937.5   109,172   0   109,172   937.5   109,172   0   109,172   937.5   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,172   109,	51. 75 10.	736, 079. 00	38, 094, 227	-302, 324	38, 396, 551		instructions)	10. 00
12.00   Contract Labor: Top Level	12 30. 94 11.	59, 147. 42	1, 830, 244	0	1, 830, 244			11. 00
management and other management and administrative services  13.00 Contract labor: Physician-Part A - Administrative Home office and/or related organization salaries and wage-related costs Home office salaries 14.01 Home office: Physician Part A - Administrative 16.00 Home office: Physicians Part A - Teaching 16.02 Home office Physicians Part A - Teaching 16.02 Home office contract Physicians Part A - Teaching 16.02 Home office contract Physicians Part A - Teaching	0.00 12.	0.00	0	0	0		1	12 00
13.00   Contract Labor: Physician-Part   109,172   0   109,172   937.5     A - Administrative   Home office and/or related organization salaries and wage-related costs   Home office salaries   19,635,170   0   19,635,170   476,247.4     14.01   Home office: Physician Part A   0   0   0   0     15.00   Home office: Physician Part A   0   0   0   0     16.00   Home office and Contract   0   0   0   0     16.01   Home office Physicians Part A   - Teaching   Home office contract   0   0   0     16.02   Home office contract   0   0   0   0     16.03   Home office contract   0   0   0   0     16.04   Home office contract   0   0   0   0     16.05   Home office contract   0   0   0   0     16.06   Home office contract   0   0   0   0     16.07   Home office contract   0   0   0   0     16.08   Home office contract   0   0   0   0     16.09   Home office contract   0   0   0   0     16.00   Home office contract   0   0   0   0     17.00   19,635,170   476,247.4     19,635,170   0   19,635,170   476,247.4     19,635,170   0   19,635,170   476,247.4     19,635,170   0   0   0   0     19,635,170   0   0   0     19,635,170   0   0   0     19,635,170   0   0   0     19,635,170   0   0     19,635,170   0   0     19,635,170   0   0     19,635,170   0   0     19,635,170   0   0     19,635,170   0   0     19,635,170   0   0     19,635,170   0   0     19,635,170   0   0     19,635,170   0   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0     19,635,170   0	0.00 12.	0.00	0	O	O		management and other	12.00
14.00 Home office and/or related organization salaries and wage-related costs  14.01 Home office salaries  14.02 Related organization salaries  15.00 Home office: Physician Part A - Administrative  16.00 Home office and Contract Physicians Part A - Teaching  16.01 Home office Physicians Part A - Teaching  16.02 Home office contract Physicians Part A - Teaching  16.02 Home office contract Physicians Part A - Teaching	116. 45 13.	937. 50	109, 172	0	109, 172		Contract Labor: Physician-Part	13. 00
14. 01       Home office salaries       19,635,170       0       19,635,170       476,247.4         14. 02       Related organization salaries       0       0       0       0       0         15. 00       Home office: Physician Part A - Teaching       0       0       0       0       0         16. 00       Home office and Contract Physicians Part A - Teaching       0       0       0       0       0       0         16. 02       Home office contract Physicians Part A - Teaching       0       0       0       0       0       0       0	0. 00 14.	0. 00	0	0	0		Home office and/or related	14. 00
14.02 Related organization salaries  15.00 Home office: Physician Part A - Administrative  16.00 Home office and Contract Physicians Part A - Teaching  16.01 Home office Physicians Part A - Teaching  16.02 Home office contract Physicians Part A - Teaching	41. 23 14.	474 247 44	10 425 170	0	10 425 170			14 01
- Administrative  16.00 Home office and Contract		0.00	19, 033, 170	0	19, 033, 170			
16.00 Home office and Contract	0. 00 15.	0. 00	0	0	0			15.00
Physicians Part A - Teaching Home office Physicians Part A 0 0 0 0 0.0 - Teaching Home office contract 0 0 0 0 0.0 Physicians Part A - Teaching	0. 00 16.	0. 00	0	0	0			16. 00
- Teaching  16. 02 Home office contract  Physicians Part A - Teaching		0.00					Physicians Part A - Teaching	4. 04
16.02 Home office contract 0 0 0 0.0	0.00 16.	0. 00	0	U	0		-	16. 01
	0. 00 16.	0. 00	0	0	0		Home office contract	16. 02
WAGE-RELATED COSTS							WAGE-RELATED COSTS	
17. 00 Wage-related costs (core) (see 13, 517, 792 0 13, 517, 792	17.		13, 517, 792	0	13, 517, 792			17. 00
instructions)  18.00 Wage-related costs (other) (see instructions)	18.						Wage-related costs (other)	18. 00
19. 00 Excluded areas 7, 798, 555 0 7, 798, 555	19.		7, 798, 555	0	7, 798, 555		Excluded areas	
20.00 Non-physician anesthetist Part 0 0 0 0 0 0 21.00 Non-physician anesthetist Part 333,938 0 333,938	20.		333. 938	0	333. 938		A	
22. 00   Physician Part A - 6,679 0 6,679	22.			0	·		В	
Admi ni strati ve				U			Admi ni strati ve	
22. 01   Physici an Part A - Teaching   84, 598   0 84, 598   23. 00   Physici an Part B   353, 974   0 353, 974	22.			0	·			
24.00 Wage-related costs (RHC/FQHC) 166,969 0 166,969	24.			0			Wage-related costs (RHC/FQHC)	24.00
25.00 Interns & residents (in an 0 0 0	25.		0	0	0		,	25. 00
approved program) 25.50   Home office wage-related   3,399,706   0 3,399,706	25.		3, 399, 706	0	3, 399, 706		Home office wage-related	25. 50
(core) 25. 51 Related organization 0 0 0	25.		0	0	Ω			25 51
wage-related (core)			0		_		wage-related (core)	
25.52 Home office: Physician Part A	25.		0	0	0		- Administrative -	25. 52

17.00

18.00

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0115 Peri od: Worksheet S-3 From 07/01/2021 Part II Date/Time Prepared: 06/30/2022 11/29/2022 11:30 am Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of Sal ari es (col. 2 ± col. Salaries in (from Wkst. col. 4 3) A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 0 25. 53 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 0 0 0.00 0. 00 26.00 27.00 Administrative & General 5.00 1, 618, 572 -190, 843 1, 427, 729 82, 846. 00 17. 23 27.00 28.00 4, 013, 646 4, 013, 646 42, 203. 52 95. 10 28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 6.00 540, 423 -2, 539 537, 884 5, 666. 00 94. 93 29.00 30.00 Operation of Plant 7.00 0.00 30.00 0.00 . Laundry & Linen Service 8.00 16.86 31.00 31.00 284, 592 -596 283, 996 16, 845. 00 0.00 32.00 Housekeepi ng 9.00 0.00 32.00 33.00 Housekeeping under contract 1, 615, 855 1, 615, 855 74, 725. 58 21.62 33.00 (see instructions) 34.00 Dietary 10.00 1, 077, 975 -842, 066 235, 909 11, 610. 00 20. 32 34.00 35.00 Dietary under contract (see  $\cap$ 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 814, 734 814, 734 41, 090. 00 19.83 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 0 Nursing Administration 13.00 946, 305 21, 934. 00 41. 96 38.00 38.00 -25, 851 920 454 39.00 Central Services and Supply 14.00 287, 428 -4, 258 283, 170 13, 229. 00 21. 41 39.00 2, 019, 454 6, 387. 00 50.80 40.00 Pharmacy 15.00 -1, 694, 969 324, 485 40.00 Medical Records & Medical Records Library 41.00 16.00 0 C 0 0.00 0.00 41.00

0

0

0

0

0

0

0.00

0.00

0.00 42.00

0.00 43.00

42.00

Social Service

43.00 Other General Service

				12,12,111 0,1112 0,11	`	111 210	u 01 101 III 0III0 2	.002 .0
HOSPITAL WAGE INDEX INFORMATION				Provi der C		Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part III Date/Time Prep 11/29/2022 11:	pared:
		Worksheet A	Amount	Recl assi fi cat	Adjusted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.		(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet	",		00 0)	
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		88, 678, 012	-1, 417, 009	87, 261, 00	3 2, 110, 051. 06	41. 35	1.00
	instructions)							
2.00	Excluded area salaries (see		39, 795, 941	-329, 237	39, 466, 70	4 775, 960. 00	50. 86	2.00
	instructions)							
3.00	Subtotal salaries (line 1		48, 882, 071	-1, 087, 772	47, 794, 29	9 1, 334, 091. 06	35. 83	3.00
	minus line 2)							
4.00	Subtotal other wages & related		21, 574, 586	0	21, 574, 58	6 536, 332. 38	40. 23	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		16, 924, 177	0	16, 924, 17	7 0.00	35. 41	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		87, 380, 834	-1, 087, 772	86, 293, 06	2 1, 870, 423. 44	46. 14	6.00
7.00	Total overhead cost (see		12, 404, 250	-1, 946, 388	10, 457, 86	2 316, 536. 10	33. 04	7.00
	instructions)							

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS
Provider CCN: 15-0115
From 07/01/2021
To 06/30/2022
Part IV
Date/Time Prepared:
11/29/2022 11:30 am

	10 00/30/2022	11/29/2022 11:	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		l
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 515, 428	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	o	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	ol	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	ol	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		l
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	ol	6.00
7.00	Employee Managed Care Program Administration Fees	ol	7.00
	HEALTH AND INSURANCE COST		l
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	ol	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	12, 141, 362	8.02
8. 03	Heal th Insurance (Purchased)	ol	8.03
9. 00	Prescription Drug Plan	ol	9.00
10.00	Dental, Hearing and Vision Plan	ol	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	79, 257	11.00
12.00		ol	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	1, 781, 838	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00		485, 694	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16, 00
	Non cumulative portion)		ł
	TAXES		l
17.00	FICA-Employers Portion Only	6, 121, 989	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unempl oyment Insurance	5, 344	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		l
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21.00
	instructions))		ł
22.00	Day Care Cost and Allowances	o	22.00
	Tuition Reimbursement	131, 592	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	22, 262, 504	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

			11/29/2022 11	:30 am
	Cost Center Description	Contract	Benefit Cost	
		Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospi tal	0	0	2.00
3.00	SUBPROVI DER - I PF	0	0	3.00
4.00	SUBPROVI DER - I RF	0	0	4.00
5.00	Subprovi der - (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	0	0	8. 00
9.00	NURSING FACILITY			9. 00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospi tal -Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D. P. ) I			12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14. 01
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	0	18. 00

Heal th	Financial Systems ME	MORIAL HOSP & HE	ALTH CARE CTI	₹	In Lie	eu of Form CMS-2	2552-10
HOME H	EALTH AGENCY STATISTICAL DATA		Provi der C	F	Period: From 07/01/2021		
			Component	CCN: 15-7222   1	To 06/30/2022	11/29/2022 11	
					Home Health Agency I	PPS	
			_			20	
0. 00	County				DUBOI S	00	0.00
			Title XVIII	Title XIX	0ther	Total	
	HOME HEALTH AGENCY STATISTICAL DATA	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	Home Health Aide Hours	0	2, 321				
2. 00	Unduplicated Census Count (see instructions)	0.00	859. 00		630.00 loyees (Full Ti		2.00
				INGINDEL OF LIIP	royees (ruir ii	me Equi vai ent)	
		Enter the number	r of hours in	Staff	Contract	Total	
		your normal	work week				
		0		1.00	2. 00	3. 00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	0		1.00	2.00	3.00	
3.00	Administrator and Assistant Administrator(s)		40. 00	•		l .	1
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			1. 00 4. 81		l .	4. 00 5. 00
6. 00	Direct Nursing Service			12. 89			6.00
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			0. 78 5. 89			1
9. 00	Physical Therapy Supervisor			0.00		l .	9.00
10.00	Occupational Therapy Service			3. 19			1
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0. 00 0. 17			1
13. 00	Speech Pathology Supervisor			0. 00			1
14. 00	Medical Social Service			0. 17			
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0.00			
17. 00	Home Health Aide Supervisor			0. 00			1
18. 00	Other (specify)			0.00	0.00		18. 00
						CBSA Data 1.00	
10.00	HOME HEALTH AGENCY CBSA CODES						10.00
19. 00 20. 00	Enter in column 1 the number of CBSAs where List those CBSA code(s) in column 1 serviced					1 99915	19. 00 20. 00
	first code).	F F.:					
		Full Epi Without W		LUPA Episodes	PEP Only	Total (cols.	
		Outliers			Epi sodes	1-4)	
	PPS ACTIVITY DATA	1. 00	2. 00	3. 00	4. 00	5. 00	
21. 00	Skilled Nursing Visits	3, 298	863				
22. 00	Skilled Nursing Visit Charges	836, 854	229, 212				1
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	2, 017 545, 048	950 256, 243				
25.00	Occupational Therapy Visits	755	746	$ $ $\epsilon$	22	1, 529	25. 00
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	203, 689	200, 773 29	1		411, 994 65	ı
28. 00	Speech Pathology Visit Charges	9, 415	7, 801				
29.00	Medical Social Service Visits	20	13				
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	6, 120 882	3, 978 461				
32. 00	Home Health Aide Visit Charges	103, 194	53, 937	117			
33. 00	Total visits (sum of lines 21, 23, 25, 27,	7, 007	3, 062	126	109	10, 304	33.00
34.00	29, and 31) Other Charges	o	0		o	0	34.00
35. 00	Total Charges (sum of lines 22, 24, 26, 28,	1, 704, 320	751, 944	35, 121	25, 728	2, 517, 113	35. 00
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	7, 007		76	60	7, 143	36.00
37. 00	outlier)  Total Number of Outlier Episodes		1, 476		0	1, 476	37.00
	Total Non-Routine Medical Supply Charges	32, 850	18, 101		52		

Health Financial Systems MEM	MORIAL HOSP & F	HEALTH CARE CT	R	In Lie	eu of Form CMS	S-2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (	CCN: 15-0115	Peri od:	Worksheet S	-8
		Component	CCN: 15-8507	From 07/01/2021 To 06/30/2022		
				RHC I	Cost	
Territoria de la companya della companya della companya de la companya della comp				1	. 00	
Clinic Address and Identification				E22 COUTH MADI	L CTDEET	1 00
1.00 Street		C	ity	522 SOUTH MAPI State	ZIP Code	1.00
			. 00	2.00	3. 00	
2.00 City, State, ZIP Code, County		FRENCH LICK			N 47432	2.00
O OO HOODITAL BACED FOLIO ONLY D	II DII C				1. 00	0 0 00
3.00   HOSPITAL-BASED FOHCS ONLY: Designation - Ente	er "R" for rura	al or "U" for		nt Award	Date	0 3.00
				1. 00	2.00	
Source of Federal Funds				1.00	2.00	
4.00 Community Health Center (Section 330(d), PHS	Act)				T	4.00
5.00 Migrant Health Center (Section 329(d), PHS Ad						5.00
6.00 Health Services for the Homeless (Section 340	O(d), PHS Act)					6.00
7.00 Appalachian Regional Commission 8.00 Look-Alikes						7.00
8.00 Look-Alikes 9.00 OTHER (SPECIFY)					1	8. 00 9. 00
7. 00 OTHER (SECTED)						7.00
				1. 00	2.00	
10.00 Does this facility operate as other than a hoyes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of o	other operatio	ons in column	N		0 10.00
Tiour s. )	Sun	dav	I M	onday	Tuesday	
	from	to	from	to	from	
	1. 00	2. 00	3.00	4. 00	5. 00	
Facility hours of operations (1)		T	lac. ac	47.00	107.00	
11. 00   CLINIC			08: 00	17: 00	07: 00	11.00
				1. 00	2.00	
12.00 Have you received an approval for an exception	on to the produ	uctivity stand	lard?	N N	2.00	12.00
13.00 Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report.	d in CMS Pub.' umn 1. If yes,	100-04, chapte enter in colu	er 9, section umn 2 the	N		0 13.00
numbers below.					000	
				der name	CCN number	
14.00 RHC/FOHC name. CCN number				1.00	2. 00	14.00
14.00 RHC/FQHC name, CCN number	Y/N	V				14.00
14.00 RHC/FQHC name, CCN number	Y/N 1. 00	V 2.00		1. 00	2. 00	
15.00 Have you provided all or substantially all	1. 00		XVIII	1. 00 XI X	2.00 Total Visits	
	1. 00		XVIII	1. 00 XI X	2.00 Total Visits	S
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	1. 00		XVIII	1. 00 XI X	2.00 Total Visits	S
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	1. 00		XVIII	1. 00 XI X	2.00 Total Visits	S
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	1. 00		XVIII	1. 00 XI X	2.00 Total Visits	S
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1. 00		XVIII	1. 00 XI X	2.00 Total Visits	S
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	1. 00	2.00	XVIII 3. 00	1. 00 XI X	2.00 Total Visits	S
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1. 00	2. 00 Co	XVIII	1. 00 XI X	2.00 Total Visits	S
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1.00	2. 00  Co  4  ORANGE	XVIII 3.00	1. 00 XI X 4. 00	2.00 Total Visits 5.00	S
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00 Tuesday	2.00  Color 4  ORANGE Wedr	XVIII 3.00  unty 00  esday	1. 00  XI X  4. 00	2.00 Total Visits 5.00	15.00
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00 Tuesday	2.00  Co 4  ORANGE  Wedr	XVIII 3.00  unty 00  esday to	1.00 XIX 4.00 Thu	2.00 Total Visits 5.00	15.00
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00 Tuesday	2.00  Color 4  ORANGE Wedr	XVIII 3.00  unty 00  esday	1. 00  XI X  4. 00	2.00 Total Visits 5.00	15.00

Health Financial Systems ME	MORIAL HOSP & F	HEALTH CARE C	TR	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der	CCN: 15-0115	Peri od:	Worksheet S-8	
		Component	CCN: 15-8507	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 11	
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	06: 00	15: 00				11.00

Health Financial Systems MEM	MORIAL HOSP & H	IEALTH CARE CT	R	In Lie	eu of Form CMS	5-2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der 0	CCN: 15-0115	Peri od:	Worksheet S-	-8
		Component	CCN: 15-8508	From 07/01/2021 To 06/30/2022		
				RHC II	Cost	
01: - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1				1.	00	
Clinic Address and Identification  1.00 Street				105 COOPER STR	PEET	1.00
1.00   Street		Ci	ty	State	ZIP Code	1.00
			00	2.00	3. 00	
2.00 City, State, ZIP Code, County		L00G00TEE		IN	47553	2.00
					1.00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "II" for	urhan		1. 00	0 3.00
3. 00   HOSELTINE BASED TRIES ONET. BEST GRACTOR ELLE	ci it for fure	1 01 0 101		nt Award	Date	3.00
				1. 00	2.00	
Source of Federal Funds			_			
4.00 Community Health Center (Section 330(d), PHS						4.00
5.00 Migrant Health Center (Section 329(d), PHS A						5.00
<ul><li>6.00 Health Services for the Homeless (Section 340</li><li>7.00 Appalachian Regional Commission</li></ul>	o(u), PHS ACT)					6. 00 7. 00
8. 00 Look-Alikes						8.00
9. 00 OTHER (SPECIFY)						9. 00
10 00 Deep this facility asserts as other than a h	: 4-1   1   1	NIC FOLICO F		1.00	2. 00	0 10 00
10.00 Does this facility operate as other than a house yes or "N" for no in column 1. If yes, indicated 2. (Enter in subscripts of line 11 the type of hours.)	ate number of o	other operatio	ns in column			0 10.00
modi 3. )	Sund	day	M	londay	Tuesday	
	from	to	from	to	from	
	1. 00	2. 00	3. 00	4. 00	5. 00	
Facility hours of operations (1) 11.00 CLINIC			08: 00	17: 00	loo. 00	11 00
11.00 CLINIC			08: 00	17:00	08: 00	11. 00
				1. 00	2.00	
12.00 Have you received an approval for an exception	on to the produ	uctivity stand	lard?	N		12.00
13.00 Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu	umn 1. If yes,	enter in colu	ımn 2 the	N		0 13.00
number of providers included in this report. numbers below.	List the names	s of all provi	ders and			
Trumber 3 below.			Provi	der name	CCN number	
				1. 00	2. 00	
14.00 RHC/FQHC name, CCN number						14.00
					Total Visits	
	Y/N	V	XVIII	XIX		5
15 00 Have you provided all or substantially all	Y/N 1. 00	V 2. 00	3. 00	4.00	5. 00	
15.00 Have you provided all or substantially all  GMF cost? Fnter "Y" for yes or "N" for no in	1. 00					15. 00
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	1. 00					
GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	1. 00					
GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	1. 00					
GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	1. 00					
GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1. 00					
GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	1. 00	2. 00				
GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2. 00 Cot 4.	3.00			15. 00
GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1.00	2. 00 Cot MARTI N	3.00 unty	4.00	5.00	
GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2.00  Cou  4.  MARTI N  Wedn	3.00 unty 00 esday	4. 00 Thur	5. 00	15. 00
GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00 Tuesday	2.00  Cou 4.  MARTIN  Wedn  from	3.00  unty 00  esday to	4.00 Thur	5.00 -sday to	15.00
GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2.00  Cou  4.  MARTI N  Wedn	3.00 unty 00 esday	4. 00 Thur	5. 00	15.00

Health Financial Systems ME	MORIAL HOSP & I	HEALTH CARE C	TR	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der	CCN: 15-0115	Peri od:	Worksheet S-8	
		Component	CCN: 15-8508	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 11	
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 00	13: 00				11.00

Heal th	Financial Systems MEMORIAL HOSP & HEA	LTH CARE CTR		In Lie	u of Form CMS-2	2552-10	
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15		eri od:	Worksheet S-1		
				rom 07/01/2021 o 06/30/2022	Date/Time Pre	narod:	
				0 00/30/2022	11/29/2022 11		
					1. 00		
	Uncompensated and indigent care cost computation						
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 c	ivided by line 20	02 column	8)	0. 227694	1.00	
2 00	Medicaid (see instructions for each line)				20 775 012	2 00	
2. 00 3. 00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				20, 775, 013 N	2. 00 3. 00	
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplements.	ntal navments fro	om Medicai	d?	IN	4. 00	
5. 00	If line 4 is no, then enter DSH and/or supplemental payments		om mour ou.	α.	0	5. 00	
6.00	Medi cai d charges				67, 465, 959	6.00	
7.00	Medicaid cost (line 1 times line 6)				15, 361, 594	7.00	
8.00							
	< zero then enter zero)	6 1 11 )					
0.00	Children's Health Insurance Program (CHIP) (see instructions Net revenue from stand-alone CHIP	for each line)			0	0.00	
9. 00 10. 00	Stand-alone CHIP charges				0	9. 00 10. 00	
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00	
12. 00	Difference between net revenue and costs for stand-alone CHIF	(line 11 minus	line 9: i1	f < zero then	0	12.00	
	enter zero)	•					
	Other state or local government indigent care program (see in						
13.00	Net revenue from state or local indigent care program (Not in					13.00	
14. 00	Charges for patients covered under state or local indigent ca	re program (Not	included i	n lines 6 or	0	14. 00	
15. 00	[10] State or local indigent care program cost (line 1 times line	14)			0	15. 00	
16. 00	State or local indigent care program cost (line 1 times line Difference between net revenue and costs for state or local i		aram (line	a 15 minus line		16.00	
10.00	13; if < zero then enter zero)	nargent care pro	gram (TTT	2 13 1111103 11110		10.00	
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see						
47.00	instructions for each line)	6 - 1 1 1 -			0	47.00	
17. 00 18. 00	Private grants, donations, or endowment income restricted to Government grants, appropriations or transfers for support of	9			0	17. 00 18. 00	
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and loc			(sum of lines	0	19.00	
	8, 12 and 16)			,			
			i nsured	Insured	Total (col. 1		
			atients 1.00	pati ents 2.00	+ col . 2) 3.00		
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00		
20.00	Charity care charges and uninsured discounts for the entire f	acility	2, 505, 637	316, 605	2, 822, 242	20.00	
	(see instructions)						
21. 00	Cost of patients approved for charity care and uninsured disc	ounts (see	570, 519	316, 605	887, 124	21. 00	
22. 00	instructions) Payments received from patients for amounts previously writte	n off as	0	0	0	22. 00	
22.00	charity care	11 011 43	J	J	o l	22.00	
23. 00	Cost of charity care (line 21 minus line 22)		570, 519	316, 605	887, 124	23. 00	
					1. 00		
24 00	Does the amount on line 20 column 2, include charges for pati	ent days beyond :	a Length o	of stay limit	1.00 N	24.00	
2 00	imposed on patients covered by Medicaid or other indigent car		a rongtii t	5. Stay		21.00	
25. 00	If line 24 is yes, enter the charges for patient days beyond	the indigent care	e program'	s length of	0	25. 00	
26. 00	stay limit Total bad debt expense for the entire hospital complex (see i	nstructions)			8, 050, 005	26. 00	
27. 00	Medicare reimbursable bad debts for the entire hospital compl	,	i ons)		102, 099	27. 00	
27. 01	Medicare allowable bad debts for the entire hospital complex	•			157, 074	27. 01	
28. 00	Non-Medicare bad debt expense (see instructions)		•		7, 892, 931	28. 00	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt e	xpense (see inst	ructions)		1, 852, 148		
	Cost of uncompensated care (line 23 column 3 plus line 29)				2, 739, 272		
31. 00	Total unreimbursed and uncompensated care cost (line 19 plus	line 30)			2, 739, 272	31.00	

	FINANCIAL SYSTEMS MER SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	WURLAL HUSP & HE	Provider C		Peri od:	Worksheet A	2332-10
RECEAS	STITEMENT AND ADDUSTMENTS OF TRIAL BALANCE O	I LAFLINGLS	Frovider C	F	From 07/01/2021 o 06/30/2022	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +-	
		1. 00	2. 00	3.00	4.00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		6, 822, 083			6, 822, 083	
2.00	00200 CAP REL COSTS-MVBLE EQUIP		5, 704, 128	5, 704, 128	0	5, 704, 128	
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0 1, 618, 572	444, 557	2, 063, 129	-154, 097	1, 909, 032	4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS	540, 423	3, 593, 985			4, 134, 408	1
8.00	00800 LAUNDRY & LI NEN SERVI CE	284, 592	70, 221			354, 813	
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0 1, 077, 975	619, 100	1, 697, 075	1	0 406, 310	
11. 00	01100 CAFETERI A	0	017, 100	1,077,075	1, 282, 650		1
13. 00	01300 NURSING ADMINISTRATION	946, 305	97, 395			1, 043, 626	1
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	287, 428 2, 019, 454	167, 628 17, 121, 463	1		442, 313 603, 530	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	2,019,434	17, 121, 403	19, 140, 917		003, 530	16.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	О	0	(	1,,		1
22. 00	02200    &R SERVI CES-OTHER PRGM. COSTS APPRVD   I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 321, 234	1, 238, 388	2, 559, 622	-1, 151, 155	1, 408, 467	22.00
30. 00	03000 ADULTS & PEDIATRICS	7, 630, 594	1, 576, 749	9, 207, 343	-2, 155, 316	7, 052, 027	30.00
31.00	03100 INTENSIVE CARE UNIT	3, 398, 220	222, 466	3, 620, 686		3, 505, 058	31.00
40.00	04000 SUBPROVI DER - I PF	1, 284, 770	33, 906			1, 317, 068	1
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	557, 775 0	143, 207 0	700, 982		696, 987 653, 417	
44. 00	04400 SKILLED NURSING FACILITY	1, 399, 390	184, 781	1			1
F0 00	ANCILLARY SERVICE COST CENTERS	E 000 007	0 500 775	44.740.476	70.050	44 (75 040	F0 00
50. 00 52. 00	05000 OPERATING ROOM	5, 238, 397	9, 509, 775 0			14, 675, 819 1, 306, 835	•
53. 00	05300 ANESTHESI OLOGY	3, 686, 317	650, 995	1		4, 273, 628	
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 523, 607	1, 586, 904			7, 872, 873	
56. 00 60. 00	05600 RADI OI SOTOPE 06000 LABORATORY	181, 502 3, 224, 528	642, 115 5, 673, 613			822, 791 8, 898, 023	
65.00	06500 RESPIRATORY THERAPY	1, 363, 464	493, 650			1, 850, 313	1
66.00	06600 PHYSI CAL THERAPY	2, 901, 353	265, 996			3, 053, 994	66.00
69.00	06900 ELECTROCARDI OLOGY	2, 646, 966	2, 215, 334			4, 790, 782	
69. 01 69. 02	06901   PULMONARY   06902   CARDI OPULMONARY	100, 996	51, 672	1	ή	0 152, 668	
69. 03	06903 SLEEP LAB	256, 833	28, 651	1		285, 484	1
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	(	0	1 200 275	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	5, 510, 960	5, 510, 960	1, 290, 275 0	1, 290, 275 5, 510, 960	1
73.00	07300 DRUGS CHARGED TO PATIENTS	ō	0	(			1
74. 00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	0	(	0	0	74.00
88 00	08800 RURAL HEALTH CLINIC	383, 737	110, 351	494, 088	8 0	494, 088	88 00
88. 01	08801 RURAL HEALTH CLINIC II	503, 774	49, 931	553, 705		553, 705	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1 201 24	0	0	
90. 00 90. 01	09000   CLI NI C   09001   MED	510, 154 0	580, 910 0	1, 091, 064	-170, 729 0	920, 335 0	1
90. 02	09002 ONCOLOGY	2, 482, 651	974, 541	3, 457, 192	-82, 566	3, 374, 626	1
90. 03	09003 OUTPATIENT CENTER	0	0	1 500 016	0	0	
90. 04 90. 05	09004 HBURG URGENT CARE CLINIC 09005 DIABETES MGMT CLINIC	1, 248, 333 60, 564	254, 885 2, 156			1, 402, 358 62, 720	
91.00	09100 EMERGENCY	9, 648, 113	626, 570			10, 046, 154	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
95. 00	OTHER REIMBURSABLE COST CENTERS  09500 AMBULANCE SERVICES	2, 467, 266	163, 234	2, 630, 500	-20, 770	2, 609, 730	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	2,407,200	103, 234	2,030,300	0	2,007,730	1
101.00	10100 HOME HEALTH AGENCY	2, 024, 818	354, 803	2, 379, 621	-84, 713	2, 294, 908	101.00
116 00	SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE	ol	0		ol	0	116. 00
118.00		67, 820, 105	67, 787, 103				
	NONREI MBURSABLE COST CENTERS						1
	19000  GIFT, FLOWER, COFFEE SHOP & CANTEEN   19200  PHYSICIANS' PRIVATE OFFICES	0 30, 146, 756	0 4, 584, 993	34, 731, 749	0	0 34, 731, 749	190.00
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	866, 493	19, 941			886, 434	
	07950 LODGE	2, 744	11, 457	1	1		194. 00
	07951 OTHER NRCC 07952 MEMORIAL HOSPITAL FOUNDATION	0 121, 556	0 4, 412	1	0	0 125, 968	194. 01
	07953 MKT/PHY SERVICES	232, 157	58, 156	1		290, 313	1
194. 04	07954 COMMUNITY EDUCATION	383, 689	114, 338	498, 027	0	498, 027	194. 04
	07955 VOLUNTEER 07956 MAB	262, 056	17, 098			279, 154	
	07956 MAB 07957 OFFSITE COVID SCREENING	0	0 -56	1		0 152, 855	194. 06 194. 07
	1	<u> </u>		1 30	.52,711	.52,655	1

Health Financial Systems ME	MORIAL HOSP & H	EALTH CARE CTF	₹	In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provi der Co		Peri od:	Worksheet A	
			1 -	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 11	pared: :30 am_
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
194. 08 07958 PUBLIC RELATIONS	0	0	(	0	0	194. 08
194. 09 07959 UNUSED SPACE	0	0	(	0	0	194. 09
194. 10 07960 EMERGENCY PREPAREDNESS	46, 471	1, 396, 414	1, 442, 885	0	1, 442, 885	194. 10
194. 11 07961 HOME OFFICE	0	0		0	0	194. 11
200.00   TOTAL (SUM OF LINES 118 through 199)	99, 882, 027	73, 993, 856	173, 875, 883	0	173, 875, 883	200. 00

Health FinancialSystemsMEMORIAL HOSPRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0115

Peri od: From 07/01/2021 To 06/30/2022 Date/Ti me Prepared: 11/29/2022 11: 30 am

				11/29/2022 11	
	Cost Center Description	Adjustments	Net Expenses For	117272922	00 4
		(See A-8)	Allocation		
		6. 00	7. 00		
4 00	GENERAL SERVICE COST CENTERS	045.054	7 707 407	,1	1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	915, 054 2, 759			1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	25, 261, 293	l '		4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	27, 797, 795			5.00
6. 00	00600 MAI NTENANCE & REPAI RS	1, 899, 410		1	6.00
8.00	00800 LAUNDRY & LINEN SERVICE	0			8. 00
9.00	00900 HOUSEKEEPI NG	1, 632, 661	1, 632, 661		9. 00
10.00	01000 DI ETARY	-1, 886			10.00
11.00	01100 CAFETERI A	-594, 634			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	-47, 218			13.00
14. 00 15. 00	01500 PHARMACY	-2, 603 -298, 853			14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 600, 731	1, 600, 731		16.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	l		21.00
22. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	-263, 171	1, 145, 296		22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0	7, 052, 027		30.00
31.00	03100 INTENSIVE CARE UNIT	0	3, 505, 058		31.00
40. 00 41. 00	04000 SUBPROVI DER - I PF	-178, 361	1, 138, 707		40.00
43.00	04100 SUBPROVI DER - I RF 04300 NURSERY	-87, 665 0	1		41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0			44.00
00	ANCILLARY SERVICE COST CENTERS		1,7000,000	1	1 00
50.00	05000 OPERATING ROOM	-1, 667, 234	13, 008, 585		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	.,	l control of the cont	52.00
53.00	05300 ANESTHESI OLOGY	-3, 907, 840			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-3, 995, 413	l '		54.00
56. 00 60. 00	05600   RADI OI SOTOPE   06000   LABORATORY	140 704	822, 791		56. 00 60. 00
65.00	06500 RESPIRATORY THERAPY	-169, 794 -7, 257	8, 728, 229 1, 843, 056	1	65.00
66. 00	06600 PHYSI CAL THERAPY	-402, 375			66.00
69. 00	06900 ELECTROCARDI OLOGY	-504, 670			69.00
69. 01	06901 PULMONARY	0	0		69. 01
69. 02	06902 CARDI OPULMONARY	0	152, 668	3	69. 02
69. 03	06903 SLEEP LAB	-40	285, 444		69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1 200 275		70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0			71. 00 72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0			73.00
74.00	07400 RENAL DI ALYSI S	0			74.00
, 00	OUTPATIENT SERVICE COST CENTERS				7 00
88.00	08800 RURAL HEALTH CLINIC	-1, 003	493, 085	5	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	-225	553, 480		88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90. 00 90. 01	09000   CLI NI C   09001   I MED	-326, 973 0	593, 362 0		90. 00 90. 01
90.01	09001 TWED	0	· -	1	90.01
90. 02	09003 OUTPATIENT CENTER	0		i e	90.03
90. 04	09004 HBURG URGENT CARE CLINIC	-298, 957	1, 103, 401		90.04
90.05	09005 DI ABETES MGMT CLINIC	0	62, 720		90.05
91.00	09100 EMERGENCY	-5, 324, 911	4, 721, 243		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
05 00	OTHER REIMBURSABLE COST CENTERS  09500 AMBULANCE SERVICES	422 224	2 107 404	T	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	-422, 236 0	1	1	96.00
	10100 HOME HEALTH AGENCY	0			101.00
. 3 1 . 00	SPECIAL PURPOSE COST CENTERS		2,2,1,700		1
116.00	11600 HOSPI CE	0	0		116. 00
118.00	7	40, 606, 384	176, 060, 681		118.00
405	NONREI MBURSABLE COST CENTERS			,1	100 5
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
	) 19200 PHYSI CI ANS' PRI VATE OFFI CES I 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	34, 731, 749 886, 434		192. 00 192. 01
	007950 LODGE	0	14, 201		194.00
	107951 OTHER NRCC	l 0	14, 201		194.00
	207952 MEMORIAL HOSPITAL FOUNDATION	0		l e e e e e e e e e e e e e e e e e e e	194. 02
	07953 MKT/PHY SERVICES	3, 462, 944	3, 753, 257		194. 03
	07954 COMMUNITY EDUCATION	0	498, 027		194. 04
	07955 VOLUNTEER	0	279, 154		194. 05
	5 07956 MAB	0	152.055		194.06
	7 07957  OFFSITE COVID SCREENING 3 07958  PUBLIC RELATIONS	0 107	152, 855 107		194. 07 194. 08
174.00	DIO 7 700 TO DELLO INCENTIONO	107	107	1	1174.00

Health Financial Systems	ME	MORIAL HOSP & I	HEALTH CARE CT	₹	In L	ieu of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUST	FMENTS OF TRIAL BALANCE (	OF EXPENSES	Provi der C	CN: 15-0115	Period: From 07/01/20: To 06/30/20:	Worksheet A 21 22 Date/Time Pre	enared:
					10 00, 00, 20.	11/29/2022 11	
Cost Center Des	scription	Adjustments	Net Expenses		· .		
		(See A-8)	For				

			11/29/2022 11	. JU alli
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
		Allocation		
	6. 00	7. 00		
194. 09 07959 UNUSED SPACE	0	0		194. 09
194. 10 07960 EMERGENCY PREPAREDNESS	0	1, 442, 885		194. 10
194. 11 07961 HOME OFFICE	0	0		194. 11
200.00   TOTAL (SUM OF LINES 118 through 199)	44, 069, 435	217, 945, 318		200. 00

| Period: | Worksheet A-6 | From 07/01/2021 | To 06/30/2022 | Date/Time Prepared: Health Financial Systems RECLASSIFICATIONS Provi der CCN: 15-0115

					To 06/30/2022 Date/Time Pre	
		Increases			1172772022	. 00 4
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	Other E 00		
	A - LABOR AND DELIVERY	3.00	4.00	5. 00		
1.00	NURSERY	43. 00	583, 454	69, 963		1.00
2. 00	DELIVERY ROOM & LABOR ROOM	5200	<u>1, 166, 9</u> 09	13 <u>9, 9</u> 26		2.00
	O CAFFTEDIA		1, 750, 363	209, 889		
1. 00	B - CAFETERI A CAFETERI A	11.00	814, 734	467, 916		1. 00
	0		814, 734	467, 916		
	C - BILLABLE SUPPLES					
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	1, 290, 275		1. 00
2. 00	TATTENTS	0.00	o	0		2. 00
3.00		0.00	O	0		3.00
4.00		0.00	0	0		4.00
5. 00 6. 00		0. 00 0. 00	0	0		5. 00 6. 00
7. 00		0.00	o	0		7. 00
8. 00		0. 00	Ö	0		8. 00
9. 00		0. 00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00 12. 00		0. 00 0. 00	0	0		11. 00 12. 00
13. 00		0. 00	Ö	Ö		13.00
14.00		0. 00	0	0		14.00
15. 00 16. 00		0. 00 0. 00	0	0		15.00
17. 00		0.00	0	0		16. 00 17. 00
18. 00		0.00	ő	ő		18. 00
19. 00		0. 00	0	0		19.00
20.00		0.00	0	0		20.00
21. 00 22. 00		0. 00 0. 00	0	0		21. 00 22. 00
22.00	0			1, 290, 275		22.00
	D - DRUGS RECLASS		_1			
1. 00 2. 00	DRUGS CHARGED TO PATIENTS	73. 00 0. 00	0	17, 226, 363 0		1. 00 2. 00
3. 00		0.00	ő	ő		3. 00
4.00		0. 00	0	0		4.00
5. 00		0.00	0	0		5.00
6. 00 7. 00		0. 00 0. 00	0	0		6. 00 7. 00
8. 00		0.00	Ö	o		8. 00
9. 00		0.00	O	0		9.00
10.00		0.00	0	0		10.00
11. 00 12. 00		0. 00 0. 00	0	0		11. 00 12. 00
13. 00		0.00	Ö	o		13. 00
14.00		0.00	О	0		14.00
15.00		0.00	0	0		15.00
16. 00 17. 00		0. 00 0. 00	0	0		16. 00 17. 00
18. 00		0.00	ő	Ö		18. 00
19. 00		0.00	О	0		19.00
20. 00			•	0		20. 00
	E - INTERN AND RESIDENT RECLA	ASS	0	17, 226, 363		
1.00	I &R SERVI CES-SALARY &	21. 00	0	1, 151, 155		1.00
	FRI NGES APPRVD	+		1 151 155		
	F - DISABILITY LEAVE RECLASS		0	1, 151, 155		
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	52, 809		1.00
2.00	MAINTENANCE & REPAIRS	6. 00	o	2, 539		2.00
3. 00 4. 00	LAUNDRY & LINEN SERVICE DIETARY	8. 00 10. 00	0	596 27, 332		3. 00 4. 00
4. 00 5. 00	NURSING ADMINISTRATION	13. 00	0	27, 332 25, 851		4. 00 5. 00
6.00	CENTRAL SERVICES & SUPPLY	14. 00	Ö	4, 258		6.00
7.00	PHARMACY	15. 00	o	56, 014		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	147, 620		8.00
9. 00 10. 00	INTENSIVE CARE UNIT SUBPROVIDER - IPF	31. 00 40. 00	0	69, 787 12, 420		9. 00 10. 00
11. 00	SUBPROVI DER - I RF	41. 00	ő	9, 843		11. 00
12.00	SKILLED NURSING FACILITY	44.00	O	26, 913		12.00
13. 00 14. 00	OPERATING ROOM ANESTHESIOLOGY	50. 00 53. 00	0	68, 393 107, 785		13. 00 14. 00
15. 00	RADI OLOGY – DI AGNOSTI C	54. 00	0	29, 509		14. 00 15. 00
	1	00	٩	=:/00/		

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Peri od: Worksheet A-6 From 07/01/2021 To 06/30/2022 Date/Time Prepared: 11/29/2022 11:30 am Provider CCN: 15-0115

					11/29/2022 11:30 am
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5. 00	
16.00	LABORATORY	60.00	0	19, 648	16.00
17.00	RESPI RATORY THERAPY	65. 00	0	20, 577	17.00
18.00	PHYSI CAL THERAPY	66. 00	0	103, 642	18.00
19.00	ELECTROCARDI OLOGY	69.00	0	46, 446	19.00
20.00	SLEEP LAB	69. 03	0	3, 441	20.00
21.00	RURAL HEALTH CLINIC	88. 00	0	558	21.00
22.00	RURAL HEALTH CLINIC II	88. 01	0	10, 188	22.00
23.00	CLINIC	90.00	0	16, 299	23.00
24.00	ONCOLOGY	90. 02	o	48, 844	24. 00
25.00	HBURG URGENT CARE CLINIC	90. 04	o	47, 877	25. 00
26.00	EMERGENCY	91. 00	o	39, 725	26.00
27.00	AMBULANCE SERVICES	95.00	o	63, 044	27.00
28.00	HOME HEALTH AGENCY	101.00	o	38, 001	28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192. 00	O	297, 829	29.00
30.00	PSYCHI ATRI C/PSYCHOLOGI CAL	192. 01	o	8, 529	30.00
	SERVI CES				
31.00	COMMUNITY EDUCATION	194. 04	O	2, 353	31.00
32.00	VOLUNTEER	194. 05	O	8, 339	32.00
	0 — — — — —	T		1, 417, 009	
	G - PHARMACY RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73. 00	1, 638, 955	0	1.00
	TOTALS	— — T	1, 638, 955	$\frac{0}{0}$	
	H - VOLUNTEER/GUEST SVC				
1.00	OFFSITE COVID SCREENING	194. 07	138, 034	14, 877	1.00
	TOTALS		138, 034	1 <del>4,</del> 877	
500.00	Grand Total: Increases		4, 342, 086	21, 777, 484	500.00
	•				•

Health Financial Systems RECLASSIFICATIONS MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10 | Peri od: | Worksheet A-6 | From 07/01/2021 | To 06/30/2022 | Date/Time Prepared: Provider CCN: 15-0115

						To 06/30/2022	Date/Time Prepared: 11/29/2022 11:30 am
		Decreases		011		1	117 277 2022 1 1 00 diii
	Cost Center 6.00	Li ne # 7.00	Sal ary 8. 00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - LABOR AND DELIVERY	7.00	0.00	7. 00	10.00		
1. 00	ADULTS & PEDIATRICS	30. 00	1, 750, 363	209, 889			1.00
2. 00		0.00	0 1, 750, 363	<u>0</u> 209, 889		<u>)</u>	2.00
	B - CAFETERIA		1, 750, 565	209, 009			
1.00	DI ETARY	10. 00	814, 734	467, 916		)	1.00
	O DILLIANI E CURRI EC		814, 734	467, 916			
1. 00	C - BILLABLE SUPPLES NURSING ADMINISTRATION	13. 00	0	74			1.00
2. 00	CENTRAL SERVICES & SUPPLY	14. 00	Ö	12, 704			2. 00
3.00	PHARMACY	15. 00	O	2, 310			3. 00
4. 00 5. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	194, 479			4. 00 5. 00
6. 00	SUBPROVI DER - I PF	40.00	ol Ol	115, 566 1, 588		•	6.00
7. 00	SUBPROVI DER - I RF	41.00	ō	3, 995			7. 00
8.00	SKILLED NURSING FACILITY	44.00	0	25, 333		•	8.00
9. 00 10. 00	OPERATING ROOM ANESTHESIOLOGY	50. 00 53. 00	0	72, 121 3, 479			9. 00 10. 00
11. 00	RADI OLOGY-DI AGNOSTI C	54. 00	Ö	89, 093		•	11.00
12.00	RADI OI SOTOPE	56. 00	О	584		•	12. 00
13.00	LABORATORY	60.00	0	118			13.00
14. 00 15. 00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65. 00 66. 00	0	5, 952 111, 659		•	14. 00 15. 00
16. 00	ELECTROCARDI OLOGY	69. 00	Ö	47, 114			16.00
17. 00	CLINIC	90. 00	О	158, 863			17. 00
18.00	ONCOLOGY	90. 02	0	82, 552		1	18.00
19. 00 20. 00	HBURG URGENT CARE CLINIC EMERGENCY	90. 04 91. 00	0	85, 243 213, 736			19. 00 20. 00
21. 00	AMBULANCE SERVICES	95. 00	Ö	10, 687			21.00
22. 00	HOME HEALTH AGENCY	1 <u>01.</u> 00		53, 025			22. 00
	D - DRUGS RECLASS		0	1, 290, 275			
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 186	(		1.00
2.00	DI ETARY	10. 00	О	8, 115			2. 00
3. 00 4. 00	CENTRAL SERVICES & SUPPLY	14.00	0	39			3.00
4. 00 5. 00	PHARMACY ADULTS & PEDIATRICS	15. 00 30. 00	0	16, 896, 122 585		•	4. 00 5. 00
6. 00	INTENSIVE CARE UNIT	31. 00	ō	62			6. 00
7.00	SUBPROVI DER - I PF	40.00	0	20			7. 00
8. 00 9. 00	OPERATING ROOM ANESTHESIOLOGY	50. 00 53. 00	0	232 60, 205			8. 00 9. 00
10.00	RADI OLOGY-DI AGNOSTI C	54. 00	Ö	148, 545		1	10.00
11.00	RADI OI SOTOPE	56. 00	О	242		1	11.00
12. 00 13. 00	RESPIRATORY THERAPY	65.00	0	849			12.00
14. 00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66. 00 69. 00	0	1, 696 24, 404		1	13. 00 14. 00
15. 00	CLINIC	90.00	ō	11, 866			15. 00
16. 00	ONCOLOGY	90. 02	0	14			16.00
17. 00 18. 00	HBURG URGENT CARE CLINIC EMERGENCY	90. 04 91. 00	0	15, 617 14, 793			17. 00 18. 00
19. 00	AMBULANCE SERVICES	95. 00	o	10, 083		•	19. 00
20.00	HOME HEALTH AGENCY	1 <u>01.</u> 00	0	3 <u>1, 6</u> 88			20. 00
	O LINTERN AND DESIDENT DECL	100	0	17, 226, 363			
1. 00	E - INTERN AND RESIDENT RECLA	22. 00	0	1, 151, 155			1.00
00	COSTS APPRVD		1				1.00
	O DI CARLLI TV. LEAVE PECLACO		0	1, 151, 155			
1. 00	F - DISABILITY LEAVE RECLASS ADMINISTRATIVE & GENERAL	5. 00	52, 809	0	(	٦	1.00
2. 00	MAINTENANCE & REPAIRS	6. 00	2, 539	0		•	2. 00
3. 00	LAUNDRY & LINEN SERVICE	8. 00	596	0			3. 00
4.00	DI ETARY	10.00	27, 332	0			4.00
5. 00 6. 00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13. 00 14. 00	25, 851 4, 258	0			5. 00 6. 00
7. 00	PHARMACY	15. 00	56, 014	0	(		7.00
8.00	ADULTS & PEDIATRICS	30.00	147, 620	0		1	8.00
9. 00 10. 00	INTENSIVE CARE UNIT SUBPROVIDER - IPF	31. 00 40. 00	69, 787 12, 420	0			9. 00 10. 00
11. 00	SUBPROVIDER - IPF	41. 00	9, 843	0		•	11.00
12.00	SKILLED NURSING FACILITY	44.00	26, 913	0	(		12. 00
13.00	OPERATI NG ROOM	50.00	68, 393	0			13.00
14. 00 15. 00	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	53. 00 54. 00	107, 785 29, 509	0			14. 00 15. 00
16. 00	LABORATORY	60.00	19, 648	0		ó	16. 00
		· ·					'

Health Financial Systems RECLASSIFICATIONS Peri od: From 07/01/2021 To 06/30/2022 Date/Ti me Prepared: 11/29/2022 11:30 am Provider CCN: 15-0115

						11/29/2022	11. 30 aiii
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
17.00	RESPI RATORY THERAPY	65. 00	20, 577	0	0		17. 00
18.00	PHYSI CAL THERAPY	66. 00	103, 642	0	0		18.00
19. 00	ELECTROCARDI OLOGY	69. 00	46, 446	0	0		19. 00
20.00	SLEEP LAB	69. 03	3, 441	0	0		20. 00
21. 00	RURAL HEALTH CLINIC	88. 00	558	0	0		21.00
22.00	RURAL HEALTH CLINIC II	88. 01	10, 188	0	0		22. 00
23.00	CLI NI C	90. 00	16, 299	0	0		23. 00
24.00	ONCOLOGY	90. 02	48, 844	0	0		24.00
25.00	HBURG URGENT CARE CLINIC	90. 04	47, 877	0	0		25. 00
26.00	EMERGENCY	91. 00	39, 725	0	0		26.00
27.00	AMBULANCE SERVICES	95. 00	63, 044	0	0		27. 00
28. 00	HOME HEALTH AGENCY	101. 00	38, 001	0	0		28. 00
29. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	297, 829	0	0		29. 00
30.00	PSYCHI ATRI C/PSYCHOLOGI CAL	192. 01	8, 529	0	0		30.00
l	SERVI CES						
31.00	COMMUNITY EDUCATION	194. 04	2, 353	0	0		31.00
32.00	VOLUNTEER	194. 05	8, 339	0	0		32.00
I	0 — — — — —		1, 417, 009				
I	G - PHARMACY RECLASS						
1.00	PHARMACY	15. 00	1, 638, 955	0	0		1.00
I	TOTALS		1, 638, 955				
I	H - VOLUNTEER/GUEST SVC						
1.00	ADMINISTRATIVE & GENERAL	5. 00	138, 034	14, 877	0		1.00
ļ	TOTALS		138, 034	14, 877			
500.00	Grand Total: Decreases		5, 759, 095	20, 360, 475			500.00

HIT designated Assets

Reconciling Items

Subtotal (sum of lines 1-7)

7.00

8.00

9.00

0

0

0

30, 809, 760

45, 059, 618

7.00

8.00

9.00

RECONCILIATION OF CAPITAL COSTS CENTERS Worksheet A-7 Provi der CCN: 15-0115 Peri od: From 07/01/2021 Part I Date/Time Prepared: 11/29/2022 11:30 am 06/30/2022 Acqui si ti ons Begi nni ng Purchases Donati on Total Disposals and Retirements Bal ances 1.00 2.00 3.00 4.00 5.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 11, 154, 563 1.00 1.00 Land 33, 525 33, 525 2.00 Land Improvements 0 0 0 0 0 0 0 2.00 3.00 Buildings and Fixtures 121, 605, 691 893, 243 893, 243 3.00 0 4.00 Building Improvements 30, 809, 760 30, 809, 760 4.00 5.00 Fi xed Equi pment 5.00 6.00 Movabl e Equi pment 114, 778, 710 44, 132, 850 44, 132, 850 6.00

45, 059, 618

7. U	reconciling reals	0	U	1 9	Ч	U	7.00
10.	OO Total (line 8 minus line 9)	278, 348, 724	45, 059, 618	0	45, 059, 618	30, 809, 760	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1. 0	) Land	11, 188, 088	0				1.00
2. 0	D Land Improvements	0	0				2.00
3.0	Buildings and Fixtures	122, 498, 934	0				3.00
4.0	Building Improvements	0	0				4. 00
5.0	Fixed Equipment	0	0				5.00
6.0	Movable Equipment	158, 911, 560	0				6.00
7.0	HIT designated Assets	0	0				7. 00
8.0	Subtotal (sum of lines 1-7)	292, 598, 582	0				8.00
9. 0	Reconciling Items	0	0				9.00
10.	OO Total (line 8 minus line 9)	292, 598, 582	0				10.00

278, 348, 724

Health Financial Systems ME	MORIAL HOSP & F	IEALTH CARE CTF	?	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7	
				rom 07/01/2021 o 06/30/2022	Part II   Date/Time Pre	nared·
				0 00, 00, 2022	11/29/2022 11	: 30 am
		SU	IMMARY OF CAPI	ΓAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
				(see	instructions)	
				instructions)		
	9. 00	10. 00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00 CAP REL COSTS-BLDG & FIXT	3, 476, 189	841, 323	2, 344, 574	159, 997	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	5, 704, 128	0	(	0	0	2.00
3.00 Total (sum of lines 1-2)	9, 180, 317	841, 323	2, 344, 574	159, 997	0	3.00
	SUMMARY O	F CAPITAL				

Cost Center Description	Other	Total (1)		
	Capi tal -Rel at	(sum of cols.		
	ed Costs (see	9 through 14)		
	instructions)			
	14. 00	15. 00		
PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUI	MN 2, LINES 1 a	and 2	
1.00 CAP REL COSTS-BLDG & FLXT	0	6, 822, 083		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	5, 704, 128		2.00
3.00 Total (sum of lines 1-2)	0	12, 526, 211		3.00

Health Financial Systems ME	MORIAL HOSP & I	HEALTH CARE CTI	3	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 07/01/2021 To 06/30/2022		pared:
	COM	PUTATION OF RA	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C		_			_	
1. 00 CAP REL COSTS-BLDG & FIXT	133, 687, 022	l .	133, 687, 02			1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	158, 911, 560	l .	158, 911, 56			2.00
3.00 Total (sum of lines 1-2)	292, 598, 582		292, 598, 58			3.00
	ALLUCA	TION OF OTHER (	JAPI IAL	SUMMARY C	OF CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at	cols. 5			
		ed Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	1					
1.00 CAP REL COSTS-BLDG & FLXT	0			0 6, 735, 817	841, 323	1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	0	0		5, 706, 887	0	2.00
3.00 Total (sum of lines 1-2)	0	0		0 12, 442, 704	841, 323	3.00
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see	9 through 14)	
				instructions)		
	11. 00	12. 00	13.00	14.00	15. 00	

0 0 0

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT
CAP REL COSTS-MVBLE EQUIP

159, 997

159, 997

0 0 0

7, 737, 137 1. 00 5, 706, 887 2. 00 13, 444, 024 3. 00

0 0 0

1. 00 2. 00

3.00 Total (sum of lines 1-2)

ADJUSTMENTS TO EXPENSES Provider CCN: 15-0115 Peri od: Worksheet A-8 From 07/01/2021 06/30/2022 Date/Time Prepared: 11/29/2022 11:30 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL -2,344,574 CAP REL COSTS-BLDG & FIXT 1.00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 discounts (chapter 8) 5.00 Refunds and rebates of 5.00 0.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone services (pay 7.00 0 00 7.00 stations excluded) (chapter 8.00 Television and radio service 0.00 8.00 (chapter 21) 9.00 Parking lot (chapter 21) 0.00 9.00 Provi der-based physician A-8-2 -12, 640, 269 10.00 10.00 adjustment 11.00 Sale of scrap, waste, etc. В -5, 945 ADMINISTRATIVE & GENERAL 5.00 11.00 (chapter 23) Related organization 64, 804, 263 12.00 12.00 A-8-1 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 Cafeteria-employees and guests -594, 634 CAFETERI A 11.00 14.00 В 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 16.00 0 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than В -298, 853 PHARMACY 15.00 17.00 pati ents Sale of medical records and -26, 479 MEDI CAL RECORDS & LIBRARY 18.00 R 16.00 18.00 abstracts 19.00 Nursing and allied health 0.00 19.00 0 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0 00 ol 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical OPHYSICAL THERAPY 24.00 A-8-3 66.00 therapy costs in excess of limitation (chapter 14) 0 \*\*\* Cost Center Deleted \*\*\* 25.00 25.00 Utilization review 114.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL 1.00 26.00 COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP 0 \*\*\* Cost Center Deleted \*\*\* 28.00 Non-physician Anesthetist 19.00 28.00 Physicians' assistant 29 00 0.00 29 00 Adjustment for occupational 0 \*\*\* Cost Center Deleted \*\*\* 30.00 A-8-3 67.00 30.00 therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99 instructions)

ADJUSTMENTS TO EXPENSES Provider CCN: 15-0115 Peri od: Worksheet A-8 From 07/01/2021 06/30/2022 Date/Time Prepared: 11/29/2022 11:30 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Cost Center Description Amount Wkst. A-7 (2) Ref. 1.00 2.00 3.00 4.00 5.00 31.00 Adjustment for speech A-8-3 0 \*\*\* Cost Center Deleted \*\*\* 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 32.00 0 0.00 Depreciation and Interest ADVERTISING - NURSING ADMIN -2, 155 NURSING ADMINISTRATION 13.00 33.00 ADVERTISING - SKILLED NURSING OADULTS & PEDIATRICS 33.01 30.00 33.01 Α ADVERTISING - CARING HANDS 33.02 Α -240 SUBPROVI DER - I PF 40.00 33.02 ADVERTISING - PT 33.03 Α OPHYSICAL THERAPY 66.00 33.03 ADVERTISING - SLEEP CENTER ADVERTISING - FRENCH LICK O SLEEP LAB 33.04 Α 69.03 33.04 -1,003 RURAL HEALTH CLINIC 33 05 88.00 33 05 Α ADVERTISING - LOOGOOTEE -225 RURAL HEALTH CLINIC II 33.06 Α 88.01 33.06 ADVERTISING - WOUND CARE 33.07 OCLINIC 90.00 33.07 Α ADVERTISING - HUNTINGBURG -140 HBURG URGENT CARE CLINIC 33.08 90.04 33.08 Α ADVERTISING - AMBULANCE -4, 709 AMBULANCE SERVICES ol 33 09 95 00 33 09 Α PHYSICIAN RECRUITMENT -960 &R SERVICES-OTHER PRGM. 33.10 Α 22.00 33.10 COSTS APPRVD MISCELLANEOUS REVENUE - ADMIN -606, 196 ADMINISTRATIVE & GENERAL 33 11 В 5.00 33.11 MI SCELLANEOUS - ENGINEERING OMAINTENANCE & REPAIRS 0 33. 12 6.00 33.12 В MISCELLANEOUS - DIETARY -1, 886 DI ETARY ol 33. 13 В 10.00 33.13 MISCELLANEOUS - CLINICAL В -45, 063 NURSING ADMINISTRATION 13.00 33.15 33.15 MISCELLANEOUS - STERILE PROC -2, 603 CENTRAL SERVICES & SUPPLY 33. 16 В 14.00 33. 16 MISCELLANEOUS - PERINATAL SVCS OADULTS & PEDIATRICS 33.17 В 30.00 0 33.17 MI SCELLANEOUS - REHAB 33. 18 В -58, 645 SUBPROVI DER - I RF 41.00 33.18 33. 19 MISCELLANEOUS - RADIOLOGY В -257 RADI OLOGY-DI AGNOSTI C 54.00 33.19 33. 20 MISCELLANEOUS - LABS В -19, 794 LABORATORY 60.00 33. 20 MI SCELLANEOUS - THERAPY -399, 442 PHYSI CAL THERAPY 33. 21 R 66.00 33.21 33.22 MISCELLANEOUS - SLEEP LAB В -40 SLEEP LAB 69.03 33.22 MISCELLANEOUS - FRENCH LICK
MISCELLANEOUS - HBURG URGENT 33. 23 В ORURAL HEALTH CLINIC 88.00 33.23 OHBURG URGENT CARE CLINIC 33. 25 33.25 90.04 В CARE CL 33. 26 MI SCELLANEOUS - AMBULANCE В -417, 108 AMBULANCE SERVICES 95.00 0 33.26 33. 27 CRNA EXPENSE -913, 013 OPERATING ROOM 50.00 33.27 Α 33.28 CRNA EXPENSE -2, 584, 608 ANESTHESI OLOGY 53.00 0 33.28 Α 2,759 CAP REL COSTS-MVBLE EQUIP I/R START UP COSTS 33. 29 Α 2.00 33.29 AMORTI ZATI ON 33.30 I/R START UP COSTS 11, 370 MAINTENANCE & REPAIRS 33.30 Α 6.00 AMORTI ZATI ON 33.31 I/R START UP COSTS 219, 884 I &R SERVI CES-OTHER PRGM. 22.00 33.31 Α AMORTI ZATI ON COSTS APPRVD OADMINISTRATIVE & GENERAL 33.32 **GAI NSHARE** 5.00 33.32 Α TOTAL (sum of lines 1 thru 49) 44, 069, 435 50.00 50.00 (Transfer to Worksheet A,

<sup>|</sup> column 6, line 200.) | | (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Peri od: Worksheet A-8-1 From 07/01/2021

OFFICE	COSTS			To 06/30/2022	Date/Time Pre	
	Li ne No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount	: 30 alli
	1.00	2. 00	3. 00	4. 00	5 5. 00	
		MENTS REQUIRED AS A RESULT OF				
1.00	50.00	OPERATING ROOM	AMBULATORY SURGERY CENTER	3, 353, 161	4, 090, 717	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL	3, 259, 628	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFITS	25, 261, 293	0	3.00
4.00	5. 00	ADMINISTRATIVE & GENERAL	A&G	28, 409, 936	0	4.00
4. 01	6. 00	MAINTENANCE & REPAIRS	PLANT ENGINEERING	1, 888, 040	0	4.01
4.02	9. 00	HOUSEKEEPI NG	ENVI RONMENTAL SERVI CES	1, 632, 661	0	4.02
4.03	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	1, 627, 210	0	4.03
4.04	194. 03	MKT/PHY SERVICES	PHYSICIAN SERVICES	3, 462, 944	0	4.04
4.05	1	PUBLIC RELATIONS	PUBLIC RELATIONS	107	0	4.05
5. 00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			68, 894, 980	4, 090, 717	5. 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.

	·		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	С	MHHCC	O. OO MEM HOS OP SURG	40.00	6. 00
7.00	В		O. OO MEMORIAL HOME O	100.00	7.00
8.00			0.00	0.00	8. 00
9.00			0.00	0.00	9. 00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

Heal th I	Financial Syst	ems		MEMORIA	AL HOSP & HE	ALTH CARE CTF	?	In Lieu	of Form CMS-	2552-10
STATEME OFFICE		SERVI CES	FROM	RELATED ORGANIZATIO	ONS AND HOME	Provider Co	CN: 15-0115	Peri od: From 07/01/2021 To 06/30/2022	Worksheet A-8 Date/Time Pre	epared:
		Wkst. A-7	Ref.							
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6. 00	7.00								
	A. COSTS INCUR	RED AND AD	JUSTN	MENTS REQUIRED AS A	RESULT OF T	RANSACTIONS W	/I TH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:									
1.00	-737, 556		0							1.00
2.00	3, 259, 628		9							2.00
3.00	25, 261, 293		0							3.00
4.00	28, 409, 936		0							4.00
4. 01	1, 888, 040	i	0							4. 01
4. 02	1, 632, 661	1	0							4.02
4. 03	1, 627, 210		0							4.03
4. 04	3, 462, 944	1	0							4.04

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

4 05

5.00

nas i	or been posted to worksheet A,	cordining i and/or 2, the amount arrowable should be indicated in cordinin 4 or this part	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	SURGERY CENTER	6.00
7.00	HOME OFFICE	7.00
8.00		8.00
9.00		9.00
9. 00 10. 00		10.00
100.00		100.00

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

0

107

64, 804, 263

4.05

5.00

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

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

						0 06/30/2022	11/29/2022 1	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	100 (
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	22. 00	I&R SERVICES-OTHER PRGM.	1, 243, 894	0	1, 243, 894	197, 500	8, 023	1.00
		COSTS APPRVD						
2. 00	40. 00	SUBPROVI DER - I PF	178, 121	178, 121	0	181, 300	0	2.00
3.00	41. 00	SUBPROVI DER - I RF	29, 020			179, 000	0	3.00
4. 00	50. 00	OPERATING ROOM	16, 665	16, 665	0	246, 400	0	4.00
5. 00	53. 00	ANESTHESI OLOGY	1, 323, 232	1, 323, 232	0	239, 400	0	5.00
6. 00	54.00	RADI OLOGY-DI AGNOSTI C	3, 995, 156			271, 900	0	6. 00
7. 00	60. 00	LABORATORY	150, 000			271, 900	0	7. 00
8. 00		RESPIRATORY THERAPY	7, 257	7, 257	0	211, 500	0	8. 00
9. 00		PHYSI CAL THERAPY	2, 933		0		0	9. 00
10.00		ELECTROCARDI OLOGY	504, 670			211, 500	0	10.00
11. 00		CLINIC	326, 973			211, 500	0	11. 00
12. 00		HBURG URGENT CARE CLINIC	298, 817	298, 817	0	211, 500	0	12.00
13. 00		EMERGENCY	5, 324, 911	5, 324, 911	0	211, 500	0	13. 00
14. 00		AMBULANCE SERVICES	419		_	211, 500	0	14. 00
200.00	70.00	TIMBOLI WOE SERVI SES	13, 402, 068				8, 023	
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Li mi t	Unadjusted RCE			of Malpractice	
		1 40.1121 11 61	2	Li mi t	Continuing	Share of col.	Insurance	
					Education	12	11104141100	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		I&R SERVICES-OTHER PRGM.	761, 799				0	1. 00
		COSTS APPRVD						
2. 00	40. 00	SUBPROVIDER - IPF	0	0	0	0	0	2. 00
3.00		SUBPROVI DER - I RF	0			0	0	3.00
4. 00	50. 00	OPERATING ROOM	0	0	0	0	0	4.00
5. 00	53. 00	ANESTHESI OLOGY	0	0	0	0	0	5. 00
6. 00	54. 00	RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	6. 00
7. 00	60. 00	LABORATORY	0	0	0	0	0	7. 00
8. 00	65. 00	RESPIRATORY THERAPY	l 0	0	0	0	0	8. 00
9. 00		PHYSI CAL THERAPY	0	0	0	0	0	
10.00		ELECTROCARDI OLOGY	0	0	0	0	0	10.00
11. 00		CLINIC	0	0	0	0	0	11.00
12. 00		HBURG URGENT CARE CLINIC	0	0	0	0	0	12.00
13. 00		EMERGENCY	0	0	0	0	0	13.00
14. 00		AMBULANCE SERVICES	0	0	0	0	0	14.00
200. 00			761, 799	38, 090	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance	,		
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00	22. 00	I&R SERVICES-OTHER PRGM.	0	761, 799	482, 095	482, 095		1.00
		COSTS APPRVD						
2. 00		SUBPROVI DER - I PF	0	0	0	178, 121		2. 00
3. 00		SUBPROVI DER - I RF	0	0		29, 020		3.00
4. 00		OPERATING ROOM	0	0	0			4.00
5. 00	53. 00	ANESTHESI OLOGY	0	0	0	1, 323, 232		5.00
6. 00		RADI OLOGY-DI AGNOSTI C	0	0	0	3, 995, 156		6. 00
7. 00		LABORATORY	0	0	0	150, 000		7.00
8. 00	65. 00	RESPIRATORY THERAPY	0	0	0	7, 257		8.00
9. 00	66. 00	PHYSI CAL THERAPY	0	0	0	2, 933		9.00
10.00	69. 00	ELECTROCARDI OLOGY	0	0	0	504, 670		10.00
11. 00	90. 00	CLINIC	0	0	0	326, 973		11.00
12.00	90. 04	HBURG URGENT CARE CLINIC	0	0	0	298, 817		12.00
13. 00	91. 00	EMERGENCY	0	0	0	5, 324, 911		13.00
14.00	95. 00	AMBULANCE SERVICES	0	0	0	419		14.00
200.00			0	761, 799	482, 095	12, 640, 269		200.00

Provi der CCN: 15-0115

Period: Worksheet B From 07/01/2021 Part I

				To 06/30/2022	Date/Time Pre	
		CAPI TAL REI	LATED COSTS		11/29/2022 11	: 30 am
Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
	Allocation			DEPARTMENT		
	(from Wkst A col. 7)					
	0	1. 00	2.00	4. 00	4A	
GENERAL SERVICE COST CENTERS						
1. 00   00100   CAP REL COSTS-BLDG & FLXT 2. 00   00200   CAP REL COSTS-MVBLE EQUIP	7, 737, 137 5, 706, 887	7, 737, 137	5, 706, 88	,		1. 00 2. 00
4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT	25, 261, 293	0	1	I I		4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	29, 706, 827	213, 584		366, 285	30, 444, 235	5.00
6. 00 00600 MAI NTENANCE & REPAI RS	6, 033, 818	4, 525			6, 179, 675	6.00
8. 00   00800   LAUNDRY & LI NEN SERVI CE 9. 00   00900   HOUSEKEEPI NG	354, 813 1, 632, 661	24, 517 0	i .	I I	470, 273 1, 632, 661	8. 00 9. 00
10. 00 01000 DI ETARY	404, 424	24, 289	17, 91	60, 523	507, 151	10.00
11. 00   01100   CAFETERI A	688, 016	75, 158		1	1, 027, 632	11.00
13. 00   01300   NURSI NG   ADMI NI STRATI ON 14. 00   01400   CENTRAL   SERVI CES & SUPPLY	996, 408 439, 710	17, 050 14, 216			1, 262, 177 537, 060	13. 00 14. 00
15. 00   01500   PHARMACY	304, 677	44, 704	32, 97		465, 602	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1, 600, 731	0			1, 600, 731	16. 00
21. 00   02100   1&R SERVI CES-SALARY & FRINGES APPRVD 22. 00   02200   1&R SERVI CES-OTHER PRGM. COSTS APPRVD	1, 151, 155 1, 145, 296	0 63, 031	46, 49	0   338, 964	1, 151, 155 1, 593, 782	21. 00 22. 00
INPATIENT ROUTINE SERVICE COST CENTERS	1, 145, 290	03, 031	40, 49	330, 904	1, 593, 762	22.00
30. 00 03000 ADULTS & PEDIATRICS	7, 052, 027	383, 039			9, 188, 302	30.00
31. 00   03100   INTENSI VE CARE UNI T	3, 505, 058	175, 866			4, 664, 555	31.00
40. 00   04000   SUBPROVI DER -   PF 41. 00   04100   SUBPROVI DER -   RF	1, 138, 707 609, 322	138, 933 72, 486		1	1, 706, 540 875, 846	40. 00 41. 00
43. 00   04300   NURSERY	653, 417	45, 482			882, 133	43.00
44. 00 04400 SKILLED NURSING FACILITY	1, 558, 838	78, 829	58, 14	352, 110	2, 047, 921	44.00
ANCILLARY SERVICE COST CENTERS  50. 00 05000 OPERATING ROOM	13, 008, 585	522, 218	385, 186	1, 326, 370	15, 242, 359	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 306, 835	90, 965			1, 764, 267	52.00
53. 00   05300   ANESTHESI OLOGY	365, 788	0	1		1, 283, 864	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 56. 00   05600   RADI OI SOTOPE	3, 877, 460	175, 620			5, 848, 684 890, 091	54. 00 56. 00
60. 00   06000   LABORATORY	822, 791 8, 728, 229	11, 933 84, 757			9, 697, 718	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 843, 056	31, 105			2, 241, 623	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 651, 619	72, 655		I I	3, 495, 620	66.00
69. 00   06900   ELECTROCARDI OLOGY 69. 01   06901   PULMONARY	4, 286, 112 0	165, 480 0	i .	I I	5, 240, 816 0	69. 00 69. 01
69. 02   06902   CARDI OPULMONARY	152, 668	20, 568	1	1	214, 318	69. 02
69. 03 06903 SLEEP LAB	285, 444	23, 629	· ·		391, 510	69. 03
70. 00   07000   ELECTROENCEPHALOGRAPHY 71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 290, 275	0			0 1, 290, 275	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	5, 510, 960	0		íl	5, 510, 960	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	18, 865, 318	0	l .	420, 476	19, 285, 794	73. 00
74. 00 O7400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	0	0		0	0	74.00
88. 00   08800   RURAL HEALTH CLINIC	493, 085	24, 297	17, 922	98, 305	633, 609	88. 00
88.01 08801 RURAL HEALTH CLINIC II	553, 480	56, 054			777, 509	88. 01
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	71 007	1	0	0	89.00
90. 00   09000   CLI NI C 90. 01   09001   I MED	593, 362 0	71, 987 0	53, 09	126, 699	845, 145 0	90. 00 90. 01
90. 02   09002   0NCOLOGY	3, 374, 626	152, 761	112, 67	624, 396	4, 264, 459	90. 02
90. 03 09003 OUTPATIENT CENTER	0	(7.500	40.00	0	0	90. 03
90. 04   09004   HBURG URGENT CARE CLINIC 90. 05   09005   DI ABETES MGMT CLINIC	1, 103, 401 62, 720	67, 522 6, 969	1		1, 528, 705 90, 367	90. 04 90. 05
91. 00   09100   EMERGENCY	4, 721, 243	135, 940			7, 422, 494	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVICES	2, 187, 494	27, 367	20, 186	616, 806	2, 851, 853	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	2, 187, 494	27, 307	20, 180	0 0 0	2, 651, 653	96.00
101.00 10100 HOME HEALTH AGENCY	2, 294, 908	31, 782	23, 442	509, 720	2, 859, 852	101.00
SPECIAL PURPOSE COST CENTERS  116. 00 11600 HOSPI CE		0	.l	ol ol	0	114 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0 176, 060, 681	3, 149, 318		- 1	159, 909, 323	116. 00 118. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12, 593				190.00
192. 00 19200  PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201  PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	34, 731, 749 886, 434	1, 292, 440 31, 139			44, 635, 251 1, 160, 653	
194. 00 07950 LODGE	14, 201	365, 305			649, 658	1
194. 01 07951 OTHER NRCC	0	0		·		194. 01
194. 02 07952 MEMORI AL HOSPITAL FOUNDATION 194. 03 07953 MKT/PHY SERVICES	125, 968 3, 753, 257	12, 736 1, 015			179, 283 3, 814, 581	
194. 04 07954 COMMUNITY EDUCATION	498, 027	62, 490	1		3, 814, 581 704, 441	
	,	, , , , , , ,		,	,	

| Peri od: | Worksheet B | From 07/01/2021 | Part | To 06/30/2022 | Date/Time | Prepared:

			''	00/30/2022	11/29/2022 11	
		CAPITAL RELATED COSTS				
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost			BENEFI TS		
	Allocation			DEPARTMENT		
	(from Wkst A					
	col. 7)					
	0	1. 00	2. 00	4. 00	4A	
194. 05 07955  VOLUNTEER	279, 154	0	0	65, 091	344, 245	194. 05
194. 06 07956 MAB	0	0	0	0	0	194. 06
194. 07 07957 OFFSITE COVID SCREENING	152, 855	0	0	35, 413	188, 268	194. 07
194. 08 07958 PUBLI C RELATI ONS	107	0	0	0	107	194. 08
194. 09 07959 UNUSED SPACE	0	0	0	0	0	194. 09
194. 10 07960 EMERGENCY PREPAREDNESS	1, 442, 885	0	0	11, 922	1, 454, 807	194. 10
194. 11 07961 HOME OFFICE	0	2, 810, 101	2, 072, 719	0	4, 882, 820	194. 11
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	217, 945, 318	7, 737, 137	5, 706, 887	25, 261, 293	217, 945, 318	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0115

Peri od: Worksheet B
From 07/01/2021 Part I
To 06/30/2022 Date/Time Prepared: 11/29/2022 11:30 am

					11/29/2022 11	:30 am
Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	E & GENERAL	REPAI RS	LINEN SERVICE			
	5. 00	6. 00	8. 00	9. 00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	20 444 225					
	30, 444, 235	7 400 05/				5.00
6.00 00600 MAINTENANCE & REPAIRS	1, 003, 381	7, 183, 056	1			6.00
8.00  00800 LAUNDRY & LINEN SERVICE	76, 357	23, 422	570, 052			8. 00
9. 00   00900   HOUSEKEEPI NG	265, 092	0	0	1, 897, 753		9.00
10. 00  01000 DI ETARY	82, 345	23, 204	4, 493	6, 150	623, 343	10.00
11. 00   01100   CAFETERI A	166, 855	71, 800		19, 032	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	204, 937	16, 288	1	4, 317	0	13.00
	1 1					
14. 00 01400 CENTRAL SERVICES & SUPPLY	87, 201	13, 581		3, 600	0	14.00
15. 00   01500   PHARMACY	75, 599	42, 707	i	11, 320	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	259, 907	0	0	0	0	16.00
21.00   02100   1&R SERVICES-SALARY & FRINGES APPRVD	186, 911	0	0	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	258, 779	60, 214	0	15, 961	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	1, 491, 886	365, 924	111, 184	96, 993	263, 204	30.00
	1 1					1
	757, 374	168, 007		44, 533	126, 645	31.00
40. 00   04000   SUBPROVI DER - 1 PF	277, 087	132, 725		35, 181	37, 863	
41. 00  04100  SUBPROVI DER - I RF	142, 209	69, 247			27, 130	41.00
43. 00  04300  NURSERY	143, 230	43, 450	306	11, 517	45, 311	43.00
44.00 04400 SKILLED NURSING FACILITY	332, 517	75, 306	24, 549	19, 961	123, 190	44.00
ANCILLARY SERVICE COST CENTERS		.,		, ,		
50. 00 05000 OPERATING ROOM	2, 474, 871	498, 884	89, 662	132, 236	0	50.00
	1	86, 900				•
52. 00   05200   DELI VERY ROOM & LABOR ROOM	286, 461	86, 900		23, 034	0	52.00
53. 00   05300   ANESTHESI OLOGY	208, 458	0	0	O	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	949, 639	167, 773	69, 584	44, 470	0	54.00
56. 00   05600   RADI 0I SOTOPE	144, 522	11, 400	0	3, 022	0	56.00
60. 00   06000   LABORATORY	1, 574, 599	80, 970	2, 114	21, 462	0	60.00
65. 00 06500 RESPIRATORY THERAPY	363, 968	29, 715		7, 876	0	65.00
66. 00   06600   PHYSI CAL THERAPY	567, 577	69, 409		18, 398	0	66.00
	1 1					•
69. 00 06900 ELECTROCARDI OLOGY	850, 941	158, 086	l I	41, 903	0	69.00
69. 01  06901   PULMONARY	0	0	0	0	0	69. 01
69. 02   06902   CARDI OPULMONARY	34, 798	19, 649	533	5, 208	0	69. 02
69. 03  06903   SLEEP LAB	63, 569	22, 573	3, 288	5, 983	0	69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	ol	0	0	ol	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	209, 499	0	0	ام	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	894, 804	0	Ö	ŏ	0	72.00
		0		U O		
73. 00 07300 DRUGS CHARGED TO PATIENTS	3, 131, 396	0	0	٥	0	73.00
74. 00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	102, 878	23, 212	0	6, 153	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	126, 243	53, 549	0	14, 194	0	88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90. 00   09000   CLI NI C	137, 225	68, 770	1, 006	18, 228	0	90.00
	137, 223	00,770	1,000	10, 220	0	•
	0	445 005	10.10	00		90. 01
90. 02   09002   0NCOLOGY	692, 412	145, 935			0	90. 02
90. 03 09003 OUTPATIENT CENTER	0	0	1, 292		0	90. 03
90. 04   09004   HBURG URGENT CARE CLINIC	248, 213	64, 504	79, 759	17, 098	0	90.04
90. 05 09005 DIABETES MGMT CLINIC	14, 673	6, 657	0	1, 765	0	90.05
91. 00 09100 EMERGENCY	1, 205, 176	129, 865	0	34, 422	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 200,	.=.,	1	,		92.00
OTHER REIMBURSABLE COST CENTERS						72.00
	440.050	0/ 114	10	( 000		05 00
95. 00 09500 AMBULANCE SERVI CES	463, 050	26, 144	1	6, 930	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	이	0	96.00
101.00 10100 HOME HEALTH AGENCY	464, 348	30, 362	0	8, 048	0	101.00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 H0SPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1	2, 800, 232			623, 343	
NONREI MBURSABLE COST CENTERS	21,020,707	2,000,232	300,007	730, 032	023, 343	1110.00
	2 552	12 020		2 100	0	100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 553	12, 030		3, 189		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	7, 247, 395	1, 234, 690		327, 271		192.00
192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	188, 453	29, 748	0	7, 885		192. 01
194. 00 07950 LODGE	105, 484	348, 982	0	92, 502	0	194.00
194. 01 07951 OTHER NRCC	0	0	i			194. 01
194. 02 07952 MEMORI AL HOSPI TAL FOUNDATI ON	29, 110	12, 167	_	3, 225		194. 02
	1 1					194. 02
194. 03 07953 MKT/PHY SERVI CES	619, 366	970		257		
194. 04 07954 COMMUNITY EDUCATION	114, 379	59, 697	0	15, 824		194. 04
194. 05 07955  VOLUNTEER	55, 894	0	0	0		194. 05
194. 06 07956 MAB	0	0	0	ol	0	194.06
194.07 07957 OFFSITE COVID SCREENING	30, 569	0	o	ol	0	194. 07
194. 08 07958 PUBLI C RELATIONS	17	0	1	ő		194. 08
194. 09 07959 UNUSED SPACE	0	0		o		194.00
177. UTO 1737 UNUSED SEMOL	1 9	0	1 0	ળ	0	1174.09

Health Financial Systems	MEMORIAL HOSP & HEAL	TH CARE CTR	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 15-0115	Peri od: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Prepared:

						11/29/2022	11:30 am
	Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	REPAI RS	LINEN SERVICE			
		5. 00	6. 00	8. 00	9. 00	10.00	
194. 10 07960	EMERGENCY PREPAREDNESS	236, 214	0	0	0		0 194. 10
194. 11 07961	HOME OFFICE	792, 814	2, 684, 540	0	711, 568		0 194. 11
200. 00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	0	0	0		0 201.00
202. 00	TOTAL (sum lines 118 through 201)	30, 444, 235	7, 183, 056	570, 052	1, 897, 753	623, 34	13 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0115

Peri od: Worksheet B From 07/01/2021 Part I To 06/30/2022 Date/Ti me Prepared: 11/29/2022 11: 30 am

Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	11/29/2022 11 MEDI CAL	: 30 am
		ADMI NI STRATI O N	SERVICES & SUPPLY		RECORDS & LI BRARY	
CENEDAL CEDVICE COCT CENTEDS	11. 00	13. 00	14. 00	15. 00	16.00	
GENERAL SERVICE COST CENTERS  1. 00 00100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00   00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
8.00   00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	4 005 040					10.00
11. 00   01100   CAFETERI A	1, 285, 319					11.00
13. 00   01300   NURSING ADMINISTRATION 14. 00   01400   CENTRAL SERVICES & SUPPLY	14, 867 8, 798	1, 502, 586	670, 330			13. 00 14. 00
15. 00   01500   PHARMACY	5, 748 5, 073		4, 384	604, 685		15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0,070	l ől	0	001,000		16. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	o	0	0		21. 00
22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	7, 930	0	60	0	0	22. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	103, 432		20, 367	0	,	30.00
31. 00   03100   I NTENSI VE CARE UNI T	57, 905		5, 346	0	,	31.00
40. 00   04000   SUBPROVI DER -   PF	18, 966	125, 543	644	0	-,	40.00
41. 00   04100   SUBPROVI DER -   1 RF 43. 00   04300   NURSERY	10, 087	66, 771	448	0	3, 760	41.00
43.00   04300   NURSERY 44.00   04400   SKILLED   NURSING   FACILITY	9, 866 26, 746	l	2, 179	0	.,	43. 00 44. 00
ANCILLARY SERVICE COST CENTERS	20, 740	177,034	2, 177		4,031	44.00
50. 00   05000   OPERATI NG   ROOM	81, 810	ol	195, 726	0	216, 213	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	19, 732	o	0	0		52.00
53. 00   05300   ANESTHESI OLOGY	20, 775	o	19, 407	0	13, 602	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	56, 104	0	17, 790	0	225, 232	54.00
56. 00   05600   RADI 01 SOTOPE	2, 763	0	217	0	34, 397	56.00
60. 00   06000   LABORATORY	55, 539	0	195, 908	0	178, 823	60.00
65. 00 06500 RESPI RATORY THERAPY	27, 287	0	20, 695	0	19, 243	65.00
66. 00 06600 PHYSI CAL THERAPY	53, 737	0	2, 093	0	35, 447	66.00
69. 00   06900   ELECTROCARDI OLOGY 69. 01   06901   PULMONARY	35, 725 0	0	48, 583 0	0	107, 123	69. 00 69. 01
69. 02   06902   CARDI OPULMONARY	2, 224		272	0	3, 099	69. 02
69. 03   06903   SLEEP LAB	5, 744	l ő	972	0	3, 858	69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	Ö	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o	74, 595	0	28, 183	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	58, 452	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	26, 311	0	0	604, 685		73.00
74. 00 07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS	( 2(4		E 42		2.045	00.00
88. 00   08800   RURAL HEALTH CLINIC 88. 01   08801   RURAL HEALTH CLINIC II	6, 364 9, 104	0	543 630	0	2, 045 2, 527	88. 00 88. 01
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	9, 104 0		030	0	2, 327	89. 00
90. 00   09000   CLI NI C	9, 957	ا	2, 319	0	10, 106	90.00
90. 01   09001   I MED	0	o	0	0		90. 01
90. 02 09002 ONCOLOGY	52, 208	o	7, 193	0	59, 929	90. 02
90. 03 09003 OUTPATIENT CENTER	0	0	0	0	0	90. 03
90. 04 09004 HBURG URGENT CARE CLINIC	21, 002	0	2, 902	0	11, 671	90.04
90. 05 09005 DI ABETES MGMT CLINIC	1, 196		125	0	387	90.05
91. 00   09100   EMERGENCY	78, 300	0	9, 997	0	162, 647	91.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	56, 279	ol	3, 057	0	19, 596	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0 0	l I	3, 037	0	,	96.00
101.00 10100 HOME HEALTH AGENCY	41, 446		2, 006	0		
SPECIAL PURPOSE COST CENTERS		-1	=1777	-		
116. 00 11600 H0SPI CE	0		0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	927, 277	1, 502, 586	638, 458	604, 685	1, 597, 159	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	314, 849		25, 911	0	,	
192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	14, 999		72	0		192. 01
194. 00 07950 LODGE	100	0	47	0		194.00
194. 01 07951 OTHER NRCC 194. 02 07952 MEMORI AL HOSPI TAL FOUNDATION	2 416	0	0 44	0		194. 01 194. 02
194. 02 07952 MEMORIAL HOSPITAL FOUNDATION 194. 03 07953 MKT/PHY SERVICES	2, 416 2, 559		53	0		194. 02 194. 03
194. 04 07954 COMMUNI TY EDUCATI ON	12, 302		1, 635	0		194. 03
194. 05 07955 VOLUNTEER	4, 197	ا م	113	0		194. 05
194. 06 07956 MAB	0		0	0		194. 06
194. 07 07957 OFFSITE COVID SCREENING	4, 597	o	0	0		194. 07
194. 08 07958 PUBLIC RELATIONS	0	0	0	0	0	194. 08

Health Financial Systems

MEMORIAL HOSP & HEALTH CARE CTR

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0115

Peri od: Worksheet B
From 07/01/2021 Part I
To 06/30/2022 Date/Time Prepared: 11/29/2022 11:30 am

Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL ADMI NI STRATI O SERVICES & RECORDS & SUPPLY LI BRARY Ν 11. 00 13.00 14.00 15.00 16.00 194. 09 07959 UNUSED SPACE 0 194. 09 0 194. 10 07960 EMERGENCY PREPAREDNESS 2,023 3, 997 0 0 194. 10 0 194. 11 194. 11 07961 HOME OFFICE 0 0 0 0 200. 00 201. 00 Cross Foot Adjustments 200.00 Negative Cost Centers 0 201.00 1, 860, 638 202. 00 202.00 TOTAL (sum lines 118 through 201) 1, 285, 319 1, 502, 586 670, 330 604, 685

In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0115 Peri od: Worksheet B From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/29/2022 11:30 am INTERNS & RESIDENTS SERVI CES-SALA | SERVI CES-OTHE Subtotal Intern & Total Cost Center Description RY & FRINGES R PRGM COSTS Residents Cost & Post Stepdown Adjustments 21. 00 22. 00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 1, 338, 066 21.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 1, 936, 726 22.00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 473, 156 13, 519, 554 -1, 158, 007 12, 361, 547 30.00 684, 851 03100 INTENSIVE CARE UNIT 6. 277, 151 31 00 6, 277, 151 31 00 40.00 04000 SUBPROVI DER - I PF 16, 281 23, 565 2, 388, 923 -39, 846 2, 349, 077 40.00 1, 224, 932 04100 SUBPROVI DER - I RF 1, 224, 932 41.00 41.00 43.00 04300 NURSERY 0 1, 205, 523 0 1, 205, 523 43.00 04400 SKILLED NURSING FACILITY 44.00 0 2, 833, 439 0 2, 833, 439 44 00 ANCILLARY SERVICE COST CENTERS 50.00 19, 352, 627 18, 931, 761 05000 OPERATING ROOM 171, 964 248, 902 -420, 866 50.00 05200 DELIVERY ROOM & LABOR ROOM 2, 217, 230 52.00 2, 217, 230 52.00 05300 ANESTHESI OLOGY 53.00 0 C 1, 546, 106 0 1, 546, 106 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 7, 379, 276 7, 379, 276 C 54.00 05600 RADI OI SOTOPE 0 56.00 1,086,412 1,086,412 56.00 11, 807, 133 11, 807, 133 06000 LABORATORY 0 0 60.00 0 60.00 06500 RESPIRATORY THERAPY 65.00 0 2, 710, 407 0 2, 710, 407 65 00 06600 PHYSI CAL THERAPY 4, 260, 002 4, 260, 002 66.00 66.00 69.00 06900 ELECTROCARDI OLOGY 44, 772 64, 803 6, 627, 872 -109, 575 6, 518, 297 69.00 06901 PULMONARY 69.01 69.01 389, 676 -109, 575 06902 CARDI OPULMONARY 69.02 44, 772 64,803 280, 101 69.02 69.03 06903 SLEEP LAB 0 C 497, 497 0 497, 497 69.03 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 Ω 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 1, 602, 552 71 00 C 1, 602, 552 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 6, 464, 216 0 6, 464, 216 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 23, 354, 761 23, 354, 761 73.00 07400 RENAL DIALYSIS 74.00 74.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 774, 804 774, 804 88.00 88.01 08801 RURAL HEALTH CLINIC II 4,070 5, 891 993, 717 -9, 961 88.01 983.756 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00  $\cap$ 89 00 90.00 09000 CLI NI C 0 1,092,756 1,092,756 90.00 09001 I MED 90.01 90.01 09002 ONCOLOGY 90.02 14.246 20, 619 5. 308. 877 5, 274, 012 90.02 -34.86590.03 09003 OUTPATIENT CENTER 1, 292 1, 292 90.03 90.04 09004 HBURG URGENT CARE CLINIC 41, 719 60, 385 2,075,958 -102, 104 1, 973, 854 90.04 09005 DIABETES MGMT CLINIC 90.05 115, 170 115, 170 90.05 91 00 09100 EMERGENCY 78 351 113, 405 9, 234, 657 -191, 756 9, 042, 901 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 3, 426, 952 95.00 0 3, 426, 952 0 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 0 0 101.00 10100 HOME HEALTH AGENCY 3, 416, 465 3, 416, 465 101. 00 SPECIAL PURPOSE COST CENTERS

116.00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 143, 185, 937 -2, 176, 555 889, 331 1, 287, 224 141, 009, 382 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 40, 653 40, 653 190. 00 55, 011, 472 192.00 19200 PHYSICIANS' PRIVATE OFFICES 393, 788 569, 972 -963, 760 54, 047, 712 192. 00 192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 1, 405, 813 192. 01 0 C 1, 405, 813 0 194. 00 07950 LODGE 1, 196, 773 1, 196, 773 194. 00 194. 01 07951 OTHER NRCC 0 C 0 0 0 194.01 194. 02 07952 MEMORIAL HOSPITAL FOUNDATION 226, 245 194. 02 0 226, 245 0 C

32, 561

4, 438, 880

987, 968

-79, 690

47, 129

4, 438, 880 194. 03

908, 278 194. 04

194. 03 07953 MKT/PHY SERVICES

194. 04 07954 COMMUNITY EDUCATION

Health Financial Systems ME	MORIAL HOSP & HE	EALTH CARE CTR	2	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC		Period: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Pre 11/29/2022 11	pared: :30 am
	INTERNS & F	RESI DENTS				
Cost Center Description	SERVI CES-SALA S RY & FRI NGES F	SERVICES-OTHE R PRGM. COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	21. 00	22. 00	24. 00	25. 00	26. 00	
194. 05 07955 VOLUNTEER	0	0	404, 44	9 0	404, 449	194. 05
194. 06 07956 MAB	0	0	(	0 0	0	194. 06
194. 07 07957 OFFSITE COVID SCREENING	0	0	223, 43		223, 434	•
194. 08 07958 PUBLIC RELATIONS	0	0	12	4 0		194. 08
194. 09 07959 UNUSED SPACE	0	0	(	0		194. 09
194. 10 07960 EMERGENCY PREPAREDNESS	0	0	1, 697, 04		1, 697, 041	•
194. 11 07961 HOME OFFICE	22, 386	32, 401	9, 126, 52	9 -54, 787	9, 071, 742	ł
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)	1, 338, 066	1, 936, 726	217, 945, 31	3, 274, 792	214, 670, 526	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0115

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2021 | Part II | To 06/30/2022 | Date/Time Prepared:

Cost Center Description				Ţ	06/30/2022		
Assigned floor			CAPI TAL REI	_ATED COSTS		11/29/2022 11	: 30 am
PRIFECT STREAM   PRIVATE STREAM	Cost Center Description	Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	BENEFI TS	
SEMBLA SERVICE DOST CENTERS   D			1 00	2.00	24	4.00	
2 00   00000   QAP   REL COSTS-AMPILE EQUIP	GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
0.00   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000	1.00   O0100   CAP REL COSTS-BLDG & FIXT   O0200   CAP REL COSTS-MVBLE EQUIP   4.00   O0400   EMPLOYEE BENEFITS DEPARTMENT   5.00   O0500   ADMINISTRATIVE & GENERAL	_	1			0	2. 00 4. 00 5. 00
11.00   01100   CAFETERIA   0   75, 158   55, 347   130, 595   0   11.00   13.00   130, 0130   01300   01400   CENTRAL SERVICES & SUPPLY   0   14, 216   10, 846   24, 707   0   13.00   13.00   130, 0130   01400   CENTRAL SERVICES & SUPPLY   0   14, 216   10, 846   24, 707   0   16.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00	8. 00   00800   LAUNDRY & LI NEN SERVI CE 9. 00   00900   HOUSEKEEPI NG	0	24, 517 0	18, 084 0	42, 601 0	0	8. 00 9. 00
15.00   OISOO  PHARMACY   0   44, 704   32, 774   77, 678   0   15.00	11.00   01100   CAFETERIA 13.00   01300   NURSING   ADMINISTRATION	0	75, 158 17, 050	55, 437 12, 576	130, 595 29, 626	0	11. 00 13. 00
	15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL   RECORDS & LI BRARY	0	44, 704 0	32, 974		0	15. 00 16. 00
31.00   03100   INTENSIVE CARE UNIT   0   175, 866   129, 718   305, 884   0   31.00   0400   04100   SUBPROVIDER - IPF   0   138, 933   102, 477   241, 410   0   40.00   41.00   04100   SUBPROVIDER - I RF   0   77, 486   53, 465   125, 951   0   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00   41.00	22.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD INPATIENT ROUTINE SERVICE COST CENTERS	0	63, 031			0	22. 00
43.00   04300 NNRSERY   0   45,482   33,548   79,030   0,45,00	31. 00   03100   I NTENSI VE CARE UNI T 40. 00   04000   SUBPROVI DER -   I PF	0	175, 866 138, 933	129, 718 102, 477	305, 584 241, 410	0	31. 00 40. 00
50.00	43.00   04300   NURSERY 44.00   04400   SKILLED NURSING FACILITY	0	45, 482	33, 548	79, 030	0	43.00
54.00   OS400   RADIOLOGY-DI AGNOSTIC   O   175, 620   129, 537   305, 157   O   54.00   OS600   OS600   CABORATORY   O   84, 757   62, 517   147, 274   O   60.00   OS600   OS600   RASPIRATORY THERAPY   O   84, 757   62, 517   147, 274   O   60.00   OS600   OS600   RESPIRATORY THERAPY   O   72, 655   53, 590   126, 245   O   66.00   OS600   OS600   RESPIRATORY THERAPY   O   72, 655   53, 590   126, 245   O   60.00   OS600   OS600   RESPIRATORY THERAPY   O   O   72, 655   53, 590   126, 245   O   60.00   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   OS600   OS600   RESPIRATORY THERAPY   O   O   O   O   O   O   OS600	50. 00   05000   OPERATING ROOM   52. 00   05200   DELIVERY ROOM & LABOR ROOM	0		67, 095		0	52.00
65. 00   06500   RESPIRATORY THERAPY   0   31, 105   22, 943   54, 048   0   65, 00   66. 00   06600   PHYSI CAL THERAPY   0   72, 655   53, 590   126, 245   0   66, 00   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   06900   069	54. 00   05400   RADI OLOGY-DI AGNOSTI C 56. 00   05600   RADI OI SOTOPE	0	11, 933	8, 802	20, 735	0	54. 00 56. 00
69.01   06901   PULMONARY   0   0   0   0   0   0   0   0   0	65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY	_	31, 105 72, 655	22, 943 53, 590	54, 048 126, 245	0	65. 00 66. 00
70.00   07000   CONTROL	69. 01   06901   PULMONARY 69. 02   06902   CARDI OPULMONARY	0	0 20, 568	0 15, 171	0 35, 739	0	69. 01 69. 02
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   73. 00	70.00 O7000 ELECTROENCEPHALOGRAPHY 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	70. 00 71. 00
88. 00   08800   RURAL HEALTH CLINIC   0   24,297   17,922   42,219   0   88. 01   08801   RURAL HEALTH CLINIC III   0   56,054   41,345   97,399   0   88. 01   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   0   0	73.00   07300   DRUGS CHARGED TO PATIENTS 74.00   07400   RENAL DIALYSIS	0	0	0	0	0	73. 00
89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   89.000   90.00   09000   CLINIC   0   0   0   0   0   0   0   0   0   90.01   09001   IMED   0   0   0   0   0   0   0   0   90.02   09002   ONCOLOGY   0   152, 761   112, 676   265, 437   0   90.02   90.03   09003   OUTPATIENT CENTER   0   0   0   0   0   0   0   90.04   09004   HBURG URGENT CARE CLINIC   0   67, 522   49, 804   117, 326   0   90.04   90.05   09005   DI ABETES MGMT CLINIC   0   6, 969   5, 140   12, 109   0   90.05   91.00   09100   EMERGENCY   0   135, 940   100, 269   236, 209   0   91.00   92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   00   0   0	88. 00 08800 RURAL HEALTH CLINIC	0					
90. 01   09001   IMED   0   0   0   0   0   0   0   0   0	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	o	0	89. 00
90. 04   09004   HBURG URGENT CARE CLINIC   0   67, 522   49, 804   117, 326   0   90. 04   90. 05   09005   DI ABETES MGMT CLINIC   0   6, 969   5, 140   12, 109   0   90. 05   91. 00   09100   EMERGENCY   0   135, 940   100, 269   236, 209   0   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   92. 00   0THER REIMBURSABLE COST CENTERS   0   27, 367   20, 186   47, 553   0   95. 00   96. 00   09500   DURABLE MEDI CAL EQUI P-RENTED   0   0   0   0   0   0   0101. 00   10100   HOME HEALTH AGENCY   0   31, 782   23, 442   55, 224   0   116. 00   11600   HOSPI CE   0   0   0   0   0   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   0   3, 149, 318   2, 322, 929   5, 472, 247   0   118. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   1, 292, 440   953, 300   2, 245, 740   0   192. 01 19200   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   365, 305   269, 448   634, 753   0   194. 01 07951   OTHER NRCC   0   0   0   0   0   0   194. 03 07953   MKT/PHY SERVI CES   0   1, 015   749   1, 764   0   194. 03 07953   MKT/PHY SERVI CES   0   1, 015   749   1, 764   0   194. 04 07954   COMMUNI TY EDUCATION   0   62, 490   46, 092   108, 582   0   194. 04 07954   COMMUNI TY EDUCATION   0   194. 03   194. 04 07955   COMMUNI TY EDUCATION   0   109. 00   194. 04 07954   COMMUNI TY EDUCATION   0   62, 490   46, 092   108, 582   0   194. 04 07955   COMMUNI TY EDUCATION   0   62, 490   46, 092   108, 582   0   194. 04 07955   COMMUNI TY EDUCATION   0   194. 03   194. 04 07954   COMMUNI TY EDUCATION   0   62, 490   46, 092   108, 582   0   194. 04 07955   COMMUNI TY EDUCATION   0   62, 490   46, 092   108, 582   0   194. 04 07955   COMMUNI TY EDUCATION   0   194. 03   194. 04 07954   COMMUNI TY EDUCATION   0   62, 490   46, 092   108, 582   0   194. 04 07955   COMMUNI TY EDUCATION   0   194. 03   194. 04 07954   COMMUNI TY EDUCATION   0   194. 03   194. 04 07955   COMMUNI TY EDUCATION   0   194. 03   194. 04 07955   COMMUNI TY EDUCATION   0   194. 03   194. 04 07955   COMMUNI TY EDUCATION   0   194. 03   194. 04 07	90. 01   09001   MED 90. 02   09002   ONCOLOGY	0	0	0	0	0	90. 01 90. 02
92. 00	90. 04 09004 HBURG URGENT CARE CLINIC	_	l .			0	90. 04
95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	135, 940	100, 269		0	1
SPECIAL PURPOSE COST CENTERS   116. 00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.00   116.0	95. 00   09500   AMBULANCE   SERVI CES   96. 00   09600   DURABLE   MEDI CAL   EQUI P-RENTED	0	0	0	O	0	96. 00
NONRE   MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   12,593   9,288   21,881   0   190.00   192.00   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   1,292,440   953,300   2,245,740   0   192.00   192.01   19201   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   31,139   22,968   54,107   0   192.01   194.00   194.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00   195.00	SPECIAL PURPOSE COST CENTERS		, -				
192. 00   19200   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   1, 292, 440   953, 300   2, 245, 740   0   192. 00   192. 01   19201   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   31, 139   22, 968   54, 107   0   192. 01   194. 00   194. 01   194. 01   195. 01   194. 01   195. 01   194. 01   195. 01   194. 02   195. 01   194. 02   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   195. 01   19	118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	3, 149, 318				
194. 01 07951 OTHER NRCC 0 0 0 0 0 194. 01 194. 02 07952 MEMORI AL HOSPI TAL FOUNDATI ON 0 12, 736 9, 394 22, 130 0 194. 02 194. 03 07953 MKT/PHY SERVI CES 0 1, 015 749 1, 764 0 194. 03 194. 04 07954 COMMUNI TY EDUCATI ON 0 62, 490 46, 092 108, 582 0 194. 04	192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES 192. 01   19201   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	1, 292, 440 31, 139	953, 300 22, 968	2, 245, 740 54, 107	0	192. 00 192. 01
194. 04 07954 COMMUNI TY EDUCATI ON 0 62, 490 46, 092 108, 582 0 194. 04	194.01 07951 OTHER NRCC 194.02 07952 MEMORIAL HOSPITAL FOUNDATION	0	0 12, 736	9, 394	0 22, 130	0	194. 01 194. 02
	194. 04 07954 COMMUNITY EDUCATION		62, 490	46, 092	108, 582	0	194. 04

					11/29/2022 11	:30 am
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1. 00	2. 00	2A	4. 00	
194. 06 07956 MAB	0	0	0	0	0	194. 06
194. 07 07957 OFFSITE COVID SCREENING	0	0	0	0	0	194. 07
194. 08 07958 PUBLI C RELATIONS	0	0	0	0	0	194. 08
194. 09 07959 UNUSED SPACE	0	0	0	0	0	194. 09
194. 10 07960 EMERGENCY PREPAREDNESS	0	0	0	0	0	194. 10
194. 11 07961 HOME OFFICE	0	2, 810, 101	2, 072, 719	4, 882, 820	0	194. 11
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	7, 737, 137	5, 706, 887	13, 444, 024	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0115

Peri od: Worksheet B From 07/01/2021 Part II To 06/30/2022 Date/Time Prepared:

11/29/2022 11:30 am Cost Center Description ADMINISTRATIV MAINTENANCE & LAUNDRY & HOUSEKEEPI NG DI ETARY E & GENERAL **REPAIRS** LINEN SERVICE 5.00 9.00 10.00 6.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 00500 ADMINISTRATIVE & GENERAL 5.00 371, 123 5.00 6.00 00600 MAINTENANCE & REPAIRS 12, 230 20, 092 6.00 8.00 00800 LAUNDRY & LINEN SERVICE 931 43, 598 8.00 66 00900 HOUSEKEEPI NG 3 231 3, 231 9 00 9 00 C 0 10.00 01000 DI ETARY 1,004 65 344 10 43,627 10.00 01100 CAFETERI A 11.00 2,034 201 32 0 11.00 13.00 01300 NURSING ADMINISTRATION 2, 498 46 0 7 0 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 1,063 38 1,537 0 14.00 15.00 01500 PHARMACY 921 119 19 0 15.00 0 16.00 01600 MEDICAL RECORDS & LIBRARY 3, 168 C 0 0 0 16.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 2.278 0 21.00 C 0 0 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 0 27 22.00 3, 154 168 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 18, 184 1,024 8 504 165 18, 421 30.00 03100 INTENSIVE CARE UNIT 8, 864 31.00 9, 231 3.240 31.00 470 76 04000 SUBPROVI DER - I PF 40 00 3.377 371 643 60 2.650 40 00 04100 SUBPROVI DER - I RF 1, 733 194 847 31 1,899 41.00 41.00 04300 NURSERY 43.00 1,746 122 23 20 3, 171 43.00 04400 SKILLED NURSING FACILITY 44.00 4,053 211 1,878 34 8, 622 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 30, 165 1, 395 6. 857 225 50.00 05200 DELIVERY ROOM & LABOR ROOM 3.491 2, 317 39 52.00 243 0 52.00 53.00 05300 ANESTHESI OLOGY 2.541  $\cap$ 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 11, 575 76 54.00 54.00 469 5, 322 0 56.00 05600 RADI OI SOTOPE 1, 761 32 5 56.00 0 06000 LABORATORY 19, 192 60.00 226 162 37 0 60.00 06500 RESPIRATORY THERAPY 65.00 4, 436 83 13 0 65.00 0 6, 918 66, 00 06600 PHYSI CAL THERAPY 194 1.355 31 0 66.00 06900 ELECTROCARDI OLOGY 10, 372 71 0 69.00 69.00 442 2.686 06901 PULMONARY 0 9 69.01 69.01 0 C 0 0 69.02 06902 CARDI OPULMONARY 424 55 41 0 69.02 06903 SLEEP LAB 69.03 775 63 251 10 0 69.03 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 0 0 C 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 2.553 C 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 10,906 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 38, 167 0 0 0 73.00 74 00 07400 RENAL DIALYSIS C 0 Ω 74 00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 1, 254 10 0 88.00 65 0 88.01 08801 RURAL HEALTH CLINIC II 1,539 150 0 24 0 88.01 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 89 00 Ω 0 0 90.00 09000 CLI NI C 1,673 192 77 31 0 90.00 90.01 09001 I MED 0 0 0 90.01 09002 ONCOLOGY 90.02 90.02 8.439 408 1.009 66 0 09003 OUTPATIENT CENTER 99 0 90.03 90 03 Ω C 0 90.04 09004 HBURG URGENT CARE CLINIC 3,025 180 6, 100 29 0 90.04 90.05 09005 DIABETES MGMT CLINIC 3 90.05 179 19 C 0 09100 EMERGENCY O 91.00 91 00 363 59 0 14,689 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 5, 644 95.00 95.00 73 0 3 12 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 96 00 C 0 0 Ω 101.00 10100 HOME HEALTH AGENCY 5,660 85 14 0 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 0 116, 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 256, 214 7,832 43, 295 1, 251 43, 627 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 43 34 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 88.389 303 557 3, 454 192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 192.01 2.297 83 0 13 194. 00 07950 LODGE 0 194.00 1, 286 976 157 194. 01 07951 OTHER NRCC 0 0 0 194. 01 C 194. 02 07952 MEMORIAL HOSPITAL FOUNDATION 355 0 5 0 194, 02 34 194. 03 07953 MKT/PHY SERVICES 0 0 194. 03 7.549 194. 04 07954 COMMUNITY EDUCATION 0 27 0 194.04 1.394 167 194. 05 07955 VOLUNTEER 681 0 0 0 194.05 C 194.06 07956 MAB 0 0 0 194.06 0 C 194. 07 07957 OFFSITE COVID SCREENING 373 C 0 0 0 194.07 194. 08 07958 PUBLIC RELATIONS 0 0 0 194.08 0 0 194. 09 07959 UNUSED SPACE 0 0 0 194.09

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provider CCN: 15-0115	Period: Worksheet B From 07/01/2021 Part II To 06/30/2022 Date/Time Prepared:

						11/29/2022	11:30 am_
	Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	REPAI RS	LINEN SERVICE			
		5. 00	6. 00	8. 00	9. 00	10.00	
194. 10 07960	EMERGENCY PREPAREDNESS	2, 879	0	0	0		0 194. 10
194. 11 07961	HOME OFFICE	9, 663	7, 509	0	1, 216		0 194. 11
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0		0 201.00
202 00	TOTAL (sum Lines 118 through 201)	371 123	20 092	43 598	3 231	43 62	27 202 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0115

Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVI CES &	PHARMACY	11/29/2022 11 MEDI CAL RECORDS &	30 am
	11. 00	N 13. 00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS						
1. 00   00100   CAP REL COSTS-BLDG & FIXT   2. 00   00200   CAP REL COSTS-MVBLE EQUIP   4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT   5. 00   00500   ADMI NI STRATI VE & GENERAL   6. 00   00600   MAI NTENANCE & REPAIRS   8. 00   00800   LAUNDRY & LI NEN SERVICE   9. 00   00900   HOUSEKEEPING   10. 00   01000   DI ETARY   11. 00   01100   CAFETERIA   13. 00   01300   NURSI NG ADMI NI STRATI ON   14. 00   01400   CENTRAL SERVICES & SUPPLY   15. 00   01500   PHARMACY   16. 00   01600   MEDI CAL RECORDS & LI BRARY   21. 00   02100   L&R SERVICES-SALARY & FRINGES APPRVD   22. 00   02200   L&R SERVICES-OTHER PRGM. COSTS APPRVD	132, 862 1, 537 909 524 0 0	33, 714 0 0 0 0	28, 255 185 0 0	79, 446 0 0	3, 168 0	1. 00 2. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 21. 00 22. 00
INPATIENT ROUTINE SERVICE COST CENTERS		-1	-			
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 40. 00   04000   SUBPROVI DER - I PF 41. 00   04100   SUBPROVI DER - I RF 43. 00   04300   NURSERY 44. 00   04400   SKI LLED   NURSING   FACILITY	10, 692 5, 986 1, 961 1, 043 1, 020 2, 765	8, 600 2, 817 1, 498 1, 465	859 225 27 19 0 92	0 0 0 0 0	54 41 9 6 7 6	30. 00 31. 00 40. 00 41. 00 43. 00 44. 00
ANCILLARY SERVICE COST CENTERS  50 00 05000 OPERATING ROOM	8 457	Π	8 250	0	331	50.00
50. 00   05000   0PERATING ROOM   52. 00   05200   DELIVERY ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY   54. 00   05400   RADI OLOGY-DI AGNOSTI C   56. 00   05600   RADI OLOGY-DI AGNOSTI C   56. 00   06600   LABORATORY   65. 00   06500   RESPIRATORY   THERAPY   66. 00   06600   PHYSI CAL   THERAPY   69. 00   06900   ELECTROCARDI OLOGY   69. 01   06901   PULMONARY   69. 02   06902   CARDI OPULMONARY   69. 03   06903   SLEEP LAB   70. 00   07000   ELECTROENCEPHALOGRAPHY   71. 00   07100   MEDI CAL   SUPPLIES   CHARGED   TO PATI ENTS   73. 00   07300   RUGS   CHARGED   TO PATI ENTS   74. 00   07400   RENAL   DI ALYSI S   00TPATI ENT   SERVI CE   COST   CENTERS   88. 01   08800   RURAL   HEALTH   CLINI C   11   89. 00   08900   FEDERALLY   QUALI FIED   HEALTH   CENTER   90. 01   09001   IMED   09002   ONCOLOGY   90. 03   09003   OUTPATI ENT   CENTER   90. 04   099004   HBURG   URGENT   CARE   CLINI C   90. 05   09905   DI ABETES   MGMT   CLINI C   91. 00   09100   EMERGENCY   92. 00   09200   OBSERVATION   BEDS   (NON-DISTINCT   PART)	8, 457 2, 040 2, 148 5, 799 286 5, 741 2, 821 5, 555 3, 693 0 230 594 0 0 2, 720 0 658 941 0 1, 029 0 5, 397 0 2, 171 124 8, 094	000000000000000000000000000000000000000	8, 250 0 818 750 9 8, 258 872 88 2, 048 0 111 41 0 3, 144 0 0 0 0 0 0 0 0 0 0 0 0 1 23 27 0 0 0 0 0 1 1 4 1 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	331 10 21 344 53 273 29 54 164 0 5 6 0 43 89 792 0	50. 00 52. 00 53. 00 54. 00 60. 00 65. 00 66. 00 69. 01 69. 02 69. 03 70. 00 71. 00 72. 00 73. 00 74. 00 88. 01 88. 01 88. 01 89. 00 90. 01 90. 02 90. 03 90. 04 90. 05 91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	5, 817	0	129	0	30	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0 4, 284		0 85	0	0 16	96. 00 101. 00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	95, 856		0 26, 912	0 79, 446		116. 00 118. 00
190. 00 19000 G FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 194. 00 07950 LODGE 194. 01 07951 OTHER NRCC 194. 02 07952 MEMORI AL HOSPI TAL FOUNDATI ON 194. 03 07953 MKT/PHY SERVI CES 194. 04 07954 COMMUNI TY EDUCATI ON 194. 05 07955 VOLUNTEER 194. 06 07956 MAB 194. 07 07957 OFFSI TE COVI D SCREENI NG 194. 08 07958 PUBLI C RELATI ONS	0 32, 542 1, 550 10 0 250 264 1, 272 434 0 475	0 0 0 0 0 0 0	0 1, 092 3 2 0 2 2 69 5 0 0	0 0 0 0 0 0 0 0 0	395 6 0 0 0 2 0 0 0	190. 00 192. 00 192. 01 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08

MEMORIAL HOSP & HEALTH CARE CTR

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

						11/29/2022 11	: 30 alli
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI O	SERVICES &		RECORDS &	
			N	SUPPLY		LI BRARY	
		11. 00	13. 00	14. 00	15. 00	16.00	
194. 09 07959	UNUSED SPACE	0	0	0	0	0	194. 09
194. 10 07960	EMERGENCY PREPAREDNESS	209	0	168	0	0	194. 10
194. 11 07961	HOME OFFICE	0	0	0	0	0	194. 11
200. 00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	132, 862	33, 714	28, 255	79, 446	3, 168	202.00

Provider CCN: 15-0115

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 07/01/2021 Part II

			To	rom 07/01/2021 o 06/30/2022	Part II Date/Time Pre	
	INTERNS &	RESI DENTS			11/29/2022 11	: 30 am
Cost Center Description	SERVI CES-SALA	SERVI CES-OTHE	Subtotal	Intern &	Total	
	RY & FRINGES	R PRGM. COSTS		Residents Cost & Post		
				Stepdown		
	21. 00	22. 00	24. 00	Adjustments 25.00	26. 00	
GENERAL SERVI CE COST CENTERS  1. 00 00100 CAP REL COSTS-BLDG & FIXT						1 00
1. 00   00100   CAP REL COSTS-BLDG & FLXT 2. 00   00200   CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
5. 00   00500   ADMI NI STRATI VE & GENERAL 6. 00   00600   MAI NTENANCE & REPAI RS						6.00
8. 00   00800   LAUNDRY & LI NEN SERVI CE 9. 00   00900   HOUSEKEEPI NG						8. 00 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
14. 00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL   RECORDS & LI BRARY						15. 00 16. 00
21. 00   02100   MEDICAL RECORDS & ELBRARY 21. 00   02100   L&R SERVICES-SALARY & FRINGES APPRVD	2, 278					21.00
22.00   02200   1 &R SERVICES-OTHER PRGM. COSTS APPRVD   INPATIENT ROUTINE SERVICE COST CENTERS		113, 694				22. 00
30. 00 03000 ADULTS & PEDIATRICS			738, 833	0	738, 833	30.00
31. 00 O3100 I NTENSI VE CARE UNI T			342, 317	0	342, 317	1
40. 00   04000   SUBPROVI DER -   PF 41. 00   04100   SUBPROVI DER -   RF			253, 325 133, 221	0	253, 325 133, 221	1
43. 00   04300   NURSERY			86, 604	0	86, 604	1
44.00   04400   SKILLED NURSING FACILITY   ANCILLARY SERVICE COST CENTERS			158, 606	U]	158, 606	44.00
50. 00 O5000 OPERATING ROOM			963, 084 144, 200	0	963, 084 166, 200	1
52.00   05200   DELIVERY ROOM & LABOR ROOM 53.00   05300   ANESTHESI OLOGY			166, 200 5, 528	0	166, 200 5, 528	1
54. 00   05400   RADI OLOGY-DI AGNOSTI C			329, 492	0	329, 492	1
56. 00   05600   RADI 01 SOTOPE 60. 00   06000   LABORATORY			22, 881 181, 163	0	22, 881 181, 163	1
65. 00 06500 RESPIRATORY THERAPY			62, 302	0	62, 302	1
66. 00   06600   PHYSI CAL THERAPY 69. 00   06900   ELECTROCARDI OLOGY			140, 440 307, 014	0	140, 440 307, 014	1
69. 01   06901   PULMONARY			0	0	0	
69. 02   06902   CARDI OPULMONARY 69. 03   06903   SLEEP   LAB			36, 514 42, 798	0	36, 514 42, 798	1
70. 00 07000 ELECTROENCEPHALOGRAPHY			0	0	0	
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00   07200   IMPL. DEV. CHARGED TO PATIENTS			5, 740 10, 995	0	5, 740 10, 995	1
73.00   07300   DRUGS CHARGED TO PATIENTS 74.00   07400   RENAL DIALYSIS			121, 125	0	121, 125	1
74. 00   07400   RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS			0	U <sub>I</sub>	0	74.00
88. 00 08800 RURAL HEALTH CLINIC			44, 232	0	44, 232	
88. 01   08801   RURAL HEALTH CLINIC II 89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER			100, 084 0	0	100, 084 0	1
90. 00   09000   CLI NI C			128, 199	0	128, 199	
90. 01   09001   I MED 90. 02   09002   0NCOLOGY			0 281, 151	0	0 281, 151	
90. 03 09003 OUTPATIENT CENTER			99	0	99	90. 03
90. 04   09004   HBURG URGENT CARE CLINIC 90. 05   09005   DI ABETES MGMT CLINIC			128, 971 12, 440	0	128, 971 12, 440	1
91. 00 09100 EMERGENCY			260, 084	0	260, 084	1
92.00 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				0		92.00
95. 00 O9500 AMBULANCE SERVI CES			59, 261	0	59, 261	
96. 00   09600   DURABLE MEDICAL EQUIP-RENTED 101. 00   10100   HOME HEALTH AGENCY			0 65, 368	0	0 65, 368	96. 00 101. 00
SPECIAL PURPOSE COST CENTERS			0	ما	0	11/ 00
116.00   11600   HOSPICE 118.00   SUBTOTALS (SUM OF LINES 1 through 117)	0	O	0 5, 188, 071	0	0 5, 188, 071	116. 00 118. 00
NONRE MBURSABLE COST CENTERS		-				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES			21, 963 2, 372, 472	0	21, 963 2, 372, 472	190. 00 192. 00
192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES			58, 059	0	58, 059	192. 01
194. 00 07950 LODGE 194. 01 07951 OTHER NRCC			637, 184 0	0	637, 184 0	194. 00 194. 01
194. 02 07952 MEMORIAL HOSPITAL FOUNDATION			22, 776	0	22, 776	194. 02
194.03 07953  MKT/PHY SERVICES 194.04 07954  COMMUNITY EDUCATION			9, 584 111, 511	0	9, 584 111, 511	194. 03 194. 04
	I .	'	,	91	,	

near th Finan	crai systems we	MURIAL HUSP & F	TEALTH CARE CIT	ζ	III LI e	u of Form CNS-2	2552-10
ALLOCATION (	OF CAPITAL RELATED COSTS		Provi der Co		Period: From 07/01/2021	Worksheet B Part II	
					To 06/30/2022	Date/Time Pre 11/29/2022 11	
		INTERNS &	RESI DENTS				
	Cost Center Description	SERVI CES-SALA	SERVI CES-OTHE	Subtotal	Intern &	Total	
		RY & FRINGES	R PRGM. COSTS		Residents Cost & Post		
					Stepdown		
					Adjustments		
		21. 00	22. 00	24.00	25. 00	26.00	
194. 05 07955	VOLUNTEER			1, 12	0 0	1, 120	194. 05
194. 06 07956	MAB				0 0	0	194. 06
194. 07 07957	OFFSITE COVID SCREENING			84	8 0	848	194. 07
194. 08 07958	PUBLIC RELATIONS				0 0	0	194. 08
194. 09 07959	UNUSED SPACE				0 0	0	194. 09
	EMERGENCY PREPAREDNESS			3, 25	6 0	3, 256	194. 10
194. 11 07961	HOME OFFICE			4, 901, 20	8 0	4, 901, 208	194. 11
200. 00	Cross Foot Adjustments	2, 278	113, 694	115, 97	2 0	115, 972	200. 00
201. 00	Negative Cost Centers	0	0		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2, 278	113, 694	13, 444, 02	4  O	13, 444, 024	202.00

Provider CCN: 15-0115

| Peri od: | Worksheet B-1 | From 07/01/2021 | To 06/30/2022 | Date/Time Prepared:

				Т	o 06/30/2022	Date/Time Pre 11/29/2022 11	
		CAPITAL RE	LATED COSTS			1172772022 11	
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	
	oost center bescription	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	n	E & GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SALARI ES)			
		1. 00	2.00	4. 00	5A	5. 00	
	GENERAL SERVI CE COST CENTERS		ı	ı		ı	
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	914, 868	914, 868				1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0		1			4.00
5.00	00500 ADMINISTRATIVE & GENERAL	25, 255	25, 255			187, 501, 083	5.00
6.00	00600 MAINTENANCE & REPAIRS	535				-,,	6.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	2, 899	2, 899	283, 996	0	470, 273 1, 632, 661	8. 00 9. 00
10.00	01000 DI ETARY	2, 872	2, 872	1	Ö	507, 151	1
11. 00	01100 CAFETERI A	8, 887	8, 887		0	1, 027, 632	
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	2, 016				1, 262, 177 537, 060	1
15. 00	01500 PHARMACY	1, 681 5, 286				465, 602	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	0			0		1
21. 00	02100   &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	.,,	
22. 00	O2200   1 & R SERVI CES-OTHER PRGM. COSTS APPRVD   INPATIENT ROUTINE SERVI CE COST CENTERS	7, 453	7, 453	1, 321, 234	0	1, 593, 782	22.00
30. 00	03000 ADULTS & PEDIATRICS	45, 292	45, 292	5, 732, 611	0	9, 188, 302	30.00
31. 00	03100 INTENSIVE CARE UNIT	20, 795				4, 664, 555	
40.00	04000 SUBPROVI DER - I PF	16, 428	1			1, 706, 540	1
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	8, 571 5, 378	8, 571 5, 378			875, 846 882, 133	1
44. 00	04400 SKILLED NURSING FACILITY	9, 321			0		44.00
F0 00	ANCILLARY SERVICE COST CENTERS			5 470 004		45.040.050	
50. 00 52. 00	O5000   OPERATING ROOM   O5200   DELIVERY ROOM & LABOR ROOM	61, 749 10, 756	1			1 7 - 1 - 7 - 1 - 7	50.00 52.00
53. 00	05300 ANESTHESI OLOGY	10, 730	0,730	3, 578, 532		1, 283, 864	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	20, 766	1			5, 848, 684	
56.00	05600 RADI OI SOTOPE	1, 411	1, 411	181, 502		890, 091	
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	10, 022 3, 678	1		0	9, 697, 718 2, 241, 623	
66. 00	06600 PHYSI CAL THERAPY	8, 591	8, 591		Ö	3, 495, 620	
69. 00	06900 ELECTROCARDI OLOGY	19, 567	19, 567		0	5, 240, 816	
69. 01 69. 02	06901 PULMONARY 06902 CARDI OPULMONARY	2, 432	0 2, 432	0 100, 996	0	0 214, 318	69. 01 69. 02
69. 03	06903 SLEEP LAB	2, 794	1		Ö	391, 510	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	_	0	0	1, 290, 275	1
72.00	07300 DRUGS CHARGED TO PATIENTS	0			0	5, 510, 960 19, 285, 794	
74. 00	07400 RENAL DIALYSIS	0					74.00
	OUTPATIENT SERVICE COST CENTERS		0.070		0		
88. 00 88. 01	08800   RURAL HEALTH CLINIC   08801   RURAL HEALTH CLINIC   I	2, 873 6, 628			U	033,009	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0, 020		0	O	0	89.00
90.00	09000 CLI NI C	8, 512	l .	493, 855	0	845, 145	
90. 01 90. 02	09001   I MED	18, 063	_	0 2, 433, 807	0	0 4, 264, 459	90. 01 90. 02
90. 02	09003 OUTPATIENT CENTER	18,003	18,003	2, 433, 607	0	4, 204, 439	90.02
90. 04	09004 HBURG URGENT CARE CLINIC	7, 984	7, 984	1, 200, 456	0	1, 528, 705	
90.05	09005 DI ABETES MGMT CLINIC	824		60, 564		90, 367	90.05
91. 00 92. 00	O9100   EMERGENCY   O9200   OBSERVATION   BEDS (NON-DISTINCT PART)	16, 074	16, 074	9, 608, 388	0	7, 422, 494	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95. 00	09500 AMBULANCE SERVI CES	3, 236	1				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED  10100 HOME HEALTH AGENCY	0		1	0		96.00
101.00	SPECIAL PURPOSE COST CENTERS	3, 758	3, 758	1, 986, 817	0	2, 859, 852	]101.00
116.00	11600 H0SPI CE	0	0	0		0	116.00
118. 00		372, 387	372, 387	66, 582, 112	-30, 444, 235	129, 465, 088	118. 00
100 00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 489	1 490	Ιο	0	21 001	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	152, 823			_	44, 635, 251	1
192. 01	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 682	3, 682	857, 964	0	1, 160, 653	192. 01
	07950 LODGE	43, 195				649, 658	
	07951   OTHER NRCC   07952   MEMORIAL HOSPITAL FOUNDATION	1, 506	_	0 121, 556	I	179, 283	194. 01 194. 02
	07953 MKT/PHY SERVICES	120				3, 814, 581	
	07954 COMMUNITY EDUCATION	7, 389					

332, 277

7, 737, 137

8. 457107

332, 277

5, 706, 887

6. 237935

46, 471

25, 261, 293

0. 256551

0.000000

0

1, 454, 807 194. 10

4, 882, 820 194. 11

30, 444, 235 202. 00

0. 162368 203. 00

0.001979 205.00

371, 123 204. 00

200.00

201.00

206.00

207.00

194. 10 07960 EMERGENCY PREPAREDNESS

Part I)

Part II)

(per Wkst. B-2)

Parts III and IV)

II)

Cross Foot Adjustments

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

Unit cost multiplier (Wkst. B, Part I)

NAHE adjustment amount to be allocated

Negative Cost Centers

194. 11 07961 HOME OFFICE

200.00

201.00

202.00

203.00

204.00

205.00

206.00

207.00

		MORIAL HOSP & F				u of Form CMS-:	
COST	ALLOCATION - STATISTICAL BASIS		Provi der Co		Period: From 07/01/2021	Worksheet B-1	
				7	To 06/30/2022	Date/Time Pre 11/29/2022 11	
	Cost Center Description	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	. 50 aiii
		REPAI RS	LINEN SERVICE	(SQUARE FEET)	(PATIENT	(HOURS)	
		(SQUARE FEET)	(POUNDS OF LAUNDRY)		DAYS)		
		6. 00	8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS	889, 078	l				6. 00
8.00	00800 LAUNDRY & LI NEN SERVI CE	2, 899	804, 736				8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 872	6, 343	886, 179 2, 872			9.00
11. 00	01100 CAFETERI A	8, 887	0	8, 887		1, 992, 318	1
13.00	01300 NURSING ADMINISTRATION	2, 016	0	2, 016		23, 045	1
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	1, 681 5, 286	28, 361	1, 68° 5, 286		13, 638 7, 864	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	0, 200	Ö	3, 200		0	1
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	(	-	0	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	7, 453	0	7, 453	3 0	12, 292	22.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	45, 292	156, 958	45, 292	9, 294	160, 325	30.00
31.00	03100   NTENSI VE CARE UNI T	20, 795				89, 756	
40. 00	04000 SUBPROVI DER - I PF	16, 428	11, 870			29, 399	
41. 00 43. 00	O4100   SUBPROVI DER -   RF   O4300   NURSERY	8, 571 5, 378	15, 640 432			15, 636 15, 293	
44.00	04400 SKILLED NURSING FACILITY	9, 321	34, 656			41, 458	•
	ANCILLARY SERVICE COST CENTERS					, , , , , , , , , , , , , , , , , , , ,	
50.00	05000 OPERATING ROOM	61, 749				126, 811	•
52. 00 53. 00	O5200   DELI VERY ROOM & LABOR ROOM   O5300   ANESTHESI OLOGY	10, 756	42, 775 0	10, 756		30, 586 32, 203	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	20, 766	98, 231			86, 964	1
56.00	05600 RADI OI SOTOPE	1, 411	0	1, 411		4, 283	1
60. 00 65. 00	06000   LABORATORY   06500   RESPI RATORY   THERAPY	10, 022	2, 985	10, 022 3, 678		86, 088 42, 296	1
66.00	06600 PHYSI CAL THERAPY	3, 678 8, 591	25, 016			83, 296	1
69.00	06900 ELECTROCARDI OLOGY	19, 567	49, 578			55, 376	1
69. 01	06901 PULMONARY	0	0		-	0	
69. 02 69. 03	06902 CARDI OPULMONARY 06903 SLEEP LAB	2, 432 2, 794	752 4, 641	2, 432 2, 794		3, 448 8, 903	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	2, , ,	.	0, 700	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(		0	71.00
72. 00 73. 00	O7200   IMPL. DEV. CHARGED TO PATIENTS   O7300   DRUGS CHARGED TO PATIENTS	0	0		0 0	0 40, 783	72. 00 73. 00
74.00	07400 RENAL DI ALYSI S	0	0			40, 783	1
	OUTPATIENT SERVICE COST CENTERS			I			
	O8800  RURAL HEALTH CLINIC   O8801  RURAL HEALTH CLINIC II	2, 873	0		1		88. 00 88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	6, 628	0	6, 628		14, 111	89.00
90.00	09000 CLI NI C	8, 512	1, 420	8, 512	0	15, 434	1
90. 01	09001 I MED	0	0	10.04	0	0	
90. 02 90. 03	O9002   ONCOLOGY   O9003   OUTPATI ENT CENTER	18, 063	18, 626 1, 824			80, 926 0	1
90. 04	09004 HBURG URGENT CARE CLINIC	7, 984	112, 595		1	32, 554	1
90. 05	09005 DIABETES MGMT CLINIC	824	0			1, 854	
91. 00 92. 00	O9100   EMERGENCY   O9200   OBSERVATION   BEDS (NON-DISTINCT PART)	16, 074	0	16, 074	0	121, 369	91.00
<del>7</del> 2.00	OTHER REIMBURSABLE COST CENTERS						72.00
	09500 AMBULANCE SERVICES	3, 236	60				95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0			0	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	3, 758	0	3, 758	3 0	64, 244	101.00
116.00	11600 HOSPI CE	0		(		0	116.00
118.00		346, 597	799, 141	343, 698	22, 011	1, 437, 335	118.00
190 00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 489	0	1, 489	ol ol	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	152, 823				488, 032	
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 682	l e	3, 682			192. 01
	007950 LODGE 07951 OTHER NRCC	43, 195	0	43, 195			194. 00 194. 01
	07951 OTHER NRCC	1, 506	0	1, 506			194.01
194. 03	07953 MKT/PHY SERVICES	120	0	120	o	3, 966	194. 03
	07954   COMMUNITY EDUCATION   07955   VOLUNTEER	7, 389	0	7, 389			194. 04 194. 05
	07955  VOLUNTEER 07956  MAB	0	0				194. 05
	07957 OFFSITE COVID SCREENING	0	o				194. 07

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0115	Period: Worksheet B-1
		From 07/01/2021

				Fi	com 07/01/2021 o 06/30/2022	Date/Time Pre	
	Cost Center Description	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	11/29/2022 11 CAFETERIA	: 30 am
	·	REPAI RS	LINEN SERVICE	(SQUARE FEET)	(PATI ENT	(HOURS)	
		(SQUARE FEET)	(POUNDS OF		DAYS)		
			LAUNDRY)				
	,	6. 00	8. 00	9. 00	10. 00	11. 00	
194. 08 07958	PUBLIC RELATIONS	0	0	0	0	0	194. 08
194. 09 07959	UNUSED SPACE	0	0	0	0	0	194. 09
	EMERGENCY PREPAREDNESS	0	0	0	0	3, 135	194. 10
194. 11 0796°	HOME OFFICE	332, 277	0	332, 277	0	0	194. 11
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	7, 183, 056	570, 052	1, 897, 753	623, 343	1, 285, 319	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8. 079219	0. 708371	2. 141501	28. 319613	0. 645137	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	20, 092	43, 598	3, 231	43, 627	132, 862	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 022599	0. 054177	0. 003646	1. 982054	0. 066687	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

CONT. CENTER. LEGAL SERVICE COST CENTERS (CONT.)  LEASE ALL SERVICE COST CENTERS (CONT.)  LEASE ALL SERVICE COST CENTERS (CONT.)  LOUD DOTUGLAR REL COST SERVICE COST CENTERS (REVENUE)  1.00  DOTUGLA					rom 07/01/2021 o 06/30/2022		
Control Poscription							:30 am
ADMINISTRATIO   SERVICES   COSTED   PROVIDES   PROVIDES   COSTED	Cost Contor Doscription	NUDSTNC	CENTRAL	DHADMACV	MEDICAL	RESI DENTS	
CERESPAL SERVICE COST CONTROL   1.00   CORP COST COST COST COST COST COST COST COST	cost center bescription						
MRS.   RFOULS.				REQUIS.)		•	
CEREBRAL SERVICE COST CENTERS			,		(KEVENOE)	TTWL)	
1.00	CENEDAL SEDVICE COST CENTEDS	13. 00	14. 00	15. 00	16. 00	21. 00	
4.00   0.0000   MAINTERANCE & REPAIRS	1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
5.00   DOSOD MANI INSTRATION & GENERAL   5.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.0							
8.00   0.0800   JAJANDRY & LINEN SERVICE     0   0   0   0   0   0   0   0   0							
0.000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.0000							
10.00   01000   DETARY							
13.00	10. 00 01000 DI ETARY						10.00
14. 00   14.00   14.00   14.00   14.00   14.00   15.00   15.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.		351 867					
16. 00   1600 MEDICAL RECORDS & LIBRARY   0   0   0   7711, 313, 505   16. 00   22. 00   0700 D   18. SERVICE-SALARY & FRINGES APPROV   0   1, 038   0   0   0   3. 35   27. 00   22. 00   0700 D   18. SERVICE-SALARY & FRINGES APPROV   0   1, 038   0   0   0   0   2. 35   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27. 00   27		1	11, 594, 717				
21.00		-1					
		-1	0			1, 315	
0.00   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.0000   0.000   0.00	22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	1, 038	C	0		
31.00   03100   INTENSIVE CARE UNIT		160 325	352 296		13 614 480	465	30.00
11.00   04100 SUBPROVI DER - 1RF		1					
43. 00   04300   NURSERY   15, 293   0   0   1, 683, 626   0   43. 00		1					
44 00   04400   SKILLED   NURSING FACILITY   41,458   37,687   0   1,540,884   0,44,00		1					
0.00   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.0000000   0.00000000	44.00 04400 SKILLED NURSING FACILITY	1	-				
52.00   OS200   OSE200   DELIVERY ROOM & LABOR ROOM   O   O   O   2, 497, 981   O   S2.00   S5.00   OS500			3 385 407		82 650 261	160	50 00
54.00   OS400   RADIO LOGY-DI AGNOSTIC   O   307,710   O   86,098,048   O   54.00   OS600   OS600   RADIO ISOTOPE   O   3,755   O   3,148,867   O   56.00   OS600   OS600   RADIO ISOTOPE   O   3,388,586   O   68,357,497   O   O   60.00   OS600   OS600   RESPIRATORY THERAPY   O   36,198   O   13,549,969   O   66.00   OS600   OS600   RESPIRATORY THERAPY   O   36,198   O   13,549,969   O   66.00   OS600   OS600   RESPIRATORY THERAPY   O   36,198   O   13,549,969   O   66.00   OS600   OS600   RESPIRATORY THERAPY   O   36,198   O   13,549,969   O   66.00   OS600   OS600   RESPIRATORY THERAPY   O   36,198   O   13,549,969   O   66.00   OS600   OS600   RESPIRATORY THERAPY   O   36,198   O   0,99,018   OS600   OS600   RESPIRATORY THERAPY   O   36,198   O   0,99,018   OS600   OS600   RESPIRATORY THERAPY   O   0   0   O   0   O   0   OS600   OS600   RESPIRATORY THERAPY   O   0   0   O   0   O   O   OS600   OS600   RESPIRATORY   O   0   0   O   O   O   O   OS600   OS600   RESPIRATORY   O   0   O   O   O   O   OS600   RESPIRATORY   O   0   O   O   O   O   O   OS600   RESPIRATORY   O   O   O   O   O   O   OS600   RESPIRATORY   O   O   O   O   O   O   O   OS600   RESPIRATORY   O   O   O   O   O   OS600   RESPIRATORY   O   O   O   O   O   O   OS600   RESPIRATORY   O   O   O   O   O   OS600   OS600   RESPIRATORY   O   O   O   O   O   OS600   OS600   RUBAL HEALTH CLINIC   O   O   O   O   O   OS600   OS600   RUBAL HEALTH CLINIC   O   O   O   O   O   OS600   OS600   RUBAL HEALTH CLINIC   O   O   O   O   O   OS600   OS600   RUBAL HEALTH CLINIC   O   O   O   O   O   OS600   OS600   RUBAL HEALTH CLINIC   O   O   O   O   O   OS600   O		1					
56.00   OSGOO   RADIO I SOTOPE   0   3,755   0   13,148,867   0   56.00		1 1					
0.00   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000		1 -1		-			
66. 00   06600   PHYSI CAL THERAPY   0   36, 198   0   13, 549, 969   0   66, 00   69. 00   06900   ELECTROCARD IOLOGY   0   840, 355   0   40, 949, 085   44   69, 00   69. 01   06901   PULMONARY   0   0   0   0   0   0   0   0   69. 01   06902   CARDIO PULMONARY   0   0   0   0   0   0   0   0   69. 02   06902   CARDIO PULMONARY   0   0   0   0   0   1, 184, 646   44   69, 02   69. 03   06903   SLEEP LAB   0   16, 819   0   1, 474, 855   0   69, 02   69. 00   07000   ELECTROCARD PHALOGRAPHY   0   0   0   0   0   0   0   0   70. 00   07000   ELECTROCARD PHALOGRAPHY   0   0   0   0   0   0   0   72. 00   07200   MPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   74. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   75. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   76. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   77. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   89. 00   08900   RUBAL HEALTH CLINIC   0   0   9, 391   0   781, 635   0   88. 00   89. 01   08901   RUBAL HEALTH CLINIC   1   0   10, 903   0   95, 869   4   88. 01   89. 00   08900   EDETRALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   0   89. 01   09901   IMED   0   0   0   0   0   0   0   0   89. 02   09902   00000   00000   00000   0   0   0	60. 00   06000   LABORATORY	1	3, 388, 586		68, 357, 497	0	60.00
69.00   06900   06900   06900   06900   06900   074,085   44   69.00   08.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00   09.00		1 -1				-	
69.01		0				-	
69.03   06903   SLEEP LAB	69. 01   06901   PULMONARY	O	0	C	0	-	
70.00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   0   0   0   0		0					
72.00   07200   IMPL DEV. CHARGED TO PATIENTS   0   0   0   0   22, 343, 956   0   72.00	70. 00 07000 ELECTROENCEPHALOGRAPHY	1	0				70. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   117, 252, 699   0   73. 00   74. 00   07400   RENAL DIALYSIS   0   0   0   0   0   0   0   74. 00   07400   RENAL DIALYSIS   0   0   0   0   0   0   74. 00   07400   RENAL DIALYSIS   0   0   0   0   0   74. 00   07400   RENAL DIALYSIS   0   0   0   0   0   88. 01   08800   RURAL HEALTH CLINIC   0   9, 391   0   781, 635   0   88. 00   89. 00   08900   REDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   89. 00   09900   EDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   90. 01   09900   09900   REDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   90. 02   09900   0000   0000   0   0   0   0		-1	1, 290, 275			-	
74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   74. 00		-1	0			-	
88. 00   08800   RURAL HEALTH CLINIC   0   9, 391   0   781, 635   0   88. 00   88. 01   08801   RURAL HEALTH CLINIC   1   0   10,903   0   965, 869   4   88. 01   89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   90. 00   09000   CLINIC   0   40,117   0   3, 863, 263   0   90. 00   90. 01   09001   IMED   0   0   0   0   0   0   0   90. 02   09002   ONCOLOGY   0   124, 421   0   22, 908, 637   14   90. 02   90. 03   09003   OUTPATI ENT CENTER   0   0   0   0   0   0   0   90. 04   90908   URENT CARE CLINIC   0   50, 196   0   4, 461, 499   41   40. 499   90. 05   09005   DI ABETES MGMT CLINIC   0   2, 156   0   147, 842   0   90. 05   91. 00   09000   BERREGENCY   0   172, 920   0   62, 173, 999   77   91. 00   92. 00   09000   OBSERVATION BEDS (NON-DISTINCT PART)   92. 00   95. 00   09500   AMBULANCE SERVI CES   0   52, 873   0   7, 490, 900   0   96. 00   101. 00   10100   HOME HEALTH AGENCY   0   34, 693   0   3, 976, 571   0   101. 00   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   351, 867   11, 043, 438   100   610, 595, 128   874   118. 00   192. 00   19200   PERREGENCY   0   816   0   98, 769, 826   387   192. 00   192. 01   19201   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   448, 181   0   98, 769, 826   387   192. 00   192. 01   19201   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   448, 181   0   98, 769, 826   387   192. 00   194. 01   07951   OTHER NRCC   0   0   0   0   0   0   0   194. 02   07952   MEMORIA LH HOSPITAL FOUNDATION   0   762   0   0   0   0   0   194. 02   194. 03   07952   MEMORIA LH HOSPITAL FOUNDATION   0   762   0   0   0   0   0   194. 03   07952   MEMORIA LH HOSPITAL FOUNDATION   0   762   0   0   0   0   0   194. 03   07952   MEMORIA LH HOSPITAL FOUNDATION   0   762   0   0   0   0   0   194. 03   07952   MEMORIA LH HOSPITAL FOUNDATION   0   0   0   0   0   0   0   0   0   194. 03   07952   MEMORIA LH HOSPITAL FOUNDATION   0   0   0   0   0   0   0   0   0   194. 03   07952   MEMORIA LH HOSPITAL FOUNDATION   0   0   0   0   0   0   0   0   0	74.00 07400 RENAL DIALYSIS	O	0			0	
88.01 08801 RURAL HEALTH CLINIC II 0 10,903 0 965,869 4 88.01 0890 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89.00 90.00 09000 CLINIC 0 40,117 0 3,863,263 0 90.00 90.00 90.00 1 INC 0 0 40,117 0 3,863,263 0 90.00 90.00 90.01 IMED 0 0 0 0 0 0 0 0 0 0 0 0 90.01 90.01 90.01 IMED 0 0 124,421 0 22,908,637 14 90.02 90.03 90.03 0UTPATIENT CENTER 0 0 0 0 0 0 0 0 0 0 90.03 90.04 99.04 HBURG URGENT CARE CLINIC 0 50,196 0 4,461,499 41 90.04 90.05 9905 DI ABETES MGMT CLINIC 0 2,156 0 147,842 0 90.05 9905 DI ABETES MGMT CLINIC 0 172,920 0 62,173,999 77 91.00 91.00 91.00 EMERGENCY 0 172,920 0 62,173,999 77 91.00 92.00 GDSERVATION BEDS (NON-DISTINCT PART) 92.00 9200 GDSERVATION BEDS (NON-DISTINCT PART) 92.00 9000 DURABLE MEDICAL EQUIP-RENTED 0 0 0,00 0 0 0 96.00 101.00 HOME HEALTH AGENCY 0 34,693 0 3,976,571 0 101.00 101.00 HOME HEALTH AGENCY 0 34,693 0 3,976,571 0 101.00 101.00 HOME HEALTH AGENCY 0 34,693 10 0 7,490,900 0 96.00 118.00 116.00 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) 351,867 11,043,438 100 610,595,128 874 118.00 NONREI MBURSABLE COST CENTERS  116.00 1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 448,181 0 98,769,826 387 192.00 192.00 19200 PhySICI AND PRIVATE OFFICES 0 448,181 0 98,769,826 387 192.00 192.01 19200 19200 PhySICI AND PRIVATE OFFICES 0 448,181 0 98,769,826 387 192.00 192.01 19200 19200 PhySICI AND PRIVATE OFFICES 0 448,181 0 98,769,826 387 192.00 192.01 19200 19200 PhySICI AND PRIVATE OFFICES 0 448,181 0 98,769,826 387 192.00 192.01 19200 19200 PhySICI AND PRIVATE OFFICES 0 448,181 0 98,769,826 387 192.00 192.01 19200 19200 PhySICI AND PRIVATE OFFICES 0 448,181 0 98,769,826 387 192.00 192.01 19200 19700 PHYSICI AND PRIVATE OFFICES 0 448,181 0 98,769,826 387 192.00 194.00 194.01 194.01 197951 OTHER NRCC 0 0 0 0 0 0 0 194.02 194.03 194.03 19953 MKT/PHY SERVICES 0 0 194.02 194.03 19953 MKT/PHY SERVICES 0 0 194.02 194.03 19953 MKT/PHY SERVICES 0 0 194.02 194.03 194.03 19953 MKT/PHY SERVICES 0 0 194.02 194.03 194.03 194.03 194.03 194.03 194.03 194.03 194.03 194.03 194.03 194.03 194.03 194.03 194.0			9 391		781 635	0	88 00
90. 00   09000   CLINIC   0   40, 117   0   3, 863, 263   0   90. 00   90. 01   90. 01   1MED   0   0   0   0   0   0   0   0   0		1				4	
90. 01   09001   MED   0   0   0   0   0   0   0   0   0		0	0	C	0		
90. 02 09002 0NCOLOGY 0 124, 421 0 22, 908, 637 14 90. 02 90. 03 00703 0UTPATI ENT CENTER 0 0 0 0 0 0 0 0 90. 03 90. 03 0UTPATI ENT CENTER 0 0 0 0 0 0 0 90. 03 90. 03 0UTPATI ENT CENTER 0 0 50, 196 0 4, 461, 499 41 90. 04 90. 05 90. 05 09005 DI ABETES MGMT CLI NI C 0 2, 156 0 147, 842 0 90. 05 91. 00 90000 BERGENCY 0 172, 920 0 62, 173, 999 77 91. 00 09100 EMERGENCY 0 172, 920 0 62, 173, 999 77 91. 00 09100 DISERVATION BEDS (NON-DISTINCT PART) 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 09500 AMBULANCE SERVI CES 0 5 52, 873 0 7, 490, 900 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 96. 00 101. 00 10100 HOME HEALTH AGENCY 0 34, 693 0 3, 976, 571 0 101. 00 10100 HOME HEALTH AGENCY 0 0 34, 693 0 3, 976, 571 0 101. 00 SPECIAL PURPOSE COST CENTERS  116. 00 11600 HOSPI CE 0 0 0 0 0 0 116. 00 11600 HOSPI CE 0 0 0 0 0 0 0 116. 00 118. 00 NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT., FLOWER, COFFEE SHOP & CANTEEN 0 0 0, 98, 769, 826 387 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 484, 181 0 98, 769, 826 387 192. 00 192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 484, 181 0 98, 769, 826 387 192. 00 192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 1, 246 0 1, 530, 321 0 192. 01 194. 01 07951 0 THER NRCC 0 0 0 0 0 0 194. 01 194. 01 194. 01 07952 MEMORI AL HOSPI TAL FOUNDATION 0 762 0 0 0 194. 02 194. 03 107953 MEMORI AL HOSPI TAL FOUNDATION 0 762 0 0 0 194. 03 194. 03 107953 MEMORI AL HOSPI TAL FOUNDATION 0 0 911 0 418, 230 0 194. 03 194. 03 107953 MEMORI AL HOSPI TAL FOUNDATION 0 0 911 0 418, 230 0 194. 03 194. 03 107953 MEMORI AL HOSPI TAL FOUNDATION 0 0 911 0 0 418, 230 0 194. 03 107953 MEMORI AL HOSPI TAL FOUNDATION 0 0 911 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			40, 117		3, 863, 263	-	
90. 04   09004   HBURG URGENT CARE CLINIC   0   50, 196   0   4, 461, 499   41   90. 04   90. 05   09005   DI ABETES MGMT CLINIC   0   2, 156   0   147, 842   0   90. 05   91. 00   09100   EMERGENCY   0   172, 920   0   62, 173, 999   77   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   92. 00   95. 00   09500   AMBULANCE SERVICES   0   52, 873   0   7, 490, 900   0   95. 00   96. 00   09600   DURABLE MEDI CAL EQUI P-RENTED   0   0   0   0   0   96. 00   101. 00   10100   HOME HEALTH AGENCY   0   34, 693   0   3, 976, 571   0   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   351, 867   11, 043, 438   100   610, 595, 128   874   118. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   448, 181   0   98, 769, 826   387   192. 01 19201   PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES   0   448, 181   0   98, 769, 826   387   194. 00 07950   LONGE   0   0   0   0   0   194. 01 07951   OTHER NRCC   0   0   0   0   194. 02 07952   MEMORI AL HOSPITAL FOUNDATION   0   762   0   0   194. 03 07953   MKT/PHY SERVICES   0   194. 03   194. 03 07953   MKT/PHY SERVICES   0   194. 03   197. 00   194. 03   07953   MKT/PHY SERVICES   0   194. 03   197. 00   194. 03   07953   MKT/PHY SERVICES   0   0   0   0   199. 00   194. 03   07953   MKT/PHY SERVICES   0   0   0   190. 05   0   0   0   0   0   0   190. 00   194. 03   190. 04   194. 04   07955   0   0   0   0   194. 05   07955   MKT/PHY SERVICES   0   0   0   194. 05   07955   MEMORI AL HOSPITAL FOUNDATION   0   0   0   194. 05   07955   MEMORI AL HOSPITAL FOUNDATION   0   0   0   194. 05   07955   MEMORI AL HOSPITAL FOUNDATION   0   0   0   194. 05   07955   MEMORI AL HOSPITAL FOUNDATION   0   0   0   194. 05   07955   MEMORI AL HOSPITAL FOUNDATION   0   0   0   194. 05   07955   MEMORI AL HOSPITAL FOUNDATION   0   0   194. 06   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955   07955	90. 02 09002 ONCOLOGY	o	124, 421	ď	22, 908, 637	14	90. 02
90. 05		0	0 50 196		0	-	
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0THER REI MBURSABLE COST CENTERS   95. 00   09500   AMBURANCE SERVI CES   0   52,873   0   7,490,900   0   95. 00   96. 00   0   0   0   0   0   0   0   0   0		o o					
OTHER REI MBURSABLE COST CENTERS   O   52,873   O   7,490,900   O   95.00		o	172, 920	C	62, 173, 999	77	
95. 00							92.00
101. 00   10100   HOME   HEALTH   AGENCY   0   34, 693   0   3, 976, 571   0   101. 00   101. 00   SPECI   AL   PURPOSE   COST   CENTERS   116. 00   11600   HOSPI   CE   SUBTOTALS (SUM OF LINES 1 through 117)   351, 867   11, 043, 438   100   610, 595, 128   874   118. 00   NONREI   MBURSABLE   COST   CENTERS	95. 00 09500 AMBULANCE SERVI CES	0	52, 873	C			
SPECI AL PURPOSE COST CENTERS   116. 00   11600   HOSPI CE   SUBTOTALS (SUM OF LINES 1 through 117)   351,867   11,043,438   100   610,595,128   874   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   190. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   448,181   0   98,769,826   387   192. 00   192. 01   19201   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   1,246   0   1,530,321   0   192. 01   194. 00   107950   LODGE   0   816   0   0   0   194. 00   194. 01   107951   OTHER NRCC   0   0   0   0   194. 01   194. 02   194. 03   07953   MEMORI AL HOSPITAL FOUNDATION   0   762   0   0   0   194. 03   194. 03   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0   194. 03   0		1	0 34 693				
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   351, 867   11, 043, 438   100   610, 595, 128   874   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   1		<u> </u>	34, 073		3, 770, 371	0	101.00
NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   190. 00     192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   448, 181   0   98, 769, 826   387   192. 00     192. 01   19201   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   1, 246   0   1, 530, 321   0   192. 01     194. 00   07950   LODGE   0   816   0   0   0   0   194. 00     194. 01   07951   OTHER NRCC   0   0   0   0   0   194. 01     194. 02   07952   MEMORI AL HOSPITAL FOUNDATION   0   762   0   0   0   194. 02     194. 03   07953   MKT/PHY SERVI CES   0   911   0   418, 230   0   194. 03     190. 00   0   0   0   0   0   0     190. 00   0   0   0   0     190. 00   0   0   0   0     190. 00   0   0   0     190. 00   0   0   0     190. 00   0   0   0     190. 00   0   0     190. 00   0   0     190. 00   0   0     190. 00   0   0     190. 00   0   0     190. 00   0     190. 00   0     190. 00   0     190. 00   0     190. 00   0     190. 00   0     190. 00   0     190. 00   0     190. 00   0     190. 00   0     190. 00   0     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00     190. 00			0			074	
192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES		351,867	11, 043, 438	100	010, 595, 128	874	118.00
192. 01   19201   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   1, 246   0   1, 530, 321   0   192. 01   194. 00   194. 00   194. 01   194. 01   194. 01   194. 02   194. 02   194. 03   19795   MKT/PHY SERVI CES   0   11, 530, 321   0   192. 01   194. 00   194. 02   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 03   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   194. 04   1		0	0	C			
194. 00   07950   LODGE		0					
194. 02 07952 MEMORI AL HOSPITAL FOUNDATION 0 762 0 0 194. 02 194. 03 07953 MKT/PHY SERVICES 0 911 0 418, 230 0 194. 03	194. 00 07950 LODGE	o o			0	0	194. 00
194. 03 07953 MKT/PHY SERVI CES 0 911 0 418, 230 0 194. 03		0	ŭ		0		
	194. 03 07953 MKT/PHY SERVICES				418, 230		
		1			0		

				10	06/30/2022	11/29/2022 11	
	Cost Center Description	NURSI NG ADMI NI STRATI O N (DI RECT NURS. HRS.)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S. )	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (REVENUE)	I NTERNS & RESI DENTS SERVI CES-SALA RY & FRI NGES (ASSI GNED TI ME)	. GO UIII
	1	13. 00	14. 00	15. 00	16. 00	21. 00	
194. 05 07955	•	0	1, 946	0	0		194. 05
194. 06 07956		0	0	0	0		194. 06
	OFFSITE COVID SCREENING	0	0	0	0		194. 07
	PUBLIC RELATIONS	0	0	0	0		194. 08
	UNUSED SPACE	0	0	0	0		194. 09
	EMERGENCY PREPAREDNESS	0	69, 139	0	0		194. 10
	HOME OFFICE	0	0	0	0	22	194. 11
200.00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	4 500 50/	.70 000		4 0/0 /00		201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 502, 586	670, 330	604, 685	1, 860, 638	1, 338, 066	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	4. 270324	0. 057813	6, 046. 850000	0. 002616	1, 017. 540684	203.00
204. 00	Cost to be allocated (per Wkst. B,	33, 714	28, 255	79, 446	3, 168	2, 278	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 095815	0. 002437	794. 460000	0. 000004	1. 732319	205. 00
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0115 Peri od: Worksheet B-1 From 07/01/2021 06/30/2022 Date/Time Prepared: 11/29/2022 11:30 am INTERNS & **RESI DENTS** SERVI CES-OTHE Cost Center Description R PRGM COSTS (ASSI GNED TIME) 22.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FLXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 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 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 21.00 02200 & SERVICES-OTHER PRGM. COSTS APPRVD 22 00 1, 315 22 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 465 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 0 04000 SUBPROVI DER - I PF 40 00 40 00 16 04100 SUBPROVI DER - I RF 41.00 0 41.00 04300 NURSERY 0 43.00 43.00 44.00 04400 SKILLED NURSING FACILITY 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 169 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 05300 ANESTHESI OLOGY 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 56.00 05600 RADI OI SOTOPE 0 56.00 0 60.00 06000 LABORATORY 60.00 65.00 06500 RESPIRATORY THERAPY 65 00 0 66.00 06600 PHYSI CAL THERAPY 66.00 06900 ELECTROCARDI OLOGY 44 69.00 69.00 0 69.01 06901 PULMONARY 69.01 06902 CARDI OPULMONARY 44 69.02 69.02 0 69. 03 06903 SLEEP LAB 69.03 70 00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 88.00 08801 RURAL HEALTH CLINIC II 88.01 4 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 09000 CLINIC 90 00 90 00 90.01 09001 I MED 90.01 09002 ONCOLOGY 14 90.02 90.02 0 09003 OUTPATIENT CENTER 90.03 90.03 90.04 09004 HBURG URGENT CARE CLINIC 41 90 04 90.05 09005 DIABETES MGMT CLINIC 0 90.05 91.00 09100 EMERGENCY 77 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 874 118 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 387 192.00 192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 192 01 0 194. 00 07950 LODGE 194.00 194. 01 07951 OTHER NRCC 194.01 0 194. 02 07952 MEMORIAL HOSPITAL FOUNDATION 194. 02 194. 03 07953 MKT/PHY SERVICES 194.03 194. 04 07954 COMMUNITY EDUCATION 194.04 194. 05 194. 05 07955 VOLUNTEER

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0115	Period: Worksheet B-1

		To 06/30/2022 Date/Time Prepared: 11/29/2022 11:30 am
	INTERNS &	
	RESI DENTS	
Cost Center Description	SERVI CES-0THE	
	R PRGM. COSTS	
	(ASSI GNED	
	TIME)	
	22. 00	
194. 06 07956 MAB	0	194. 06
194. 07 07957 OFFSI TE COVI D SCREENI NG	0	194. 07
194. 08 07958 PUBLIC RELATIONS	0	194. 08
194. 09 07959 UNUSED SPACE	0	194. 09
194. 10 07960 EMERGENCY PREPAREDNESS	0	194. 10
194. 11 07961 HOME OFFI CE	22	194. 11
200.00 Cross Foot Adjustments		200.00
201.00 Negative Cost Centers		201. 00
202.00   Cost to be allocated (per Wkst. B, Part I)	1, 936, 726	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	1, 472. 795437	203. 00
204.00 Cost to be allocated (per Wkst. B,	113, 694	204.00
Part II)		
205.00 Unit cost multiplier (Wkst. B, Part	86. 459316	205. 00
206.00 NAHE adjustment amount to be allocated		206.00
(per Wkst. B-2)		
207.00 NAHE unit cost multiplier (Wkst. D,		207. 00
Parts III and IV)		

| Peri od: | Worksheet C | From 07/01/2021 | Part I | Date/Time Prepared: | Provider CCN: 15-0115

			T	o 06/30/2022	Date/Time Pre 11/29/2022 11	
		Title	xVIII	Hospi tal	PPS	. 30 aiii
		11 21 0		Costs	110	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
555 C 5511 C 5555 T P C 511	(from Wkst.	Adj.	l rotal ocoto	Di sal I owance	.014. 00010	
	B, Part I,	7.09		5. 64. 1 6.14.166		
	col . 26)					
	1.00	2.00	3.00	4.00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	12, 361, 547		12, 361, 547	0	12, 361, 547	30.00
31. 00 03100 I NTENSI VE CARE UNI T	6, 277, 151		6, 277, 151	0	6, 277, 151	31.00
40. 00   04000   SUBPROVI DER - I PF	2, 349, 077		2, 349, 077	0	2, 349, 077	40.00
41. 00   04100   SUBPROVI DER -   RF	1, 224, 932		1, 224, 932	0	1, 224, 932	41.00
43. 00   04300   NURSERY	1, 205, 523		1, 205, 523	o	1, 205, 523	43.00
44.00 04400 SKILLED NURSING FACILITY	2, 833, 439		2, 833, 439	0	2, 833, 439	
ANCILLARY SERVICE COST CENTERS	2/000/10/		2/000/10/	٩١	2,000,107	
50. 00 05000 OPERATING ROOM	18, 931, 761		18, 931, 761	0	18, 931, 761	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 217, 230		2, 217, 230	0	2, 217, 230	
53. 00   05300   ANESTHESI OLOGY	1, 546, 106		1, 546, 106	o	1, 546, 106	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	7, 379, 276		7, 379, 276	o	7, 379, 276	54.00
56. 00   05600   RADI OI SOTOPE	1, 086, 412		1, 086, 412	0	1, 086, 412	56.00
60. 00   06000   LABORATORY	11, 807, 133		11, 807, 133	0	11, 807, 133	60.00
65. 00 06500 RESPIRATORY THERAPY	2, 710, 407	0		0	2, 710, 407	65.00
66. 00   06600   PHYSI CAL THERAPY	4, 260, 002	0	_, ,	0	4, 260, 002	66.00
69. 00 06900 ELECTROCARDI OLOGY	6, 518, 297		6, 518, 297	0	6, 518, 297	69.00
69. 01 06901 PULMONARY	0,310,277		0,310,277	0	0, 310, 277	69. 01
69. 02   06902   CARDI OPULMONARY	280, 101		280, 101	0	280, 101	69. 02
69. 03   06903   SLEEP LAB	497, 497		497, 497	0	497, 497	69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	477, 477		0	0	477, 477	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 602, 552		1, 602, 552	0	1, 602, 552	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 464, 216		6, 464, 216	0	6, 464, 216	
73. 00 07300 DRUGS CHARGED TO PATIENTS	23, 354, 761		23, 354, 761	0	23, 354, 761	73.00
74. 00   07400   RENAL DI ALYSI S	23, 334, 701		23, 354, 701	0	23, 334, 701	
OUTPATIENT SERVICE COST CENTERS	0		0	<u> </u>		74.00
88. 00 08800 RURAL HEALTH CLINIC	774, 804		774, 804	0	774, 804	88. 00
88. 01   08801 RURAL HEALTH CLINIC   I	983, 756		983, 756	0	983, 756	
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	903, 730		963, 730	0	963, 730	89.00
90. 00   009000   FEDERALLY QUALIFIED HEALTH CENTER	1, 092, 756		1, 092, 756	0	1, 092, 756	
90. 01   09001   I MED	1,092,730		1,092,730	0	1,092,750	90.00
90. 01   09001   TWED 90. 02   09002   0NCOLOGY	5, 274, 012		5, 274, 012	0	5, 274, 012	90.01
90. 02   09002   0NCOLOGT 90. 03   09003   OUTPATI ENT CENTER	1, 292		1, 292	0	1, 292	
90. 04   09004   HBURG URGENT CARE CLINIC	1, 973, 854		1, 973, 854	ol ol	1, 973, 854	90.03
90. 04   09004   ABONG ONGENT CARE CLINIC 90. 05   09005 DI ABETES MGMT CLINIC	115, 170		115, 170	0	1, 973, 634	90.04
	1		•	0	· ·	
91. 00   09100   EMERGENCY 92. 00   09200   0BSERVATION   BEDS (NON-DISTINCT PART)	9, 042, 901		9, 042, 901	U U	9, 042, 901	91.00
, , , , , , , , , , , , , , , , , , , ,	3, 455, 561		3, 455, 561		3, 455, 561	92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	2 424 052		2 424 052	ol	2 424 052	95.00
	3, 426, 952		3, 426, 952 0	· · · · · · · · · · · · · · · · · · ·	3, 426, 952	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	2 41/ 4/5		·	0	0	96.00
101. 00 10100 HOME HEALTH AGENCY	3, 416, 465		3, 416, 465		3, 416, 465	101.00
SPECIAL PURPOSE COST CENTERS			1 ^		^	114 00
116.00 11600 HOSPICE 200.00  Subtotal (see instructions)	144 464 043	0	0	o		116.00
	144, 464, 943	0		١	144, 464, 943	
201.00 Less Observation Beds 202.00 Total (see instructions)	3, 455, 561 141, 009, 382	0	3, 455, 561	0	3, 455, 561	
202.00 [TOTAL (See LIISTRUCTIONS)	141,009,382	1	141, 009, 382	ı Y	141, 009, 382	12U2. UU

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0115 Peri od: Worksheet C From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/29/2022 11:30 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TEFRA + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 13, 614, 480 13, 614, 480 30.00 31.00 03100 INTENSIVE CARE UNIT 10, 372, 952 10, 372, 952 31.00 04000 SUBPROVI DER - I PF 2, 339, 364 2, 339, 364 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 1.437.174 1, 437, 174 41.00 04300 NURSERY 43.00 1, 683, 626 1, 683, 626 43.00 44.00 04400 SKILLED NURSING FACILITY 1,540,884 1, 540, 884 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 9, 345, 074 73, 305, 187 0. 229059 0.000000 50.00 82, 650, 261 50.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 2, 466, 544 31, 437 2, 497, 981 0.887609 0.000000 52 00 53.00 05300 ANESTHESI OLOGY 906, 929 4, 292, 644 5, 199, 573 0.297352 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 10, 759, 836 75, 338, 212 86, 098, 048 0.085708 0.000000 54.00 13, 148, 867 56.00 05600 RADI OI SOTOPE 0.082624 0.000000 379, 277 12, 769, 590 56.00 60.00 06000 LABORATORY 11, 771, 586 56, 585, 911 68, 357, 497 0.172726 0.000000 60.00 06500 RESPIRATORY THERAPY 2, 625, 334 65.00 4, 730, 486 7, 355, 820 0.368471 0.000000 65.00 06600 PHYSI CAL THERAPY 13, 549, 969 0.000000 66.00 6, 466, 461 7,083,508 0.314392 66,00 69 00 06900 ELECTROCARDI OLOGY 12, 843, 512 28, 105, 573 40, 949, 085 0.159181 0.000000 69 00 06901 PULMONARY 0.000000 0.000000 69.01 69.01 69.02 06902 CARDI OPULMONARY 1,053 1, 183, 593 1, 184, 646 0. 236443 0.000000 69.02 06903 SLEEP LAB 69.03 0 1, 474, 855 1, 474, 855 0.337319 0.000000 69.03 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0.000000 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 606, 010 8, 167, 175 10, 773, 185 0.148754 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 6, 648, 818 15, 695, 138 22, 343, 956 0. 289305 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 31, 245, 282 73.00 86,007,408 117, 252, 690 0 199183 0.000000 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0.000000 74.00 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 0 781, 635 781, 635 08801 RURAL HEALTH CLINIC II 88.01 0 965, 869 965, 869 88.01 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 90.00 09000 CLI NI C 81, 214 3, 782, 049 3, 863, 263 0. 282858 0.000000 90.00 90 01 09001 I MED 0 000000 0.000000 90 01 09002 ONCOLOGY 90.02 157, 776 22, 750, 861 22, 908, 637 0.230219 0.000000 90.02 90.03 09003 OUTPATIENT CENTER 0.000000 0.000000 90.03 90.04 09004 HBURG URGENT CARE CLINIC 7,936 4, 453, 563 4, 461, 499 0.442419 0.000000 90.04 09005 DIABETES MGMT CLINIC 0 779007 0.000000 90.05 90.05 147, 842 147, 842 10, 627, 613 51, 546, 386 91.00 09100 EMERGENCY 62, 173, 999 0.145445 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 7, 544, 425 8, 698, 387 0.397265 0.000000 92.00 92.00 1, 153, 962 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1, 279, 371 6, 211, 529 7, 490, 900 0.457482 0.000000 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0.000000 96.00 101.00 10100 HOME HEALTH AGENCY 3, 976, 571 3, 976, 571 101.00 0 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 142, 362, 068 476, 931, 447 619, 293, 515 200.00 201.00 Less Observation Beds 201.00 202.00 142, 362, 068 476, 931, 447 619, 293, 515 202.00 Total (see instructions)

Peri od: Worksheet C
From 07/01/2021 Part I
To 06/30/2022 Date/Time Prepared: 11/29/2022 11:30 am

			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient	THE AVIII	1103pi tui	113
	oost center bescription	Ratio			
		11. 00			
I NF	PATIENT ROUTINE SERVICE COST CENTERS				
	000 ADULTS & PEDIATRICS				30.00
	100 INTENSIVE CARE UNIT				31.00
	000 SUBPROVI DER - I PF				40.00
41.00 041	100 SUBPROVI DER - I RF				41.00
43.00 043	300 NURSERY				43.00
44. 00   044	400 SKILLED NURSING FACILITY				44.00
ANC	CILLARY SERVICE COST CENTERS				
50.00 050	OOO OPERATING ROOM	0. 229059			50.00
52. 00   052	200 DELIVERY ROOM & LABOR ROOM	0. 887609			52.00
	300 ANESTHESI OLOGY	0. 297352			53.00
	400 RADI OLOGY-DI AGNOSTI C	0. 085708			54.00
56. 00 056	600 RADI OI SOTOPE	0. 082624			56.00
60.00 060	DOO LABORATORY	0. 172726			60.00
	500 RESPI RATORY THERAPY	0. 368471			65.00
66.00 066	600 PHYSI CAL THERAPY	0. 314392			66.00
	900 ELECTROCARDI OLOGY	0. 159181			69.00
69. 01 069	901 PULMONARY	0. 000000			69. 01
69. 02 069	902 CARDI OPULMONARY	0. 236443			69. 02
69. 03 069	903 SLEEP LAB	0. 337319			69. 03
70.00 070	DOO ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00   071	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 148754			71.00
72. 00   072	200 IMPL. DEV. CHARGED TO PATIENTS	0. 289305			72. 00
73. 00   073	300 DRUGS CHARGED TO PATIENTS	0. 199183			73.00
	400 RENAL DIALYSIS	0. 000000			74. 00
רטס	TPAȚI ENT SERVI CE COST CENTERS				
88. 00 088	800 RURAL HEALTH CLINIC				88.00
88. 01   088	801 RURAL HEALTH CLINIC II				88. 01
	900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00 090	DOO CLI NI C	0. 282858			90.00
90. 01 090	OO1 I MED	0. 000000			90. 01
90. 02   090	OO2 ONCOLOGY	0. 230219			90. 02
90. 03   090	003 OUTPATIENT CENTER	0. 000000			90. 03
90. 04 090	004 HBURG URGENT CARE CLINIC	0. 442419			90.04
90. 05   090	005 DIABETES MGMT CLINIC	0. 779007			90.05
91.00 091	100 EMERGENCY	0. 145445			91.00
92. 00 092	200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 397265			92.00
OTH	HER REIMBURSABLE COST CENTERS				
95.00 095	500 AMBULANCE SERVICES	0. 457482			95.00
96. 00   096	600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
101.00 101	100 HOME HEALTH AGENCY				101.00
SPE	ECLAL PURPOSE COST CENTERS				
116. 00 116	600 HOSPI CE				116.00
200. 00	Subtotal (see instructions)				200. 00
201. 00	Less Observation Beds				201.00
202. 00	Total (see instructions)				202.00

					10 06/30/2022	11/29/2022 11	
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
30.00	03000 ADULTS & PEDI ATRI CS	12, 361, 547		12, 361, 54			
31.00	03100 INTENSIVE CARE UNIT	6, 277, 151		6, 277, 15		-, ,	
40.00	04000 SUBPROVI DER - I PF	2, 349, 077		2, 349, 07		, , .	1
41.00	04100 SUBPROVI DER - I RF	1, 224, 932		1, 224, 93		1, 224, 932	
43.00	04300 NURSERY	1, 205, 523		1, 205, 52			
44.00	04400 SKILLED NURSING FACILITY	2, 833, 439		2, 833, 43	9 0	2, 833, 439	44. 00
	ANCILLARY SERVICE COST CENTERS	,				1	
50. 00	05000 OPERATING ROOM	18, 931, 761		18, 931, 76			1
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 217, 230		2, 217, 23		, , , , , , , , , , , , , , , , , , , ,	
53.00	05300 ANESTHESI OLOGY	1, 546, 106		1, 546, 10		., ,	
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 379, 276		7, 379, 27		7, 379, 276	
56. 00	05600 RADI OI SOTOPE	1, 086, 412		1, 086, 41		, , .	
60.00	06000 LABORATORY	11, 807, 133		11, 807, 13		, ,	1
65. 00	06500 RESPI RATORY THERAPY	2, 710, 407	0	_, ,		_,	1
66. 00	06600 PHYSI CAL THERAPY	4, 260, 002	0	4, 260, 00		.,	
69. 00	06900 ELECTROCARDI OLOGY	6, 518, 297		6, 518, 29		6, 518, 297	
69. 01	06901 PULMONARY	0			0		
69. 02	06902 CARDI OPULMONARY	280, 101		280, 10		280, 101	
69. 03	06903 SLEEP LAB	497, 497		497, 49			1
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0	1	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 602, 552		1, 602, 55		1, 602, 552	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	6, 464, 216		6, 464, 21			
73.00	07300 DRUGS CHARGED TO PATIENTS	23, 354, 761		23, 354, 76			
74. 00	07400 RENAL DI ALYSI S	0			0 0	0	74. 00
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	774, 804		774, 80	4 0	774, 804	88. 00
88. 00	08801 RURAL HEALTH CLINIC	983, 756		983, 75			1
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	903, 730			0 0		1
90.00	09000 CLINIC	1, 092, 756		1, 092, 75	-		
90.00	09001 I MED	1, 092, 730		1,092,73	0 0	,	90.00
90. 01	09002 ONCOLOGY	5, 274, 012		5, 274, 01	-	1	
90. 02	09003 OUTPATIENT CENTER	1, 292		1, 29		1, 292	
90. 03	09004 HBURG URGENT CARE CLINIC	1, 973, 854		1, 973, 85		1, 973, 854	1
90.05	09005 DI ABETES MGMT CLINIC	115, 170		115, 17			1
91. 00	09100 EMERGENCY	9, 042, 901		9, 042, 90		9, 042, 901	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 455, 561		3, 455, 56		3, 455, 561	
72.00	OTHER REIMBURSABLE COST CENTERS	3, 433, 301		3, 433, 30	1	3, 433, 301	72.00
95.00	09500 AMBULANCE SERVICES	3, 426, 952		3, 426, 95	2 0	3, 426, 952	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0, 120, 702			0 0		1
	10100 HOME HEALTH AGENCY	3, 416, 465		3, 416, 46	-	3, 416, 465	1
	SPECIAL PURPOSE COST CENTERS	57 1.07 100		0,110,10	<u> </u>	57 1157 155	1.01.00
116.00	11600 HOSPI CE	0			o	0	116. 00
200.00		144, 464, 943	0				
201.00	1 ,	3, 455, 561		3, 455, 56		3, 455, 561	
202.00		141, 009, 382	0				
		,			,	•	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Peri od:

Provider CCN: 15-0115 Worksheet C From 07/01/2021 Part I Date/Time Prepared: 06/30/2022 11/29/2022 11:30 am Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TEFRA + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 13, 614, 480 13, 614, 480 30.00 31.00 03100 INTENSIVE CARE UNIT 10, 372, 952 10, 372, 952 31.00 04000 SUBPROVI DER - I PF 2, 339, 364 2, 339, 364 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 1.437.174 1, 437, 174 41.00 04300 NURSERY 43.00 1, 683, 626 1, 683, 626 43.00 44.00 04400 SKILLED NURSING FACILITY 1,540,884 1, 540, 884 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 9, 345, 074 73, 305, 187 0. 229059 0.000000 50.00 82, 650, 261 50.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 2, 466, 544 31, 437 2, 497, 981 0.887609 0.000000 52 00 53.00 05300 ANESTHESI OLOGY 906, 929 4, 292, 644 5, 199, 573 0.297352 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 10, 759, 836 75, 338, 212 86, 098, 048 0.085708 0.000000 54.00 56.00 05600 RADI OI SOTOPE 0.082624 0.000000 379, 277 12, 769, 590 13, 148, 867 56.00 60.00 06000 LABORATORY 11, 771, 586 56, 585, 911 68, 357, 497 0.172726 0.000000 60.00 06500 RESPIRATORY THERAPY 65.00 2, 625, 334 4, 730, 486 7, 355, 820 0.368471 0.000000 65 00 06600 PHYSI CAL THERAPY 13, 549, 969 66.00 6, 466, 461 7,083,508 0.314392 0.000000 66,00 69 00 06900 ELECTROCARDI OLOGY 12, 843, 512 28, 105, 573 40, 949, 085 0.159181 0.000000 69 00 06901 PULMONARY 0.000000 0.000000 69.01 69.01 69.02 06902 CARDI OPULMONARY 1,053 1, 183, 593 1, 184, 646 0. 236443 0.000000 69.02 06903 SLEEP LAB 69.03 0 1, 474, 855 1, 474, 855 0.337319 0.000000 69.03 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0.000000 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 606, 010 8, 167, 175 10, 773, 185 0.148754 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 6, 648, 818 15, 695, 138 22, 343, 956 0. 289305 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 31, 245, 282 73.00 86,007,408 117, 252, 690 0 199183 0.000000 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0.000000 74.00 OUTPATIENT SERVICE COST CENTERS 88.00 0. 991261 0.000000 88.00 08800 RURAL HEALTH CLINIC 0 781, 635 781, 635 08801 RURAL HEALTH CLINIC II 1.018519 88.01 0 965, 869 965, 869 0.000000 88 01 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 0.000000 89.00 90.00 09000 CLI NI C 81, 214 3, 782, 049 3, 863, 263 0. 282858 0.000000 90.00 90 01 09001 I MED 0.000000 0.000000 90 01 09002 ONCOLOGY 90.02 157, 776 22, 750, 861 22, 908, 637 0.230219 0.000000 90.02 90.03 09003 OUTPATIENT CENTER 0.000000 0.000000 90.03 90.04 09004 HBURG URGENT CARE CLINIC 7,936 4, 453, 563 4, 461, 499 0.442419 0.000000 90.04 09005 DIABETES MGMT CLINIC 0 779007 0.000000 90.05 90.05 147, 842 147, 842 10, 627, 613 91.00 09100 EMERGENCY 51, 546, 386 62, 173, 999 0.145445 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 8, 698, 387 0.397265 0.000000 92.00 92.00 1, 153, 962 7, 544, 425 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1, 279, 371 6, 211, 529 7, 490, 900 0.457482 0.000000 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0.000000 96.00 101.00 10100 HOME HEALTH AGENCY 3, 976, 571 3, 976, 571 101.00 0 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 142, 362, 068 476, 931, 447 619, 293, 515 200.00 201.00 Less Observation Beds 201.00 202.00 142, 362, 068 476, 931, 447 619, 293, 515 Total (see instructions) 202.00

06/30/2022 Date/Time Prepared: 11/29/2022 11:30 am Title XIX Hospi tal Cost PPS Inpatient Cost Center Description Ratio 11.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31 00 31.00 40. 00 |04000 | SUBPROVI DER - I PF 40.00 41.00 04100 SUBPROVI DER - I RF 41.00 04300 NURSERY 43.00 43.00 44.00 04400 SKILLED NURSING FACILITY 44 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 53. 00 | 05300 | ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 56.00 05600 RADI OI SOTOPE 0.000000 56.00 60.00 06000 LABORATORY 0. 000000 60.00 06500 RESPIRATORY THERAPY 65.00 0. 000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 06901 PULMONARY 0.000000 69.01 69.01 06902 CARDI OPULMONARY 0.000000 69 02 69.02 69.03 06903 SLEEP LAB 0.000000 69.03 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 07400 RENAL DIALYSIS 74.00 0.000000 74.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 88.00 08801 RURAL HEALTH CLINIC II 88. 01 0.000000 88.01 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0.000000 89.00 90.00 09000 CLI NI C 0.000000 90.00 90.01 09001 I MED 0.000000 90.01 90. 02 09002 ONCOLOGY 0.000000 90.02 90.03 09003 OUTPATIENT CENTER 0.000000 90.03 90.04 09004 HBURG URGENT CARE CLINIC 0.000000 90.04 90.05 09005 DIABETES MGMT CLINIC 0.000000 90.05 91.00 09100 EMERGENCY 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0.000000 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 96.00 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE 116.00

200.00

201.00

202.00

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Health Financial Systems ME	MORIAL HOSP & I	HEALTH CARE CTE	₹	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part I Date/Time Pre 11/29/2022 11	epared:
		Title	: XVIII	Hospi tal PPS		
Cost Center Description	Capi tal Related Cost	Swing Bed Adjustment	Reduced Capi tal	Total Patient Days	Per Diem (col. 3 /	
	(from Wkst.	Aujustillerit	Related Cost		col. 4)	
	B, Part II,		(col. 1 -		(01. 4)	
	col. 26)		col . 2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	738, 833	0	738, 83	3 12, 313	60.00	30.00
31.00 INTENSIVE CARE UNIT	342, 317		342, 31			31.00
40. 00 SUBPROVI DER - I PF	253, 325	0	253, 32			
41. 00 SUBPROVI DER - I RF	133, 221	0	133, 22			
43. 00 NURSERY	86, 604		86, 60	· ·		
44.00 SKILLED NURSING FACILITY	158, 606		158, 60	· ·		1
200.00 Total (lines 30 through 199)	1, 712, 906		1, 712, 90	6 25, 030		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
	6. 00	col . 6) 7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	3, 556	213, 360				30.00
31. 00   INTENSIVE CARE UNIT	1, 641		•			31.00
40. 00 SUBPROVIDER - I PF	290		•			40.00
41. 00 SUBPROVI DER – I RF	559		•			41.00
43. 00 NURSERY	0		1			43.00
44.00 SKILLED NURSING FACILITY	3, 138	114, 411				44.00
200.00 Total (lines 30 through 199)	9, 184					200.00

MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0115 Peri od: Worksheet D From 07/01/2021 Part II 06/30/2022 Date/Time Prepared: 11/29/2022 11:30 am Title XVIII Hospi tal Total Charges Ratio of Cost Capital Costs Cost Center Description Capi tal Inpati ent to Charges (column 3 x Related Cost (from Wkst. Program (from Wkst. C, Part I, (col. 1 ÷ Charges column 4) B, Part II, col. 8) col. 2) col. 26) 1. 00 4. 00 5. 00 2.00 3.00 ANCILLARY SERVICE COST CENTERS 50 00 50 00 05000 OPERATING ROOM 963 084 82, 650, 261 0.011653 4, 370, 128 50.925 05200 DELIVERY ROOM & LABOR ROOM 166, 200 2, 497, 981 0.066534 52.00 52.00 05300 ANESTHESI OLOGY 5, 199, 573 53.00 5, 528 0.001063 342, 830 364 53.00 329, 492 05400 RADI OLOGY-DI AGNOSTI C 86, 098, 048 5, 457, 706 54.00 0.003827 20,887 54.00 56.00 05600 RADI OI SOTOPE 22, 881 13, 148, 867 0.001740 179, 254 312 56.00 60.00 06000 LABORATORY 181, 163 68, 357, 497 0.002650 4, 623, 251 12, 252 60.00 65.00 06500 RESPIRATORY THERAPY 62, 302 7, 355, 820 0.008470 1,007,451 8, 533 65.00 140, 440 1, 477, 539 66.00 06600 PHYSI CAL THERAPY 13, 549, 969 0.010365 15, 315 66,00 69.00 06900 ELECTROCARDI OLOGY 307, 014 40, 949, 085 0.007497 5, 807, 212 43, 537 69.00 69.01 06901 PULMONARY 0.000000 69.01 06902 CARDI OPULMONARY 36, 514 1, 184, 646 0.030823 0 69.02 69.02 0 06903 SLEEP LAB 0.029018 69.03 42, 798 1, 474, 855 0 0 69.03 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 5, 740 10, 773, 185 0.000533 1, 297, 563 692 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 10, 995 4, 012, 332 22, 343, 956 0.000492 1 974 72.00 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 121, 125 117, 252, 690 0.001033 11, 561, 112 11, 943 73.00 07400 RENAL DIALYSIS 74.00 0.000000 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 44, 232 781, 635 0.056589 0 Ω 88.00 88.01 08801 RURAL HEALTH CLINIC II 100,084 965, 869 0.103621 0 0 88.01 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0.000000 0 89.00 90 00 09000 CLI NI C 128. 199 3, 863, 263 0.033184 40, 174 1, 333 90 00 09001 I MED 90.01 0.000000 0 90.01 90.02 09002 ONCOLOGY 281, 151 22, 908, 637 0.012273 81, 742 1,003 90.02 90.03 09003 OUTPATIENT CENTER 99 0.000000 0 90.03 09004 HBURG URGENT CARE CLINIC 90 04 128 971 4, 461, 499 0.028908 2.050 59 90 04 90.05 09005 DIABETES MGMT CLINIC 12, 440 147, 842 0.084144 0 90.05 09100 EMERGENCY 260, 084 62, 173, 999 0.004183 4, 986, 344 20, 858 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 206, 535 8, 698, 387 0.023744 412, 577 9.796 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 96.00 Total (lines 50 through 199) 3, 557, 071 200.00 576, 837, 564 45, 659, 265 199, 783 200. 00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	ER PASS THROUGH COS	STS Provider C	F	eriod: rom 07/01/2021 o 06/30/2022	Worksheet D Part III Date/Time Pre 11/29/2022 11	pared: :30 am
		Ti tl e	XVIII	Hospi tal	PPS	_
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATI ENT ROUTINE SERVI CE COST CENTERS   30.00   03000   ADULTS & PEDI ATRI CS   31.00   03100   INTENSI VE CARE UNI T   40.00   04000   SUBPROVI DER - I PF   41.00   04100   SUBPROVI DER - I RF   43.00   04300   NURSERY   04300   NURSERY   04300   NURSERY   04300   04300   NURSERY   04300   04300   NURSERY   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   04300   043	0 0 0 0 0 0 0		1	0 0 0 0	0 0 0 0	31. 00 40. 00 41. 00 43. 00
44.00 04400 SKILLED NURSING FACILITY	0	C	0	0	_	44.00
200. 00 Total (lines 30 through 199)	0	C	0	0		200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 40. 00   04000   SUBPROVI DER - I PF 41. 00   04100   SUBPROVI DER - I RF 43. 00   04300   NURSERY 44. 00   04400   SKI LLED   NURSI NG   FACI LI TY Total (Lines 20 through 100)	0 0	C	4, 472 1, 337 958 1, 600 4, 350	0. 00 0. 00 0. 00 0. 00 0. 00	3, 556 1, 641 290 559 0 3, 138	31. 00 40. 00 41. 00 43. 00 44. 00
200.00 Total (lines 30 through 199)  Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		nj 25, U3U		9, 184	200.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 40. 00   04000   SUBPROVI DER - I PF 41. 00   04100   SUBPROVI DER - I RF	0 0 0					30. 00 31. 00 40. 00 41. 00
43.00   04300   NURSERY 44.00   04400   SKILLED   NURSING FACILITY	0					43.00

30.00 31. 00 40. 00 41.00 43. 00 44. 00

200.00

44.00 | 04400 | SKILLED NURSING FACILITY | 200.00 | Total (lines 30 through 199)

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0115 Peri od: Worksheet D From 07/01/2021 Part IV To 06/30/2022 Date/Time Prepared: THROUGH COSTS

					. 0 00, 00, 2022	11/29/2022 11	: 30 am
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	·	Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS				_		
50.00	05000 OPERATING ROOM	0	0		0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
56.00	05600 RADI OI SOTOPE	0	0		0	0	56.00
60.00	06000 LABORATORY	0	0		0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
69. 01	06901 PULMONARY	0	0		0	0	69. 01
69. 02	06902 CARDI OPULMONARY	0	0		0	0	69. 02
69. 03	06903 SLEEP LAB	0	0		0	0	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l o		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
	OUTPATIENT SERVICE COST CENTERS	•	•	•	<u> </u>	•	
88.00	08800 RURAL HEALTH CLINIC	0	0	(	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0		0	0	88. 01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00
90.00	09000 CLI NI C	0	0		0	0	90.00
90. 01	09001 I MED	0	0		0	0	90. 01
90.02	09002 ONCOLOGY	0	0		0	0	90. 02
90. 03	09003 OUTPATI ENT CENTER	0	0		0	0	90. 03
90.04	09004 HBURG URGENT CARE CLINIC	0	0		0	0	90.04
90.05	09005 DIABETES MGMT CLINIC	0	0		0	0	90.05
91.00	09100 EMERGENCY	0	0		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			)	0	92.00
	OTHER REIMBURSABLE COST CENTERS				•		
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	1
200.00	1 1	0	0		0	0	200.00
		•	•	•	•	•	•

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0115 THROUGH COSTS

						Date/Time Pre 11/29/2022 11	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
			sum of cols.	Outpati ent	(from Wkst.	to Charges	
			1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col . 8)	col . 7)	
				and 4)		(see	
		4.00			7.00	instructions)	
	ANGLILIADY CEDVICE COCT CENTERS	4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS    05000   OPERATING ROOM		0		82, 650, 261	0. 000000	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	(		0.00000	50.00
		0	0			l .	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0		5, 199, 573		1
	05600 RADI OLOGY-DI AGNOSTI C	0	0		86, 098, 048 13, 148, 867	l	
	06000 LABORATORY	0	0	1	10, 110, 00,	1	
	06500 RESPI RATORY THERAPY	0	0	(			
	06600 PHYSI CAL THERAPY	0	0		7, 355, 820	<b>l</b>	66.00
	06900 ELECTROCARDI OLOGY	0	0		13, 549, 969 40, 949, 085		
	06901 PULMONARY	0	0		0 40, 949, 085	0.00000	
	06901 CARDI OPULMONARY	0	0		1, 184, 646	<b>l</b>	
	06903 SLEEP LAB	0	0		1, 164, 846	l e	
	07000 ELECTROENCEPHALOGRAPHY		0		0 1,474,633	0.00000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		10, 773, 185		
	07200 IMPL. DEV. CHARGED TO PATIENTS		0				
	07300 DRUGS CHARGED TO PATIENTS		0			<b>l</b>	
	07400 RENAL DIALYSIS		0			i e	
	OUTPATIENT SERVICE COST CENTERS	ı o			0	0.000000	74.00
	08800 RURAL HEALTH CLINIC	0	0		781, 635	0.000000	88. 00
	08801 RURAL HEALTH CLINIC II		0				
	08900 FEDERALLY QUALIFIED HEALTH CENTER	l ol	0	(	0	0. 000000	
	09000 CLINIC	l ol	0	(	3, 863, 263	0. 000000	
	09001 I MED	l ol	0		0 0	0. 000000	
90. 02	09002 ONCOLOGY	o	0		22, 908, 637	0.000000	
	09003 OUTPATIENT CENTER	o	0		0	0.000000	
	09004 HBURG URGENT CARE CLINIC	o	0		4, 461, 499	l	
	09005 DI ABETES MGMT CLINIC	o	0		147, 842		
91.00	09100 EMERGENCY		0		62, 173, 999	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	0		8, 698, 387	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS	<u>'</u>				<u> </u>	
95.00	09500 AMBULANCE SERVICES						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(	0	0. 000000	96.00
200.00	Total (lines 50 through 199)	o	0	(	576, 837, 564		200.00

alth Financial	Systems	MEMORI AL	HOSP & HEAD	LTH CARE	CTR	In Li	eu of Form CMS-2552-10

Health Financial Systems	ME	MORIAL HOSP & HE	EALTH CARE CTE	?	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENTHROUGH COSTS	NT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS		<u>!</u>	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Pre 11/29/2022 11	pared: :30 am
			Title	XVIII	Hospi tal	PPS	
Cost Center I	Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷		Costs (col. 8	3	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13.00	
ANCILLARY SERVICE		·					
50.00 05000 OPERATING RO		0. 000000	4, 370, 128	(	0 19, 144, 124	0	50.00
52. 00   05200   DELI VERY ROOF		0. 000000	0		0	0	52.00
53. 00   05300   ANESTHESI OLO		0. 000000	342, 830		0 1, 375, 193	0	53.00
54. 00   05400 RADI OLOGY-DI	AGNOSTI C	0. 000000	5, 457, 706	(	0 22, 176, 617	0	54.00
56. 00   05600   RADI 0I SOTOPE		0. 000000	179, 254	(	5, 626, 957	0	56.00
60. 00   06000   LABORATORY		0. 000000	4, 623, 251	(	0 6, 897, 945	0	60.00
65. 00 06500 RESPIRATORY	THERAPY	0. 000000	1, 007, 451	(	1, 008, 206	0	65.00
66. 00 06600 PHYSI CAL THEI	RAPY	0. 000000	1, 477, 539		0 195, 735	0	66.00
69. 00 06900 ELECTROCARDI	OLOGY	0. 000000	5, 807, 212		0 11, 923, 755	0	69.00
69. 01 06901 PULMONARY		0. 000000	0		0	0	69. 01
69. 02 06902 CARDI OPULMONA	ARY	0. 000000	0		0 652, 960	0	69. 02
69. 03 06903 SLEEP LAB		0. 000000	0		0 417, 510	0	69. 03
70. 00 07000 ELECTROENCEPI	HALOGRAPHY	0. 000000	0		0 0	0	70.00
	LIES CHARGED TO PATIENTS	0. 000000	1, 297, 563		2, 345, 303	0	71.00
72. 00   07200   MPL. DEV. CI		0. 000000	4, 012, 332		6, 448, 026	0	72.00
73. 00 07300 DRUGS CHARGEI		0. 000000	11, 561, 112	ĺ	0 37, 553, 886	0	73.00
74. 00 07400 RENAL DI ALYSI		0. 000000	0		0 0	Ö	74.00
OUTPATIENT SERVICE		0.00000			<u> </u>		,
88. 00 08800 RURAL HEALTH		0. 000000	0	(	0 0	0	88. 00
88. 01   08801 RURAL HEALTH		0. 000000	0		0	0	88. 01
	ALIFIED HEALTH CENTER	0. 000000	0	ĺ	0	Ö	89.00
90. 00   09000   CLINIC	TELL TED TIETETH GENTER	0. 000000	40, 174		0 1, 211, 377	0	90.00
90. 01 09001 I MED		0. 000000	10, 17 1		0 1,211,077	0	90. 01
90. 02 09002 ONCOLOGY		0. 000000	81, 742		9, 491, 185	0	90.02
90. 03 09003 OUTPATIENT CI	ENTER	0. 000000	01, 712		n ,, 1, 1, 1, 100	0	90.03
90. 04 09004 HBURG URGENT		0. 000000	2, 050	'	362, 129	0	90.04
90. 05 09005 DI ABETES MGM		0. 000000	2,030		0 302, 127	0	90.05
91. 00 09100 EMERGENCY	CETIVIO	0. 000000	4, 986, 344		11, 820, 138	Ö	91.00
	BEDS (NON-DISTINCT PART)	0. 000000	412, 577		997, 533	0	92.00
OTHER REIMBURSABLE		0.000000	712, 377	· · · · · · · · · · · · · · · · · · ·	777, 333	0	72.00
95. 00 09500 AMBULANCE SEI							95.00
96. 00 09600 DURABLE MEDIC		0. 000000	n	1	0	0	
	50 through 199)	0.000000	45, 659, 265		0 139, 648, 579	_	200.00
200.00   1000 (11100	55 t odgii 177)	1	10, 007, 200	'	107,010,077		1-30.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0115 Peri od: Worksheet D From 07/01/2021 Part V Date/Time Prepared: 06/30/2022 11/29/2022 11:30 am Title XVIII Hospi tal Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 2.00 5.00 1.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 229059 19, 144, 124 4, 385, 134 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0.887609 0 52.00 0 53.00 05300 ANESTHESI OLOGY 0. 297352 1, 375, 193 408, 916 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.085708 22, 176, 617 0 0 1, 900, 713 54.00 56.00 05600 RADI OI SOTOPE 0.082624 5, 626, 957 0 0 464, 922 56.00 06000 LABORATORY 6, 897, 945 0 60. nn 0.172726 1, 191, 454 427 60.00 06500 RESPIRATORY THERAPY 0 65.00 0.368471 1,008,206 0 371, 495 65.00 66.00 06600 PHYSI CAL THERAPY 0. 314392 195, 735 0 61,538 66.00 11, 923, 755 0 o 1, 898, 035 06900 ELECTROCARDI OLOGY 69.00 0.159181 69.00 0 06901 PULMONARY 0 69.01 0.000000 Ω 69.01 69.02 06902 CARDI OPULMONARY 0.236443 652, 960 154, 388 69.02 06903 SLEEP LAB 0 0 69.03 0.337319 417, 510 140, 834 69.03 07000 ELECTROENCEPHALOGRAPHY 0 0 70 00 0.000000 70 00 0 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.148754 2, 345, 303 0 0 348, 873 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 289305 6, 448, 026 0 0 1, 865, 446 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0. 199183 37, 553, 886 0 38, 462 7, 480, 096 73.00 07400 RENAL DIALYSIS 0 0.000000 74 00 74.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 88.01 08801 RURAL HEALTH CLINIC II 88.01 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 89 00 90.00 09000 CLI NI C 0. 282858 1, 211, 377 342, 648 90.00 09001 I MED 0.000000 0 90.01 90.01 0 09002 ONCOLOGY 0. 230219 0 90.02 9, 491, 185 2, 185, 051 90.02 0 09003 OUTPATIENT CENTER 0.000000 90.03 0 90.03 90.04 09004 HBURG URGENT CARE CLINIC 0.442419 362, 129 0 0 160, 213 90.04 0 90.05 09005 DIABETES MGMT CLINIC 0.779007 0 0 90.05 0 09100 EMERGENCY 11, 820, 138 1, 719, 180 91 00 0.145445 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0. 397265 997, 533 0 396, 285 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 457482 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 96.00 0.000000 0 0 0 200.00 Subtotal (see instructions) 139, 648, 579 38, 889 25, 475, 221 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 25, 475, 221 202. 00 202.00 Net Charges (line 200 - line 201) 0 38.889 139, 648, 579

In Lieu of Form CMS-2552-10 Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0115 Peri od: Worksheet D From 07/01/2021 Part V 06/30/2022 Date/Time Prepared: 11/29/2022 11:30 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.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000000000 52.00 52.00 0 53.00 05300 ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 56.00 05600 RADI OI SOTOPE 0 56.00 06000 LABORATORY 74 0 60. nn 60.00 06500 RESPIRATORY THERAPY 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 0 69.00 06900 ELECTROCARDI OLOGY 69.00 06901 PULMONARY 0 69.01 69.01 69.02 06902 CARDI OPULMONARY 0 69.02 06903 SLEEP LAB 0 69.03 69.03 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 7,661 07400 RENAL DIALYSIS 74.00 74 00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 88.01 08801 RURAL HEALTH CLINIC II 88.01 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 89 00 90.00 09000 CLI NI C 90.00 90.01 09001 I MED 00000 90.01 09002 ONCOLOGY 0 90.02 90.02 09003 OUTPATIENT CENTER 0 90.03 90.03 90.04 09004 HBURG URGENT CARE CLINIC 0 90.04 09005 DIABETES MGMT CLINIC 90.05 0 90.05 09100 EMERGENCY 91 00 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 0 95.00 09500 AMBULANCE SERVICES 95.00

0

0

0

7, 735

7, 735

96.00

200.00

201.00

202.00

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

Only Charges

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

200.00

201.00

	Figure 1 Control	MODIAL HOCD A	UEAL THE CARE OFF		111	. C. F OHC . /	2550 40
	Financial Systems ME TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	MORIAL HOSP & F	Provider C		Period:	u of Form CMS-2 Worksheet D	2552-10
APPURI	TONWENT OF INPATTENT ANCILLARY SERVICE CAPITA	AL 00313	Provider C	UN. 13-0113	From 07/01/2021	Part II	
			· ·	CCN: 15-S115	To 06/30/2022	Date/Time Pre 11/29/2022 11	pared: :30 am_
				XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col . 2)			
		col . 26)	0.00	0.00		5 00	
	ANOULLARY OFFICE OF COST OFFITERS	1. 00	2.00	3. 00	4. 00	5. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	0/0.004	00 (50 0(4	0.04475			
50.00	05000 OPERATING ROOM	963, 084				0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	166, 200		0.06653		0	52.00
53.00	05300 ANESTHESI OLOGY	5, 528				0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	329, 492				100	1
56.00	05600 RADI OI SOTOPE	22, 881				0	56.00
60.00	06000 LABORATORY	181, 163				206	60.00
65.00	06500 RESPI RATORY THERAPY	62, 302				3	65.00
66. 00 69. 00	06600   PHYSI CAL THERAPY   06900   ELECTROCARDI OLOGY	140, 440				12	1
69. 00	06900 PULMONARY	307, 014 0			· ·	29	69.00
69. 01	06902 CARDI OPULMONARY			0.0000			69.01
69. 02	06903 SLEEP LAB	36, 514				0	69.02
	1	42, 798 0					
70. 00 71. 00	07000   ELECTROENCEPHALOGRAPHY   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	5. 740	1				71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10, 995					71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	121, 125				57	73.00
74.00	07400 RENAL DI ALYSI S	121, 125					•
74.00	OUTPATIENT SERVICE COST CENTERS	0		0.00000	0	U	74.00
88. 00	08800 RURAL HEALTH CLINIC	44, 232	781, 635	0. 05658	9 0	0	88.00
88. 01	08801 RURAL HEALTH CLINIC II	100, 084				0	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0					89.00
90.00	09000 CLINIC	128, 199	-			Ö	90.00
90. 01	09001 I MED	120, 177		0. 00000			90.00
90. 02	09002 ONCOLOGY	281, 151	-			Ö	ł
90. 03	09003 OUTPATIENT CENTER	99				0	90.03
90. 04	09004 HBURG URGENT CARE CLINIC	128, 971	1			Ö	90.04
90. 05	09005 DI ABETES MGMT CLINIC	12, 440				0	90.05
91.00	09100 EMERGENCY	260, 084				366	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	
	OTHER REIMBURSABLE COST CENTERS	1				J.	
95.00	09500 AMBULANCE SERVICES	_	_	0.000	-	_	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	1			0	
200.00	Total (lines 50 through 199)	3, 350, 536	576, 837, 564	I	252, 055	1/3	200. 00

	Figure 1 of Contract	EMORIAL LIGOR & L	JEALTH CARE OTTE			1 . 11 .	. C. F OHC .	0550 40
	Financial Systems ME TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	EMORIAL HOSP & F RVICE OTHER PAS				i od:	u of Form CMS-2 Worksheet D	2552-10
THROUG	H COSTS		Component	CCN: 15-S115	From To	m 07/01/2021 06/30/2022	Part IV Date/Time Pre 11/29/2022 11	
			Title	XVIII	Sul	bprovi der  - I PF	PPS	
	Cost Center Description	Non Physician		Nursi ng		lied Health	Allied Health	
		Anesthetist	Program	Program		ost-Stepdown		
		Cost	Post-Stepdown			Adjustments		
		1. 00	Adjustments 2A	2.00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	ZA	2.00		SA	3.00	
50.00	05000 OPERATING ROOM	0	0		0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	Ö	
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	ő	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
56.00	05600 RADI OI SOTOPE	0	0		0	0	0	56.00
60.00	06000 LABORATORY	0	0		0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0		0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69. 00
69. 01	06901 PULMONARY	0	0		0	0	0	
69. 02	06902 CARDI OPULMONARY	0	0		0	0	0	69. 02
69. 03	06903 SLEEP LAB	0	0		0	0	0	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
	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 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		0	0	0	73.00 74.00
74.00	OUTPATIENT SERVICE COST CENTERS	0	0		U	U	U	74.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	-		0	0	0	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	0	
90.00	09000 CLINIC	0	0		0	0	Ö	90.00
90. 01	09001 I MED	0	0		0	0	o o	90.01
90. 02	09002 ONCOLOGY	0	0		0	0	0	90. 02
90. 03	09003 OUTPATIENT CENTER	0	0		0	0	0	90. 03
90.04	09004 HBURG URGENT CARE CLINIC	0	0		0	0	0	90. 04
90. 05	09005 DI ABETES MGMT CLINIC	0	0		0	0	0	90. 05
	09100 EMERGENCY	0	0		0	0	0	
02 00	OOOOO ORCEDVATION REDC (NON DISTINCT DART)	1	I	ı			۸ .	02 00

0

0

0 200.00

0 92.00 95.00 0 96.00

Total (lines 50 through 199)

<b>APPORT</b>	Financial Systems MEI TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	MORIAL HOSP & F RVICE OTHER PAS		CN: 15-0115	Period: From 07/01/2021	u of Form CMS-2 Worksheet D Part IV	
TTIKOOC			Component		To 06/30/2022		pared: :30 am
			Title	xVIII	Subprovi der - I PF	PPS	
	Cost Center Description	All Other	Total Cost	Total	9		
		Medical Education	(sum of cols. 1, 2, 3, and	Outpatient Cost (sum of	(from Wkst. C, Part I,	to Charges (col. 5 ÷	
		Cost	1, 2, 3, and 4)	col s. 2, 3,	col. 8)	col . 7)	
		0031	7)	and 4)	COI. 0)	(see	
						instructions)	
		4. 00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS				_		
50.00	05000 OPERATING ROOM	0	0	1	0 82, 650, 261	0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0 2, 497, 981	0. 000000	
53.00	05300 ANESTHESI OLOGY	0	0		0 5, 199, 573	0. 000000	
54. 00 56. 00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	0	0		0 86, 098, 048 0 13, 148, 867	0. 000000 0. 000000	
60.00	06000 LABORATORY	0	0	1	0 13, 148, 867 0 68, 357, 497	0.000000	
65.00	06500 RESPIRATORY THERAPY	0	0	1	0 7, 355, 820		
66.00	06600 PHYSI CAL THERAPY	0	0	1	0 13, 549, 969	0. 000000	
69.00	06900 ELECTROCARDI OLOGY	0	0	1	0 40, 949, 085	0. 000000	
69. 01	06901 PULMONARY	0	0		0 0	0. 000000	
69. 02	06902 CARDI OPULMONARY	0	0		0 1, 184, 646	0.000000	69. 02
69. 03	06903 SLEEP LAB	0	0		0 1, 474, 855	0. 000000	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	l .	0	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0 10, 773, 185	0. 000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	0 22, 343, 956	0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 117, 252, 690	0. 000000	
74. 00	07400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	0	0		0 0	0. 000000	74.00
88.00	08800 RURAL HEALTH CLINIC	0	0		0 781, 635	0. 000000	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0		0 965, 869	0.000000	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.000000	89. 00
90.00	09000 CLI NI C	0	0		0 3, 863, 263	0. 000000	1
90. 01	09001   I MED	0	0	1	0 0	0. 000000	1
90. 02	09002 ONCOLOGY	0	0		0 22, 908, 637	0. 000000	1
90. 03 90. 04	09003 OUTPATIENT CENTER 09004 HBURG URGENT CARE CLINIC	0	0		0 0 4, 461, 499	0.000000	1
90.04	09005 DIABETES MGMT CLINIC	0	0		0 4, 461, 499 0 147, 842	0. 000000 0. 000000	
91.00	09100 EMERGENCY	0	0		0 62, 173, 999		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1	0 8, 698, 387	0. 000000	
	OTHER REIMBURSABLE COST CENTERS			1	2,2.2,007	2: 223000	1
95.00	09500 AMBULANCE SERVICES						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0. 000000	
200.00	Total (lines 50 through 199)	0	0	d .	0 576, 837, 564		200.00

	MORIAL HOSP & HE				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der Co		Peri od:	Worksheet D	
THROUGH COSTS		Component (		From 07/01/2021 To 06/30/2022		pared: :30 am
		Title	: XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8	3	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0. 000000	0		0		50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000	0				52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000	0	(	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	26, 053	•		0	54.00
56. 00   05600   RADI 0I SOTOPE	0. 000000	0	(	0	0	56.00
60. 00  06000  LABORATORY	0. 000000	77, 640	(	0	0	60.00
65. 00  06500 RESPI RATORY THERAPY	0. 000000	367			0	65.00
66. 00  06600 PHYSI CAL THERAPY	0. 000000	1, 136			0	66. 00
69. 00  06900  ELECTROCARDI OLOGY	0. 000000	3, 885		0	0	69. 00
69. 01  06901  PULMONARY	0. 000000	0			0	69. 01
69. 02  06902  CARDI OPULMONARY	0. 000000	0			0	69. 02
69. 03   06903   SLEEP LAB	0. 000000	0		-	1	69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		-	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	19			0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0			0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	55, 442	(			73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000	0	(	0	0	74.00
OUTPATIENT SERVICE COST CENTERS			1			
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0			_	88. 00
88. 01   08801   RURAL HEALTH CLINIC II	0. 000000	0				88. 01
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0			1	89.00
90. 00   09000   CLI NI C	0. 000000	0			1	90.00
90. 01   09001   I MED	0. 000000	0			1	90. 01
90. 02   09002   0NCOLOGY	0. 000000	0			1	90.02
90. 03 09003 OUTPATIENT CENTER	0. 000000	0	(		1	90. 03
90. 04   09004   HBURG URGENT CARE CLINIC	0. 000000	0			1	90.04
90. 05 09005 DI ABETES MGMT CLINIC	0.000000	07 512			1	90.05
91. 00 09100 EMERGENCY	0.000000	87, 513				91.00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0	0	92.00
95. 00 09500 AMBULANCE SERVICES	T					95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	0	
200.00 Total (lines 50 through 199)	0.000000	252, 055	•			200.00
200.00   Total (Trilos 00 till ough 177)	1	202, 000	`	0	,	1200.00

				_			
		MORIAL HOSP & I				u of Form CMS-1	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 07/01/2021	Worksheet D Part II	
			Component		To 06/30/2022	Date/Time Pre 11/29/2022 11	pared: :30 am
				XVIII	Subprovi der – I RF	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col . 2)			
		col. 26)					
		1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	963, 084		0. 01165		0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	166, 200		0. 06653		0	52.00
53.00	05300 ANESTHESI OLOGY	5, 528	5, 199, 573			0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	329, 492	86, 098, 048	0. 00382	7 11, 378	44	54.00
56.00	05600 RADI OI SOTOPE	22, 881		0.00174		0	56.00
60.00	06000 LABORATORY	181, 163	68, 357, 497	0. 00265	0 44, 417	118	60.00
65.00	06500 RESPIRATORY THERAPY	62, 302	7, 355, 820	0. 00847	0 5, 601	47	65.00
66.00	06600 PHYSI CAL THERAPY	140, 440	13, 549, 969	0. 01036	5 833, 268	8, 637	66.00
69.00	06900 ELECTROCARDI OLOGY	307, 014	40, 949, 085	0.00749	7 12, 122	91	69.00
69. 01	06901 PULMONARY	0	0	0. 00000	0 0	0	69. 01
69. 02	06902 CARDI OPULMONARY	36, 514	1, 184, 646	0. 03082	3 0	0	69. 02
69. 03	06903 SLEEP LAB	42, 798	1, 474, 855	0. 02901	8 0	0	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0.00000	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 740	10, 773, 185			1	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	10, 995			· ·	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	121, 125				161	73.00
74. 00	07400 RENAL DI ALYSI S	0		0. 00000		0	1
, ,, ,,	OUTPATIENT SERVICE COST CENTERS			0.0000	<u> </u>		7 00
88. 00	08800 RURAL HEALTH CLINIC	44, 232	781, 635	0. 05658	9 0	0	88.00
88. 01	08801 RURAL HEALTH CLINIC II	100, 084				0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0.00000		0	89. 00
90.00	09000 CLINIC	128, 199	-			_	90.00
90. 01	09001 I MED	0	0,000,200	0. 00000		0	
90. 02	09002 ONCOLOGY	281, 151	22, 908, 637	0. 01227		0	
90. 03	09003 OUTPATIENT CENTER	99		0.00000		0	90.03
90. 04	09004 HBURG URGENT CARE CLINIC	128, 971		•		0	
90. 05	09005 DI ABETES MGMT CLINIC	12, 440		0.08414		0	90.05
91. 00	09100 EMERGENCY	260, 084				1	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	200,004		0.00000		0	
72.00	OTHER REIMBURSABLE COST CENTERS		0,070,307	0.00000	0  0	0	72.00
95.00	09500 AMBULANCE SERVI CES						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.00000	0	0	
200.00	Total (lines 50 through 199)	3, 350, 536	576, 837, 564		1, 065, 450	9, 132	200. 00

Hoal th	Financial Systems ME	EMORIAL HOSP & F	JENITU CADE CTE	5	In Lie	eu of Form CMS-:	2552 10
APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEISH COSTS		S Provider Component (	CN: 15-0115 CCN: 15-T115	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Pre 11/29/2022 11	pared:
			Title	XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adjustments	Nursi ng Program		Allied Health	
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	_	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0			0	54.00
56.00	05600 RADI OI SOTOPE	0	0			0	56.00
60.00	06000 LABORATORY	0	0			0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0			0	65.00
66. 00 69. 00	06600 PHYSI CAL THERAPY	0	0			0	66. 00 69. 00
69. 00	06900 ELECTROCARDI OLOGY 06901 PULMONARY	0	0			0	69.00
69. 01	06901 POLMONARY	0	0			0	69.01
69. 02	06903 SLEEP LAB	0	0			0	69.02
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0			0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0			0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0			0	73.00
	07400 RENAL DIALYSIS	0	0			_	1
, 00	OUTPATIENT SERVICE COST CENTERS	<u> </u>					,
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0		0 0	0	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0		0 0	0	89.00
90.00	09000 CLI NI C	0	0		0 0	0	90.00
90. 01	09001 I MED	0	0		0 0	0	90. 01
90.02	09002 ONCOLOGY	0	0		0 0	0	90. 02
90. 03	09003 OUTPATIENT CENTER	0	0		0 0	0	90. 03
90. 04	09004 HBURG URGENT CARE CLINIC	0	0		0 0	0	90. 04
90. 05	09005 DI ABETES MGMT CLINIC	0	0		0 0	0	90. 05
91.00	09100 EMERGENCY	I ol	0		0 0	0	91.00

0 0 0

0

0

0 92.00 95.00 0 96.00 0 200.00

91.00

91.00

09100 EMERGENCY

92. 00 | 09100 | EMERGENCY | 92. 00 | 09200 | OBSERVATION | BEDS (NON-DISTINCT PART) | OTHER REIMBURSABLE COST CENTERS | 95. 00 | 09600 | DURABLE MEDICAL EQUIP-RENTED | 200. 00 | Total (Lines 50 through 199)

	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	EVICE OTHER PAS	Component	CCN: 15-T115	Period: From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 11	pared: :30 am
			Title	· XVIII	Subprovi der  - I RF	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Education	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col . 7)	
				and 4)		(see	
		4. 00	5.00	6. 00	7. 00	instructions) 8.00	
	ANCILLARY SERVICE COST CENTERS	4.00	5.00	0.00	7.00	8.00	
50.00	05000 OPERATING ROOM	0	0		0 82, 650, 261	0. 000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			0 2, 497, 981	0. 000000	
53.00	05300 ANESTHESI OLOGY	0			0 5, 199, 573	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0			0 86, 098, 048	0. 000000	
56.00	05600 RADI OI SOTOPE	0			0 13, 148, 867	0. 000000	
60.00	06000 LABORATORY	0	0		0 68, 357, 497	0. 000000	1
65.00	06500 RESPIRATORY THERAPY	0	0	1	0 7, 355, 820	0. 000000	
66.00	06600 PHYSI CAL THERAPY	0	0		0 13, 549, 969	0. 000000	
69.00	06900 ELECTROCARDI OLOGY	0	0		0 40, 949, 085	0. 000000	
69. 01	06901 PULMONARY	0	l o		0 0	0. 000000	
69. 02	06902 CARDI OPULMONARY	0	0		0 1, 184, 646	0.000000	
69. 03	06903 SLEEP LAB	0	0		0 1, 474, 855	0.000000	69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 10, 773, 185	0.000000	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 22, 343, 956	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 117, 252, 690	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0		0 0	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0		•	0 781, 635	0. 000000	
88. 01	08801 RURAL HEALTH CLINIC II	0	0	•	0 965, 869	0. 000000	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0. 000000	
90.00	09000 CLI NI C	0	0		0 3, 863, 263	0. 000000	
90. 01	09001   I MED	0	0		0 0	0. 000000	1
90. 02	09002 ONCOLOGY	0	0		0 22, 908, 637	0. 000000	
90.03	09003 OUTPATIENT CENTER	0	0		0 0	0. 000000	
90.04	09004 HBURG URGENT CARE CLINIC	0	0		0 4, 461, 499	0. 000000	
90.05	09005 DI ABETES MGMT CLINIC	0	0		0 147, 842	0.000000	1
91.00	09100 EMERGENCY	0	0		0 62, 173, 999		1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 8, 698, 387	0. 000000	92.00
05 00	OTHER REIMBURSABLE COST CENTERS  O9500 AMBULANCE SERVI CES						95.00
95. 00 96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0	0. 000000	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS   Provider CCN: 15-0115   From 07/01/2021   From 07/01/2021   To 06/30/2022   Tart IV Pate/71/2022   To 06/30/2022   To 06/30/2022   Tart IV Pate/71/2022   To 06/30/2022   To 06/30/2	Health Financial Systems ME	EMORIAL HOSP & HE	ALTH CARE CTE	?	In lie	u of Form CMS-2	2552-10
Component CON: 15-T115				CN: 15-0115 F	Peri od:		2002 10
Cost Center Description	THROUGH COSTS		Component			Date/Time Pre	pared: :30 am
Rati 0 of Cost to Charges			Title	: XVIII	•		
Charges	Cost Center Description						
Cost (col   6			9		9		
COL. 7)   X COL. 10)   X COL. 12)   Y. COL. 12)   Y. COL. 12.   Y. COL			Charges				
NOTITION							
ANCILLARY SERVICE COST CENTERS							
SO   00   05000   05000   05000   0   0		9. 00	10. 00	11. 00	12.00	13. 00	
52.00   05200   DELI VERY ROOM & LABOR ROOM   0.000000   0   0   0   0   52.				1			
53.00   05300   AMBESTHESI OLOGY   0.000000   11,378   0   0   0   53.							
54.00   05400   RADI OLOGY-DI AGNOSTI C   0.000000   11,378   0   0   0   54.  66.00   05600   RADI OI SOTOPE   0.000000   0   0   0   0   0   56.  66.00   066000   LABORATORY   0.000000   44,417   0   0   0   60.  65.00   06600   CASORATORY   14   17   0   0   0   0   60.  65.00   06600   CASORATORY   14   17   0   0   0   0   0   60.  66.00   06600   PHYSI CAL THERAPY   0.000000   5,601   0   0   0   66.  67.00   06900   ELECTROCARDI OLOGY   0.000000   12,122   0   0   0   66.  68.01   06900   DILLMONARY   0.000000   0   0   0   0   69.  69.02   06900   CASORI ODULMONARY   0.000000   0   0   0   0   69.  69.03   06903   SLEEP LAB   0.000000   0   0   0   0   0   69.  69.03   06903   SLEEP LAB   0.000000   0   0   0   0   0   69.  71.00   07000   ELECTROENCEPHALOGRAPH   0.000000   0   0   0   0   0   0    71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.000000   1,663   0   0   0   0   0    72.00   07200   IMPL DEV. CHARGED TO PATI ENTS   0.000000   0   0   0   0   0   0    73.00   07300   BRUGS CHARGED TO PATI ENTS   0.000000   0   0   0   0   0    74.00   07400   RENAL DI ALYSIS   0.000000   0   0   0   0   0    88.01   08800   RURAL HEALTH CLINIC   1   0.000000   0   0   0   0   0    90.01   09001   IMED   0.000000   0   0   0   0   0    90.02   09000   CLOLOGY   0.000000   0   0   0   0   0    90.03   09000   CLOLOGY   0.000000   0   0   0   0    90.04   09004   HBURG URGENT CARE CLINIC   0.000000   0   0   0   0    90.05   09005   DIABETES NIGHT CLINIC   0.000000   0   0   0   0    90.06   09005   DIABETES NIGHT CLINIC   0.000000   0   0   0   0    90.07   09005   DIABETES NIGHT CLINIC   0.000000   0   0   0   0    90.08   09005   DIABETES NIGHT CLINIC   0.000000   0   0   0   0    90.09   09005   DIABETES NIGHT CLINIC   0.000000   0   0   0   0    90.01   0710   MEDICARSEN CES   0.000000   0   0   0   0    90.02   0710   0710   0710   0710   0710   0710   0710   0710   0710   0710   0710   0710   0710   0710   0710   0710   0710   0710   0710   0710   0710   0710   0710   0710   0710   0710   0			-			_	52.00
56. 00   05600  RADI OI SOTIOPE   0. 000000   0   0   0   56.   60. 00   06000  LABORATORY   0. 000000   44, 417   0   0   0   0   60.   65. 00   06500  RESPI RATORY THERAPY   0. 000000   5, 601   0   0   0   0   65.   66. 00   06600  PHYSI CAL THERAPY   0. 000000   833, 268   0   0   0   0   66.   69. 00   06900  ELECTROCARDI OLOGY   0. 000000   12, 122   0   0   0   0   69.   69. 01   06901  PULIMONARY   0. 000000   0   0   0   0   0   0   69.   69. 02   06902  CARDI OPULIMONARY   0. 000000   0   0   0   0   0   0   69.   69. 03   06903  SLEEP LAB   0. 000000   0   0   0   0   0   0   0		ł					53.00
60. 00   06000   LABORATORY   0. 000000   44, 417   0   0   0   0   60. 65. 00   05500   RESPI RATORY THERAPY   0. 000000   5, 601   0   0   0   0   65. 66. 00   06600   PHYSI CAL THERAPY   0. 000000   833, 268   0   0   0   0   0   65. 66. 00   06600   PHYSI CAL THERAPY   0. 000000   12, 122   0   0   0   0   0   0   69. 69. 01   06900   ELECTROCARDI OLOGY   0. 000000   0   0   0   0   0   0   0		ł				_	54.00
65. 00   06500   RESPIRATORY THERAPY   0.000000   5, 601   0   0   0   65. 66. 00   06600   PHYSI CAL THERAPY   0.000000   833, 268   0   0   0   0   66. 67. 69. 00   06900   ELECTROCARDI OLOGY   0.000000   12, 122   0   0   0   0   0   0   69. 01   06901   PULMONARY   0.000000   0   0   0   0   0   0   0			-			0	56.00
66. 00   06600   PHYSI CAL THERAPY   0. 000000   833, 268   0   0   0   66. 69. 00   0. 000000   0. 00   0. 000000   0. 00   0. 000000   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00   0. 00		• • • • • • • • • • • • • • • • • • •		1	-	0	60.00
69. 00 06900   ELECTROCARDI OLOGY		• • • • • • • • • • • • • • • • • • •					65.00
69. 01   06901   PULMONARY   0.000000   0 0 0 0 0 0 0 69. 69. 02   06902   CARDI OPULMONARY   0.000000   0 0 0 0 0 0 0 0 0 0 0 0 0						_	66.00
69. 02   06902   CARDI OPULMONARY   0.000000   0   0   0   0   0   69. 69. 03   06903   SLEEP LAB   0.000000   0   0   0   0   0   0   0						_	69.00
69. 03 06903 SLEEP LAB			-			_	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		l l	0			0	69. 02
71. 00			0		1	0	69. 03
72. 00		0. 000000	0			0	70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS			1, 663			0	71.00
74. 00		0. 000000	0	(	0	0	72.00
SECTION   SERVICE COST CENTERS   SERVICE COST CENTERS	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	155, 552	(	0	0	73.00
88. 00		0. 000000	0	(	0	0	74.00
88. 01   08801   RURAL HEALTH CLINIC I I   0.000000   0   0   0   0   0   88. 89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0.000000   0   0   0   0   0   0   89. 99. 00   09000   CLINIC   0.000000   950   0   0   0   0   0   90. 99. 99. 01   09001   IMED   0.000000   0   0   0   0   0   0   90. 99. 99. 02   09002   0NCOLOGY   0.000000   0   0   0   0   0   0   90. 99. 99. 03   099003   0UTPATIENT CENTER   0.000000   0   0   0   0   0   90. 99. 99. 04   09904   HBURG URGENT CARE CLINIC   0.000000   0   0   0   0   90. 99. 99. 05   09005   DI ABETES MGMT CLINIC   0.000000   0   0   0   0   99. 99. 99. 00   09100   EMERGENCY   0.000000   180   0   0   0   99. 99. 99. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART)   0.000000   0   0   0   0   99. 00000   0   0   0   0   0   99. 000000   0   0   0   0   0   0   0   0							
89. 00	88.00 08800 RURAL HEALTH CLINIC	0. 000000	0	(	0	0	88. 00
90. 00   09000   CLINI C   0. 000000   950   0   0   0   90. 90. 90. 01   09001   IMED   0. 000000   0   0   0   0   0   0   90. 90. 02   09002   0NCOLOGY   0. 000000   0   0   0   0   0   0   90. 90. 03   09003   0UTPATI ENT CENTER   0. 000000   0   0   0   0   0   90. 90. 04   09004   BBURG URGENT CARE CLINI C   0. 000000   0   0   0   0   0   90. 90. 05   09005   DI ABETES MGMT CLINI C   0. 000000   0   0   0   0   0   90. 91. 00   09100   EMERGENCY   0. 000000   180   0   0   0   91. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART)   0. 000000   0   0   0   0   0   92. 00   0THER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   95.		0. 000000	0	(	0	0	88. 01
90. 01   09001   IMED   0.000000   0   0   0   0   0   90. 90. 90. 02   09002   0NCOLOGY   0.000000   0   0   0   0   0   0   90. 90. 03   09003   0UTPATI ENT CENTER   0.000000   0   0   0   0   0   90. 90. 04   09004   HBURG URGENT CARE CLINIC   0.000000   0   0   0   0   0   90. 90. 05   09005   DI ABETES MGT CLINIC   0.000000   0   0   0   0   0   90. 91. 00   09100   EMERGENCY   0.000000   180   0   0   0   91. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART)   0.000000   0   0   0   0   92. 00   00000   0   0   0   0   0   0   92. 00   00000   0   0   0   0   0   0   0		0. 000000	-		0	0	89. 00
90. 02		0. 000000	950	(	0	0	90.00
90. 03   09003   0UTPATI ENT CENTER   0. 000000   0   0   0   0   90. 90. 90. 04   09004   HBURG URGENT CARE CLINIC   0. 000000   0   0   0   0   0   90. 90. 90. 05   09005   DI ABETES MGMT CLINIC   0. 000000   0   0   0   0   0   0   90. 90. 90. 00   00	90. 01   09001   I MED	0. 000000	0	(	0	0	90. 01
90. 04   09004   HBURG URGENT CARE CLINIC   0. 000000   0   0   0   0   0   90.    90. 05   09005   DI ABETES MGMT CLINIC   0. 000000   0   0   0   0   0   90.    91. 00   09100   EMERGENCY   0. 000000   180   0   0   0   91.    92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0. 000000   0   0   0   0   92.    95. 00   09500   AMBULANCE SERVICES   95.	90. 02   09002   0NCOLOGY	0. 000000	0	(	0	0	90. 02
90. 05	90. 03 09003 OUTPATIENT CENTER	0. 000000	0	(	0	0	90.03
91. 00   09100   EMERGENCY   0. 000000   180   0   0   0   91.    0   0   0   0   0   92.    0   0   0   0   0   0   0   0   0	90. 04 09004 HBURG URGENT CARE CLINIC	0. 000000	0	(	0	0	90.04
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0. 000000   0   0   0   0   92.   95. 00   09500   AMBULANCE SERVICES   95.	90.05 09005 DIABETES MGMT CLINIC	0. 000000	0	(	0	0	90.05
OTHER REI MBURSABLE COST CENTERS  95. 00   09500   AMBULANCE SERVI CES   95.	91. 00 09100 EMERGENCY	0. 000000	180	(	0	0	91.00
95. 00 09500 AMBULANCE SERVICES 95.	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	(	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
96. 00   09600  DURABLE MEDI CAL EQUI P-RENTED   0. 000000  0  0  0  0  96.	95. 00 09500 AMBULANCE SERVICES						95.00
		0. 000000	0	(	0	0	96.00
200.00   Total (lines 50 through 199)   1,065,450   0   0   0   200.	200.00   Total (lines 50 through 199)		1, 065, 450	(	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0115 Peri od: Worksheet D From 07/01/2021 Part V 06/30/2022 Date/Time Prepared: 11/29/2022 11:30 am Title XIX Hospi tal Cost Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, Subject To Subject To inst.) Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 229059 657, 399 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0.887609 0 52.00 0 0 53.00 05300 ANESTHESI OLOGY 0. 297352 0 42, 432 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.085708 0 960, 695 0 0 0 0 0 0 0 0 0 0 54.00 56.00 05600 RADI OI SOTOPE 0.082624 0 79, 877 56.00 0 60. nn 06000 LABORATORY 0.172726 0 790, 754 60.00 0 06500 RESPIRATORY THERAPY 65.00 0.368471 0 25, 283 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 314392 95, 675 0 66.00 139, 747 06900 ELECTROCARDI OLOGY 0 69.00 69.00 0.159181 0 06901 PULMONARY 0.000000 69.01 69.01 0 0 69.02 06902 CARDI OPULMONARY 0.236443 0 69.02 06903 SLEEP LAB 69.03 0.337319 27, 765 0 69.03 07000 ELECTROENCEPHALOGRAPHY 70 00 0.000000 Ω 0 70 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.148754 0 70, 208 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 289305 0 109, 713 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0. 199183 0 1, 428, 393 0 73.00 07400 RENAL DIALYSIS 74.00 0.000000 O 74 00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 88.01 08801 RURAL HEALTH CLINIC II 88.01 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 89 00 90.00 09000 CLI NI C 0. 282858 87, 455 0 90.00 09001 I MED 0.000000 90.01 90.01 0 0 0 09002 ONCOLOGY 0. 230219 90.02 90.02 216, 891 0 09003 OUTPATIENT CENTER 90.03 0.000000 0 90.03 0 90.04 09004 HBURG URGENT CARE CLINIC 0.442419 0 57, 433 0 90.04 0 09005 DIABETES MGMT CLINIC 90.05 0.779007 0 1.852 0 90.05 1, 297, 159 09100 EMERGENCY 0 91.00 91 00 0.145445 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0. 397265 0 68, 691 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 457482 0 291, 235 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 96.00 0.000000 0 0 6, 448, 657 200.00 Subtotal (see instructions) 0 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 0 202.00 202.00 Net Charges (line 200 - line 201) 0 0 6, 448, 657

In Lieu of Form CMS-2552-10 Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0115 Peri od: Worksheet D From 07/01/2021 Part V 06/30/2022 Date/Time Prepared: 11/29/2022 11:30 am Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 150, 583 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 0 0 53.00 05300 ANESTHESI OLOGY 12, 617 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 82, 339 0 54.00 56.00 05600 RADI OI SOTOPE 6,600 0 56.00 06000 LABORATORY 136, 584 60.00 0 60.00 06500 RESPIRATORY THERAPY 65.00 9, 316 0 65.00 66.00 06600 PHYSI CAL THERAPY 30, 079 66.00 0 69.00 06900 ELECTROCARDI OLOGY 22, 245 69.00 06901 PULMONARY 0 69.01 69.01 0 69.02 06902 CARDI OPULMONARY 0 0 69.02 06903 SLEEP LAB 0 69.03 9, 366 69.03 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 10, 444 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 31, 741 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 284, 512 0 73.00 07400 RENAL DIALYSIS 74.00 0 74 00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 88.01 08801 RURAL HEALTH CLINIC II 88.01 89 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 90.00 09000 CLI NI C 24, 737 90.00 90. 01 09001 I MED 90.01 09002 ONCOLOGY 0 90.02 49.932 90.02 09003 OUTPATIENT CENTER 0 90.03 90.03 90.04 09004 HBURG URGENT CARE CLINIC 25, 409 0 90.04 09005 DIABETES MGMT CLINIC 90.05 1, 443 0 90.05

188, 665

27, 289

133, 235

1, 237, 136

1, 237, 136

0

0

0

0

0

91.00

92.00

95.00

96.00

200.00

201.00

202.00

09100 EMERGENCY

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

OTHER REIMBURSABLE COST CENTERS

09500 AMBULANCE SERVICES

Only Charges

96. 00 | 09600 | DURABLE MEDICAL EQUIP-RENTED

91 00

92.00

95.00

200.00

201.00

Heal th	Financial Systems MEMORIAL HOS	SP & HEALTH CARE CTR	In lie	u of Form CMS-2	2552-10		
	ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0115	Peri od:	Worksheet D-1			
	From 07/01/202' To 06/30/202'						
		Title XVIII	Hospi tal	11/29/2022 11 PPS	:30 am		
	Cost Center Description	TITLE XVIII	поѕрі таі	PPS			
	oust defiter beschiptron			1. 00			
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS						
1.00	Inpatient days (including private room days and swing	-bed days, excluding newborn)		12, 313	1.00		
2.00	Inpatient days (including private room days, excluding			12, 313			
3.00	Private room days (excluding swing-bed and observation	n bed days). If you have only p	rivate room days,	0	3.00		
4 00	do not complete this line.	. 12 1 . 1		0.074	4 00		
4. 00	Semi-private room days (excluding swing-bed and observ		21 -6 +6	8, 871			
5. 00	Total swing-bed SNF type inpatient days (including prireporting period	rvate room days) through becembe	er 31 or the cost	0	5. 00		
6. 00	Total swing-bed SNF type inpatient days (including pri		31 of the cost	0	6.00		
7. 00	reporting period (if calendar year, enter 0 on this li Total swing-bed NF type inpatient days (including priv		31 of the cost	0	7.00		
0.00	reporting period						
8. 00	Total swing-bed NF type inpatient days (including priving period (if calendar year, enter 0 on this li		31 of the cost	0	8.00		
9. 00	Total inpatient days including private room days applinewborn days) (see instructions)		g swing-bed and	3, 556	9. 00		
10.00	Swing-bed SNF type inpatient days applicable to title		room days)	0	10.00		
11. 00	through December 31 of the cost reporting period (see Swing-bed SNF type inpatient days applicable to title	0	11.00				
	December 31 of the cost reporting period (if calendar	• .					
12. 00	Swing-bed NF type inpatient days applicable to titles through December 31 of the cost reporting period	V or XIX only (including private	te room days)	0	12.00		
13. 00	Swing-bed NF type inpatient days applicable to titles after December 31 of the cost reporting period (if cal			0	13. 00		
14. 00	Medically necessary private room days applicable to the			0	14.00		
15. 00	Total nursery days (title V or XIX only)	The Trogram (excruding swring-bed	uays)	0			
16. 00	Nursery days (title V or XIX only)			0			
10.00	SWING BED ADJUSTMENT				10.00		
17. 00	Medicare rate for swing-bed SNF services applicable to	o services through December 31 o	of the cost	0. 00	17. 00		
40.00	reporting period			0.00	10.00		
18. 00	Medicare rate for swing-bed SNF services applicable to reporting period	o services after December 31 of	the cost	0. 00	18. 00		
19. 00	Medicaid rate for swing-bed NF services applicable to reporting period	services through December 31 of	f the cost	0. 00	19. 00		
20. 00	Medicaid rate for swing-bed NF services applicable to	services after December 31 of	the cost	0.00	20.00		
	reporting period						
21. 00	Total general inpatient routine service cost (see ins			12, 361, 547	1		
22. 00	Swing-bed cost applicable to SNF type services through $5 \times 1$ ine 17)	h December 31 of the cost report	ting period (line	0	22.00		
23. 00	Swing-bed cost applicable to SNF type services after I	0	23. 00				
0.4.00	x line 18)						
24. 00	Swing-bed cost applicable to NF type services through $7 \times 1$ ine 19)	December 31 of the cost reporti	ng period (line	0	24.00		
25. 00	Swing-bed cost applicable to NF type services after De	ecember 31 of the cost reportino	g period (line 8	0	25. 00		
26. 00	x line 20) 00   Total swing-bed cost (see instructions)						
27. 00							
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			12, 361, 547	27.00		
28. 00	General inpatient routine service charges (excluding s	swing-bed and observation bed ch	narges)	0	1		
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00		

	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12, 313	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12, 313	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
4 00	do not complete this line.	0.074	4 00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	8, 871	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	O	0.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
,, 00	reporting period	ŭ.	,, 00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	3, 556	9.00
	newborn days) (see instructions)		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
11 00	through December 31 of the cost reporting period (see instructions)	0	11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12.00	through December 31 of the cost reporting period	J	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)		15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
18. 00	reporting period  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
16.00	reporting period	0.00	16.00
19. 00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
	Total general inpatient routine service cost (see instructions)	12, 361, 547	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
22.00	5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	U	23. 00
24. 00	,	0	24.00
2 00	7 x line 19)	ŭ.	2 00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	26.00
27. 00		12, 361, 547	27.00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	0	29. 00
	Semi -pri vate room charges (excluding swing-bed charges)		30.00
	General inpatient routine service cost/charge ratio (line 27 + line 28)	0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)		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 minus line 33)(see instructions)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	12, 361, 547	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)	1, 003, 94	38 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	3, 570, 011	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	3, 570, 011	

	Financial Systems ME ATION OF INPATIENT OPERATING COST	MORIAL HOSP & H		R CN: 15-0115	In Lie Period:	u of Form CMS-2 Worksheet D-1	
CONICUI	ATTOM OF THEATTENS OF LINE COST		i i ovi dei C	ON. 13-0113	From 07/01/2021		
					To 06/30/2022	Date/Time Pre 11/29/2022 11	
	Cook Cooks December 1	Takal		XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col. 1		Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
10.00	Luporpy (IIII V a VIV II)	1. 00	2.00	3. 00	4.00	5. 00	10.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0. (	00 0	0	42.00
43.00	INTENSIVE CARE UNIT	6, 277, 151	4, 472	1, 403. 6	1, 641	2, 303, 406	43.00
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description	,		'			
48. 00	Program inpatient ancillary service cost (Wk	rct D 2 col 2	Line 200)			1. 00 8, 721, 048	48. 00
	Total Program inpatient costs (sum of lines			ons)		14, 594, 465	•
	PASS THROUGH COST ADJUSTMENTS					.,	
50.00	Pass through costs applicable to Program inp	oatient routine	services (fro	m Wkst. D, su	m of Parts I and	338, 979	50.00
51. 00	  Pass through costs applicable to Program inp	natient ancillar	v services (f	rom Wkst D	sum of Parts II	199, 783	51.00
	and IV)		, <u> </u>				
52.00	Total Program excludable cost (sum of lines		Lotod 1	vol al ar : !	hotiot	538, 762	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	9 1	nateu, non-ph	ysician anest	netist, and	14, 055, 703	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION						1
	Program di scharges					0	
	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
	Difference between adjusted inpatient operat	ing cost and ta	rget amount (	line 56 minus	line 53)	0	1
58.00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	eporting period	endi ng 1996,	updated and c	ompounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the	market basket		0.00	60.00
61.00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% o	f the target		
62. 00	Relief payment (see instructions)	matructions)				0	62.00
63.00		nent (see instru	ctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Dece	mber 31 of th	e cost report	ing period (See	0	64.00
	instructions)(title XVIII only)	· ·		·			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after Decemb	er 31 of the	cost reportin	g period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
. <del>.</del>	CAH (see instructions)						
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	ne costs through	December 31	of the cost r	eporting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost rep	orting period	0	68.00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routing costs (	lino 47 : lin	o 49)		0	69.00
69.00	PART III - SKILLED NURSING FACILITY, OTHER N					U	1 69.00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	tine service	cost (line 37	)		70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71.00
73.00	Medically necessary private room cost applic	,	(line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine serv	vice costs (line	72 + line 73	)			74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	Worksheet B,	Part II, column		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77. 00	Program capital-related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	roulder recer	de)			78. 00 79. 00
80.00	Total Program routine service costs for comp	, ,		,	nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi	tati on		,	,		81.00
82.00	Inpatient routine service cost limitation (I		* .				82.00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		15)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ns)				85.00
	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					3, 442	87.00
87 NN							
87. 00 88. 00	, ,	•	line 2)			1, 003. 94	1

Health Financial Systems ME	MORIAL HOSP & F	HEALTH CARE CTR	2	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 11	pared: :30 am_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	738, 833	12, 361, 547	0. 05976	9 3, 455, 561	206, 535	90.00
91.00 Nursing Program cost	0	12, 361, 547	0.00000	0 3, 455, 561	0	91.00
92.00 Allied health cost	0	12, 361, 547	0.00000	0 3, 455, 561	0	92.00
93.00 All other Medical Education	0	12, 361, 547	0. 00000	3, 455, 561	0	93. 00

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115		Worksheet D-1
	Component CCN: 15-S115	From 07/01/2021 To 06/30/2022	
	Title XVIII	Subprovi der -	PPS

		I PF		
	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1, 337	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days	)	1, 337	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only	private room days,	0	3.00
	do not complete this line.			
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1, 337	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through Dece	mber 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December	er 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	or or the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December	per 31 of the cost	0	7. 00
	reporting period			
8.00	Total swing-bed NF type inpatient days (including private room days) after Decembe	r 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)		200	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding newborn days) (see instructions)	ing swing-bed and	290	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private	e room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	o i com dayo,	ŭ	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private	e room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	-		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including pri	vate room days)	0	12.00
12 00	through December 31 of the cost reporting period		0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including priafter December 31 of the cost reporting period (if calendar year, enter 0 on this		0	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-b		0	14.00
15. 00		ca aays)	0	15. 00
	Nursery days (title V or XIX only)		0	16.00
	SWING BED ADJUSTMENT			
17. 00		1 of the cost	0. 00	17. 00
40.00	reporting period			40.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31	or the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31	of the cost	0.00	19. 00
17.00	reporting period	or the cost	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 o	f the cost	0.00	20. 00
	reporting period			
21. 00			2, 349, 077	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reposition $5 \times 1$ in $6 \times 1$	orting period (line	0	22. 00
23. 00		ting period (line A	0	23. 00
20.00	x line 18)	ang pontou (initio	·	20.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost repo	rting period (line	0	24.00
	7 x line 19)			
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost report	ing period (line 8	0	25. 00
26. 00	x line 20)   Total swing-bed cost (see instructions)		0	26. 00
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 2)	6)	2, 349, 077	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	5)	2, 347, 011	27.00
28.00	General inpatient routine service charges (excluding swing-bed and observation bed	charges)	0	28. 00
29.00	Private room charges (excluding swing-bed charges)		0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)		0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	ructions)	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 minus line 33)(see inst Average per diem private room cost differential (line 34 x line 31)	uctions)	0. 00 0. 00	35.00
36.00			0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost	differential (line		37.00
	27 minus line 36)		· · ·	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
00.05	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		4 75/	00.00
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1, 756. 98	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35)	,	509, 524 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 + line 40)	′	509, 524	
55	1.1.1	I	337, 324	

	Financial Systems MEM TATION OF INPATIENT OPERATING COST	MORIAL HOSP & H		R CN: 15-0115	In Lie	u of Form CMS-2 Worksheet D-1	
COMI O	ATTON OF THE ATTENT OF ENATING COST			CCN: 15-S115	From 07/01/2021 To 06/30/2022	Date/Time Pre	pared:
			Title	e XVIII	Subprovi der -	11/29/2022 11 PPS	:30 am
Cost Center Description Total Total Average Per Program Days							
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Inpatient Cost	Inpatient Days	Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1. 00	2.00	3.00	4. 00 00 0	5.00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	<u> </u>		η <u></u> 0.	00  0	0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	C	0.	00 0	0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45.00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description	I					47.00
48. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3	3. line 200)			1. 00 40, 527	48. 00
49. 00				ons)		550, 051	
50. 00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, s	um of Parts I and	54, 946	50.00
51. 00		atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	773	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines! Total Program inpatient operating cost exclud		alated non nh	velcian anco	thatist and	55, 719 494, 332	
55.00	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		патец, поп-рп	ysi ci aii ailes	thetist, and	474, 332	33.00
	Program di scharges						54.00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operati	ing cost and ta	arget amount (	line 56 minus	s line 53)	0	57.00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost repeared basket	porting period	endi ng 1996,	updated and	compounded by the	0.00	58. 00 59. 00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 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						0	61.00
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ıcti ons)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine costinstructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost repor	ting period (See	0	64.00
65. 00	7 7	ts after Decemb	oer 31 of the	cost reporti	ng period (See	0	65. 00
66. 00	1	ne costs (line	64 plus line	65)(title XV	III only). For	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	n December 31	of the cost	reporting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after [	December 31 of	the cost re	porting period	0	68.00
69. 00	Total title V or XIX swing-bed NF inpatient   PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70.00	Skilled nursing facility/other nursing facili	ity/ICF/IID rou	ıtine service	cost (line 3	7)		70.00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line	,	ine 70 ÷ line	2)			71.00
73.00	Medically necessary private room cost application	abĺe to Program					73.00
74. 00 75. 00	Total Program general inpatient routine servicapital-related cost allocated to inpatient	•		,	Part II, column		74.00 75.00
76. 00	26, line 45)   Per diem capital-related costs (line 75 ÷ li	•					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess	s costs (from p		*.			79.00
80.00   Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00   Inpatient routine service cost per diem limitation						80.00	
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81	•				82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (: Program inpatient ancillary services (see in:		is)				83. 00 84. 00
85.00	Utilization review - physician compensation	(see instructio					85.00
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		nrough 85)				86.00
87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0 00	87. 00 88. 00	
	Observation bed cost (line 87 x line 88) (see	•				l	89.00

Health Financial Systems ME	MORIAL HOSP & F	HEALTH CARE CTR	₹	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (	CCN: 15-S115	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 11	
		Title	XVIII	Subprovi der -	PPS	
				I PF	01 11	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
		ŕ		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	253, 325	2, 349, 077	0. 10784	0 0	0	90.00
91.00 Nursing Program cost	0	2, 349, 077	0. 00000	00	0	91.00
92.00 Allied health cost	0	2, 349, 077	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 349, 077	0. 00000	0 0	0	93.00

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0115	Peri od: From 07/01/2021	Worksheet D-1
	Component CCN: 15-T115		
	Title XVIII	Subprovi der -	PPS
		I RF	

		II the Aviii	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			958	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		ivate room days	958 0	2. 00 3. 00
3.00	do not complete this line.	ys). It you have only pr	rvate room days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation b			958	4.00
5. 00	Total swing-bed SNF type inpatient days (including private roreporting period	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)		21 -6 +1	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private rooreporting period	ili days) through becember	31 Of the Cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (excluding	swi ng-bed and	559	9. 00
	newborn days) (see instructions)			_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		oom days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
12 00	through December 31 of the cost reporting period	V only (including privat	o room days)	0	13. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this line	e) ,	U	13.00
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service 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 servic	es after December 31 of	the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instruction	5)		1, 224, 932	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	0	22.00
22.00	5 x line 17)	21 of the east reportin	a ported (line (	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December $x$ line 18)	31 of the cost reporting	g period (iine 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through Decembe $7 \times 1$ ine 19)	r 31 of the cost reporti	ng period (line	0	24.00
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		1, 224, 932	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation hed ch	arges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)		a. goo)	0	
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	11 22)/ 1	+:)	0.00	
34.00	Average per diem private room charge differential (line 32 mi		LI OIIS)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	HE 31)	}	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	1, 224, 932	
57.00	27 minus line 36)			., 22 1, 702	]
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	HOTHENTO			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			4 070 /-	20.00
38.00	Adjusted general inpatient routine service cost per diem (see			1, 278. 63	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	•		714, 754 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39			714, 754	
	, , , , , , , , , , , , , , , , , , , ,	•	1	.,	

	Financial Systems MENTATION OF INPATIENT OPERATING COST	MORIAL HOSP & H		R CN: 15-0115	In Lie	u of Form CMS-2 Worksheet D-1	
			CCN: 15-T115	From 07/01/2021 To 06/30/2022	Date/Time Pre	pared:	
	Title XVIII Subprovider -			11/29/2022 11 PPS	: 30 am		
	Cost Center Description Total Total Average Per Program Days P				Program Cost		
	cost center bescription	Inpatient Cost	Inpatient Days	Diem (col. ÷ col. 2)		(col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1. 00	2. 00	3.00	4.00	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	U <sub>I</sub>		η	0	0	42.00
	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	C	0. (	00 0	0	
44. 00 45. 00	4						44. 00 45. 00
46.00	4						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.00
40.00	December 1 and 1 and 2 a	-+	11 200)			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			ons)		306, 234 1, 020, 988	•
EO 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp.	ationt routing	convices (fre	m Wks+ D si	m of Dorte L one	77 725	50.00
50. 00		atrent routine	services (110	III WKSt. D, St	III OI PAILS I AIR	77, 735	30.00
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	9, 132	51.00
52.00	Total Program excludable cost (sum of lines					86, 867	52.00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-ph	ysician anest	hetist, and	934, 121	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	<u></u>					
54. 00 55. 00	Program discharges Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	56.00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (	line 56 minus	line 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and c	ompounded by the		•
60. 00	market basket Lesser of Lines 53/54 or 55 from prior year	cost report. up	dated by the	market basket		0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by				0	61.00		
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x	(60), or 1% o	f the target		
62.00	Relief payment (see instructions)	ont (ooo i notsu	ationa)			0	
63. 00	PROGRAM INPATIENT ROUTINE SWING BED COST						03.00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	mber 31 of th	e cost report	ing period (See	0	64. 00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportir	g period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66. 00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	o costs through	Docombor 21	of the cost r	concerting ported	_	67.00
67.00	(line 12 x line 19)	_					87.00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	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 Skilled nursing facility/other nursing facil				)		70. 00
71.00	, ,		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	,	(line 14 x l	ine 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv	•		•	Deat II and a		74.00
75. 00	Capital-related cost allocated to inpatient   26, line 45)	routine service	costs (trom	worksneet B,	Part II, column		75. 00
76. 00 77. 00	Per diem capital related costs (line 75 ÷ line						76. 00 77. 00
78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						78.00
79.00	1 33 3			*.	nua lina 70)		79.00
80. 00 81. 00	Total Program routine service costs for companient routine service cost per diem limi		ost iriii tati 0	(IIIIe /o IIII	ilus IIIIe /9)		80. 00 81. 00
82.00	Inpatient routine service cost limitation (I		* .				82.00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in:		13)				83. 00 84. 00
85.00	Utilization review - physician compensation	(see instructio					85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rougn 85)				86.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	)	line 2)			0 00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see	•	,				89.00

Health Financial Systems	IEMORIAL HOSP & I	HEALTH CARE CTF	}	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 07/01/2021		
		Component	CCN: 15-T115	To 06/30/2022	Date/Time Pre 11/29/2022 11	
		T: 41 -	VV/I I I	Cultura and allera		: 30 alli
		litie	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	133, 221	1, 224, 932	0. 10875	8 0	0	90.00
91.00 Nursing Program cost	0	1, 224, 932	0.00000	0 0	0	91.00
92.00 Allied health cost	0	1, 224, 932	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	1, 224, 932	0. 00000	0 0	0	93.00

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0115	Peri od: From 07/01/2021	Worksheet D-1
	Component CCN: 15-5305		
	Title XVIII	Skilled Nursing	PPS
		Facility	

PART - ALL PROMISER COMPONENTS    PART - ALL PROMISER COMPONENTS			Facility		
INSPITE LANS   INSP		Cost Center Description		1.00	
IMPARTIANT DAYS		DADT I ALL DOOVEDED COMPONENTS		1.00	
Impattent days (including private room days and seing-bed days, excluding needorn)					
Impatient days (including private room days, excluding swing-bed and nesborn days)   1,300   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00	1.00			4, 350	1.00
Private room days (excluding swing-bed and observation bed days)   1					2.00
5.00   Somi-p-rivate room days (excluding saving-bed and observation bed days)   1.500   Total swing-bed SK type inpatient days (including private room days) after December 31 of the cost   0.500   Total swing-bed SK type inpatient days (including private room days) after December 31 of the cost   0.500   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost   0.700   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost   0.700   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost   0.700   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost   0.700   Total inpatient days including private room days after December 31 of the cost   0.700   Total inpatient days including private room days after December 31 of the cost   0.700   Total inpatient days applicable to this line)   0.700   Total inpatient days applicable of title XVII only (including private room days)   0.700   Total inpatient days applicable of title XVII only (including private room days)   0.700   Total probable MF type inpatient days applicable to title XVII only (including private room days)   0.700   Total probable MF type inpatient days applicable to title XVII only (including private room days)   0.700   Total probable MF type inpatient days applicable to title XVII only (including private room days)   0.700   Total probable MF type inpatient days applicable to title XVII only (including private room days)   0.700   Total probable MF type inpatient days applicable to title XVII only (including private room days)   0.700   Total probable MF type inpatient days applicable to title XVII only (including private room days)   0.700   Total probable MF type inpatient days applicable to the Program (excluding swing-bed days)   0.700   Total probable MF type inpatient days applicable to the Program (excluding swing-bed days)   0.700   Total probable MF type inpatient da	3.00	Private room days (excluding swing-bed and observation bed days). If you have only pri	vate room days,		3. 00
Total swing-bed SNF type inpatient days (including private room days) through becember 31 of the cost reporting period (ir calendar year, enter 0 on this line)  7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (ir calendar year, enter 0 on this line)  8.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10.00 Saing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  11.00 Saing-bed SNF type inpatient days applicable to tille XVIII only (including private room days)  11.00 Saing-bed SNF type inpatient days applicable to tille XVIII only (including private room days)  12.00 Swing-bed SNF type inpatient days applicable to tille XVIII only (including private room days)  13.00 Swing-bed SNF type inpatient days applicable to tilles V or XIX only (including private room days)  13.00 Swing-bed SNF type inpatient days applicable to tilles V or XIX only (including private room days)  14.00 Total nursery days (tille V or XIX only)  15.00 Exceeding SNF type inpatient days applicable to tilles V or XIX only (including private room days)  16.00 Nursery days (tille V or XIX only)  17.00 Medical room of the cost reporting period (if calendar year, enter 0 on this line)  18.00 Medical room of the cost reporting period (if calendar year, enter 0 on this line)  19.00 Medical room of the cost reporting period (if calendar year, enter 0 on this line)  19.00 Medical room of the cost reporting period (including swing-bed Mrs. services applicable to services through December 31 of the cost room of the cost reporting period (including swing-bed Nrs. services applicable to services after December 31 of the cost reportin					
reporting period (if calendar year, enter 0 on this line) 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.0					
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total swing-bed NF type inpatient days (including private room days) shrough December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the cost reporting period   Recommendation of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the cost reporting period (if calendar year, enter 0 on this line)   Recommendation of the co	5.00		131 of the cost	0	5.00
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reporting period  8. 00 Total sing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10. 00 Suling-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 though becember 31 of the cost reporting period (is cell endar year, enter 0 on this line)  12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 through December 31 of the cost reporting period (is cell endar year, enter 0 on this line)  13. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) of 12. 00 through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00	7. 00		31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line)   0.00   10   10   10   10   10   10		reporting period			
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December 31 of the cost reporting period (if calendar year, enter 0 on this line)   0   12.00	11. 00		oom days) after	0	11.00
through December 31 of the cost reporting period 1.0 O Sung-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.0 O Sung-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.1 O Medically necessary private room days applicable to the Program (excluding swing-bed days) 1.1 O Total nursery days (title V or XIX only) 1.0 Total nursery days (title V or XIX only) 1.0 Total nursery days (title V or XIX only) 1.0 Total nursery days (title V or XIX only) 1.0 Total nursery days (title V or XIX only) 1.0 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 1.0 O Total nursery days (title V or XIX only) 1.0 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 1.0 O Total care rate for swing-bed SNF services applicable to services after December 31 of the cost 1.0 O Total care rate for swing-bed NF services applicable to services after December 31 of the cost 1.0 O Total general inpatient routine service cost (see instructions) 1.0 Total general inpatient routine service cost (see instructions) 1.0 Total general inpatient routine service safter December 31 of the cost reporting period (line 5 x line 17) 1.0 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 1.0 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 1.0 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 1.0 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20) 1.0 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 1.0 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 1.0 Swing-bed cost applicable to NF type services after December 31 of th			,		
13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) a free Docember 31 of the cost reporting period (if call endar year, enter 0 on this line)   0   14.00   0   15.00   15.00   16.00   16.00   16.00   17.00   16.00   17.00   16.00   17.00   16.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00	12.00		e room days)	0	12.00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   14,00   14,00   15.00   16.00   10   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00	40.00				40.00
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   16.00   Nursery days (title V or XIX only)   16.00   16.00   Nursery days (title V or XIX only)   16.00   17.00   17.00   17.00   18.00   18.00   18.00   18.00   18.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00	13. 00			0	13.00
15.00 Total nursery days (title V or XIX only)  16.00 Nesery days (title V or XIX only)  17.00 SWING BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period of Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period of Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period of Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period of Nedicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period of 12.00 Total general inpatient routine service cost (see instructions)  10.00 Total general inpatient routine service cost (see instructions)  10.00 Total general inpatient routine services after December 31 of the cost reporting period (line 5 x line 18)  10.00 Nang-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18)  10.00 Nang-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  10.00 Nang-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  10.00 Nang-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  10.00 Total swing-bed cost (see instructions)  10.00 Nang-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  10.00 Nang-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 30)  10.00 Nang-bed cost (see instructions)  10.00 Nang-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 30)  10.00 Nang-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 30)  10.00 Nang-bed cost applicable to NF type s	14 00			0	14 00
16.00 Nursery days (title v or XIX only)  17.00 SWING BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost or reporting period or reporting period of reporting period of reporting period or reporting r			lays)	-	
SWING BED ADJUSTMENT  17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (19. 00 Medicard rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (19. 00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0. 00 properting period (19. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0. 00 properting period (19. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost (19. 00 properting period (1		J 3 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		-	
reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (19.00) Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost (19.00) Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost (19.00) December 31 of the cost (19.00) Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost (19.00) December 31 of the cost reporting period (19.00) December			<u>'</u>		
18. 00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 0	17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of	f the cost	0.00	17.00
reporting period Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 20.00 period 20.00 Total general inpatient routine service cost (see instructions) 2.833, 439 21.00 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.30 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed charges) 28.00 29.00 Private room charges (excluding swing-bed charges) 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 2					
19.00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service cost net of swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 29 + line 3) 31.00 Average perivate room per diem charge (line 29 + line 3) 32.00 Average perivate room per diem charge (line 30 + line 4) 33.00 Average peridem private room per diem charge (line 30 + line 4) 34.00 Average peridem private room charge differential (line 32 minus line 33) (see instructions) 37.00 General inpatient routine service cost for swing-bed cost and private room cost differential (line 3 x line 31) 38.00 Average per diem private room cost differential (line 30 x line 31) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instru	18. 00		the cost	0. 00	18. 00
reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  1.00 Total general inpatient routine service cost (see instructions)  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 833, 439 21.00  2. 830, 439 21.00  2. 830, 439 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 830, 430 21.00  2. 8	10 00		the cost	0.00	10.00
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29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 833, 439)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00	28 00		arnes)	0	28 00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 833, 439)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00			ii gcs)		
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 833, 439) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00					
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 833, 439)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  9.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  38.00 Average semi-private room per diem charge (line 30 ÷ line 4)  39.00 Average per diem private room cost differential (line 34 x line 31)  50.00 35.00  35.00 36.00  36.00  37.00  37.00  38.00  39.00  40.00	31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 833, 439)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  34.00 35.00 35.00 36.00 37.00 36.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37					
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 833, 439)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  35.00 36.00 37.00  37.00 37.00  38.00 37.00					
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 833, 439)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 37.00  37.00 38.00  38.00 39.00			tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2,833,439 and 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)					
27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00			fferential (line	-	
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00	37.00		Torontial (Tille	2, 000, 407	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00					
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 40.00					
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)					
41.00   Total Program general impatient routine service cost (Tine 39 + Tine 40)					
	41.00	Tiotal Program general impatient routine service cost (fine 39 + fine 40)	I		41.00

	Financial Systems MER ATION OF INPATIENT OPERATING COST	MORIAL HOSP & H	HEALTH CARE CTI		In Lie Peri od:	u of Form CMS-2 Worksheet D-1	
COMPUT	ATTON OF INFATTENT OFERATING COST			CCN: 15-5305	From 07/01/2021 To 06/30/2022		
						11/29/2022 11	
			litle	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description	Total Inpati ent	Total Inpati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
42. 00	NURSERY (title V & XIX only)	1. 00	2.00	3. 00	4. 00	5. 00	42.00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT					 	43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description			•		1. 00	
48. 00	Program inpatient ancillary service cost (Wk					1. 00	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)	(see instructi	ons)			49. 00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, su	m of Parts I and		50.00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancilla	ry services (f	rom Wkst. D,	sum of Parts II		51.00
52.00	Total Program excludable cost (sum of lines						52.00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, non-ph	ysician anest	hetist, and		53.00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						54.00
55. 00	, 9						55.00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing coot and to	arget emount (	lino E4 minuo	Line E2)		56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and to	arget amount (	Title 56 IIITlus	111le 55)		58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and c	ompounded by the	<u> </u>	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, u	pdated by the	market basket			60.00
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less than				,	 	61.00
	amount (line 56), otherwise enter zero (see		ts (Tries or X	00), 01 1% 0	r the target		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instr	uctions)				62. 00 63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost renort	ing period (See		64.00
	instructions)(title XVIII only)	· ·		·			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts arter becenii	ber 31 of the	cost reportin	g perrod (see		65.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	II only). For		66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	h December 31	of the cost r	eporting period		67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after l	December 31 of	the cost rep	orting period		68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs	(line 67 + lin	e 68)			69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil				)	2, 833, 439	70. 00
71.00	Adjusted general inpatient routine service c				,	651. 37	1
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	•	m (line 14 v l	ine 35)		2, 043, 999	72. 00 73. 00
74. 00	Total Program general inpatient routine serv					2, 043, 999	
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	Worksheet B,	Part II, column	0	75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	,				1	76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu					0	
79.00	Aggregate charges to beneficiaries for exces			,	70)	0	
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		cost limitatio	n (iine 78 Mi	nus iine 79)	0.00	1
82.00	Inpatient routine service cost limitation (	ine 9 x line 8				0	82.00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		ns)			2, 043, 999 940, 824	
85.00	Utilization review - physician compensation	(see instruction				0	85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		hrough 85)			2, 984, 823	86. 00
87. 00	Total observation bed days (see instructions	)				0	
	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se						88. 00 89. 00
	, 37 (30)		•			. 91	

Health Financial Systems ME	MORIAL HOSP &	HEALTH CARE CTF	?	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 07/01/2021		
		Component	CCN: 15-5305	To 06/30/2022	Date/Time Pre 11/29/2022 11	pared:
		Ti +l o	XVIII	Skilled Nursing		. 30 aiii
		11116	AVIII	Facility	113	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
555 551151 55551 Pt1 611	0001	(from line	col umn 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		,		(from line	(col. 3 x	
				89)	col. 4) (see	
				,	instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	C	0	0. 00000	00	0	90.00
91.00 Nursing Program cost	C	0	0. 00000	00	0	91.00
92.00 Allied health cost	0	0	0. 00000	00	0	92.00
93.00 All other Medical Education	0	0	0. 00000	0 0	0	93.00

	Financial Systems MEMORIAL HOSP & HE			u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0115	Peri od: From 07/01/2021	Worksheet D-1	
				Date/Time Pre	
		Title XIX	Hospi tal	11/29/2022 11 Cost	:30 am
	Cost Center Description	THE AIX	1103pi tai	0031	
	<u> </u>			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed da	uvs excluding newborn)		12, 313	1.00
2. 00	Inpatient days (including private room days, excluding swing			12, 313	2.00
3. 00	Private room days (excluding swing-bed and observation bed of		rivate room days,	0	3.00
	do not complete this line.		-		
1.00	Semi-private room days (excluding swing-bed and observation			8, 871	4.00
. 00	Total swing-bed SNF type inpatient days (including private r reporting period	room days) through December	er 31 of the cost	0	5. 00
. 00	Teporiting period Total swing-bed SNF type inpatient days (including private r	nom days) after December	31 of the cost	0	6. 00
. 00	reporting period (if calendar year, enter 0 on this line)	com days) arter becomber	or or the cost	· ·	0.00
. 00	Total swing-bed NF type inpatient days (including private ro	oom days) through Decembe	r 31 of the cost	0	7. 00
	reporting period			_	
3. 00	Total swing-bed NF type inpatient days (including private re	oom days) after December :	31 of the cost	0	8. 00
. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Program (excluding	n swing_hed and	103	9. 00
. 00	newborn days) (see instructions)	to the rrogram (exertain)	g swillig bed dild	103	7.00
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10.00
	through December 31 of the cost reporting period (see instru			_	
1. 00	Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11. 00
2. 00	December 31 of the cost reporting period (if calendar year, Swing-bed NF type inpatient days applicable to titles V or X		te room days)	0	12. 00
2.00	through December 31 of the cost reporting period	arx only (merdaring priva	te room days)	O	12.00
3. 00	Swing-bed NF type inpatient days applicable to titles V or X			0	13.00
	after December 31 of the cost reporting period (if calendar				
4.00	Medically necessary private room days applicable to the Prog	ram (excluding swing-bed	days)	0	14.00
5. 00 6. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			1, 600 55	
0.00	SWING BED ADJUSTMENT				10.00
7. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0.00	17.00
	reporting period				
8. 00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0. 00	18. 00
9. 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	es through December 31 o	f the cost	0.00	19. 00
7. 00	reporting period	es through beechber 51 0	the cost	0.00	17.00
0.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20.00
	reporting period				
1.00	Total general inpatient routine service cost (see instruction			12, 361, 547	21.00
2. 00	Swing-bed cost applicable to SNF type services through Decem $5 \times 1$ ine 17)	nber 31 of the cost repor	ting period (line	0	22. 00
3. 00	Swing-bed cost applicable to SNF type services after December	er 31 of the cost reporti	na period (line 6	0	23. 00
	x line 18)				
4. 00	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost report	ing period (line	0	24. 00
E 00	7 x line 19)	21 of the cost marries	a ported (line o	0	25 00
5. 00	Swing-bed cost applicable to NF type services after December $x$ line 20)	31 of the cost reporting	g perioa (iine 8	0	25. 00
6. 00	Total swing-bed cost (see instructions)			0	26. 00
7. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		12, 361, 547	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
8.00	General inpatient routine service charges (excluding swing-b	ed and observation bed cl	harges)	0	28. 00

	Cost Center Description	1.00	
	DART I ALL DROWLDED COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12, 313	1.00
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12, 313	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
0.00	do not complete this line.	· ·	0.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	8, 871	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost		5. 00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	103	9. 00
9.00	newborn days) (see instructions)	103	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
.0.00	through December 31 of the cost reporting period (see instructions)	· ·	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
14.00		0	14.00
15.00	Total nursery days (title V or XIX only)	1, 600	
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT	55	16. 00
17 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
17.00	reporting period	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
	reporting period		
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
	reporting period		
20. 00		0. 00	20. 00
21 00	reporting period	10 0/1 547	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	12, 361, 547 0	21. 00 22. 00
22.00	5 x line 17)	U	22.00
23. 00		0	23. 00
20.00	x line 18)		20.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
04 05	x line 20)	_	04 00
26.00		10 2/1 5/7	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	12, 361, 547	27. 00
28 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Pri vate room charges (excluding swing-bed charges)	0	
30.00		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	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	12, 361, 547	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 003. 94	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	1,003.74	39.00
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	103, 406	
			•

CUMPLIT	Financial Systems ME ATION OF INPATIENT OPERATING COST	MORIAL HOSP & H	Provider C		In Lie Period:	u of Form CMS-2 Worksheet D-1	
CUMPUI	ATTOM OF INFATIENT OPERATING COST		Frovi der C	1	Period: From 07/01/2021 Fo 06/30/2022		
						11/29/2022 11	
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	Program Cost	
		I npati ent	Inpatient	Diem (col. 1	g	(col. 3 x	
		1.00	Days 2.00	÷ col . 2) 3.00	4.00	<u>col . 4)</u> 5. 00	
42. 00	NURSERY (title V & XIX only)	1, 205, 523	1, 600			41, 440	42.00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT	6, 277, 151	4, 472	1, 403. 60	129	181, 072	43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT						45.00
46. 00							46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					355, 327	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(	see instructi	ons)		681, 245	49.00
50. 00	Pass through costs applicable to Program inp	atient routine	servi ces (fro	m Wkst. D, sum	of Parts I and	0	50.00
			•				
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillar	y services (f	rom Wkst. D, s	um of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclu		lated, non-phy	ysician anesth	etist, and	0	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	54.00
	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	rgot amount (	lino 56 minus	Lino 52)	0	
58. 00	Bonus payment (see instructions)	ing cost and ta	inger amount (	The 50 minus	111le 55)	0	1
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, i	updated and co	mpounded by the	0.00	59.00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost roport un	dated by the	markot baskot		0.00	60.00
	If line 53/54 is less than the lower of line				the amount by	0.00	61.00
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	Instructions)				0	62.00
63.00	1	ent (see instru	ctions)				63.00
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	to through Doo	mbox 21 of th	a agat manamti	ng pariod (Caa	0	64.00
64. 00	instructions)(title XVIII only)	its through bece	illiber 31 Of the	e cost reporti	ng perrou (see	U	04.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporting	period (See	0	65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66.00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	o costs through	Docombor 21	of the cost re	porting poriod	0	67.00
07.00	(line 12 x line 19)	le costs till ough	December 31 (	or the cost re	por tring perrou	O	07.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	rting 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 N Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service c	•		, ,			71.00
72. 00	Program routine service cost (line 9 x line	,					72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv	•	7				73.00
75.00	Capital-related cost allocated to inpatient	•			art II, column		75.00
7, 00	26, line 45)	0)			·		7, 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu						78.00
79. 00	Aggregate charges to beneficiaries for exces	, ,		,	70)		79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost limitation	n (line 78 min	us line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost per dreim frim		)				82.00
83. 00	Reasonable inpatient routine service costs (	see instruction	* .				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ins)				84. 00 85. 00
86.00	Total Program inpatient operating costs (sum	•					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	, , , , , , , , , , , , , , , , , , ,				
	Total observation bed days (see instructions	)				3, 442	87.00
87. 00 88. 00	Adjusted general inpatient routine cost per	diem (line 27 -	line 2)			1, 003. 94	88 00

Health Financial Systems ME	MORIAL HOSP & F	HEALTH CARE CTR	2	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Period: From 07/01/2021	Worksheet D-1	
				To 06/30/2022	Date/Time Pre 11/29/2022 11	pared: :30 am
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	738, 833	12, 361, 547	0. 05976	9 3, 455, 561	206, 535	90.00
91.00 Nursing Program cost	0	12, 361, 547	0.00000	0 3, 455, 561	0	91.00
92.00 Allied health cost	0	12, 361, 547	0.00000	0 3, 455, 561	0	92.00
93.00 All other Medical Education	0	12, 361, 547	0. 00000	3, 455, 561	0	93.00

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0115		Worksheet D-1
	Component CCN: 15-S115	From 07/01/2021 To 06/30/2022	
	Title XIX	Subprovi der -	Cost
		I PF	

			I PF		
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			1, 337	1. 00 2. 00
2. 00 3. 00	Private room days (excluding swing-bed and observation bed da		vate room days	1, 337 0	3.00
0.00	do not complete this line.	ye) yeuave ey p	rato room dayo,		0.00
4. 00	Semi-private room days (excluding swing-bed and observation b			1, 337	4.00
5. 00	Total swing-bed SNF type inpatient days (including private roreporting period	om days) through December	31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December 3	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
7.00	reporting period	iii days) trii dagii beceiibei	31 Of the cost	O	7.00
8. 00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December 3°	l of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swi ng-bed and	531	9. 00
40.00	newborn days) (see instructions)				10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		oom days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private ro	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		e room davs)	0	12.00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13. 00
14. 00	Medically necessary private room days applicable to the Progr			0	14.00
15.00	Total nursery days (title V or XIX only)			1, 600	15. 00
16. 00	Nursery days (title V or XIX only)			55	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	f the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of t	the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19. 00
	reporting period	Ü			
	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of tr	ne cost	0.00	20. 00
21.00	Total general inpatient routine service cost (see instruction			2, 349, 077	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb $5 \times 1$ ine 17)	er 31 of the cost reporti	ng period (iine	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through Decembe $7 \times 1$ ine $19$ )	r 31 of the cost reportin	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
26 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 349, 077	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		, 1		
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed cha	arges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31.00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	. True 20)		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 mi	nus line 33)(see instruct	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li		1 0113)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	110 01)		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost dit	fferential (line		37.00
37.00	27 minus line 36)	and private room cost uri	Torontrai (Tille	2, 347, 077	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see		T	1, 756. 98	20 00
38. 00 39. 00	Program general inpatient routine service cost per diem (see	•	-	932, 956	
	Medically necessary private room cost applicable to the Progr			932, 930	40.00
	Total Program general inpatient routine service cost (line 39	,		932, 956	

Health Financial Systems MEMORIAL HOSP & HEAR COMPUTATION OF INPATIENT OPERATING COST				ALTH CARE CTR In Li			eu of Form CMS-2552-10 Worksheet D-1	
COMMISSATION OF INFATILINE OFERATING COST			Component CCN: 15-S115		From 07/01/2021 To 06/30/2022 Date/Time Pi		pared:	
			Ti tl	e XIX	11/29/2022   Subprovi der -   Cos		:30 am	
	Cost Center Description	Total	Total	Average Per	IPF Program Days	Program Cost		
	cost center bescription	Inpatient Cost	I npati ent Days	Diem (col. ÷ col. 2)		(col. 3 x col. 4)		
42.00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4.00	5. 00	42.00	
42.00	Intensive Care Type Inpatient Hospital Units	<u> </u>		<u>J</u> 0. '	00  0		42.00	
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	C	0. (	00 0	0	43. 00 44. 00	
	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT	SURGICAL INTENSIVE CARE UNIT						
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.00	
40.00	Drogram i poeti ent anci llamy comi co cost (MIV	a+ D 2 aal 2	Line 200)			1.00	48. 00	
	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	932, 956						
50.00	Pass through costs applicable to Program inp	0	50.00					
51. 00		0	51.00					
52. 00	and IV) Total Program excludable cost (sum of lines	=0 and =1)				0	52.00	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	0	53.00					
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00	
55.00	Target amount per discharge		0.00	55.00				
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	0	56. 00 57. 00					
58.00	Bonus payment (see instructions)	0	58. 00					
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	0.00	59. 00					
60.00	Lesser of lines 53/54 or 55 from prior year		0.00	•				
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that		0	61.00				
42.00	amount (line 56), otherwise enter zero (see	Ü	0	62.00				
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	0	1					
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	0	64.00					
	instructions)(title XVIII only)							
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	0	65.00					
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	0	66. 00					
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	0	67.00					
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	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 Skilled nursing facility/other nursing facil				")		70. 00	
	Adjusted general inpatient routine service of		71.00					
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		72. 00 73. 00					
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							
75. 00 76. 00	Capital-related cost allocated to inpatient   26, line 45) Per diem capital-related costs (line 75 ÷ li		75. 00 76. 00					
77. 00	Program capital-related costs (line 9 x line		77.00					
78. 00 79. 00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for exces:		78. 00 79. 00					
80. 00	Total Program routine service costs for compa		80.00					
81. 00 82. 00	Inpatient routine service cost per diem limit		81. 00 82. 00					
82.00	Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions)							
84.00	Program inpatient ancillary services (see instructions)							
85. 00 86. 00								
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions	S THROUGH COST				0	87. 00	
88.00	Adjusted general inpatient routine cost per	diem (line 27 ÷				0. 00	88. 00	
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00	

Health Financial Systems		MORIAL HOSP & HEALTH CARE CTR			In Lie	In Lieu of Form CMS-2552-10				
COMPUTATION OF INPATIENT OPERATING COST			Provi der CO		Peri od:	Worksheet D-1				
					From 07/01/2021					
			Component	CCN: 15-S115	To 06/30/2022					
			VI V	Subprovi der -	11/29/2022 11	: 30 am				
I			liti	Title XIX		Cost				
					I PF					
Cost Center Descript	i on	Cost	Routine Cost	column 1 ÷	Total	Observation				
			(from line	column 2	Observati on	Bed Pass				
			21)		Bed Cost	Through Cost				
					(from line	(col. 3 x				
					89)	col. 4) (see				
						instructions)				
		1. 00	2. 00	3. 00	4. 00	5. 00				
COMPUTATION OF OBSERVATION BED PASS THROUGH COST										
90.00 Capital-related cost		253, 325	2, 349, 077	0. 10784	0 0	0	90.00			
91.00 Nursing Program cost		0	2, 349, 077	0. 00000	0 0	0	91.00			
92.00 Allied health cost		0	2, 349, 077	0. 00000	00	0	92.00			
93.00 All other Medical Education	on	0	2, 349, 077	0. 00000	0 0	0	93.00			

Health Financial Systems	MEMORIAL HOSP & HEAI	LTH CARE CTI	₹	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C	CN: 15-0115	Peri od:	Worksheet D-3	
				From 07/01/2021		
				To 06/30/2022	Date/Time Pre 11/29/2022 11	pared:
					11/29/2022 11	:30 am
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col. 2)	
			1.00	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
						1

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program	Inpatient Program Costs	
		To onal ges	Charges	(col . 1 x	
				col . 2)	
	ANDATI ENT. DOUTING OFFINIOS COOT OFFITEDO	1. 00	2. 00	3. 00	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		F 40F F04		00.00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT		5, 125, 524		30.00
31. 00 40. 00	03100 TNTENSIVE CARE UNTT		4, 427, 929		31. 00 40. 00
	04100 SUBPROVI DER – TPF		40, 710 0		41.00
	04300 NURSERY		U		43.00
43.00	ANCI LLARY SERVI CE COST CENTERS				43.00
50. 00	05000 OPERATING ROOM	0. 229059	4, 370, 128	1, 001, 017	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 887609	1, 0, 0, 120	0	52.00
	05300 ANESTHESI OLOGY	0. 297352	342, 830		53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 085708	5, 457, 706		54.00
	05600 RADI OI SOTOPE	0. 082624	179, 254		56.00
60.00	06000 LABORATORY	0. 172726	4, 623, 251	798, 556	60.00
65.00	06500 RESPI RATORY THERAPY	0. 368471	1, 007, 451	371, 216	65.00
66.00	06600 PHYSI CAL THERAPY	0. 314392	1, 477, 539	464, 526	66.00
69.00	06900 ELECTROCARDI OLOGY	0. 159181	5, 807, 212	924, 398	69.00
69. 01	06901 PULMONARY	0.000000	0	0	69. 01
69. 02	06902 CARDI OPULMONARY	0. 236443	0	0	69. 02
69. 03	06903 SLEEP LAB	0. 337319	0	0	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 148754	1, 297, 563		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 289305	4, 012, 332	1, 160, 788	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 199183	11, 561, 112		73. 00
74. 00	07400 RENAL DI ALYSI S	0.000000	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS				
	08800 RURAL HEALTH CLINIC	0. 000000		0	88. 00
	08801 RURAL HEALTH CLINIC II	0. 000000		0	88. 01
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLI NI C	0. 282858	40, 174		90.00
90. 01	09001   MED	0.000000	0	0	90. 01
	09002 ONCOLOGY	0. 230219	81, 742		90.02
	09003 OUTPATIENT CENTER	0.000000	0 050	0	90.03
	09004 HBURG URGENT CARE CLINIC	0. 442419	2, 050	1	90.04
	09005 DIABETES MGMT CLINIC 09100 EMERGENCY	0.779007	0 4, 986, 344	725 220	90. 05 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 145445 0. 397265	4, 966, 344		91.00
92.00	OTHER REIMBURSABLE COST CENTERS	0. 397203	412, 377	103, 902	92.00
95. 00	09500 AMBULANCE SERVI CES				95.00
	09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000	0	0	96.00
200.00		3.000000	45, 659, 265		
201.00			10, 007, 200	3, 721, 040	201.00
202.00			45, 659, 265		202.00
	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	1	,, 200	1	

	inancial Systems MEMORIAL HOSP & HE NT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0115	Period:	Worksheet D-3	
		Component	CCN: 15-S115	From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 11	
		Titl∈	× XVIII	Subprovi der – I PF	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
l. N	NDATIENT DOUTINE SEDVICE COST CENTEDS		1.00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS  3000 ADULTS & PEDIATRICS					30.0
4	3100 INTENSIVE CARE UNIT					31.0
	4000 SUBPROVI DER – I PF			512, 820		40. C
	4100 SUBPROVI DER - I RF			·		41.0
13. 00 O	4300 NURSERY					43.0
	NCILLARY SERVICE COST CENTERS					
	5000 OPERATING ROOM		0. 2290!		0	
	5200 DELIVERY ROOM & LABOR ROOM		0. 88760		0	
	5300 ANESTHESI OLOGY		0. 2973		0	
	5400 RADI OLOGY-DI AGNOSTI C		0. 08570	·	2, 233	
	5600 RADI OI SOTOPE 6000 LABORATORY		0. 08262 0. 17272		12 410	
	6500 RESPI RATORY THERAPY		0. 17272	· ·	13, 410 135	1
	6600 PHYSI CAL THERAPY		0. 31439		357	
	6900 ELECTROCARDI OLOGY		0. 15918	·	618	1
	6901 PULMONARY		0. 00000	·	0.0	1
	6902 CARDI OPULMONARY		0. 2364		0	
	6903 SLEEP LAB		0. 3373	19 0	0	69.
0.00 0	7000 ELECTROENCEPHALOGRAPHY		0.00000	00	0	70.
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1487	54 19	3	71.
	7200 IMPL. DEV. CHARGED TO PATIENTS		0. 28930		0	
	7300 DRUGS CHARGED TO PATIENTS		0. 19918	· ·	11, 043	
4.00	7400 RENAL DIALYSIS UTPATIENT SERVICE COST CENTERS		0.00000	00 0	0	74.0
	8800 RURAL HEALTH CLINIC		0.0000	00	0	88.
	8801 RURAL HEALTH CLINIC II		0. 00000		0	
	8900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
	9000 CLI NI C		0. 2828	58 0	0	90.
0. 01 0	9001 I MED		0.00000	00	0	90.
0.02 0	9002 ONCOLOGY		0. 2302	19 0	0	90.
	9003 OUTPATIENT CENTER		0.00000		0	
	9004 HBURG URGENT CARE CLINIC		0. 4424		0	
	9005 DIABETES MGMT CLINIC		0. 77900		0	
	9100 EMERGENCY		0. 14544	·	12, 728	1
	9200 OBSERVATION BEDS (NON-DISTINCT PART) THER REIMBURSABLE COST CENTERS		0. 3972	65 0	0	92.0
	9500 AMBULANCE SERVICES					95.
	9600 DURABLE MEDI CAL EQUI P-RENTED		0. 00000	00	n	96.
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0.0000	252, 055	40, 527	1
201. 00	Less PBP Clinic Laboratory Services-Program only charg	es (line 61)		0	, 02.	201. (
202.00	Net charges (line 200 minus line 201)		1	252, 055		202. (

	<del>_</del>	& HEALTH CARE CTF		D!		u of Form CMS-2	
INPAILENT A	NCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0115	Peri	oa: n 07/01/2021	Worksheet D-3	5
		Component	CCN: 15-T115	To	06/30/2022	Date/Time Pre 11/29/2022 11	epared:
		Title	XVIII	Sul	oprovi der – I RF	PPS	
	Cost Center Description		Ratio of Cos	st	Inpatient	I npati ent	
	Cook Control Bood ( p.t. o.)		To Charges		Program	Program Costs	
					Charges	(col . 1 x	
					ŭ	col . 2)	
			1.00		2. 00	3. 00	
	FIENT ROUTINE SERVICE COST CENTERS		T				
	ADULTS & PEDIATRICS						30.00
	INTENSIVE CARE UNIT						31.00
	SUBPROVI DER - I PF				010 1/0		40.00
	SUBPROVI DER – I RF NURSERY				818, 169		41.00
	LLARY SERVICE COST CENTERS						43.00
	OPERATING ROOM		0. 2290	59	ol	0	50.00
	DELIVERY ROOM & LABOR ROOM		0. 8876		ő	0	
	ANESTHESI OLOGY		0. 2973		319	95	
	RADI OLOGY-DI AGNOSTI C		0. 0857		11, 378	975	
	RADI OI SOTOPE		0. 0826		o	0	56.00
60.00 06000	LABORATORY		0. 1727	26	44, 417	7, 672	60.00
	RESPI RATORY THERAPY		0. 3684	71	5, 601	2, 064	65.00
	PHYSI CAL THERAPY		0. 3143	92	833, 268	261, 973	
	ELECTROCARDI OLOGY		0. 1591		12, 122	1, 930	1
	PULMONARY		0.0000		0	0	
	CARDI OPULMONARY		0. 2364		0	0	
	SLEEP LAB		0. 3373		0	0	
	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 0000 0. 1487		1 442	0 247	
	IMPL. DEV. CHARGED TO PATIENTS		0. 1467		1, 663 0	0	
	DRUGS CHARGED TO PATIENTS		0. 2843		155, 552	30, 983	
	RENAL DIALYSIS		0.0000		0	0	1
OUTPA	ATIENT SERVICE COST CENTERS		0.0000	00			1 55
88. 00 08800	RURAL HEALTH CLINIC		0.0000	00		0	88. 00
88. 01 08801	RURAL HEALTH CLINIC II		0.0000	00		0	88. 01
	FEDERALLY QUALIFIED HEALTH CENTER		0. 0000			0	
	CLINIC		0. 2828		950	269	
	I MED		0.0000		0	0	1
	ONCOLOGY		0. 2302		0	0	1
	OUTPATIENT CENTER		0.0000		0	0	
	HBURG URGENT CARE CLINIC		0. 4424		0	0	
	DIABETES MGMT CLINIC  EMERGENCY		0. 7790 0. 1454		0 180	0 26	
	OBSERVATION BEDS (NON-DISTINCT PART)		0. 1434		0	0	
	R REIMBURSABLE COST CENTERS		0.3772	00			/2.00
	AMBULANCE SERVICES						95.00
	DURABLE MEDICAL EQUIP-RENTED		0. 0000	00	o	0	
200.00	Total (sum of lines 50 through 94 and 96 through 9	98)			1, 065, 450	306, 234	
201.00	Less PBP Clinic Laboratory Services-Program only of				o		201.00
202. 00	Net charges (line 200 minus line 201)		1		1, 065, 450		202.00

	cial Systems MEMORIAL HOSP ICILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	u of Form CMS-2 Worksheet D-3	
				From 07/01/2021		
		Component	CCN: 15-5305	To 06/30/2022	Date/Time Pre 11/29/2022 11	epared: :30 am
		Title	XVIII	Skilled Nursing	PPS	
			1	Facility		
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program Charges	Program Costs (col. 1 x	
				charges	col . 2)	
			1.00	2.00	3. 00	
	ENT ROUTINE SERVICE COST CENTERS					
	ADULTS & PEDI ATRI CS					30.00
	INTENSIVE CARE UNIT					31.00
	SUBPROVIDER - I PF					40.00
	SUBPROVI DER - I RF NURSERY					41.00
	LARY SERVICE COST CENTERS					43.00
	OPERATING ROOM		0. 2290	59 0	0	50.00
	DELIVERY ROOM & LABOR ROOM		0. 8876		0	
	ANESTHESI OLOGY		0. 2973		0	
54.00 05400	RADI OLOGY-DI AGNOSTI C		0. 0857	08 80, 805	6, 926	54.00
	RADI OI SOTOPE		0. 0826	24 0	0	56.00
	LABORATORY		0. 1727		68, 297	1
	RESPI RATORY THERAPY		0. 3684		18, 225	
1 1	PHYSI CAL THERAPY		0. 3143		589, 312	
	ELECTROCARDI OLOGY PULMONARY		0. 1591 0. 0000		2, 082 0	
	CARDI OPULMONARY		0.0000		0	
	SLEEP LAB		0. 3373		0	
	ELECTROENCEPHALOGRAPHY		0.0000		0	1
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1487		2, 638	
	IMPL. DEV. CHARGED TO PATIENTS		0. 2893		0	72.00
	DRUGS CHARGED TO PATIENTS		0. 1991	1, 271, 320	253, 225	73.00
	RENAL DIALYSIS		0.0000	00	0	74.00
	FIENT SERVICE COST CENTERS			00		
	RURAL HEALTH CLINIC RURAL HEALTH CLINIC II		0.0000 0.0000		0	
	FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
	CLINIC		0. 2828		119	
90. 01 09001			0.0000		0	
	ONCOLOGY		0. 2302		0	1
	OUTPATIENT CENTER		0.0000	00	0	90.03
90. 04 09004	HBURG URGENT CARE CLINIC		0. 4424	19 0	0	90.04
	DIABETES MGMT CLINIC		0. 7790		0	
	EMERGENCY		0. 1454		0	
	OBSERVATION BEDS (NON-DISTINCT PART)		0. 3972	65 0	0	92.00
	REIMBURSABLE COST CENTERS AMBULANCE SERVICES		1			95.00
	DURABLE MEDICAL EQUIP-RENTED		0.0000	0	n	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 9	8)	0.0000	3, 702, 684	940, 824	
201.00	Less PBP Clinic Laboratory Services-Program only c			0,752,661	, ,	201.00
	Net charges (line 200 minus line 201)	3 ( 1 1 1 )	1	3, 702, 684		202.00

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

	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0115	Peri od:	Worksheet D-3	
				From 07/01/2021	D . (T) D	
				To 06/30/2022	Date/Time Pre 11/29/2022 11	
		Ti tl	e XIX	Hospi tal	Cost	. 30 aiii
	Cost Center Description		Ratio of Cos		I npati ent	
	555t 55.1to. 5555t pt. 51.		To Charges	Program	Program Costs	
				Charges	(col . 1 x	
				3.1	col . 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS			266, 001		30.00
31.00	03100 I NTENSI VE CARE UNI T			361, 555		31.00
40.00	04000 SUBPROVI DER - I PF			75, 972		40.00
41.00	04100 SUBPROVI DER - I RF			70, 035		41.00
43.00	04300 NURSERY			0		43.00
F0 00	ANCILLARY SERVICE COST CENTERS			105 000	0.4.47	
50.00	05000 OPERATING ROOM		0. 2290			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 8876		0	52.00
53.00	05300 ANESTHESI OLOGY		0. 2973		3, 544	1
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 0857			
56.00	05600 RADI 0I SOTOPE		0. 0826	· ·		1
60.00	06000 LABORATORY		0. 1727		40, 841	60.00
65.00	06500 RESPIRATORY THERAPY		0. 3684			1
66.00	06600 PHYSI CAL THERAPY		0. 3143		10, 605	66.00
69.00	06900 ELECTROCARDI OLOGY		0. 1591	· ·		1
69. 01	06901 PULMONARY		0.0000		1	69. 01
69. 02	06902 CARDI OPULMONARY		0. 2364		0	
69. 03	06903 SLEEP LAB		0. 3373		0	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY		0.0000		0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1487			•
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2893		7, 440	1
	07300   DRUGS CHARGED TO PATIENTS   07400   RENAL DI ALYSIS		0. 1991 0. 0000	· ·		1
74.00	OUTPATIENT SERVICE COST CENTERS		0.0000	0	0	74.00
88. 00	08800 RURAL HEALTH CLINIC		0. 9912	51 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II		1. 0185		0	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		l ő	89.00
90.00	09000 CLINIC		0. 2828			90.00
90. 01	09001 I MED		0.0000	· ·	0	90. 01
90. 02	09002 ONCOLOGY		0. 2302			90.02
90. 03	09003 OUTPATIENT CENTER		0.0000		0	90. 03
90. 04	09004 HBURG URGENT CARE CLINIC		0. 4424		0	90.04
90. 05	09005 DI ABETES MGMT CLINIC		0. 7790		0	90.05
91. 00	09100 EMERGENCY		0. 1454		34, 491	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 3972		750	92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES					95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		0.0000	00	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			1, 888, 050	355, 327	200.00
201.00		s (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)			1, 888, 050		202. 00

Health Fir	nancial Systems MEMORIAL HOSP	& HEALTH CARE CTI	R	In Lie	u of Form CMS-:	2552-10
	ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			CCN: 15-S115	From 07/01/2021 To 06/30/2022		pared:
		Ti tI	e XIX	Subprovi der -	Cost	. 30 alli
				I PF		
	Cost Center Description		Ratio of Cos	•	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1 00	2.00	col . 2) 3.00	
LND	ATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3.00	
	OO ADULTS & PEDIATRICS					30.00
	OO INTENSIVE CARE UNIT					31.00
	OOO SUBPROVI DER - I PF			75, 972		40.00
41.00 041	00 SUBPROVI DER - I RF					41.00
43.00 043	NURSERY					43.00
ANC	ILLARY SERVICE COST CENTERS					
	OOO OPERATING ROOM		0. 2290	59 0	0	50.00
	OO DELIVERY ROOM & LABOR ROOM		0. 8876			
	OO ANESTHESI OLOGY		0. 2973			
	00 RADI OLOGY-DI AGNOSTI C		0. 0857			
	000 RADI OI SOTOPE		0. 0826			
	OO LABORATORY		0. 1727			
	600 RESPI RATORY THERAPY		0. 3684			
	000 PHYSI CAL THERAPY 1000 ELECTROCARDI OLOGY		0. 3143 0. 1591			
	OU PULMONARY		0.1591			
	O2 CARDI OPULMONARY		0. 0000			
	103 SLEEP LAB		0. 3373			
	OO ELECTROENCEPHALOGRAPHY		0.0000			
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1487			
	OO IMPL. DEV. CHARGED TO PATIENTS		0. 2893		0	
73.00 073	OO DRUGS CHARGED TO PATIENTS		0. 1991	83 0	0	73.00
	OO RENAL DIALYSIS		0.0000	00 0	0	74.00
	PATIENT SERVICE COST CENTERS					
	OO RURAL HEALTH CLINIC		0. 9912			
	OI RURAL HEALTH CLINIC II		1. 0185			
	100 FEDERALLY QUALIFIED HEALTH CENTER		0.0000			
	000 CLINIC		0. 2828			
	001 I MED		0.0000			
	102 ONCOLOGY 103 OUTPATIENT CENTER		0. 2302 0. 0000			
	104 HBURG URGENT CARE CLINIC		0. 0000			
	005 DI ABETES MGMT CLINIC		0. 7790			1
	OO EMERGENCY		0. 1454			
	OO OBSERVATION BEDS (NON-DISTINCT PART)		0. 3972			
	ER REIMBURSABLE COST CENTERS					1
	OO AMBULANCE SERVICES					95.00
96. 00 096	OO DURABLE MEDICAL EQUIP-RENTED		0.0000	00	0	96.00
200. 00	Total (sum of lines 50 through 94 and 96 through 9	,		0		200.00
201. 00	Less PBP Clinic Laboratory Services-Program only of	charges (line 61)		0		201.00
202. 00	Net charges (line 200 minus line 201)		1	0		202.00

Health Financial Systems	MEMORIAL HOSP & HEA	LTH CARE CTR	u of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0115	Peri od: From 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Prepared: 11/29/2022 11:30 am
		T: +1 o V/// / /	Heeni tel	DDC

Title XVIII Hospital  PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS  1.00 DRG Amounts Other than Outlier Payments 1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 8, 234 instructions)  1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 6,586)	0 1. 4,447 1.
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS  1.00 DRG Amounts Other than Outlier Payments  1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 8, 234 instructions)	
1.00 DRG Amounts Other than Outlier Payments 1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 8, 234 instructions)	
1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 8,234 instructions)	
instructions)	, 447   1.
1.02   DRG amounts other than outlier payments for discharges occurring on or after October 1 (see   6,580	00/
linetructions)	, 836 1.
instructions) 1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October	0 1.
1 (see instructions)	0 1.
1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after	0 1.
October 1 (see instructions)	٠٠ ا
2.00 Outlier payments for discharges. (see instructions)	2.
2.01 Outlier reconciliation amount	0 2.
2.02 Outlier payment for discharges for Model 4 BPCI (see instructions)	0 2.
2.03 Outlier payments for discharges occurring prior to October 1 (see instructions)	998 2.
	, 789 2.
3.00 Managed Care Simulated Payments 4,310	
	6. 57 4.
Indirect Medical Education Adjustment	0.00
5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)	0.00 5.
6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for	0.00 6.
new programs in accordance with 42 CFR 413. 79(e)	0.00
7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00 7.
7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the	0.00 7.
cost report straddles July 1, 2011 then see instructions.	
8.00 Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for	0.00 8.
affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,	
1998), and 67 FR 50069 (August 1, 2002).	
8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost	0.00 8.
report straddles July 1, 2011, see instructions.	
8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital	0. 00 8.
under § 5506 of ACA. (see instructions) 9.00   Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see	0.00 9.
9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00 9.
10.00 FTE count for allopathic and osteopathic programs in the current year from your records	0.00 10.
11.00 FTE count for residents in dental and podiatric programs.	0.00 11.
12.00 Current year allowable FTE (see instructions)	0.00 12.
13.00 Total allowable FTE count for the prior year.	0.00 13.
14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,	0.00 14.
otherwise enter zero.	
15.00 Sum of lines 12 through 14 divided by 3.	0.00 15.
	4. 53   16.
17.00 Adjustment for residents displaced by program or hospital closure	0.00 17.
	4. 53 18.
	7841 19.
, , ,	4274 20. 4274 21.
· · · · · · · · · · · · · · · · · · ·	4274 21. , 281 22.
	, 686 22.
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA	, 000 22.
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105	0. 00 23.
(f)(1)(iv)(c).	0.00 20.
24.00   IME FTE Resident Count Over Cap (see instructions)	0.00 24.
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see	0.00 25.
instructions)	
26.00 Resident to bed ratio (divide line 25 by line 4) 0.00	0000 26.
27.00 IME payments adjustment factor. (see instructions) 0.00	0000 27.
28.00 IME add-on adjustment amount (see instructions)	0 28.
28.01   IME add-on adjustment amount - Managed Care (see instructions)	0 28.
29.00 Total IME payment ( sum of lines 22 and 28) 1,27	
	29.
Disproportionate Share Adjustment	2 00 20
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2. 09 30.
	6. 17 31.
32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions)	8. 26 32. 4. 62 33.
	, 186 34.
17. 12. 12. 14. 15. 16. 16. 16. 16. 16. 16. 16. 16. 16. 16	, .50  54.

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0115	Peri od: From 07/01/2021 To 06/30/2022	Worksheet E Part A Date/Time Pre 11/29/2022 11	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Adjustment				
. 00	Total uncompensated care amount (see instructions)			7, 192, 008, 710	
. 01	Factor 3 (see instructions)		0. 000159904		
. 02	Hospital uncompensated care payment (If line 34 is zero, instructions)	enter zero on this line) (	see 1, 325, 606	728, 139	35
. 03		amount (see instructions)	334, 126	544, 608	35
00	Total uncompensated care (sum of columns 1 and 2 on line		878, 734		36
	Additional payment for high percentage of ESRD beneficiar	y discharges (lines 40 thre		1	١
00	Total Medicare discharges (see instructions)		0 Before 1/1	On/After 1/1	40
			1.00	1. 01	
. 00	Total ESRD Medicare discharges (see instructions)		0		41
01	Total ESRD Medicare covered and paid discharges (see inst		0	-	
00	Divide line 41 by line 40 (if less than 10%, you do not q	ualify for adjustment)	0.00		42
00	Total Medicare ESRD inpatient days (see instructions) Ratio of average length of stay to one week (line 43 divi	ded by Line 41 divided by	7 0.00000		43
00	days)	ded by Time 41 divided by	0.00000		-
00	Average weekly cost for dialysis treatments (see instruct		0.00	0.00	
00	Total additional payment (line 45 times line 44 times lin	e 41.01)	0		46
00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MD	W cmall rural bosnitals	17, 145, 271 0		48
00	only. (see instructions)	n, Siliati turai nospitars			40
	, (===,		<b>.</b>	Amount	
		The second		1.00	1
00	Total payment for inpatient operating costs (see instruct Payment for inpatient program capital (from Wkst. L, Pt.	•	۵)	17, 514, 957 1, 228, 545	
00	Exception payment for inpatient program capital (Wkst. L,	• •	· ·	1, 228, 343	
00	Direct graduate medical education payment (from Wkst. E-4			330, 941	
00	Nursing and Allied Health Managed Care payment			0	
00	Special add-on payments for new technologies			146, 066	
01 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, li	ne 69)		0	
00	Cost of physicians' services in a teaching hospital (see			0	
00	Routine service other pass through costs (from Wkst. D, P	t. III, column 9, lines 30	through 35).	0	5
00	Ancillary service other pass through costs from Wkst. D,	Pt. IV, col. 11 line 200)		0	
00	Total (sum of amounts on lines 49 through 58)			19, 220, 509 16, 960	
00	Primary payer payments Total amount payable for program beneficiaries (line 59 m	inus Line 60)		19, 203, 549	
00	Deductibles billed to program beneficiaries			1, 947, 908	
00	Coinsurance billed to program beneficiaries			12, 704	6
00	Allowable bad debts (see instructions)			59, 664	
00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see	i netructi one)		38, 782 51	
00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	Thisti deti ons)		17, 281, 719	
00	Credits received from manufacturers for replaced devices	for applicable to MS-DRGs	(see instructions)		
00	Outlier payments reconciliation (sum of lines 93, 95 and	96). (For SCH see instructi	ons)	0	6
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		- !+	0	
50 87	Rural Community Hospital Demonstration Project (§410A Dem Demonstration payment adjustment amount before sequestrat	, ,	e instructions)	0	1
88	SCH or MDH volume decrease adjustment (contractor use onl			0	
89	Pi oneer ACO demonstration payment adjustment amount (see	,			70
90	HSP bonus payment HVBP adjustment amount (see instruction	•		0	
91	HSP bonus payment HRR adjustment amount (see instructions	5)		0	
92 93	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			0 6, 919	
. 73	, , , , , , , , , , , , , , , , , , , ,				
. 94	HRR adjustment amount (see instructions)			-6, 467	1 / (

			Т	0 06/30/2022	Date/Time Pre 11/29/2022 11	pared: :30 am
		Title	e XVIII	Hospi tal	PPS	
			FFY (	уууу)	Amount	
				)	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period prior to 10/1)	n column 0	20	21	115, 709	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af		20	22	358, 818	70. 97
70. 98	Low Volume Payment-3	,			0	70. 98
70. 99	HAC adjustment amount (see instructions)				180, 760	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			17, 575, 938	71.00
71. 01	Sequestration adjustment (see instructions)				43, 940	71. 01
71. 02	Demonstration payment adjustment amount after sequestration				0	71.02
71. 03	Sequestration adjustment-PARHM pass-throughs					71.03
72.00	Interim payments				16, 324, 714	72.00
72. 01	Interim payments-PARHM					72. 01
73. 00	Tentative settlement (for contractor use only)				0	73.00
73. 01	Tentative settlement-PARHM (for contractor use only)	0 70			4 007 004	73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.0 73)	2, 72, and			1, 207, 284	74. 00
74.01	Balance due provider/program-PARHM (see instructions)					74. 01
75.00	Protested amounts (nonallowable cost report items) in accorda	nce with			426, 963	75.00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.00
	plus 2.04 (see instructions)					
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instr	,			0	92.00
93. 00	Capital outlier reconciliation adjustment amount (see instruc	,			0	93.00
94.00	The rate used to calculate the time value of money (see instr	uctions)			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 instruc	trons)		Dri or to 10/1	0 (After 10/1	96.00
				Prior to 10/1 1.00	2.00	
	HSP Bonus Payment Amount				2.00	
100.00	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instruction	s)		0	0	102.00
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0. 0000	0.0000	
104. 00	HRR adjustment amount for HSP bonus payment (see instructions			0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonst					
200.00	Is this the first year of the current 5-year demonstration pe	riod under	the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					
201 00	Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	0. 40)				201. 00
	Medicare discharges (see instructions)	C 47)				201.00
	Case-mix adjustment factor (see instructions)					203.00
203.00	Computation of Demonstration Target Amount Limitation (N/A in	first vear	of the curren	t 5-vear demons		203.00
	period)	TITSE year	or the current	i o year demons	ti ati on	
204.00	Medicare target amount					204. 00
	Case-mix adjusted target amount (line 203 times line 204)					205. 00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement					
	Program reimbursement under the §410A Demonstration (see inst					207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	line 59)				208. 00
209.00	Adjustment to Medicare IPPS payments (see instructions)					209. 00
210.00	Reserved for future use					210. 00
211. 00	Total adjustment to Medicare IPPS payments (see instructions)					211. 00
	Comparision of PPS versus Cost Reimbursement					
	Total adjustment to Medicare Part A IPPS payments (from line	211)				212. 00
	Low-volume adjustment (see instructions)					213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS a	na cost rei:	mbursement)			218. 00
	(line 212 minus line 213) (see instructions)			ı l		

Provider CCN: 15-0115

Peri od:

LOW VOLUME CALCULATION EXHIBIT 4

Part A Exhibit 4 From 07/01/2021 Date/Time Prepared: 11/29/2022 11:30 am 06/30/2022 Title XVIII Hospi tal W/S E, Part A Amounts (from Period Prior Total (Col 2 Pre/Post Peri od Entitlement to 10/01 On/After through 4) I i ne E. Part A) 10/01 0 1.00 2.00 3.00 4.00 5.00 1.00 DRG amounts other than outlier 1. 00 1.00 payments 1.01 DRG amounts other than outlier 1.01 0 8, 234, 447 1.01 8, 234, 447 8, 234, 447 payments for discharges occurring prior to October 1 1.02 DRG amounts other than outlier 1.02 6, 586, 836 6, 586, 836 6, 586, 836 1.02 payments for discharges occurring on or after October 1 03 DRG for Federal specific 1.03 0  $\cap$ 1.03 operating payment for Model 4 BPCI occurring prior to October 1 DRG for Federal specific 1 04 1 04 0 1.04 operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for 2.00 2.00 discharges (see instructions) 2.01 Outlier payments for 2.02 0 2.01 discharges for Model 4 BPCI Outlier payments for 998 998 2.02 2.03 2.02 discharges occurring prior to October 1 (see instructions) Outlier payments for 1, 789 2.03 1, 789 1, 789 2.04 2.03 discharges occurring on or after October 1 (see instructions) Operating outlier 3.00 2.01 0 3.00 reconciliation 4.00 Managed care simulated 3.00 4, 310, 004 0 4, 310, 004 4, 310, 004 4.00 payments Indirect Medical Education Adjustment Amount from Worksheet E, Part 21. 00 0 164274 0.164274 0.164274 0 164274 5 00 5 00 A, line 21 (see instructions) 6.00 IME payment adjustment (see 22.00 1, 271, 281 0 706, 302 564, 979 1, 271, 281 6.00 instructions) 6.01 IME payment adjustment for 22.01 369, 686 0 369, 686 369, 686 6.01 managed care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor 0. 000000 0.000000 0.000000 0.000000 7.00 27.00 (see instructions) IME adjustment (see 8.00 28.00 0 8.00 instructions) IME payment adjustment add on 8.01 28.01 0 0 0 8.01 for managed care (see instructions) 1, 271, 281 9.00 Total IME payment (sum of 29.00 1, 271, 281 0 706, 302 564, 979 9.00 lines 6 and 8) 9 01 Total IME payment for managed 29 01 369, 686 0 369, 686 369, 686 9.01 care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 0. 0462 10.00 10.00 Allowable disproportionate 33.00 0.04620.0462 0.0462 share percentage (see instructions) Disproporti onate share 11.00 34.00 171, 186 95, 108 76, 078 171, 186 11.00 adjustment (see instructions) Uncompensated care payments 11.01 36, 00 878.734 334, 126 544, 608 878, 734 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment 46. 00 12.00 (see instructions) 13.00 Subtotal (see instructions) 47.00 17, 145, 271 9, 369, 983 7, 775, 288 17, 145, 271 13 00 14.00 Hospital specific payments 48.00 14.00 (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient 17, 514, 957 15. 00 15.00 49.00 17, 514, 957 9, 369, 983 8, 144, 974 operating costs (see instructions)

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0115 Peri od: Worksheet E Part A Exhibit 4 From 07/01/2021 Date/Time Prepared: 11/29/2022 11:30 am 06/30/2022 Title XVIII Hospi tal W/S E, Part A Amounts (from Period Prior Total (Col 2 Pre/Post Peri od Entitlement to 10/01 On/After through 4) I i ne E. Part A) 10/01 0 1.00 2.00 3.00 4.00 5.00 16.00 Payment for inpatient program 50.00 1, 228, 545 309, 661 918, 884 1, 228, 545 16.00 capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for 54.00 146,066 0 48, 689 97, 377 146, 066 17.00 new technologies 17.01 Net organ aquisition cost 17.01 17.02 Credits received from 68.00 0 0 0 0 17.02 manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 0 0 18.00 adjustment amount (see instructions) 9, 728, 333 19.00 SUBTOTAL 18, 889, 568 9, 161, 235 19.00 W/S L, line (Amounts from L) 0 1. 00 2.00 3. 00 4. 00 5. 00 20.00 Capital DRG other than outlier 1.00 1, 101, 594 0 277, 662 823, 932 1, 101, 594 20.00 Model 4 BPCI Capital DRG other 20. 01 1. 01 20.01 0 than outlier 21.00 Capital DRG outlier payments 2.00 488 123 488 21.00 365 Model 4 BPCI Capital DRG 21.01 2. 01 21.01 outlier payments 22.00 Indirect medical education 5.00 22.00 0.1148 0.1148 0. 1148 0.1148 percentage (see instructions) 23.00 Indirect medical education 6.00 126, 463 31, 876 94, 587 126, 463 23.00 adjustment (see instructions) Allowable disproportionate 0.0000 24.00 10.00 0.0000 0.0000 0.0000 24.00 share percentage (see instructions) 25.00 Disproportionate share 11.00 0 C 0 0 25.00 adjustment (see instructions) Total prospective capital 12.00 1, 228, 545 309, 661 918, 884 1, 228, 545 26, 00 payments (see instructions) W/S E, Part A (Amounts to line Part A) 2.00 4. 00 3. 00 5.00 27.00 Low volume adjustment factor 0.011894 0.039167 27.00 Low volume adjustment 70.96 115, 709 28.00 115, 709 28.00 (transfer amount to Wkst. E, Pt. A, line) 29.00 Low volume adjustment 70.97 358, 818 358, 818 29.00 (transfer amount to Wkst. E, Pt. A, line) 100.00 Transfer low volume 100.00 adjustments to Wkst. E, Pt. A.

Health Financial Systems	MEMORIAL HOSP & HEAL	LTH CARE CTR	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0115	Peri od: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Prepared: 11/29/2022 11:30 am

		11/29/2022 11	:30 am
	Title XVIII Hospital	PPS	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7, 735	1.00
2. 00	Medical and other services reimbursed under OPPS (see instructions)	25, 475, 221	2.00
3.00	OPPS payments	27, 217, 582	3.00
4.00	Outlier payment (see instructions)	32, 660	1
4. 01 5. 00	Outlier reconciliation amount (see instructions)	0.000	
6. 00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5	0.000	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	1
8. 00	Transitional corridor payment (see instructions)	0.00	ı
9. 00	Ancillary service other pass through costs from Wkst. D. Pt. IV, col. 13, line 200	0	ł
10.00	Organ acqui si ti ons	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7, 735	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
	Ancillary service charges	38, 889	1
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	38, 889	14. 00
15 00	Customary charges Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
	Amounts that would have been realized from patients liable for payment for services on a chargebasis		
10.00	had such payment been made in accordance with 42 CFR §413.13(e)		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17.00
18.00	Total customary charges (see instructions)	38, 889	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	31, 154	19.00
	instructions)		1
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
04 00	instructions)	7 705	04.00
	Lesser of cost or charges (see instructions)	7, 735	
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructions)	0	22. 00 23. 00
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	27, 250, 242	ı
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	21,230,242	24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25. 00
	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4, 778, 927	1
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	22, 479, 050	•
	instructions)		1
	Direct graduate medical education payments (from Wkst. E-4, line 50)	426, 979	1
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
	Subtotal (sum of lines 27 through 29)	22, 906, 029	1
	Primary payer payments Subtotal (line 30 minus line 31)	6, 734 22, 899, 295	
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	22, 077, 273	32.00
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)	0	33.00
	Allowable bad debts (see instructions)	85, 118	1
	Adjusted reimbursable bad debts (see instructions)	55, 327	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27, 715	36.00
37.00	Subtotal (see instructions)	22, 954, 622	37.00
	MSP-LCC reconciliation amount from PS&R	-35	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration  Partial or full credits received from manufacturers for replaced devices (see instructions)	0	ı
39. 98 39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 98
	Subtotal (see instructions)	22, 954, 657	ł
40. 01	Sequestration adjustment (see instructions)	57, 387	
	Demonstration payment adjustment amount after sequestration	0,,007	1
40. 03	Sequestration adjustment-PARHM pass-throughs		40. 03
	Interim payments	22, 969, 412	41.00
	Interim payments-PARHM		41.01
	Tentative settlement (for contractors use only)	0	
42. 01	Tentative settlement-PARHM (for contractor use only)	70.4:5	42.01
43.00	Balance due provider/program (see instructions)	-72, 142	1
43. 01 44. 00	Balance due provider/program-PARHM (see instructions)	0	43. 01 44. 00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		44.00
	TO BE COMPLETED BY CONTRACTOR	-	
90.00	Original outlier amount (see instructions)	0	90.00
	Outlier reconciliation adjustment amount (see instructions)	0	
	The rate used to calculate the Time Value of Money	0.00	
	Time Value of Money (see instructions)	0	•
94.00	Total (sum of lines 91 and 93)	0	94.00

Health Financial Systems	MEMORIAL HOSP & HEA	LTH CARE CTR	In Lieu	of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0115	Peri od:	Worksheet E	
			From 07/01/2021	Part B	
			To 06/30/2022	Date/Time Pre	
				11/29/2022 11	:30 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200.00

Part I

06/30/2022 Date/Time Prepared: 11/29/2022 11:30 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 16, 220, 814 22, 875, 212 1.00 Interim payments payable on individual bills, either 2 00 2 00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero List separately each retroactive lump sum adjustment 3.00 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 03/16/2022 103, 900 03/16/2022 94, 200 3.01 3.02 3.02 0 3 03 0 0 3 03 3.04 0 0 3.04 3.05 3.05 0 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 0 3.51 3.51 0 0 3.52 3.52 3 53 0 0 3 53 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 103, 900 94, 200 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 22, 969, 412 4.00 16, 324, 714 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after 5.00 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATI VE TO PROVI DER 0 0 5.01 0 0 5.02 0 5.02 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 5.52 0 0 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 5.99 5. 50-5. 98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 1, 207, 284 6.01 SETTLEMENT TO PROGRAM 6.02 72, 142 6.02 17, 531, 998 22, 897, 270 7.00 Total Medicare program liability (see instructions) 7.00 Contractor NPR Date Number (Mo/Day/Yr) 1.00 2.00 8.00 Name of Contractor 8 00

Provider CCN: 15-0115

Peri od:

From 07/01/2021

Component CCN: 15-S115

Subprovi der -Title XVIII

		Titl∈	xVIII	Subprovi der - I PF	PPS	
		I npati er	it Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		219, 486		0	
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	
3. 02			0		0	
3. 03 3. 04						
3. 04					0	
3. 03	Provider to Program			1		3.03
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51			0	)	0	3. 51
3. 52			0		0	
3.53			0		0	
3. 54			0		0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C		0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		219, 486		0	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		217, 400	•		4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR				•	
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider				L	
5. 01	TENTATI VE TO PROVI DER				0	5. 01
5. 02	TENTATI VE TO TROVIDER					
5. 03					o o	
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		C		0	
5. 51			0		0	
5. 52	6 1 1 1 1 1 (		0		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6.00
5. 00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		12, 776	,	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	
7. 00	Total Medicare program liability (see instructions)		232, 262		0	7. 00
				Contractor	NPR Date	
			<u> </u>	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		<i>y</i>	1.00	2.00	8.00
5. 55	1.10			1	I .	0.00

Component CCN: 15-T115

Subprovi der -Title XVIII

		litle	XVIII	Subprovi der - I RF	PPS	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider	11.00	995, 329		0	1.00
2. 00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	l	l .		l	
3. 01	ADJUSTMENTS TO PROVI DER		0		0	3.01
3. 02			Ö		Ō	3. 02
3.03			0		0	3. 03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53 3. 54			0		0	3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
3. 77	3. 50-3. 98)		0		١	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		995, 329		0	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	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TENTATIVE TO TROVIDER		ĺ		ĺ	5.02
5. 03			Ö		Ö	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		22, 654		0	6. 02
7.00	Total Medicare program liability (see instructions)		972, 675		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			)	1. 00	2. 00	
8. 00	Name of Contractor					8. 00
	·	•		1	•	

Component CCN: 15-5305

Title XVIII Skilled Nursing

		litle	XVIII	Killed Nursing	PPS	
		I npati en	+ Don+ A	Facility	t B	
		<u> </u>				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		1, 604, 275		0	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
0.00	write "NONE" or enter a zero					0.00
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 01	ADJUSTIMENTS TO FROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3. 04			0		0	3. 04
3. 05			0		0	3. 05
3. 03	Provider to Program		0		0	3.03
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51			0		o l	3. 51
3. 52			0		o	3. 52
3. 53			0		0	3.53
3.54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 604, 275		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TERMITTE TO TROTTEEN		0		ő	5. 02
5. 03			0		o l	5. 03
	Provider to Program			<u>'</u>		
5.50	TENTATI VE TO PROGRAM		0		0	5.50
5. 51			0		0	5. 51
5. 52			0		0	5.52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)					. 01
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		1 404 275		0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 604, 275	Contractor	NPR Date	7. 00
				Number	(Mo/Day/Yr)	
		(	)	1, 00	2.00	
8. 00	Name of Contractor					8. 00

Heal th	Financial Systems MEMORIAL HOSP & HEA	LTH CARE CTR	In Lie	u of Form CMS-:	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0115	Peri od: From 07/01/2021	Worksheet E-1 Part II	
			To 06/30/2022	Date/Time Pre	
				11/29/2022 11	:30 am
		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
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.				1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and	8 through 12, and plus	for cost		2.00
	reporting periods beginning on or after 10/01/2013, line 32)				
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1, and 8 through 12, and	d plus for cost		4.00
	reporting periods beginning on or after 10/01/2013, line 32)				
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 I				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c	certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32.00

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0115	Peri od:	Worksheet E-3
	Component CCN: 15-S115	From 07/01/2021 To 06/30/2022	Date/Time Prepared:
			11/29/2022 11:30 am
	Title XVIII	Subprovi der -	PPS
		I PF	

	IPF		
		1. 00	
P	ART II - MEDICARE PART A SERVICES - IPF PPS		Т
00 N	let Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	267, 006	] 1
	let IPF PPS Outlier Payments	9, 870	1
	let IPF PPS ECT Payments	0	1
	Inweighted intern and resident FTE count in the most recent cost report filed on or before November	0.00	-
1	15, 2004. (see instructions)	0.00	
	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0.00	
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		
	lew Teaching program adjustment. (see instructions)	0.00	
	Current year's unweighted FTE count of L&R excluding FTEs in the new program growth period of a "new	v 0.00	İ
	teaching program" (see instuctions)		
	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	v 0. 19	
	teaching program" (see instuctions)		
	ntern and resident count for IPF PPS medical education adjustment (see instructions)	0. 19	
	Average Daily Census (see instructions)	3. 663014	
	Feaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0. 026385	
	Feaching Adjustment (line 1 multiplied by line 10). Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	7, 045 283, 921	
	Augusted Net IPP PP3 Payments (Sum of Times 1, 2, 3 and 11) Nursing and Allied Health Managed Care payment (see instruction)	203, 921	
	Organ acquisition (DO NOT USE THIS LINE)		1
	cost of physicians' services in a teaching hospital (see instructions)	0	
	Subtotal (see instructions)	283, 921	
	Primary payer payments	0	1
00 S	Subtotal (line 16 less line 17).	283, 921	1
00 D	Deducti bl es	31, 812	1
	Subtotal (line 18 minus line 19)	252, 109	
	Coinsurance	26, 290	
	Subtotal (line 20 minus line 21)	225, 819	
- 1	Allowable bad debts (exclude bad debts for professional services) (see instructions)	10, 808	
- 1	Adjusted reimbursable bad debts (see instructions)	7, 025	
	Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (sum of lines 22 and 24)	232, 844	
1	Direct graduate medical education payments (see instructions)	232, 644	
	Other pass through costs (see instructions)	0	
	Outlier payments reconciliation	0	1 -
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	3
50 P	Pioneer ACO demonstration payment adjustment (see instructions)	0	3
	Recovery of accelerated depreciation.	0	1 -
- 1	Demonstration payment adjustment amount before sequestration	0	1 -
- 1	otal amount payable to the provider (see instructions)	232, 844	
- 1	Sequestration adjustment (see instructions)	582	
- 1	Demonstration payment adjustment amount after sequestration	0	
- 1	nterim payments  Entative cottlement (for contractor use only)	219, 486	
- 1	Fentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	12, 776	
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	12,770	
	1115. 2		١٦
	O BE COMPLETED BY CONTRACTOR	·	
00 0	Original outlier amount from Worksheet E-3, Part II, line 2	9, 870	5
00 0	Outlier reconciliation adjustment amount (see instructions)	0	5
- 1	The rate used to calculate the Time Value of Money	0.00	
	Time Value of Money (see instructions)	0	5
_	OR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-		١.
	Feaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	
OI C	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 026385	1 9

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0115	Peri od: From 07/01/2021	Worksheet E-3	
	Component CCN: 15-T115			
	Title XVIII	Subprovi der -	PPS	. 00 4111
		I RF		

	I RF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1.00	Net Federal PPS Payment (see instructions)	963, 228	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0055	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	11, 751	3. 00
4.00	Outlier Payments	3, 765	4.00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	0. 00	5. 01
6.00	New Teaching program adjustment. (see instructions)	0. 00	6. 00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	7. 00
	teaching program" (see instructions)		
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0. 00	8. 00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0. 00	9. 00
10.00	Average Daily Census (see instructions)	2. 624658	10.00
11. 00	Teaching Adjustment Factor (see instructions)	0. 000000	
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	978, 744	
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00			15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17. 00	Subtotal (see instructions)	978, 744	
18.00	Pri mary payer payments	0	18. 00
19.00		978, 744	
20.00	Deducti bl es	4, 596	
21. 00	Subtotal (line 19 minus line 20)	974, 148	
22. 00	Coi nsurance	0	22.00
23.00		974, 148	
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1, 484	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	965	25. 00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	·	975, 113	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29. 00	Other pass through costs (see instructions)	0	29. 00
30.00	Outlier payments reconciliation	0	30.00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31. 50
31. 98	Recovery of accelerated depreciation.	0	31. 98
31. 99	Demonstration payment adjustment amount before sequestration	0	31. 99
32.00	Total amount payable to the provider (see instructions)	975, 113	
32. 01	Sequestration adjustment (see instructions)	2, 438	
32. 02	Demonstration payment adjustment amount after sequestration	0	32. 02
33. 00	Interim payments	995, 329	
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-22, 654	35. 00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	36. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	3, 765	50.00
	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0. 00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-1	9 PHE	
	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0. 000000	
99. 01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000	99. 01

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0115	Period: From 07/01/2021	Worksheet E-3 Part VI	
		Component CCN: 15-5305	To 06/30/2022		pare : 30
		Title XVIII	Skilled Nursing Facility	PPS	
				1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL	OTHER HEALTH SERVICES FOR	TITLE XVIII PART	A PPS SNF	
	SERVICES PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				1
. 00	Resource Utilization Group Payment (RUGS)			1, 786, 619	1 1.
. 00	Routine service other pass through costs			0	1
. 00	Ancillary service other pass through costs			0	3.
00	Subtotal (sum of lines 1 through 3)			1, 786, 619	4.
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Medical and other services (Do not use this line as vacci	ne costs are included in li	ne 1 of W/S E,		5
	Part B. This line is now shaded.)				
00	Deducti bl e			0	
00	Coinsurance			178, 772	
00	Allowable bad debts (see instructions)			0	
00	Reimbursable bad debts for dual eligible beneficiaries (s	ee instructions)		0	
. 00	Adjusted reimbursable bad debts (see instructions) Utilization review			0	
. 00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lin	use 10 and 11) (see instructi	one)	1, 607, 847	
. 00	Inpatient primary payer payments	les to and try (see this tructi	0115)	1, 607, 647	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruc	tions)		0	
. 98	Recovery of accelerated depreciation.			0	
. 99	Demonstration payment adjustment amount before sequestrat	i on		0	14
5. 00	Subtotal (see instructions			1, 607, 847	
. 01	Sequestration adjustment (see instructions)			3, 572	15
. 02	Demonstration payment adjustment amount after sequestrati	on		0	15
. 75	Sequestration for non-claims based amounts (see instructi	ons)		0	15
	Interim payments			1, 604, 275	
	Tentative settlement (for contractor use only)			0	17
. 00	Balance due provider/program (line 15 minus lines 15.01,			0	
9. 00	Protested amounts (nonallowable cost report items) in acc	ordance with CMS 10 Dub 15	-2 chanter 1	0	19

Health Financial Systems	MEMORIAL HOSP & HEA	LTH CARE CTR	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0115	Peri od: From 07/01/2021	Worksheet E-3 Part VII
			To 06/30/2022	Date/Time Prepared: 11/29/2022 11:30 am
		Title XIX	Hospi tal	Cost

			00/30/2022	11/29/2022 11	: 30 am
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR XI			
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		681, 245		1.00
2.00	Medical and other services		, , , , ,	1, 237, 136	
3. 00	Organ acquisition (certified transplant centers only)		0	.,,	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		681, 245	1, 237, 136	
5. 00	Inpatient primary payer payments		0 ., 2 .0	1,207,100	5.00
6. 00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		681, 245	1, 237, 136	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		001, 210	1,207,100	7.00
	Reasonable Charges				1
8. 00	Routine service charges				8.00
9. 00	Ancillary service charges		1, 888, 050	6, 448, 657	9.00
10.00	Organ acquisition charges, net of revenue		1, 666, 030	0, 440, 037	10.00
11. 00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1 000 050	/ //O /E7	
12.00			1, 888, 050	6, 448, 657	12.00
12 00	CUSTOMARY CHARGES			0	12 00
13. 00	Amount actually collected from patients liable for payment fo	r services on a charge	0	Ü	13.00
14 00	basis		0	0	14 00
14. 00	Amounts that would have been realized from patients liable fo		U	Ü	14.00
15 00	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)	0.000000	0.000000	15 00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
16.00	Total customary charges (see instructions)	1 1611 46 1 1 1 1	1, 888, 050	6, 448, 657	
17. 00	Excess of customary charges over reasonable cost (complete on	Ty IT Time 16 exceeds	1, 206, 805	5, 211, 521	17. 00
40.00	line 4) (see instructions)				40.00
18. 00	Excess of reasonable cost over customary charges (complete on	Ty IT Tine 4 exceeds Tine	0	0	18. 00
40.00	16) (see instructions)				40.00
19. 00	Interns and Residents (see instructions)		0	0	
20. 00	Cost of physicians' services in a teaching hospital (see inst		0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line		681, 245	1, 237, 136	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid			
22. 00	Other than outlier payments		0	0	
23. 00	Outlier payments		0	0	
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		681, 245	1, 237, 136	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	)	681, 245	1, 237, 136	
32.00	Deducti bl es		0	0	
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	d 33)	681, 245	1, 237, 136	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS)		-681, 245	-1, 237, 136	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38. 00
39.00	Direct graduate medical education payments (from Wkst. E-4)		o		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		O	0	
43.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2.	O	0	43.00
	chapter 1, §115.2	·			
			· '		-

Health Financial Systems	MEMORIAL HOSP & HEA	LTH CARE CTR	In Lieu	u of Form CMS-	2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0115	Peri od: From 07/01/2021	Worksheet E-3 Part VII		
		Component CCN: 15-S115	To 06/30/2022	Date/Time Pre 11/29/2022 11		
		Title XIX	Subprovi der -	Cost		
			I PF			
			I npati ent	Outpati ent		
			1. 00	2. 00		
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES						
COMPUTATION OF NET COST OF COVERED SERVICE	ES					
1.00 Inpatient hospital/SNE/NE services	-	-	932, 956		1.00	

PART VII - CALCULATION OF REIMBURSCHENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			I npati ent	Outpati ent	
COMPUTATION OF NET COST OF COVERED SERVICES			1. 00	2. 00	
Inpati ent hospital /SNF/NF services		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX	SERVI CES		
Medical and other services   0   2.00		COMPUTATION OF NET COST OF COVERED SERVICES			
Organ acquisition (certified transplant centers only)	1.00	Inpatient hospital/SNF/NF services	932, 956		1.00
Subtotal (sum of lines 1, 2 and 3)   932,956   0 4.00   0.00   10   10   10   10   10   10	2.00	Medical and other services		0	2.00
Subtotal (sum of lines 1, 2 and 3)	3.00	Organ acquisition (certified transplant centers only)	o		3.00
Inpat   Inpa	4.00	, , , , , , , , , , , , , , , , , , , ,	932, 956	0	4.00
0	5.00		0		5.00
3.00   Subtotal (line 4 less sum of lines 5 and 6)   932,956   0   7.00				0	6.00
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable Charges   Reasonable Charges   0   8.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.			932, 956		
Reasonable Charges   0		· ·			1
8.00   Routine service charges   0   0   0   0   0   0   0   0   0					1
0	8.00		0		8.00
10.00   Organ acquisition charges, net of revenue   0   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.0			-	0	
11.00   Incentive from target amount computation   0   0   11.00   12.00   Total reasonable charges (sum of lines B through 11)   0   0   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12			-	Ū	
12.00   Total reasonable charges (sum of lines 8 through 11)   12.00   12.00   12.00   12.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00   13.00			- 1		1
CUSTOMARY CHARGES			- 1	0	
13.00   Amount actually collected from patients	12.00		<u> </u>	0	12.00
basis   14.00   Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)   15.00   Ratio of line 13 to line 14 (not to exceed 1.000000)   15.00   16.00   10.000000   15.00   10.000000   15.00   10.000000   15.00   10.000000   10.000000   15.00   10.000000   10.000000   15.00   10.000000   10.000000   10.000000   10.000000   10.000000   10.000000   10.000000   10.000000   10.000000   10.000000   10.000000   10.0000000   10.0000000   10.0000000   10.00000000   10.00000000   10.0000000000	12 00		٥	0	12 00
14.00   Amounts that would have been realized from patients Iiable for payment for services on a large basis had such payment been made in accordance with 42 CFR §413.13(e)   0.000000   0.000000   15.00   16.00   16.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00	13.00	·	U	U	13.00
a charge basis had such payment been made in accordance with 42 CFR §413.13(e)  15. 00 Ratio of line 13 to line 14 (not to exceed 1.000000)  16. 00 Total customary charges (see instructions)  17. 00 Excess of customary charges (see instructions)  18. 00 Excess of reasonable cost over reasonable cost (complete only if line 16 exceeds  19. 00 Interns and Residents (see instructions)  19. 00 Cost of physicians' services in a teaching hospital (see instructions)  10. 00 Cost of physicians' services in a teaching hospital (see instructions)  10. 00 Cost of physicians' services in a teaching hospital (see instructions)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of physicians' services (enter the lesser of line 4 or line 16)  10. 00 Cost of physicians' services (enter the lesser of line 4 or line 16)  10. 00 Cost of physicians' services (enter the lesser of line 4 or line 16)  10. 00 Cost of physicians' services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of physicians' services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of physicians' services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 00 Cost of covered services (enter the lesser of line 4 or line 16)  10. 01 Cost of covered services (enter the lesser of line 4 or line 16)  10. 01 Cost of covered services (enter the lesser of line 4 or line 16)  10. 01 Cost of covered services (enter the lesser of line 4 or line 16)  10. 01 Cost of covered services (enter the lesser of line 16)  10. 01 Cost of covered services (enter the lesser of line 16)  10. 01 Cost of covered services	14 00		0	0	14 00
15. 00	14.00		U	U	14.00
16.00   Total customary charges (see instructions)   0   16.00   17.00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   0   17.00   17.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11	15 00		0.000000	0 000000	15 00
17.00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   0   17.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.00   11.		· · · · · · · · · · · · · · · · · · ·			1
18.00   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)   0   18.00   16) (see instructions)   0   19.00   10   10   10   10   10   10   10			- 1	_	
R8.00   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)   0   18.00   19.00   19.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00	17.00		U	U	17.00
16) (see instructions)	10.00		022 05/	0	10.00
19.00   Interns and Residents' (see instructions)   0   0   19.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00	18.00		932, 956	U	18.00
20.00   Cost of physicians' services in a teaching hospital (see instructions)   0   20.00   21.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00	10.00		0		10.00
21.00   Cost of covered services (enter the lesser of line 4 or line 16)   Department of the payment of the p			-		
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				_	
22. 00       Other than outlier payments       0       0       22. 00         23. 00       Outlier payments       0       0       23. 00         24. 00       Program capital payments       0       24. 00         25. 00       Capital exception payments (see instructions)       0       25. 00         26. 00       Routine and Ancillary service other pass through costs       0       0       25. 00         27. 00       Subtotal (sum of lines 22 through 26)       0       0       27. 00         28. 00       Customary charges (title V or XIX PPS covered services only)       0       0       28. 00         29. 00       Titles V or XIX (sum of lines 21 and 27)       0       0       28. 00         29. 00       Excess of reasonable cost (from line 18)       932, 956       0       30. 00         31. 00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       932, 956       0       31. 00         32. 00       Deductibles       0       0       31. 00         33. 00       Coinsurance       0       0       33. 00         34. 00       All owable bad debts (see instructions)       0       0       34. 00         35. 00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	21.00			0	] 21.00
23.00   Outlier payments   0   0   23.00     24.00   Program capital payments   0   24.00     25.00   Capital exception payments (see instructions)   0   25.00     26.00   Routine and Ancillary service other pass through costs   0   0   26.00     27.00   Subtotal (sum of lines 22 through 26)   0   0   27.00     28.00   Customary charges (title V or XIX PPS covered services only)   0   0   28.00     29.00   Outline and Ancillary service other pass through costs   0   0   27.00     28.00   Customary charges (title V or XIX PPS covered services only)   0   0   28.00     29.00   Outlier   Ou				_	
24.00       Program capital payments       0       24.00         25.00       Capital exception payments (see instructions)       0       25.00         26.00       Routine and Ancillary service other pass through costs       0       0       26.00         27.00       Subtotal (sum of lines 22 through 26)       0       0       27.00         28.00       Customary charges (title V or XIX PPS covered services only)       0       0       28.00         29.00       Titles V or XIX (sum of lines 21 and 27)       0       0       29.00         COMPUTATION OF REIMBURSEMENT SETTLEMENT         30.00       Excess of reasonable cost (from line 18)       932,956       0       30.00         31.00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       0       0       31.00         32.00       Deductible S       0       0       31.00         33.00       Coinsurance       0       0       33.00         34.00       Allowable bad debts (see instructions)       0       0       34.00         35.00       Utilization review       0       35.00         36.00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       0       0       36.00         37.00		1 3	- 1	_	
25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 29.00 Titles V or XIX (sum of lines 21 and 27) 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT  Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 30.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Uniterim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,			- 1	0	
26.00 Routine and Ancillary service other pass through costs  27.00 Subtotal (sum of lines 22 through 26)  28.00 Customary charges (title V or XIX PPS covered services only)  29.00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  20 Deductibles  30.00 Allowable bad debts (see instructions)  30.00 Litilization review  30.00 Utilization review  30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  30.00 Subtotal (line 36 ± line 37)  30.00 Total amount payable to the provider (sum of lines 38 and 39)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  40.00 Total amount payable cost report items) in accordance with CMS Pub 15-2,  40.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  40.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,			- 1		1
27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 0 0 29. 00  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 0 0 31. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 0 0 32. 00 33. 00 Coinsurance 0 0 0 32. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 0 0 36. 00 38. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 0 0 36. 00 38. 00 Subtotal (line 36 ± line 37) 0 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 0 39. 00 41. 00 Interim payments 0 0 40. 00 42. 00 Bal ance due provider/program (line 40 minus line 41) 0 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0		' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	- 1		
28.00 Customary charges (title V or XIX PPS covered services only)  7 Titles V or XIX (sum of lines 21 and 27)  8 COMPUTATION OF REIMBURSEMENT SETTLEMENT  8 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  9 Deductibles  9 Coinsurance  10 O 31.00  10 O 32.00  11 Coinsurance  12 O O O O O O O O O O O O O O O O O O O		, o	٠		
29.00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30.00 Excess of reasonable cost (from line 18)  Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  Deductibles  Coinsurance  Allowable bad debts (see instructions)  Utilization review  Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  Therefore the Adjustments (SEE INSTRUCTIONS) (SPECIFY)  Subtotal (line 36 ± line 37)  Direct graduate medical education payments (from Wkst. E-4)  Total amount payable to the provider (sum of lines 38 and 39)  Total amount payable to the provider (sum of lines 38 and 39)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  Description of the provider (sum of lines 40 minus line 41)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  Description of the provider (sum of lines 40 minus line 41)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  Description of the provider (sum of lines 40 minus line 41)  Description of the provider (sum of lines 40 minus line 41)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  Description of the provider (sum of lines 40 minus line 41)  Description of the provider (sum of lines 40 minus line 41)  Description of the provider (sum of lines 40 minus line 41)  Description of the provider (sum of lines 40 minus line 41)  Description of the provider (sum of lines 40 minus line 41)  Description of the provider (sum of lines 40 minus line 41)  Description of the provider (sum of lines 40 minus line 41)  Description of the provider (sum of lines 40 minus line 41)  Description of the provider (sum of lines 40 minus lines 41)  Description of the provider (sum of lines 40 minus lines 41)  Description of the provider (sum of lines 40 minus lines 41)  Description of the provider (sum of lines 40 minus lines 41)			0	_	
COMPUTATION OF REIMBURSEMENT SETTLEMENT	28. 00	Customary charges (title V or XIX PPS covered services only)	0	0	28. 00
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	29. 00	Titles V or XIX (sum of lines 21 and 27)	0	0	29. 00
31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  32. 00 Deductibles  33. 00 Coinsurance  34. 00 Allowable bad debts (see instructions)  35. 00 Utilization review  36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38. 00 Subtotal (line 36 ± line 37)  39. 00 Direct graduate medical education payments (from Wkst. E-4)  40. 00 Total amount payable to the provider (sum of lines 38 and 39)  41. 00 Interim payments  42. 00 Balance due provider/program (line 40 minus line 41)  43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 0 31. 00  0 31. 00  0 32. 00  0 32. 00  0 33. 00  0 34. 00  0 35. 00  0 36. 00  0 37. 00  0 37. 00  0 38. 00  0 0 38. 00  0 0 38. 00  0 0 38. 00  0 0 39. 00  0 0 40. 00  41. 00  42. 00  43. 00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,		COMPUTATION OF REIMBURSEMENT SETTLEMENT			
32.00   Deductibles   0   0   32.00   33.00   Coinsurance   0   0   33.00   34.00   Allowable bad debts (see instructions)   0   0   34.00   35.00   Utilization review   0   35.00   35.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   0   0   0   0   0   0   0   0   0	30.00	Excess of reasonable cost (from line 18)	932, 956	0	30.00
33.00   Coinsurance   0   0   33.00   34.00   Allowable bad debts (see instructions)   0   0   34.00   35.00   Utilization review   0   35.00   36.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   0   0   36.00   37.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   0   37.00   38.00   Subtotal (line 36 ± line 37)   0   0   38.00   39.00   Direct graduate medical education payments (from Wkst. E-4)   0   39.00   40.00   Total amount payable to the provider (sum of lines 38 and 39)   0   0   40.00   41.00   Interim payments   0   0   41.00   42.00   Balance due provider/program (line 40 minus line 41)   0   0   42.00   43.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,   0   0   43.00	31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
34.00   Allowable bad debts (see instructions)	32.00	Deducti bl es	0	0	32.00
35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 35.00 35.00 0 36.00 0 37.00 0 38.00 0 39.00 0 49.00 0 40.00 0 41.00 0 42.00	33.00	Coinsurance	0	0	33.00
35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 35.00 0 36.00 0 37.00 0 38.00 0 39.00 0 49.00 0 40.00 0 41.00 0 42.00	34.00	Allowable bad debts (see instructions)	o	0	34.00
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38.00 Subtotal (line 36 ± line 37)  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 36.00  0 36.00  37.00  38.00  39.00  0 38.00  39.00  0 40.00  0 41.00  0 42.00	35.00		o		35.00
37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38. 00 Subtotal (line 36 ± line 37)  39. 00 Direct graduate medical education payments (from Wkst. E-4)  40. 00 Total amount payable to the provider (sum of lines 38 and 39)  41. 00 Interim payments  42. 00 Balance due provider/program (line 40 minus line 41)  43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 0 37. 00  3 7. 00  0 37. 00  3 7. 00  0 38. 00  0 0 37. 00  0 38. 00  0 0 40. 00  40. 00  41. 00  42. 00  43. 00	36, 00		0	0	36.00
38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 38.00 39.00 40.00 41.00 41.00 42.00 43.00			0	0	
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  39.00 40.00 41.00 0 42.00 42.00 43.00			- 1		
40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 40.00  41.00  42.00  43.00			- 1	Ĭ	00.00
41.00 Interim payments  0 41.00 42.00 Balance due provider/program (line 40 minus line 41)  0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 43.00		, , , ,	- 1	n	
42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 42.00 43.00			- 1	_	
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00			- 1	_	
			- 1	_	
Cliapte  1, 3113.2	43.00		٩	U	43.00
		[chapter 1, 3110.2	1		I

Heal th	Financial Systems	MEMORIAL HOSP & HEA	LTH CARE CTR	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0115	Peri od: From 07/01/2021	Worksheet E-3 Part VII	
			Component CCN: 15-T115			pared: :30 am
			Title XIX	Subprovi der -	Cost	
				I RF		
				I npati ent	Outpati ent	
				1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT -	- ALL OTHER HEALTH SE	RVICES FOR TITLES V OR >	(IX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICE	CES				
1.00	Inpatient hospital/SNF/NF services			0		1.00
2.00	Medical and other services				0	2.00
	1				,	1

		1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	COLITION		
1. 00	Inpatient hospital/SNF/NF services	0		1.00
2. 00	Medical and other services	ď	0	2.00
3. 00	Organ acquisition (certified transplant centers only)	0	0	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5. 00	Inpatient primary payer payments	0	O	5.00
6. 00	Outpatient primary payer payments	٩	0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES	U <sub>I</sub>	U	7.00
	Reasonable Charges			
8. 00	Routine service charges	0		8. 00
9. 00	Ancillary service charges	o	0	
10. 00		o	U	10.00
	Organ acquisition charges, net of revenue	- 1		11.00
	Incentive from target amount computation	0	0	
12.00	Total reasonable charges (sum of lines 8 through 11)	U	U	12.00
12 00	CUSTOMARY CHARGES	O	0	12 00
13. 00	Amount actually collected from patients liable for payment for services on a charge	۷	U	13. 00
14 00	basis		0	14.00
14. 00	Amounts that would have been realized from patients liable for payment for services on	0	U	14. 00
15. 00	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0.000000	0. 000000	15. 00
	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000		
16.00	Total customary charges (see instructions)	0	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	0	0	17. 00
10 00	line 4) (see instructions)		0	10 00
18. 00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	0	0	18. 00
19. 00	16) (see instructions) Interns and Residents (see instructions)	o	0	19. 00
			-	20.00
	Cost of physicians' services in a teaching hospital (see instructions)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		0	21.00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide Other than outlier payments	0	0	22. 00
		0	0	23.00
	Outlier payments	0	U	24.00
	Program capital payments Capital exception payments (see instructions)	0		25.00
	Routine and Ancillary service other pass through costs	0	0	
	Subtotal (sum of lines 22 through 26)	0	0	
	, ,	0	0	28.00
	Customary charges (title V or XIX PPS covered services only)	-1	0	29.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	U	29.00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	ما	0	20.00
	Excess of reasonable cost (from line 18)	0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	-	31.00
	Deducti bl es	0	0	32.00
	Coinsurance	0	0	33.00
	Allowable bad debts (see instructions)	0	0	34.00
	Utilization review	0	0	35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	
	Subtotal (line 36 ± line 37)	0	0	38.00
	Direct graduate medical education payments (from Wkst. E-4)	0	_ :	39.00
	Total amount payable to the provider (sum of lines 38 and 39)	0	0	
	Interim payments	0	0	
42.00	Balance due provider/program (line 40 minus line 41)	0	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2	I		l

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0115	Peri od: From 07/01/2021	Worksheet E-3 Part VII
	Component CCN: 15-5305	To 06/30/2022	Date/Time Prepared: 11/29/2022 11:30 am
	Title XIX	Skilled Nursing	Cost
		Facility	

		Title XIX	Facility	COST	
			Facility Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	ES EOD TITLES V OD VI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	S FOR TITLES V OR AL	A SERVICES		
1 00	Inpatient hospital/SNF/NF services		O		1 00
1.00	, ,		U	0	1.00
2.00	Medical and other services		0	0	2.00
3.00	Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3)		0	0	3.00
4.00			0	U	4. 00 5. 00
5. 00	Inpati ent primary payer payments		U	0	
6.00	Outpatient primary payer payments				6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
0.00	Reasonable Charges		O		0.00
8. 00	Routine service charges			0	8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
40.00	CUSTOMARY CHARGES			0	40.00
13. 00	Amount actually collected from patients liable for payment for se	rvices on a charge	0	0	13.00
14 00	basis			0	14.00
14. 00	Amounts that would have been realized from patients liable for pa		0	0	14.00
15 00	a charge basis had such payment been made in accordance with 42 Cl	-R §413.13(e)	0.000000	0.000000	15 00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)	6 line 1/	0	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete only i	Time 16 exceeds	0	0	17. 00
10 00	line 4) (see instructions)	Fline 4 avecede line	0	0	10 00
18. 00	Excess of reasonable cost over customary charges (complete only i	Tithe 4 exceeds tithe	U	0	18. 00
19. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	19. 00
20. 00		one)	0	0	20.00
21. 00	Cost of physicians' services in a teaching hospital (see instructions of covered services (enter the lesser of line 4 or line 16)	UIS)	0	0	20.00
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comp	aloted for DDS provid		U	21.00
22.00	Other than outlier payments	dieted for PP3 provid	0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24. 00			0	U	24.00
			0		25. 00
	Capital exception payments (see instructions)		0	0	
26. 00	Routine and Ancillary service other pass through costs				26.00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00 29. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		l ol	U	29.00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	0	20.00
30.00	Excess of reasonable cost (from line 18)		0		30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deducti bl es			0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	)	0	0	36.00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2		1 1		

	Financial Systems MEMORIAL HOSP & HE GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT				u of Form CMS-2	
	L EDUCATION COSTS	Provi der C		Peri od: From 07/01/2021 To 06/30/2022		pared:
		Title	: XVIII	Hospi tal	11/29/2022 11 PPS	. 30 alli
					1. 00	
1 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT Unweighted resident FTE count for allopathic and osteopathic	o programs fo	r cost roport	ing port ode	0.00	1.00
1. 00	ending on or before December 31, 1996.	c programs to	r cost report	ing perrous	0.00	1.00
2. 00 3. 00	Unweighted FTE resident cap add-on for new programs per 42 ( Amount of reduction to Direct GME cap under section 422 of M		(1) (see inst	ructions)	0. 00 0. 00	
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)	ce with 42 CF	R §413.79 (m)	. (see	0.00	
4. 00	Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (1		programs due	to a Medicare	0. 00	4.00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instraddling 7/1/2011)	structions fo	r cost report	ing periods	0. 00	4. 01
4. 02	ACA Section 5506 number of additional direct GME FTE cap sloperiods straddling 7/1/2011)	ots (see ins	tructions for	cost reporting	0. 00	4. 02
5. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus applicable subscripts	plus or minus	line 4 plus	lines 4.01 and	0. 00	5. 00
6. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	c programs fo	r the current	year from your	0. 00	
7. 00	Enter the lesser of line 5 or line 6		Primary Care	e Other	0. 00 Total	7. 00
			1.00	2. 00	3. 00	
8. 00	Weighted FTE count for physicians in an allopathic and osteo program for the current year.	opathi c	0.0	0.00	0. 00	8. 00
9. 00	If line 6 is less than 5 enter the amount from line 8, other multiply line 8 times the result of line 5 divided by the ar 6.		0.0	0.00	0. 00	9. 00
10.00	Weighted dental and podiatric resident FTE count for the cur	rrent year		0.00		10.00
10. 01 11. 00	Unweighted dental and podiatric resident FTE count for the count weighted FTE count	current year	0.0	0.00		10. 01 11. 00
12.00	Total weighted resident FTE count for the prior cost reporti	ing year (see				12.00
13. 00	<pre>instructions) Total weighted resident FTE count for the penultimate cost r year (see instructions)</pre>	reporti ng	0.0	0. 00		13. 00
14. 00 15. 00	Rolling average FTE count (sum of lines 11 through 13 divide Adjustment for residents in initial years of new programs	ed by 3).	0. 0 14. 2			14. 00 15. 00
15. 00	Unweighted adjustment for residents in initial years of new	programs	14. 2			15. 00
16.00	Adjustment for residents displaced by program or hospital cl		0.0			16.00
16. 01	Unweighted adjustment for residents displaced by program or closure	nospi tai	0.0	0.00		16. 01
17. 00 18. 00	Adjusted rolling average FTE count Per resident amount		14. 2 105, 000. 0			17. 00 18. 00
19. 00	Approved amount for resident costs		1, 494, 15	52, 500	1, 546, 650	19.00
					1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME Sec. 413.79(c)(4)	FTE resident	cap slots re	cei ved under 42	0. 00	20.00
21. 00	Direct GME FTE unweighted resident count over cap (see inst				0. 00	•
22. 00 23. 00	Allowable additional direct GME FTE Resident Count (see inst Enter the locality adjustment national average per resident	,	instructions)		0. 00 0. 00	
24.00	Multiply line 22 time line 23	amount (300	111311 4011 0113)		0	24.00
25. 00	Total direct GME amount (sum of lines 19 and 24)	I npati ent	Managed Care	e Managed Care	1, 546, 650 Total	25. 00
		Part A	Prior to 1/1		Total	
		1. 00	2. 00	2. 01	3. 00	
26. 00	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	6, 046	88	1, 001		26. 00
27. 00	Total Inpatient Days (see instructions)	16, 061				27. 00
28. 00 29. 00	Ratio of inpatient days to total inpatient days Program direct GME amount	0. 376440 582, 221			763, 840	28. 00 29. 00
29. 00	Percent reduction for MA DGME	JUZ, ZZ I	3. 2		703, 640	29. 01
30. 00 31. 00	Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount		2, 77	3, 142	5, 920 757, 920	
31.00	inet i ogi alli uli ect ome allouit		I	I	151, 920	31.00

Heal th	Financial Systems MEMORIAL HOSP & HE	ALTH CARE CT	₹	In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der C	CN: 15-0115	Peri od: From 07/01/2021 To 06/30/2022	Worksheet E-4 Date/Time Pre 11/29/2022 11	pared:
		Title	XVIII	Hospi tal	PPS	
		. =			1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TIT EDUCATION COSTS)	LE XVIII ONL	Y (NURSING PE	OGRAM AND PARAME	DICAL	
32. 00	,	Pt I sum (	of col 20 ar	nd 23 lines 74	0	32.00
32.00	and 94)	rt. r, sum v	51 COI. 20 di	10 25, 111103 74	O	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8,	sum of lines	74 and 94)	0	33.00
34.00	Ratio of direct medical education costs to total charges (li			, i	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)				0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (lin		35)		0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVII	I ONLY				
	Part A Reasonable Cost				10.00/.100	
37.00					19, 996, 122	
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69				0	
	39.00   Cost of physicians' services in a teaching hospital (see instructions) 40.00   Primary payer payments (see instructions)					40.00
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 min	us line 40)			19, 979, 162	
41.00	Part B Reasonable Cost	143 11110 40)			17, 777, 102	71.00
42.00	Reasonable cost (see instructions)				25, 783, 787	42.00
43.00	Primary payer payments (see instructions)				6, 734	•
44.00	Total Part B reasonable cost (line 42 minus line 43)				25, 777, 053	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)				45, 756, 215	45. 00
46.00	Ratio of Part A reasonable cost to total reasonable cost (li				0. 436644	
47. 00	Ratio of Part B reasonable cost to total reasonable cost (li		45)		0. 563356	47. 00
40.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND P	PARI B			757 000	40.00
48. 00 49. 00		ν (coo inctr	uctions)		757, 920 330, 941	•
	Part B Medicare GME payment (line 40 x 48) (title XVIII only				426, 979	
30.00	Trait b medicale dwc payment (Trie 47 x 40) (title xviii dii)	Y/N	Primary Car	e Other	Total	30.00
		0	1.00	2.00	3. 00	
	E-4 Calculation - In accordance with the FY 2023 IPPS Final	Rul e.				
109.00	Enter in column O, "Y" or "N" to calculate line 9 in	N	0. (	0.00	0.00	109. 00
	accordance the Federal Fiscal Year 2023 Final Rule for					
	cost reporting periods beginning prior to 10/1/2021. (see					
	instructions)		L .			<u> </u>
	e 109 column 0 is Y, you MUST open up the PY and Penultimate				) "Y" and calcu	late,
	nput amounts from line 11 columns 1 & 2 to the CY lines 12 &	13 columns 1				100.00
122.00	Override of line 22 for cost reporting periods beginning		0. (	JU		122. 00
	prior to 10/1/2021. (see instructions)		I	1		l

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

Provider CCN: 15-0115

Peri od: From 07/01/2021 To 06/30/2022 Date/Ti me Prepared: 11/29/2022 11:30 am

Unit y)					11/29/2022 11	:30 am
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1. 00	Cash on hand in banks	90, 108, 610	0	0	0	1.00
2. 00	Temporary investments	66, 288, 549	1	0	0	
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts recei vable	22, 748, 602	0	0	0	4.00
5.00	Other recei vabl e	0	0	0	0	
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	1
7. 00	Inventory	0	0	0	0	
8. 00	Prepai d expenses	0	0	0	0	
9.00	Other current assets	7, 705, 076	0	0	0	
10.00	Due from other funds	104 050 027	0	0	0	
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	186, 850, 837	0	0	0	11.00
12. 00	Land	11, 188, 088	0	0	0	12.00
13. 00	Land improvements	11, 100, 000	0	ő	0	
14. 00	Accumulated depreciation	Ö	o	0	0	
15.00	Bui I di ngs	122, 498, 934	0	0	0	15.00
16.00	Accumulated depreciation	-85, 562, 330	0	0	0	16.00
17. 00	Leasehold improvements	0	0	0	0	17. 00
18. 00	Accumulated depreciation	0	0	0	0	
19. 00	Fi xed equipment	158, 911, 560	1	0	0	1
20.00	Accumulated depreciation	-93, 699, 695	0	0	0	
21.00	Automobiles and trucks	0	0	0	0	
22. 00	Accumulated depreciation	0	0	0	0	
23. 00	Maj or movable equipment	0	0	0	0	1
24. 00 25. 00	Accumulated depreciation Minor equipment depreciable	0	0	0	0	
26. 00	Accumulated depreciation	0		0	0	
27. 00	HIT designated Assets	0		0	0	
28. 00	Accumulated depreciation	0	0	0	0	
29. 00	Mi nor equi pment-nondepreci abl e	Ö	o	0	0	
30.00	Total fixed assets (sum of lines 12-29)	113, 336, 557	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	33, 003, 585	0	0	0	
32.00	Deposits on Leases	0	0	0	0	1
33. 00	Due from owners/officers	0	0	0	0	
34.00	Other assets	12, 955, 744		0	0	1
35.00	Total other assets (sum of lines 31-34)	45, 959, 329	1	0	0	
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	346, 146, 723	0	0	0	36.00
37. 00	Accounts payable	19, 137, 479	0	0	0	37.00
38. 00	Salaries, wages, and fees payable	27, 571, 519		0	0	
39. 00	Payrol I taxes payable	27,071,017	l o	0	0	
40. 00	Notes and Loans payable (short term)	4, 934, 039	o	0	0	
41.00	Deferred income	0	o	0	0	41.00
42.00	Accel erated payments	5, 019, 859				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1, 495, 471		0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	58, 158, 367	0	0	0	45.00
	LONG TERM LIABILITIES			. 1		
46. 00	Mortgage payable	0	0	0	0	
47. 00	Notes payable	64, 875, 000	1	0	0	
48. 00	Unsecured Loans	0	0	0	0	
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	64, 875, 000	0	0	0	
51. 00	Total liabilities (sum of lines 45 and 50)	123, 033, 367	1	0	0	
31.00	CAPITAL ACCOUNTS	123, 033, 307	J 9	<u> </u>	0	31.00
52. 00	General fund balance	223, 113, 356				52.00
53.00	Specific purpose fund	., .,	0			53.00
54.00	Donor created - endowment fund balance - restricted			О		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
FC	replacement, and expansion	000 11= ==			-	F.C
59.00	Total fund balances (sum of lines 52 thru 58)	223, 113, 356	1	0	0	1
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	346, 146, 723		٩	0	60.00
	l∝′/	I	1	ļ	l	I

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0115
Period: From 07/01/2021
To 06/30/2022 Date/Time Prepared: 11/29/2022 11:30 am

General Fund Special Purpose Fund Endowne	22 11: 30 am
Fund	
1.00 2.00 3.00 4.00 5.00	
1.00 Fund balances at beginning of period 231, 265, 555 0	1.00
2.00   Net income (loss) (from Wkst. G-3, line 29)   76,912,851	2. 00
3.00   Total (sum of line 1 and line 2)   308,178,406   0	3.00
4.00   IDENTIFIED ON TRIAL BALANCE - FOUN. 183, 378 0	0 4.00
5. 00	0 5.00
6.00	0 6.00
7. 00   0   0   0   0   0   0   0   0   0	0 7. 00 0 8. 00
9.00	0 9.00
10.00 Total additions (sum of line 4-9) 183,378 0	10.00
11. 00   Subtotal (Line 3 plus Line 10)   308, 361, 784   0	11.00
12.00 HOME OFFICE DEPARTMENTS 84, 758, 314 0	0 12.00
13.00 FREESTANDING RHC DEPTS. 490, 114 0	0 13.00
14.00	0 14.00
15. 00	0 15.00
16. 00	0 16.00
17. 00	0 17.00
18.00   Total deductions (sum of lines 12-17)   85,248,428   0	18. 00
19.00 Fund balance at end of period per balance 223,113,356 0	19. 00
sheet (line 11 minus line 18)	
Endowment Plant Fund Fund	
Tunu	
6.00 7.00 8.00	
1.00 Fund balances at beginning of period 0 0	1. 00
2.00 Net income (loss) (from Wkst. G-3, line 29)	2. 00
3.00 Total (sum of line 1 and line 2) 0 0	3.00
4. 00   I DENTIFIED ON TRIAL BALANCE - FOUN.	4.00
5. 00	5.00
6. 00 7. 00	6. 00 7. 00
8.00	8.00
9.00	9.00
10.00 Total additions (sum of line 4-9)	10.00
11.00   Subtotal (line 3 plus line 10) 0	11.00
12.00 HOME OFFICE DEPARTMENTS	12.00
13.00 FREESTANDING RHC DEPTS.	13.00
14.00	14.00
15. 00	15. 00
16. 00	16.00
17. 00	17. 00
18.00 Total deductions (sum of lines 12-17) 0 0	18. 00
19.00 Fund balance at end of period per balance 0 0	19. 00
sheet (line 11 minus line 18)	I

			1	0 06/30/2022	Date/IIme Prep   11/29/2022 11:	
	Cost Center Description		Inpati ent	Outpati ent	Total	. 50 am
	3331 3311tar 23331 pt 1311		1.00	2.00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>				
	General Inpatient Routine Services					
1.00	Hospi tal		26, 476, 761		26, 476, 761	1.00
2.00	SUBPROVI DER - I PF		2, 377, 571		2, 377, 571	2.00
3.00	SUBPROVI DER - I RF		1, 437, 352		1, 437, 352	3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		0		0	5.00
6.00	Swing bed - NF		0		0	6.00
7. 00	SKILLED NURSING FACILITY		1, 637, 755		1, 637, 755	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)		31, 929, 439		31, 929, 439	10.00
44 00	Intensive Care Type Inpatient Hospital Services		40.000.540		40,000,540	44.00
11.00	INTENSIVE CARE UNIT		12, 303, 549		12, 303, 549	11.00
12. 00 13. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT					12. 00 13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of	Linos	12, 303, 549		12, 303, 549	16. 00
10.00	111-15)	Titles	12, 303, 349		12, 303, 349	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		44, 232, 988		44, 232, 988	17. 00
18. 00	Ancillary services		104, 901, 983	456, 778, 080	561, 680, 063	18.00
19. 00	Outpatient services		0 1, 70 1, 700	0	0	19. 00
20. 00	RURAL HEALTH CLINIC		0	781, 635	781, 635	
20. 01	RURAL HEALTH CLINIC II	İ	0	965, 869	965, 869	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22. 00	HOME HEALTH AGENCY			4, 128, 833	4, 128, 833	22.00
23.00	AMBULANCE SERVICES		1, 279, 371	6, 211, 529	7, 490, 900	23.00
24.00	CMHC	İ				24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPI CE		0	0	0	26.00
27.00	PHYSI CI ANS		0	100, 718, 377	100, 718, 377	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	150, 414, 342	569, 584, 323	719, 998, 665	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			173, 875, 883		29.00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32.00			0			32.00
33.00			0			33.00
34.00			0			34.00
35.00	Total additions (our of lines 20 25)		Ü	o		35. 00 36. 00
36. 00 37. 00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)		0	٩		37. 00
38.00	DEDUCT (SPECITI)		0			38. 00
39.00			0			39. 00
40.00			0			40. 00
41.00			0			41.00
42.00	Total deductions (sum of lines 37-41)		0	ا	ŀ	42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42	2)(transfer		173, 875, 883		43.00
.5. 50	to Wkst. G-3, line 4)	, (1. 4		,, 600		
	1	1		1	'	

	Financial Systems MEMORIAL HOSP & HE			u of Form CMS-2	
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0115	Peri od: From 07/01/2021	Worksheet G-3	
			To 06/30/2022	Date/Time Pre	pared:
			1	11/29/2022 11	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li			719, 998, 665	
2.00	Less contractual allowances and discounts on patients' accou	ints		474, 631, 619	2.00
3.00	Net patient revenues (line 1 minus line 2)			245, 367, 046	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		173, 875, 883	4. 00
5. 00	Net income from service to patients (line 3 minus line 4)			71, 491, 163	5.00
	OTHER I NCOME				
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			-10, 050, 264	7. 00
8. 00	Revenues from telephone and other miscellaneous communication	n services		0	8. 00
9. 00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13. 00	Revenue from Laundry and Linen service			0	13.00
14. 00	Revenue from meals sold to employees and guests			596, 520	14.00
15. 00	Revenue from rental of living quarters			0	15.00
16. 00	Revenue from sale of medical and surgical supplies to other	than patients		0	16. 00
17. 00	Revenue from sale of drugs to other than patients			298, 853	
18. 00	Revenue from sale of medical records and abstracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22.00
23. 00	Governmental appropriations			0	23.00
	MI SCELLANEOUS			14, 576, 579	
24. 50	COVID-19 PHE Fundina			0	24. 50

24.00 MISCELLANEOUS
24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

14, 576, 579 24, 50 0 24, 50 5, 421, 688 25, 00 76, 912, 851 26, 00 0 27, 00 0 28, 00 76, 912, 851 29, 00

	Equi pment					
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportati on	0	0	0	0	4.00
5.00	Administrative and General	-1, 792, 010	502, 898	0	502, 898	5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	928, 591	928, 591	0	928, 591	6. 00
7.00	Physi cal Therapy	465, 729	465, 729	0	465, 729	7. 00
8.00	Occupational Therapy	250, 835	250, 835	0	250, 835	8. 00
9.00	Speech Pathology	36, 165	36, 165	0	36, 165	9. 00
10.00	Medical Social Services	9, 273	9, 273	0	9, 273	10.00
11.00	Home Health Aide	101, 417	101, 417	0	101, 417	11.00
12.00	Supplies (see instructions)	0	53, 025	-53, 025	0	12.00
13.00	Drugs	0	31, 688	-31, 688	0	13.00
14.00	DME	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	0	15. 00
16.00	Respi ratory Therapy	0	0	0	0	16.00
17. 00	Private Duty Nursing	0	0	0	0	17. 00
18.00	Clinic	0	0	0	0	18. 00
19. 00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22. 00
23.00	All Others (specify)	0	0	0	0	23.00
23. 50	Tel emedi ci ne	0	0	0	0	23. 50
24.00	Total (sum of lines 1-23)	0	2, 379, 621	-84, 713	2, 294, 908	24.00

0

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1.00

2.00

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GENERAL SERVICE COST CENTERS
Capital Related - Bldg. &

Capital Related - Movable

1.00

2.00

Fi xtures

28, 461

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129, 878

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19.00 20.00

21.00

22.00

23.00

23.50

24.00

Home Health Aide

Respiratory Therapy

Day Care Program

Homemaker Service

Tel emedi ci ne

All Others (specify)

Private Duty Nursing

Drugs

Clinic

DMF

Supplies (see instructions)

HHA NONREIMBURSABLE SERVICES

Home Dialysis Aide Services

Health Promotion Activities

Home Delivered Meals Program

Total (sum of lines 1-23)

				HHA CCN:		From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 11	pared: :30 am
						Home Health	PPS	
						Agency I		
	·	Capital Rel	ated Costs					
		BI dgs &	Movabl e	Plant	Transportation	Reconciliatio	Administrativ	
		Fi xtures	Equi pment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance			(ACCUM. COST)	
			VALUE)	(SQUARE FEET)				
		1. 00	2. 00	3. 00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2.00	Capital Related - Movable		C			0		2.00
	Equi pment							
3. 00	Plant Operation & Maintenance	0	(			0		3.00
4. 00	Transportation (see	0	(		)	0		4.00
F 00	instructions)					500,000	4 700 040	- 00
5. 00	Administrative and General	0		)  C	)  (	-502, 898	1, 792, 010	5.00
/ 00	HHA REIMBURSABLE SERVICES			\	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		020 501	
6. 00 7. 00	Skilled Nursing Care	0	(		1	0	,20,0,.	
7. 00 8. 00	Physical Therapy Occupational Therapy	0	(			0	465, 729 250, 835	
9. 00	Speech Pathology	0	(				36, 165	
10.00	Medical Social Services	0	(			0	9, 273	
11. 00	Home Health Aide	0				) 0	101, 417	1
12. 00	Supplies (see instructions)		(			) 0	0 101, 417	
13. 00	Drugs		(		3		0	1
14. 00	DME		(		1		1	
14.00	HHA NONREI MBURSABLE SERVI CES	<u> </u>		ή	<u>'</u>	J 0		14.00
15. 00	Home Dialysis Aide Services	0	C			0 0	0	15.00
16. 00	Respiratory Therapy		(		1	0	l o	16.00
17. 00	Private Duty Nursing		Č	1		0	1 0	17.00
18. 00	Clinic	0	(			0	0	18.00
19. 00	Health Promotion Activities	o	(			0	l o	19.00
20. 00	Day Care Program	o	C			0	0	20.00
21. 00	Home Delivered Meals Program	o	Ċ			0	0	21.00
22. 00	Homemaker Service	o	C			0	0	22.00
23.00	All Others (specify)	0	C			0	0	23.00
23. 50	Tel emedi ci ne	O	(	) c		0	0	23. 50
24.00	Total (sum of lines 1-23)	o	(	) c		-502, 898	1, 792, 010	24.00
25.00	Cost To Be Allocated (per	0	(	) (		O	502, 898	25.00
	Worksheet H-1, Part I)							
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0.000000	0. 00000	0	0. 280633	26.00

Health Financial Systems MEMORIA ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 11/29/2022 11:30 am Provi der CCN: 15-0115 Peri od: From 07/01/2021 To 06/30/2022 HHA CCN: 15-7222 Home Health PPS Agency I

						Agency I		
			CAPI TAL REL	ATED COSTS				
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIV E & GENERAL	
		0	1.00	2.00	DEPARTMENT	4.0	F 00	
1. 00	Administrative and General	0	1. 00 31, 782	2. 00	4. 00 92, 273	4A 147, 497	5. 00 23, 949	1. 00
2. 00	Skilled Nursing Care	1, 189, 185	31, 702	23, 442	219, 904	1, 409, 089		2. 00
3. 00	Physical Therapy	596, 428	Ö	Ö	108, 000	704, 428		3. 00
4. 00	Occupational Therapy	321, 228	0	Ö	64, 223	385, 451	62, 585	4. 00
5.00	Speech Pathology	46, 314	0	o	3, 354	49, 668	8, 064	5.00
6.00	Medical Social Services	11, 875	0	0	2, 133	14, 008	2, 274	6.00
7. 00	Home Heal th Ai de	129, 878	0	0	19, 833	149, 711	24, 308	7. 00
8. 00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9. 00 10. 00	Drugs DME	0	0	0	0	0	0	9. 00 10. 00
11. 00	Home Dialysis Aide Services		0	0	0	0	0	11.00
12. 00	Respiratory Therapy	l ő	o o	ő	0	0	Ö	12.00
13.00	Private Duty Nursing	O	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15. 00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17. 00 18. 00	Home Delivered Meals Program Homemaker Service	0	0	0	0	0	0	17. 00 18. 00
19. 00	All Others (specify)		0	0	0	0	0	19.00
19. 50	Tel emedi ci ne	0	0	Ö	0	0	0	19. 50
20. 00	Total (sum of lines 1-19) (2)	2, 294, 908	31, 782	23, 442	509, 720	2, 859, 852	464, 348	
21.00	Unit Cost Multiplier: column					0.000000		21.00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to 6 decimal places.							
	Cost Center Description	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	Cost Center Description	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	ADMI NI STRATI O	
	Cost Center Description	REPAI RS	LINEN SERVICE				ADMINISTRATIO N	
1 00		REPAIRS 6.00	LINEN SERVICE 8.00	9. 00	10. 00	11. 00	ADMI NI STRATI 0 N 13. 00	1 00
1.00	Administrative and General	REPAI RS	LINEN SERVICE			11. 00 7, 793	ADMINISTRATIO N	1.00
1. 00 2. 00 3. 00		REPAIRS 6.00	LINEN SERVICE 8.00	9. 00	10.00	11. 00	ADMI NI STRATI O N 13. 00	
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care	REPAIRS 6.00	LINEN SERVICE 8.00	9. 00	10.00	11. 00 7, 793 18, 351	ADMI NI STRATI O N 13. 00 O	2.00
2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	REPAIRS 6.00	8. 00 0 0 0 0 0	9. 00 8, 048 0 0 0	10. 00 0 0 0 0	11. 00 7, 793 18, 351 7, 905 4, 275 222	ADMI NI STRATI 0 N 13. 00 0 0 0 0	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	REPAIRS 6.00	8. 00 0 0 0 0 0	9. 00	10. 00 0 0 0 0	11. 00 7, 793 18, 351 7, 905 4, 275 222 226	ADMI NI STRATI 0 N 13. 00 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	REPAIRS 6.00	8. 00 0 0 0 0 0 0 0	9. 00 8, 048 0 0 0	10. 00 0 0 0 0 0 0	11. 00 7, 793 18, 351 7, 905 4, 275 222	ADMI NI STRATI 0 N 13. 00 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	REPAIRS 6.00	8. 00 0 0 0 0 0	9. 00 8, 048 0 0 0	10. 00 0 0 0 0	11. 00 7, 793 18, 351 7, 905 4, 275 222 226	ADMI NI STRATI 0 N 13. 00 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	REPAIRS 6.00	8. 00 0 0 0 0 0 0 0 0	9. 00 8, 048 0 0 0	10. 00 0 0 0 0 0 0	11. 00 7, 793 18, 351 7, 905 4, 275 222 226	ADMI NI STRATI 0 N 13. 00 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	REPAIRS 6.00	8. 00 0 0 0 0 0 0 0 0	9. 00 8, 048 0 0 0	10. 00 0 0 0 0 0 0	11. 00 7, 793 18, 351 7, 905 4, 275 222 226	ADMI NI STRATI 0 N 13. 00 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	REPAIRS 6.00	8. 00 0 0 0 0 0 0 0 0 0 0 0	9. 00 8, 048 0 0 0	10. 00 0 0 0 0 0 0	11. 00 7, 793 18, 351 7, 905 4, 275 222 226	ADMI NI STRATI 0 N 13. 00 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	REPAIRS 6.00	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 8, 048 0 0 0	10. 00 0 0 0 0 0 0	11. 00 7, 793 18, 351 7, 905 4, 275 222 226	ADMI NI STRATI 0 N 13. 00 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	REPAIRS 6.00	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 8, 048 0 0 0	10. 00 0 0 0 0 0 0	11. 00 7, 793 18, 351 7, 905 4, 275 222 226	ADMI NI STRATI 0 N 13. 00 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	REPAIRS 6.00	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 8, 048 0 0 0	10. 00 0 0 0 0 0 0	11. 00 7, 793 18, 351 7, 905 4, 275 222 226	ADMI NI STRATI 0 N 13. 00 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	REPAIRS 6.00	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 8, 048 0 0 0	10. 00 0 0 0 0 0 0	11. 00 7, 793 18, 351 7, 905 4, 275 222 226	ADMI NI STRATI 0 N 13. 00 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	REPAIRS 6.00	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 8, 048 0 0 0	10.00 0 0 0 0 0 0 0 0 0 0 0 0 0	11. 00 7, 793 18, 351 7, 905 4, 275 222 226	ADMI NI STRATI 0  N  13. 00  0  0  0  0  0  0  0  0  0  0  0  0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	REPAIRS 6.00	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 8, 048 0 0 0	10. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11. 00 7, 793 18, 351 7, 905 4, 275 222 226	ADMI NI STRATI 0  N  13. 00  0  0  0  0  0  0  0  0  0  0  0  0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	6. 00 30, 362 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 8,048 0 0 0 0 0 0 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11. 00 7, 793 18, 351 7, 905 4, 275 222 226 2, 674 0 0 0 0 0 0 0	ADMI NI STRATI 0  N  13. 00  0  0  0  0  0  0  0  0  0  0  0  0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	REPAIRS 6.00	8. 00 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 8, 048 0 0 0	10. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11. 00 7, 793 18, 351 7, 905 4, 275 222 226	ADMI NI STRATI 0  N  13. 00  0  0  0  0  0  0  0  0  0  0  0  0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	6. 00 30, 362 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0	9.00 8,048 0 0 0 0 0 0 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11. 00 7, 793 18, 351 7, 905 4, 275 222 226 2, 674 0 0 0 0 0 0 0	ADMI NI STRATI 0  N  13. 00  0  0  0  0  0  0  0  0  0  0  0  0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	6. 00 30, 362 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0	9.00 8,048 0 0 0 0 0 0 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11. 00 7, 793 18, 351 7, 905 4, 275 222 226 2, 674 0 0 0 0 0 0 0	ADMI NI STRATI 0  N  13. 00  0  0  0  0  0  0  0  0  0  0  0  0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	6. 00 30, 362 0 0 0 0 0 0 0 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0	9.00 8,048 0 0 0 0 0 0 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11. 00 7, 793 18, 351 7, 905 4, 275 222 226 2, 674 0 0 0 0 0 0 0	ADMI NI STRATI 0  N  13. 00  0  0  0  0  0  0  0  0  0  0  0  0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	6. 00 30, 362 0 0 0 0 0 0 0 0 0 0 0 0 0	8. 00 0 0 0 0 0 0 0 0 0 0 0 0	9.00 8,048 0 0 0 0 0 0 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11. 00 7, 793 18, 351 7, 905 4, 275 222 226 2, 674 0 0 0 0 0 0 0	ADMI NI STRATI 0  N  13. 00  0  0  0  0  0  0  0  0  0  0  0  0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00

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

Part I

HHA CCN: 15-7222 То Date/Time Prepared: 06/30/2022 11/29/2022 11:30 am Home Health Agency I INTERNS & RESIDENTS CENTRAL PHARMACY SERVI CES-SALA | SERVI CES-OTHE Cost Center Description MEDI CAL Subtotal SERVICES & RECORDS & RY & FRINGES R PRGM. COSTS **SUPPLY** LI BRARY 14. 00 15. 00 16. 00 21.00 22. 00 24.00 1.00 Administrative and General 1.00 2,006 0 0 219, 655 0 4, 508 0 2.00 Skilled Nursing Care 1,660,739 2.00 Physical Therapy 0 2, 824 0 0 829, 534 3.00 0 0 0 3.00 Occupational Therapy 0 0 0 452, 343 4.00 4.00 32 0 0 Speech Pathology 0 5.00 59, 411 5.00 1, 457 0 0 6.00 Medical Social Services 60 0 16, 568 6.00 7.00 Home Heal th Aide 0 00000000000 1, 522 0 o 178, 215 7.00 Supplies (see instructions) 0 0 0 0 8 00 C 8 00 0 0 9.00 Drugs C 9.00 10.00 DMF 0 10.00 0 0 11.00 Home Dialysis Aide Services 0 0 0 11.00 0 Respiratory Therapy 0 12 00 12 00 Ω 0 13.00 Private Duty Nursing 0 13.00 14.00 0 14.00 Clinic 0 0 0 Health Promotion Activities 0 15.00 15.00 0 0 Day Care Program 16.00 16.00 Ω 17.00 Home Delivered Meals Program 0 0 0 17.00 0 0 0 18.00 Homemaker Service 0 0 18.00 All Others (specify) 0 0 19 00 19 00 Ω 0 19.50 Tel emedi ci ne 0 0 0 19.50 Total (sum of lines 1-19) (2) 2,006 10, 403 3, 416, 465 20.00 20.00 21.00 Unit Cost Multiplier: column 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places Cost Center Description Intern & Subtotal Allocated HHA Total HHA Resi dents A&G (see Part Costs Cost & Post II) Stepdown Adjustments 25. 00 26.00 27. 00 28.00 1.00 Administrative and General 1.00 219, 655 0 1, 774, 850 2.00 Skilled Nursing Care 1, 660, 739 114, 111 2.00 3.00 Physical Therapy 0 829, 534 56, 998 886, 532 3.00 4.00 Occupational Therapy 0 452, 343 31, 081 483, 424 4.00 Speech Pathology 5.00 0 59, 411 4, 082 63, 493 5.00 6.00 Medical Social Services 0 16, 568 1, 138 17, 706 6.00 7.00 Home Heal th Aide 178, 215 12, 245 190, 460 7.00 0 8.00 8.00 Supplies (see instructions) 0 0 C 0 9.00 Drugs 0 C 0 9.00 10.00 DMF 0 10.00 11.00 Home Dialysis Aide Services 0 0 0 0 0 0 11.00 Respiratory Therapy 0 12 00 12 00 Ω 0 13.00 Private Duty Nursing 13.00 0 14.00 Clinic 0 14.00 0 Health Promotion Activities 0 0 15.00 15.00 0 Day Care Program Ω 16.00 16.00 17.00 Home Delivered Meals Program 0 0 0 17.00 Homemaker Service 0 18.00 18.00 19.00 All Others (specify) 0 0 0 0 19.00 0 19 50 19.50 Tel emedi ci ne 0 20.00 Total (sum of lines 1-19) (2) 3, 416, 465 219,655 3, 416, 465 20.00 Unit Cost Multiplier: column 0.068711 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

Provider CCN: 15-0115

Peri od:

From 07/01/2021

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

<sup>(2)</sup> Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider CCN: 15-0115 Peri od: Worksheet H-2
From 07/01/2021 Part II
To 06/30/2022 Date/Time Prepared: 11/29/2022 11:30 am
Home Health PPS BASIS HHA CCN: 15-7222

						Home Health	PPS	
		CAPITAL REL	ATED COSTS			Agency I		
		CAPITAL REL	LATED COSTS					
	Cost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Peconciliatio	ADMI NI STRATI V	MAINTENANCE &	
	cost center bescription	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	n	E & GENERAL	REPAI RS	
		(SQUARE TELT)	(SQUARE TELT)	DEPARTMENT	"	(ACCUM. COST)	(SQUARE FEET)	
				(GROSS		(ACCOM. COST)	(SQUARE LELT)	
				SALARI ES)				
		1. 00	2. 00	4. 00	5A	5. 00	6. 00	
1. 00	Administrative and General	3, 758	3, 758	359, 666			3, 758	1.00
2. 00	Skilled Nursing Care	0	0	857, 152			0	2.00
3. 00	Physical Therapy	0	o	420, 970			o	3.00
4. 00	Occupational Therapy	0	o	250, 333			o	4.00
5. 00	Speech Pathology	0	o	13, 075			O	5.00
6.00	Medical Social Services	0	o	8, 316	l o	14, 008	o	6.00
7.00	Home Health Aide	0	o	77, 305			o	7.00
8.00	Supplies (see instructions)	0	o	0	0	0	o	8. 00
9.00	Drugs	0	o	0	0	0	o	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respi ratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00		0	0	0		0	0	14.00
15. 00		0	0	0	1	0	0	15. 00
16. 00	3	0	0	0	1	_	0	16.00
17.00		0	0	0	· -	_	0	17.00
18.00		0	0	0	0	0	0	18.00
	All Others (specify)	0	U	0	0	0	0	19.00
19. 50	1	2 750	2 750	1 007 017	0	2 050 052	2 750	19. 50
20. 00 21. 00		3, 758 31, 782	3, 758 23, 442	1, 986, 817 509, 720		2, 859, 852 464, 348	3, 758 30, 362	1
	Unit cost multiplier	8. 457158	6. 237892	0. 256551		0. 162368	8. 079297	
22.00	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	22.00
	5651 551151 B6561 F11511	LINEN SERVICE	(SQUARE FEET)	(PATI ENT	(HOURS)	ADMI NI STRATI O	SERVICES &	
		(POUNDS OF	· /	DAYS)	_ ` ´	N	SUPPLY	
		LAUNDRY)				(DI RECT NURS.	(COSTED	
						HRS.)	REQUIS.)	
		8. 00	9. 00	10. 00	11. 00	13. 00	14. 00	
1. 00	Administrative and General	0	3, 758	0			34, 693	1.00
2.00	Skilled Nursing Care	0	0	0	,		0	2.00
3.00	Physi cal Therapy	0	0	0		0	0	3.00
4.00	Occupational Therapy	0	0	0	-,	0	0	4.00
5.00	Speech Pathology Medical Social Services	0	0	0	344 351	0	0	5.00
6. 00 7. 00	Home Health Aide		0	0	4, 145	0	0	6. 00 7. 00
8. 00	Supplies (see instructions)		0	0			0	8.00
9. 00	Drugs		0	0	1	0	0	9. 00
10.00	DME	0	o	0	1	0	ő	10.00
11. 00	Home Dialysis Aide Services	0	o	0	ĺ	0	o	11.00
12.00	Respiratory Therapy	0	o	0	0	0	O	12.00
13.00		0	o	0	0	0	o	13.00
14.00		0	0	0	0	0	О	14.00
15.00	Health Promotion Activities	0	О	0	0	0	0	
	Day Care Program	0	О	0	0	0	0	16.00
	Home Delivered Meals Program	0	0	0	0	0	0	
	Homemaker Service	0	0	0	0	0	0	
19. 00		0	0	0	0	0	0	
	Tel emedi ci ne	0	0	0	0	0	0	19. 50
	Total (sum of lines 1-19) Total cost to be allocated	0	3, 758	0	64, 244		34, 693 2, 006	
21. 00	LIDIAL COST TO BE ALLOCATED	. ()	8, 048	()	41, 446	()		21.00
22 00	Unit cost multiplier	0. 000000		0. 000000				

Peri od: Worksheet H-2 From 07/01/2021 Part II To 06/30/2022 Date/Time Prepared: 11/29/2022 11:30 am BASIS HHA CCN: 15-7222

						Home Health Agency I	PPS	<u> </u>
				I NITEDNIS &	RESI DENTS	Agency I		
				I INTERNS &	KL31 DLN13			
	Cost Center Description	PHARMACY	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	_		1
	oost deliter bescription	(COSTED	RECORDS &		R PRGM. COSTS			
		REQUIS.)	LI BRARY	(ASSI GNED	(ASSI GNED			
			(REVENUE)	TIME)	TIME)			
		15. 00	16. 00	21. 00	22. 00			1
1. 00	Administrative and General	0	0	0	C	)		1.00
2.00	Skilled Nursing Care	0	1, 723, 074	0	d c			2.00
3.00	Physical Therapy	0	1, 079, 577	0	d c			3.00
4.00	Occupational Therapy	0	12, 107	0	d c			4.00
5.00	Speech Pathology	0	556, 921	0	d c			5.00
6.00	Medical Social Services	0	23, 072	0	d c			6.00
7.00	Home Health Aide	0	581, 820	0	l c			7.00
8.00	Supplies (see instructions)	0	0	0	l c			8.00
9.00	Drugs	0	0	0	d c			9.00
10.00	DME	0	0	0	d c			10.00
11.00	Home Dialysis Aide Services	0	0	0	d c			11.00
12.00	Respiratory Therapy	0	0	0	d c			12.00
13.00	Private Duty Nursing	0	0	0	ol c			13.00
14.00	Clinic	0	0	0	C	)		14.00
15.00	Health Promotion Activities	0	0	0	C	)		15.00
16.00	Day Care Program	0	0	0	C	)		16.00
17.00	Home Delivered Meals Program	0	0	0	C	)		17.00
18.00	Homemaker Service	0	0	0	C	)		18. 00
19.00	All Others (specify)	0	0	0	(	)		19.00
19. 50	Tel emedi ci ne	0	0	0	C	)		19. 50
20.00	Total (sum of lines 1-19)	0	3, 976, 571	0	(	)		20.00
21.00	Total cost to be allocated	0	10, 403		C	)		21.00
22. 00	Unit cost multiplier	0. 000000	0. 002616	0. 000000	0. 000000	)		22.00

Heal th	Financial Systems	ME	MORIAL HOSP & I	HEALTH CARE CTI	₹	In Lie	u of Form CMS-2	2552-10
	TIONMENT OF PATIENT SERVICE COST			Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:	15-7222	From 07/01/2021 To 06/30/2022		
				Titl∈	: XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
	, , , , , , , , , , , , , , , , , , ,	H-2, Part I,	Costs (from	Ancillary	Costs (cols.		Per Visit	
		col. 28, line		Costs (from	1 + 2)		(col. 3 ÷	
			Part I)	Part II)	<b>'</b>		col . 4)	
		0	1. 00	2.00	3. 00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE						
	COST LIMITATION							
	Cost Per Visit Computation							İ
1.00	Skilled Nursing Care	2.00	1, 774, 850		1, 774, 85	7, 543	235. 30	1.00
2.00	Physi cal Therapy	3.00						2.00
3. 00	Occupational Therapy	4.00	· ·	_				
4. 00	Speech Pathology	5. 00						1
5. 00	Medical Social Services	6.00			17, 70			
6. 00	Home Health Aide	7.00			190, 46			l
		7.00		l .	•		1	1
7. 00	Total (sum of lines 1-6)		3, 416, 465	0	-1			7.00
					Program Visit	:S		
			ı			. 5		
						nrt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
					to	Deducti bl es		
					Deducti bl es			
		_			Coi nsurance			
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	Limitation Cost Computation	ı		_				
8. 00	Skilled Nursing Care		99915	0				8. 00
9. 00	Physical Therapy		99915	0				9. 00
10.00	Occupational Therapy		99915	0	1, 52	!9		10.00
11. 00	Speech Pathology		99915	0	6	5		11. 00
12.00	Medical Social Services		99915	0	3	13		12.00
13.00	Home Health Aide		99915	0	1, 36	57		13.00
14.00	Total (sum of lines 8-13)			0	10, 30	)4		14.00
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA	Total Charges	Ratio (col. 3	
		H-2 Part I,	Costs (from	Ancillary	Costs (cols.	(from HHA	÷ col. 4)	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)	Records)		
			Part I)	Part II)				
		0	1. 00	2.00	3. 00	4. 00	5. 00	
	Supplies and Drugs Cost Comput	ati ons						
15.00	Cost of Medical Supplies	8.00	0	0		0 52, 199	0.000000	15.00
16.00	Cost of Drugs	9. 00	0	0		0 0	0. 000000	16. 00
			Program Visits		Cost of			
					Servi ces			
				t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
		6. 00	7. 00	8.00	9. 00	10.00	11.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF T	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	
	COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	4, 283			0 1, 007, 790		1.00
2. 00	Physical Therapy	Ö		l .		0 567, 835		2.00
3. 00	Occupational Therapy	ĺ	· ·			0 303, 185		3.00
4. 00	Speech Pathology			l .		0 40, 862		4.00
	Medical Social Services					0 40, 862		1
5.00								5.00
6.00	Home Health Aide Total (sum of lines 1-6)	0 0				0 102, 224 0 2, 032, 921		6.00
7. 00	Total (Suii OI TITIES 1-0)	1	10, 304	1	I	0 2, 032, 921	I I	7.00

	Financial Systems FIONMENT OF PATIENT SERVICE COS		MURIAL HUSP & I	HEALTH CARE CTF Provider CO		Peri od:	u of Form CMS-: Worksheet H-3	
	TOTAL SERVICE COS			HHA CCN:	15-7222	From 07/01/2021 To 06/30/2022	Part I Date/Time Pre 11/29/2022 11	pared:
				Title	XVIII	Home Health Agency I	PPS	
	Cost Center Description							
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
	Limitation Cost Computation							
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide							8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00								14.00
11.00	Total (Sam of Times o 10)	Prog	ram Covered Cha	arges	Cost of Services			11.00
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance		Part A	Part B  Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	1-	6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
45.00	Supplies and Drugs Cost Comput			1				1
	Cost of Medical Supplies Cost of Drugs	0	0 0			0 0		
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation	OF AGGREGATE	PROGRAM COST,	AGGREGATE OF TH	HE PROGRAM L	IMITATION COST, C	R BENEFICIARY	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)	1, 007, 790 567, 835 303, 185 40, 862 11, 025 102, 224 2, 032, 921						1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
	Cost Center Description	12. 00						
8. 00 9. 00 10. 00 11. 00 12. 00	Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services							8. 00 9. 00 10. 00 11. 00 12. 00

Heal th	Financial Systems	MEI	MORIAL HOSP & F	HEALTH CARE CTI	₹	In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF PATIENT SERVICE COST	ΤS		Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:	15-7222	From 07/01/2021 To 06/30/2022	Part II Date/Time Prep 11/29/2022 11:	
				Title	: XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3. 00	4.00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNISHED E	BY SHARED HOSP	TAL DEPARTME	NTS		
1.00	Physical Therapy	66.00	0. 314392	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0. 148754	0		0 col. 2, line 1	5. 00	4.00
5. 00	Cost of Drugs	73.00	0. 199183	0		0 col. 2. Line 1	6. 00	5.00

ALCULA	TION OF HHA REIMBURSEMENT SETTLEMENT	Provi der CC	N: 15-0115	Peri od:	Worksheet H-4	
		HHA CCN:	15-7222	From 07/01/2021 To 06/30/2022	Part I-II Date/Time Pre 11/29/2022 11	par : 30
		Title	XVIII	Home Health	PPS	
				Agency I Par	t B	
			Part A	Not Subject	Subject to	
				to Deductibles &	Deductibles & Coinsurance	
		-	1. 00	Coi nsurance 2.00	3. 00	
F	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST	TOMARY CHARGE		2.00	3.00	
	Reasonable Cost of Part A & Part B Services					
	Reasonable cost of services (see instructions)			0 0	0	
	Total charges			0 0	0	1 2
	Customary Charges	an cond coo		0 0	0	١,
	Amount actually collected from patients liable for payment fo on a charge basis (from your records)	or services		0	0	3
	Amount that would have been realized from patients liable for	r payment		0 0	0	_
	for services on a charge basis had such payment been made in				o l	
	with 42 CFR §413.13(b)		0.0000	0 000000	0 000000	١,
	Ratio of line 3 to line 4 (not to exceed 1.000000) Total customary charges (see instructions)		0.0000	0. 000000	0. 000000 0	
	Excess of total customary charges over total reasonable cost	(complete		0 0	0	
	only if line 6 exceeds line 1)	(comprete			o o	
	Excess of reasonable cost over customary charges (complete or	nly if line		0 0	0	8
	1 exceeds line 6)				_	
00	Primary payer amounts			0 0 Part A	0 Part B	(
				Servi ces	Servi ces	
				1.00	2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
1	Total reasonable cost (see instructions)			0		10
	Total PPS Reimbursement - Full Episodes without Outliers			0	1, 323, 042	
1	Total PPS Reimbursement - Full Episodes with Outliers			0	270, 806	
	Total PPS Reimbursement – LUPA Episodes Total PPS Reimbursement – PEP Episodes			0	21, 565 8, 937	
1	Total PPS Outlier Reimbursement – Full Episodes with Outliers	2		0	89, 922	
	Total PPS Outlier Reimbursement - PEP Episodes	3		0	3, 160	
	Total Other Payments			0	0, 100	
	DME Payments			0	Ö	1
	Oxygen Payments			0	0	119
. 00	Prosthetic and Orthotic Payments			0	0	20
. 00	Part B deductibles billed to Medicare patients (exclude coins	surance)			4, 753	2
	Subtotal (sum of lines 10 thru 20 minus line 21)			0	1, 712, 679	
	Excess reasonable cost (from line 8)			0	0	1 -
1	Subtotal (line 22 minus line 23)			0	1, 712, 679	
	Coinsurance billed to program patients (from your records)				0	
	Net cost (line 24 minus line 25)			0	1, 712, 679	
	Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i	instructions)		0	0	28
	Total costs - current cost reporting period (line 26 plus lin			0	1, 712, 679	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	10 27)		0	1, 712, 077	1
	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	Ö	1
1	Demonstration payment adjustment amount before sequestration	,		0	Ö	
	Subtotal (see instructions)			0	1, 712, 679	
. 00	Sequestration adjustment (see instructions)			0	3, 678	
	Demonstration payment adjustment amount after sequestration			0	0	
. 01		nstructions)		0	0	
. 01 . 02 . 75	Sequestration adjustment for non-claims based amounts (see in				1 700 000	12'
. 01 . 02 . 75 2. 00	Interim payments (see instructions)	ŕ		0	1, 709, 002	
. 01 . 02 . 75 . 00	Interim payments (see instructions) Tentative settlement (for contractor use only)	,		0	0	33
. 01   1   . 02   1   . 75   1   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00   . 00	Interim payments (see instructions)					33 34

TO PROGRAM BENEFICIARIES

HHA CCN: 15-7222

Peri od: From 07/01/2021 To 06/30/2022 Date/Ti me Prepared: 11/29/2022 11:30 am

				Home Health Agency I	PPS	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		(		1, 709, 002	1.00
2.00	Interim payments payable on individual bills, either		(	)	0	2.00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01 3. 02					0 0	3. 01 3. 02
3. 02						3. 02
3. 04						3. 04
3. 05					l o	3. 05
	Provi der to Program			1		
3.50			(		0	3.50
3. 51			(		0	3. 51
3. 52			(		0	3. 52
3. 53 3. 54			(		0 0	3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			1	0	3. 99
3. 77	3. 50-3. 98)				Ĭ	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		(		1, 709, 002	4.00
	(transfer to Wkst. H-4, Part II, column as appropriate,					
	line 32)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01			(		0	5. 01
5. 02			(		0	5. 02
5. 03	Dravi dan ta Draggam			)	0	5. 03
5. 50	Provider to Program		(		0	5. 50
5. 51					l ől	5. 51
5. 52			ď		0	5. 52
5. 99	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
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		,		0	4 01
6. 01	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM				1	6. 01 6. 02
7. 00	Total Medicare program liability (see instructions)				1, 709, 001	7. 00
	, , (222 301 010)			Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.05		(	)	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0115	Peri od: From 07/01/2021	Worksheet L Parts I-III	
			To 06/30/2022		pared:
		Title XVIII	Hospi tal	PPS	. SU alli
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			1, 101, 594	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2. 00	Capital DRG outlier payments			488	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost	reporting period (see ins	tructions)	37. 72	3.00
4.00	Number of interns & residents (see instructions)		ŕ	14. 53	4.00
5.00	Indirect medical education percentage (see instructions)			11. 48	5.00
6. 00	Indirect medical education adjustment (multiply line 5 by t 1.01)(see instructions)	he sum of lines 1 and 1.0	1, columns 1 and	126, 463	6.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (Worksheet	E, part A line	0. 00	7.00
8. 00	Percentage of Medicaid patient days to total days (see inst	ructions)		0. 00	8.00
9. 00	Sum of lines 7 and 8	,		0. 00	9.00
10. 00	Allowable disproportionate share percentage (see instructio	ns)		0.00	10.00
11. 00	Disproportionate share adjustment (see instructions)	·		0	11.00
12.00	Total prospective capital payments (see instructions)			1, 228, 545	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	1.00
2. 00	Program inpatient capital costs for extraordinary circumsta	nces (see instructions)		0	2.00
3. 00	Net program inpatient capital costs (line 1 minus line 2)			0	3.00
4. 00	Applicable exception percentage (see instructions)			0. 00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see		v line ()	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordina	ry circumstances (line 2	x iine 6)	0	7.00
	Capital minimum payment level (line 5 plus line 7)	Li cabl a)		0	8.00
			1	0	9.00
9. 00	Current year capital payments (from Part I, line 12, as app	agnital naumanta (lina O			
9. 00 10. 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over			0	
9. 00 10. 00 11. 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	capital payment (from pr	ior year	0	11.00
9. 00 10. 00 11. 00 12. 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital	capital payment (from pr payments (line 10 plus li	ior year ne 11)	0	11. 00 12. 00
9. 00 10. 00 11. 00 12. 00 13. 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent	capital payment (from pr payments (line 10 plus li er the amount on this lin	ior year ne 11) e)	0	11. 00 12. 00 13. 00
9. 00 10. 00 11. 00 12. 00 13. 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)  Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent Carryover of accumulated capital minimum payment level over	capital payment (from pr payments (line 10 plus li er the amount on this lin	ior year ne 11) e)	0	11. 00 12. 00 13. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	capital payment (from pr payments (line 10 plus li er the amount on this lin capital payment for the	ior year ne 11) e)	0	11. 00 12. 00 13. 00 14. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)  Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent Carryover of accumulated capital minimum payment level over	capital payment (from pr payments (line 10 plus li er the amount on this lin capital payment for the	ior year ne 11) e)	0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00

Heal th	Financial Systems	MEMORIAL HOSP & I	HEALTH CARE CT	R	In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
			Component		From 07/01/2021 To 06/30/2022	Date/Time Prep 11/29/2022 11:	pared: :30 am
					RHC I	Cost	
		Compensati on	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	383, 737	C	383, 73	7 -338, 134	45, 603	1.00
2.00	Physician Assistant	0	C		0 2, 363	2, 363	2.00
3.00	Nurse Practitioner	0	[ c		0 203, 799	203, 799	3.00
4.00	Visiting Nurse	0	l c	1	0	0	4.00
5 00	Other Nurse	0				ام	5 00

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-01	Period:   Worksheet M-1   From 07/01/2021
	Component CCN: 15-8	To 06/30/2022 Date/Time Prepared:

			Component CCN	1: 15-8507	10	06/30/2022	Date/IIMe Pre   11/29/2022 11	
						RHC I	Cost	. 50 aiii
		Adjustments	Net Expenses			1010	0031	
		riaj astiliorres	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	45, 603					1.00
2. 00	Physician Assistant	0	2, 363					2.00
3. 00	Nurse Practitioner	0	203, 799					3.00
4. 00	Visiting Nurse	0	0					4.00
5. 00	Other Nurse	0	0					5.00
6. 00	Clinical Psychologist	0	0					6.00
7. 00	Clinical Social Worker	0	0					7.00
8. 00	Laboratory Techni ci an	0	0					8.00
9. 00	Other Facility Health Care Staff Costs	0	94, 783					9.00
10. 00	Subtotal (sum of lines 1 through 9)	0	346, 548					10.00
11. 00	Physician Services Under Agreement	0	0					11.00
12. 00	Physician Supervision Under Agreement	0	0					12.00
	Other Costs Under Agreement	0	0					13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	o					14.00
15. 00	Medical Supplies	0	1, 055					15.00
16. 00	Transportation (Health Care Staff)	0	1, 033					16.00
17. 00		0	0					17.00
18. 00	Professional Liability Insurance	0	0					18.00
	Other Health Care Costs	0	0					19.00
20.00	Allowable GME Costs	U	O <sub>1</sub>					20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	1, 055					21.00
21.00	Total Cost of Health Care Services (sum of	0						21.00
22.00	lines 10, 14, and 21)	U	347, 603					22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
22 00	Pharmacy	0	12, 056					23. 00
24. 00	Dental	0	12, 030					24.00
25. 00	Optometry	0	0					25.00
25. 00	Tel eheal th	0	1, 505					25. 00
25. 01	4	0	1, 303					25. 01
26. 00	All other nonreimbursable costs	0	0					26.00
27. 00	Nonallowable GME costs	U	U <sub>I</sub>					27.00
28. 00	1	0	13, 561					28.00
26.00	Total Nonreimbursable Costs (sum of lines 23	U	13, 301					20.00
	through 27) FACILITY OVERHEAD							1
20 00	Facility Overhead Facility Costs	0	59, 643					29. 00
30.00	Administrative Costs	-1, 003	72, 278					30.00
31. 00	Total Facility Overhead (sum of lines 29 and		131, 921					31.00
31.00	30)	- 1, 003	131, 721					31.00
32. 00	Total facility costs (sum of lines 22, 28	-1, 003	493, 085					32.00
JZ. UU	and 31)	- 1, 003	473,003					32.00
	lana 31)	ļ	I					1

Heal th	Financial Systems ME	MORIAL HOSP & F	HEALTH CARE CT	3	In Lie	u of Form CMS-2	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
					From 07/01/2021		
			Component	CCN: 15-8508	To 06/30/2022	Date/Time Pre 11/29/2022 11	
					RHC II	Cost	. 30 aiii
		Compensation	Other Costs	Total (col	Reclassificat	Recl assi fi ed	
		Compensation	011101 00313	+ col . 2)	i ons	Tri al Bal ance	
				' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		(col. 3 +	
						col . 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	503, 774	0	503, 77	4 -381, 181	122, 593	1.00
2.00	Physician Assistant	0	0		0	0	2.00
3.00	Nurse Practitioner	0	0		0 174, 588	174, 588	3.00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	0	0		0	0	5.00
6.00	Clinical Psychologist	0	0		0	0	6.00
7.00	Clinical Social Worker	0	0		0	0	7.00
8.00	Laboratory Techni ci an	0	0		0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0		0 130, 337	130, 337	9.00
10.00	Subtotal (sum of lines 1 through 9)	503, 774	0	503, 77	4 -76, 256	427, 518	
11. 00	Physician Services Under Agreement	0	0		0	0	11. 00
12.00	Physician Supervision Under Agreement	0	0		0	0	12.00
13. 00	Other Costs Under Agreement	0	0		0	0	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14.00
15.00	Medical Supplies	0	751	75	1 0	751	15. 00
16. 00	Transportation (Health Care Staff)	0	0		0	0	16. 00
17. 00	Depreciation-Medical Equipment	0	0		0	0	17. 00
18. 00	Professional Liability Insurance	0	0		0	0	18. 00

0

0

0

503, 774

503, 774

0

751

751

0

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13, 650

13,650

3, 189

32, 341

35, 530

49, 931

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751

504, 525

13, 650

13, 650

3, 189

32, 341

35, 530

553, 705

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0

288

288

75, 968

75, 968

-76, 256

19.00

20.00

21.00

22.00

23.00

24.00

25.00

25.01

26.00

27.00

28.00

29.00

30.00

31.00

32.00

751

428, 269

13, 650

13, 938

3, 189

108, 309

111, 498

553, 705

0

0 25.02

288

19.00 Other Health Care Costs

Pharmacy

 ${\tt Optometry}$ 

Tel eheal th

through 27) FACILITY OVERHEAD

29.00 Facility Costs

and 31)

Dental

Allowable GME Costs

Chronic Care Management

Nonallowable GME costs

Administrative Costs

Subtotal (sum of lines 15 through 20)

lines 10, 14, and 21)
COSTS OTHER THAN RHC/FOHC SERVICES

All other nonreimbursable costs

Total Cost of Health Care Services (sum of

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

20.00

21.00

22.00

23.00

24.00

25.00

25.01

25.02

26.00

27.00

28.00

30.00

31.00

32.00

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-0115	Period: Worksheet M-1 From 07/01/2021
	Component CCN: 15-8508	To 06/30/2022 Date/Time Prepared:

			Componen	t CCN: 15-8508	То	06/30/2022	Date/Time Pro 11/29/2022 1	
						RHC II	Cost	1. 00 diii
		Adjustments	Net Expense	s				
		,	for					
			All ocation					
			(col. 5 +					
			col. 6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	122, 5	93				1.00
2.00	Physician Assistant	0		0				2.00
3.00	Nurse Practitioner	0	174, 5	88				3.00
4.00	Visiting Nurse	0		0				4.00
5.00	Other Nurse	0		0				5.00
6.00	Clinical Psychologist	0		0				6.00
7.00	Clinical Social Worker	0		0				7.00
8.00	Laboratory Techni ci an	0		0				8.00
9.00	Other Facility Health Care Staff Costs	0	130, 3	37				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	427, 5	18				10.00
11.00	Physician Services Under Agreement	o		0				11.00
12.00	Physician Supervision Under Agreement	o		0				12.00
13.00	Other Costs Under Agreement	0		0				13.00
14.00	Subtotal (sum of lines 11 through 13)	o		0				14.00
15.00	Medical Supplies	o	7.	51				15.00
16.00	Transportation (Health Care Staff)	О		О				16.00
17.00		o		О				17.00
18.00	Professional Liability Insurance	o		О				18.00
	Other Health Care Costs	o		0				19.00
20.00	Allowable GME Costs							20.00
21. 00	Subtotal (sum of lines 15 through 20)	o	7	51				21.00
22. 00	Total Cost of Health Care Services (sum of	o	428, 2					22.00
	lines 10, 14, and 21)	- ا	,_	-				
	COSTS OTHER THAN RHC/FQHC SERVICES			<u>'</u>				
23.00	Pharmacy	0	13, 6	50				23.00
24.00	Dental	o		o				24.00
25.00	Optometry	o		o				25.00
25. 01	Tel eheal th	o	2	88				25. 01
25. 02	Chronic Care Management	o		o				25. 02
26.00	All other nonreimbursable costs	o		o				26.00
27.00	Nonallowable GME costs							27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	ol	13, 9	38				28. 00
	through 27)							
	FACILITY OVERHEAD							1
29.00	Facility Costs	0	3, 1	89				29. 00
30.00	Administrative Costs	-225	108, 0					30.00
31. 00	Total Facility Overhead (sum of lines 29 and		111, 2	1				31.00
	30)		-, -					
32.00	Total facility costs (sum of lines 22, 28	-225	553, 4	80				32.00
	and 31)		-, -					
	•	'		•				•

Heal th	Financial Systems ME	MORIAL HOSP & I	HEALTH CARE CTF	₹	In Lie	u of Form CMS-2	2552-10
	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der Company		Period: From 07/01/2021 To 06/30/2022	Worksheet M-2	
			Component	CCN: 15-8507	To 06/30/2022	Date/Time Pre 11/29/2022 11	
					RHC I	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)	7	col. 2 or	
					1 x col . 3)	col . 4	
	WIGHTS AND DROPHOTIVETY	1. 00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
1 00	Positions  Dhysician	0.05	254	4 20	0 210		1 00
1. 00 2. 00	Physi ci an Physi ci an Assi stant	0. 05 0. 02		4, 20 2, 10			1. 00 2. 00
3. 00	Nurse Practitioner	1. 31					3.00
4. 00	Subtotal (sum of lines 1 through 3)	1. 31			3, 003	3, 532	4.00
5. 00	Visiting Nurse	0.00			3,003	3, 532	5.00
6. 00	Clinical Psychologist	0.00				0	6.00
7. 00	Clinical Social Worker	0.00				0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	
7. 02	Di abetes Self Management Training (FQHC	0.00				0	7. 02
	only)						
8.00	Total FTEs and Visits (sum of lines 4	1. 38	3, 532			3, 532	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9.00
						1. 00	
40.00	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVICES		247 (00	40.00
10.00	Total costs of health care services (from Wk					347, 603	
11.00	Total nonreimbursable costs (from Wkst. M-1,					13, 561	
12. 00 13. 00	Cost of all services (excluding overhead) (s Ratio of hospital-based RHC/FQHC services (I					361, 164 0. 962452	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			no 21)		131, 921	
15. 00	Parent provider overhead allocated to facili			116 31)		281, 719	
16. 00	Total overhead (sum of lines 14 and 15)	ty (see mistru	Cti ons)			413, 640	
17. 00	Allowable GME overhead (see instructions)					113, 040	
	Enter the amount from line 16					413, 640	
	Overhead applicable to hospital-based RHC/FC	OHC services (I	ine 13 x line	18)		398, 109	
	Total allowable cost of hospital-based RHC/F					745, 712	
	•				•	•	

Heal th	Financial Systems ME	MORIAL HOSP & F	HEALTH CARE CTE	2	Inlie	u of Form CMS-2	2552_10
	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC		Provi der C	CN: 15-0115	Peri od:	Worksheet M-2	
			Component		From 07/01/2021	Doto/Time Dro	norod.
			Component	CCN: 15-8508	To 06/30/2022	Date/Time Pre 11/29/2022 11	
					RHC II	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)		col. 2 or	
		1.00	2. 00	3. 00	1 x col . 3) 4.00	col . 4 5.00	
	VISITS AND PRODUCTIVITY	1. 00	2.00	3.00	4.00	5.00	
	Posi ti ons						
1. 00	Physi ci an	0.80	1, 549	4, 20	0 3, 360		1. 00
2.00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	1. 34	3, 603	2, 10	0 2, 814		3.00
4.00	Subtotal (sum of lines 1 through 3)	2. 14	5, 152		6, 174	6, 174	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00				0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	-			0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
0.00	only)	2 14	F 1F2			/ 174	0.00
8. 00	Total FTEs and Visits (sum of lines 4 through 7)	2. 14	5, 152			6, 174	8. 00
9. 00	Physician Services Under Agreements		0			0	9. 00
7.00	Triysi Crair Servi Ces Under Agreements		0			0	7.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASE	ED RHC/FQHC SEI	RVICES			
10.00	Total costs of health care services (from Wk	kst. M-1, col.	7, line 22)			428, 269	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			13, 938	11.00
12.00	Cost of all services (excluding overhead) (s					442, 207	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 968481	13.00
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		111, 273	14.00
15. 00	Parent provider overhead allocated to facili	ty (see instru	ctions)			430, 276	
16.00	Total overhead (sum of lines 14 and 15)					541, 549	
17.00	,					0	
	Enter the amount from line 16	NIC comit cos (1)	ino 10 v li	10)		541, 549	
	Overhead applicable to hospital-based RHC/FC Total allowable cost of hospital-based RHC/FC					524, 480 952, 749	
20.00	Tiotal allowable cost of hospital-based knc/f	VIIC SELVICES (	Sum ULLITIES II	Jailu 17)	ļ	932, 749	20.00

	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-0115	Peri od:	Worksheet M-3	
SERVI (			From 07/01/2021		
		Component CCN: 15-8507	To 06/30/2022	Date/Time Pre 11/29/2022 11	
		Title XVIII	RHC I	Cost	. 30 6
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES		1	7.15 7.10	
. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			745, 712	1.
. 00 . 00	Cost of injections/infusions and their administration (from W Total allowable cost excluding injections/infusions (line 1 m			17, 876 727, 836	1
.00	Total Visits (from Wkst. M-2, column 5, line 8)	irius irrie 2)		3, 532	1
. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0, 332	5.
. 00	Total adjusted visits (line 4 plus line 5)			3, 532	
. 00	Adjusted cost per visit (line 3 divided by line 6)			206. 07	7.
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(07/01/2021	(01/01/2022	
			through	through	
			12/31/2021)	06/30/2022)	
-00	Don visit normant Limit (from CMC Dub. 100 04 shanton 0, 520	( or your contractor)	1.00	2.00	0
. 00 . 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 Rate for Program covered visits (see instructions)	. 6 or your contractor)	100. 00 100. 00	113. 00 113. 00	
. 00	CALCULATION OF SETTLEMENT		100.00	113.00	7.
0. 00	Program covered visits excluding mental health services (from	contractor records)	632	539	10.
1.00	Program cost excluding costs for mental health services (line		63, 200	60, 907	11.
2. 00	Program covered visits for mental health services (from contra	actor records)	0	0	12.
3. 00	Program covered cost from mental health services (line 9 x li	•	0	0	
4. 00	Limit adjustment for mental health services (see instructions	•	0	0	14.
5.00	Graduate Medical Education Pass Through Cost (see instruction:	•	0	104 107	15.
6. 00 6. 01	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's re-		٩	124, 107 250, 993	1
6. 02	Total program preventive charges (see instructions) (from prov	•		3, 079	1
6. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		1, 522	1
6. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		74, 107	16.
	(Titles V and XIX see instructions.)				
6. 05	Total program cost (see instructions)		0	75, 629	
7.00	Primary payer amounts	(from contractor		20.051	17.
8. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(Trom contractor		29, 951	18.
9. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		43, 593	19.
	records)				
0. 00	Net Medicare cost excluding vaccines (see instructions)			75, 629	20.
1. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		10, 739	1
2.00	Total reimbursable Program cost (line 20 plus line 21)			86, 368	1
3. 00 3. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. 40 (. 6.16)		0	
	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
5. 99	Demonstration payment adjustment amount before sequestration				25.
6. 00	Net reimbursable amount (see instructions)			86, 368	
6. 01	Sequestration adjustment (see instructions)				26.
6. 02				73, 021	
8.00	Interim payments Tentative settlement (for contractor use only)			73, 021	
29. 00	,	02. 27. and 28)		13, 131	1
	1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 =	,,,			30.

ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	ALTH CARE CTR C Provider CCN: 15-0115	Peri od:	u of Form CMS-2 Worksheet M-3	
ERVI CES	Component CCN: 15-8508	From 07/01/2021 To 06/30/2022	Date/Time Pre	naror
	Component Con. 13-0300	10 00/30/2022	11/29/2022 11	
	Title XVIII	RHC II	Cost	
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (fr	om Wkst. M-2, line 20)		952, 749	1. (
OO Cost of injections/infusions and their administration (from			20, 956	1
Total allowable cost excluding injections/infusions (line 1	minus line 2)		931, 793	3.
Total Visits (from Wkst. M-2, column 5, line 8)	1: 0)		6, 174	1
.00   Physicians visits under agreement (from Wkst. M-2, column 5, .00   Total adjusted visits (line 4 plus line 5)	Tine 9)		0 6, 174	5. 6.
.00   Adjusted cost per visit (line 3 divided by line 6)			150. 92	
indicated dost per visit (time o divided by time o)		Cal cul ati on		,.
			. , ,	
		Rate Period 1		
		(07/01/2021 through	(01/01/2022 through	
		12/31/2021)	06/30/2022)	
		1.00	2. 00	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §2	0.6 or your contractor)	100.00	113. 00	8.
Rate for Program covered visits (see instructions)		100.00	113. 00	9.
CALCULATION OF SETTLEMENT		000	0.40	10.
D.OO   Program covered visits excluding mental health services (fro 1.00   Program cost excluding costs for mental health services (lin		809 80, 900	95, 824	
2.00 Program covered visits for mental health services (from cont		0 0	95, 624	1
3.00 Program covered cost from mental health services (line 9 x l	,	ő	0	1
4.00 Limit adjustment for mental health services (see instruction	•	0	0	14.
5.00 Graduate Medical Education Pass Through Cost (see instructio	ns)			15.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1,		0	176, 724	1
6.01 Total program charges (see instructions)(from contractor's r	•		302, 418	1
6.02  Total program preventive charges (see instructions)(from pro 6.03  Total program preventive costs ((line 16.02/line 16.01) time	*		904 528	1
6.04 Total Program non-preventive costs ((Time 16.02/Time 16.07) time 6.04 Total Program non-preventive costs ((Line 16 minus Lines 16.	•		104, 320	
(Titles V and XIX see instructions.)	oo ana ro, triiics . oo,		101, 020	10.
6.05 Total program cost (see instructions)		0	104, 848	16.
7.00 Primary payer amounts			0	17.
B.00 Less: Beneficiary deductible for RHC only (see instructions	) (from contractor		45, 796	18.
records) 9.00 Beneficiary coinsurance for RHC/FQHC services (see instructi	ana) (from contractor		E1 140	10
9.00 Beneficiary coinsurance for RHC/FQHC services (see instructi records)	ons) (IT on Contractor		51, 143	19.
0.00 Net Medicare cost excluding vaccines (see instructions)			104, 848	20.
1.00 Program cost of vaccines and their administration (from Wkst	. M-4, line 16)		13, 595	21.
2.00 Total reimbursable Program cost (line 20 plus line 21)			118, 443	1
3.00 Allowable bad debts (see instructions)			0	
3.01 Adjusted reimbursable bad debts (see instructions)	+		0	
4.00   Allowable bad debts for dual eligible beneficiaries (see ins 5.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	tructions)		0	
5.50 Pioneer ACO demonstration payment adjustment (see instruction)	ns)		0	
5.99 Demonstration payment adjustment amount before sequestration			-	25.
6.00 Net reimbursable amount (see instructions)			118, 443	1
6.01 Sequestration adjustment (see instructions)				26.
6.02 Demonstration payment adjustment amount after sequestration			0	
7.00 Interim payments			102, 024	1
8.00 Tentative settlement (for contractor use only)	02 27 and 20)		14 122	
9.00   Balance due component/program (line 26 minus lines 26.01, 26 0.00   Protested amounts (nonallowable cost report items) in accord			16, 123 0	1
o. oo priotested amounts (nonarrowable cost report flems) in accord	ance with two rub. 15-11	,	Ü	ا عن.

Health Financial Systems	MEMORIAL HOSP & HEAL	LTH CARE CTR	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC V	ACCINE COST	Provider CCN: 15-0115	Peri od:	Worksheet M-4

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der C		Period: From 07/01/2021	Worksheet M-4	
		Component		To 06/30/2022	Date/Time Pre 11/29/2022 11	
		Title	XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	346, 548	346, 54	18 346, 548	346, 548	1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 003940	0. 00285	0. 000000	0. 000000	2. 00
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	1, 365	98	0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	3, 098	2, 88	0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4, 463	3, 87	0 0	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	347, 603	347, 60	347, 603	347, 603	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	398, 109	398, 10	398, 109	398, 109	7. 00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 012839	0. 01113	0. 000000	0. 000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	5, 111	4, 43	32 0	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	9, 574	8, 30	0	0	10. 00
11.00	Total number of injections/infusions (from your records)	17	12	23 0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	563. 18	67. 5	0.00	0.00	12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	9	8	0	0	13. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	5, 069	5, 67	70 0	0	14.00
15. 00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		17, 87	76		15. 00
16. 00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		10, 73	89		16. 00

Health Financial Systems	MEMORIAL HOSP & HEA	LTH CARE CTR	In Lieu	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC \	ACCINE COST	Provider CCN: 15-0115	Peri od:	Worksheet M-4
			From 07/01/2021	

COMPUT	ATTON OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co		Peri od:	Worksheet M-4	
		Component		From 07/01/2021 To 06/30/2022	Date/Time Pre 11/29/2022 11	
			XVIII	RHC II	Cost	
		PNEUMOCOCCAL	I NFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCI NES	ANTI BODY	
					PRODUCTS	
		1. 00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	427, 518				
2.00	Ratio of injection/infusion staff time to total health	0. 000444	0. 00286	0.000000	0.000000	2.00
	care staff time					
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	190	1, 22	26 0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	4, 374	3, 63	0	0	4. 00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	4, 564	4, 85	56	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from	428, 269			428, 269	6.00
0.00	Worksheet M-1, col. 7, line 22)	120, 20,	120,20	120, 20,	120,20,	0.00
7. 00	Total overhead (from Wkst. M-2, line 19)	524, 480	524, 48	524, 480	524, 480	7.00
8. 00	Ratio of injection/infusion direct cost to total direct	0. 010657				8.00
	cost (line 5 divided by line 6)					
9.00	Overhead cost - injection/infusion (line 7 x line 8)	5, 589	5, 94	17 0	0	9.00
10.00	Total injection/infusion costs and their administration	10, 153	10, 80	0	0	10.00
	costs (sum of lines 5 and 9)					
11.00	Total number of injections/infusions (from your records)	24	15	55 0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	423. 04	69. 7	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program	15	10	04	0	13.00
	benefi ci ari es					
13.01	Number of COVID-19 vaccine injections/infusions			0	0	13. 01
	administered to MA enrollees					
14.00		6, 346	7, 24	19 0	0	14.00
	administration costs (line 12 times the sum of lines 13					
	and 13.01, as applicable)					
15.00	Total cost of injections/infusions and their		20, 95	56		15.00
	administration costs (sum of columns 1, 2, 2.01, and 2.02,					
	line 10) (transfer this amount to Wkst. M-3, line 2)					
16. 00	Total Program cost of injections/infusions and their		13, 59	95		16. 00
	administration costs (sum of columns 1, 2, 2.01, and 2.02,					
	line 14) (transfer this amount to Wkst. M-3, line 21)					

Health Financial Systems	MEMORIAL HOSP & HEA	LTH CARE CTR	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQ SERVICES RENDERED TO PROGRAM BENEFICIARIES	HC PROVI DER FOR	Provider CCN: 15-0115 Component CCN: 15-8507	Peri od: From 07/01/2021 To 06/30/2022	Date/Time Prepared:
				11/29/2022 11:30 am

				11/29/2022 11	: 30 a
			RHC I	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
	Total interim payments paid to hospital-based RHC/FQHC			73, 021	1.0
2. 00	Interim payments payable on individual bills, either submit			0	2.0
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3. 00	List separately each retroactive lump sum adjustment amount				3. (
	revision of the interim rate for the cost reporting period.	Also show date of each			
ļ	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider			_	_
. 01				0	3.
. 02				0	3.
. 03				0	3.
. 04				0	3.
. 05	Don't lead to Don't come			0	3.
. 50	Provider to Program			0	3.
. 50 . 51					3.
. 52					3.
53					3.
. 54				l ől	3.
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		ا	3.
	Total interim payments (sum of lines 1, 2, and 3.99) (trans			73, 021	4.
	27)			.,.	
	TO BE COMPLETED BY CONTRACTOR				
	List separately each tentative settlement payment after des	k review. Also show date of			5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
. 01				0	5.
. 02				0	5.
. 03	D			0	5.
	Provider to Program			0	-
. 50 . 51					5. 5.
. 51					5. 5.
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	00)			5. 5.
	Determined net settlement amount (balance due) based on the			١	6.
. 01	SETTLEMENT TO PROVIDER	. созт герогт. (т)		13, 131	6.
	SETTLEMENT TO PROGRAM			13, 131	6.
	Total Medicare program liability (see instructions)			86, 152	7.
	(222		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	
			1.00	2.00	

Health Financial Systems	MEMORIAL HOSP & HEA	LTH CARE CTR	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FO SERVICES RENDERED TO PROGRAM BENEFICIARIES	HC PROVI DER FOR	Provider CCN: 15-0115 Component CCN: 15-8508	Peri od: From 07/01/2021 To 06/30/2022	
				11/29/2022 11:30 am

		p		11/29/2022 11	: 30 a
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			102, 024	1.0
2. 00	00 Interim payments payable on individual bills, either submitted or to be submitted to			l ol	2.0
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
. 00					3. (
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		_		
. 01				0	3.
. 02				0	3.
. 03				l ol	3.
. 04				l ol	3.
. 05				0	3.
	Provider to Program				
. 50	-			0	3.
. 51				l ol	3.
52				l ol	3.
53				l ol	3.
54				l ol	3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.		l ol	3.	
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans		102, 024	4.	
	27)	•			
	TO BE COMPLETED BY CONTRACTOR				
. 00	List separately each tentative settlement payment after des	k review. Also show date of			5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
. 01				0	5.
. 02				0	5.
. 03				0	5.
	Provider to Program				
. 50				0	5.
. 51				0	5.
52				0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)				6.
01	SETTLEMENT TO PROVIDER			16, 123	6.
. 02	SETTLEMENT TO PROGRAM			0	6.
. 00	Total Medicare program liability (see instructions)			118, 147	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
		U	1.00	2.00	