

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050
EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet S Parts I-III Date/Time Prepared: 1/13/2025 9:02 am
--	-----------------------	---	--

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 1/13/2025	Time: 9:02 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. ☒ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(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 07/01/2024 and ending 09/30/2024 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	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
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 V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	27,242	34,907	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0	0	2.00
3.00	SUBPROVIDER - IRF	0	204	0	0	3.00
5.00	SWING BED - SNF	0	0	0	0	5.00
6.00	SWING BED - NF	0	0	0	0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0	0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	9.00
10.00	RURAL HEALTH CLINIC I	0	0	222	0	10.00
10.01	RURAL HEALTH CLINIC II	0	0	1,602	0	10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	11.00
200.00	TOTAL	0	27,446	36,731	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 15-0115		Period: From 07/01/2024 To 09/30/2024		Worksheet S-2 Part I Date/Time Prepared: 1/13/2025 9:02 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 800 WEST 9TH STREET		PO Box:						1.00		
2.00	City: JASPER		State: IN		Zip Code: 47546		County: DUBOIS		2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		MEMORIAL HOSP & HEALTH CARE CTR	150115	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF		MEMORIAL HOSP & HCC (REHAB)	15T115	99915	5	07/01/2005	N	P	O	5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF		MEMORIAL HOSP & HEALTH CARE CTR	155305	99915		08/04/1987	N	P	O	9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC		FRENCH LICK FAMILY MEDICINE	158507	99915		06/19/2009	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II		LOOGOOTEE FAMILY MEDICINE	158508	99915		12/14/2009	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2024	09/30/2024		20.00	
21.00	Type of Control (see instructions)						1			21.00	
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for 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.					Y	N		22.00		
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 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)					Y	Y		22.01		
22.02	Is this a newly merged hospital that requires a final UCP 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.					N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to 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)					N	N		N	22.03	
22.04	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								22.04		
22.04	Did this hospital receive a geographic reclassification from urban to 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)								22.04		
22.04	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								22.04		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet S-2
Part I
Date/Time Prepared:
1/13/2025 9:02 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	76	98	13	2	585	38	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	32		25.00
				Urban/Rural S	Date of Geogr		
				1.00	2.00		
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.				2			26.00
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.				2			27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.				0			35.00
				Beginning:	Ending:		
				1.00	2.00		
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.							36.00
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.				0			37.00
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)							37.01
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.							38.00
				Y/N	Y/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)				Y	Y		39.00
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)				N	N		40.00
				V	XVIII	XIX	
				1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)				N	N	N	45.00
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.				N	N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.				N	N	N	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.				N	N	N	48.00
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.				Y	Y		56.00
57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				Y			57.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet S-2 Part I Date/Time Prepared: 1/13/2025 9:02 am		
			V 1.00	XVIII 2.00	XIX 3.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).					61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)					61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
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" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				Y	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet S-2
Part I
Date/Time Prepared:
1/13/2025 9:02 am

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.25	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MEDICINE	1350	0.02	3.47	0.005731	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet S-2 Part I Date/Time Prepared: 1/13/2025 9:02 am	
				1.00	
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?				68.00
				1.00	2.00 3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 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)			N Y 1	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for 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)			N N 0	76.00
				1.00	
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
			1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		N	0	88.00
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge
			1.00	2.00	3.00
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.		0.00		0 89.00
			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 yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	91.00
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.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
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 applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0115		Period: From 07/01/2024 To 09/30/2024		Worksheet S-2 Part I Date/Time Prepared: 1/13/2025 9:02 am	
		V 1.00		XIX 2.00			
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation 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.	Y		Y		98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) 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.	N		N		98.03	
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 in column 2 for title XIX.	N		N		98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, 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.	Y		Y		98.06	
Rural Providers							
105.00	Does this hospital qualify as a CAH?	N				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00	
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) 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)					107.00	
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)					107.01	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical 1.00		Occupational 2.00		Speech 3.00	
						Respiratory 4.00	
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 project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N		110.00	
		1.00		2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
		1.00		2.00		3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0115		Period: From 07/01/2024 To 09/30/2024	Worksheet S-2 Part I Date/Time Prepared: 1/13/2025 9:02 am
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	284,844	0	0	118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	Y	N		123.00
Certified Transplant Center Information					
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	Removed and reserved				133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y			140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: MEMORIAL HOSPITAL AND HEALTH CENTER	Contractor's Name: WPS		Contractor's Number: 08101	
142.00	Street: 800 W 9TH STREET	PO Box:			
143.00	City: JASPER	State: IN		Zip Code: 47546	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y	144.00
		1.00	2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 15-0115		Period: From 07/01/2024 To 09/30/2024		Worksheet S-2 Part I Date/Time Prepared: 1/13/2025 9:02 am		
						1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N		155.00	
156.00	Subprovider - IPF	N	N	N	N		156.00	
157.00	Subprovider - IRF	N	N	N	N		157.00	
158.00	SUBPROVIDER						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		161.00	
						1.00		
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each 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)						0.00	
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						9.99	169.00
						Beginning	Ending	
						1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
						1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in 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, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0
							171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0115		Period: From 07/01/2024 To 09/30/2024		Worksheet S-2 Part II Date/Time Prepared: 1/13/2025 9:02 am	
				Y/N	Date		
				1.00	2.00		
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					Y	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	12/16/2024	Y	12/16/2024		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
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.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0115		Period: From 07/01/2024 To 09/30/2024		Worksheet S-2 Part II Date/Time Prepared: 1/13/2025 9:02 am	
		Description		Y/N		Y/N	
		0		1.00		3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N		N	
		Y/N		Date		Y/N	
		1.00		2.00		3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N			
						1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)							
Capital Related Cost							
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions						22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.						23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions						24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.						25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.						26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.						27.00
Interest Expense							
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.						28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions						29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.						30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.						31.00
Purchased Services							
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.						32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.						33.00
Provider-Based Physicians							
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.						34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.						35.00
		Y/N		Date			
		1.00		2.00			
Home Office Costs							
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 prepared by the home office? If yes, see instructions.						37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.						38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.						39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.						40.00
		1.00		2.00			
Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KERRY		BEJARANO		41.00	
42.00	Enter the employer/company name of the cost report preparer.	FORVIS MAZARS, LLP				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		KERRY.BEJARANO@US.FORVISMZARS.COM		43.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet S-2 Part II Date/Time Prepared: 1/13/2025 9:02 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		
42.00	Enter the employer/company name of the cost report preparer.			
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet S-3
Part I
Date/Time Prepared:
1/13/2025 9:02 am

Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
PART I - STATISTICAL DATA						
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	80	7,360	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		80	7,360	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	26	2,392	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		106	9,752	0.00	0	14.00
15.00 CAH visits					0	15.00
15.10 REH hours and visits				0.00	0	15.10
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	3	736		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	14	70		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 HOSPICE	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)		123				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance 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 outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01
34.00 Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet S-3
Part I
Date/Time Prepared:
1/13/2025 9:02 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	706	27	2,113			1.00
2.00	HMO and other (see instructions)	430	698				2.00
3.00	HMO IPF Subprovider	0	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 beds) (see instructions)	706	27	2,113			7.00
8.00	INTENSIVE CARE UNIT	388	28	825			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		21	360			13.00
14.00	Total (see instructions)	1,094	76	3,298	14.80	292.01	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	198	0	391	0.00	2.95	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	10	0	10	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			26			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	307	0	1,067	0.00	1.78	26.00
26.01	RURAL HEALTH CLINIC II	486	0	1,328	0.00	1.67	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				14.80	298.41	27.00
28.00	Observation Bed Days		26	1,085			28.00
29.00	Ambulance Trips	401					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	38	102			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet S-3
Part I
Date/Time Prepared:
1/13/2025 9:02 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
PART I - STATISTICAL DATA						
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	378	5	746	1.00
2.00 HMO and other (see instructions)			119	219		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				2		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 beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	378	5	746	14.00
15.00 CAH visits						15.00
15.10 REH hours and visits						15.10
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0	16	0	30	17.00
18.00 SUBPROVIDER						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 HOSPICE	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 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01
34.00 Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet S-3
Part II
Date/Time Prepared:
1/13/2025 9:02 am

		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	29,790,981	-285,383	29,505,598	612,671.58	48.16	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		1,108,922	0	1,108,922	9,921.46	111.77	3.00
4.00	Physician-Part A - Administrative		8,682	0	8,682	31.33	277.11	4.00
4.01	Physicians - Part A - Teaching		243,944	0	243,944	1,384.00	176.26	4.01
5.00	Physician and Non Physician-Part B		2,829,257	0	2,829,257	8,590.50	329.35	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		166,688	0	166,688	4,403.00	37.86	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		388,617	0	388,617	7,529.00	51.62	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		10,202,758	-32,137	10,170,621	178,805.66	56.88	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,589,860	0	1,589,860	28,307.86	56.16	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,012,076	0	4,012,076			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		1,751,532	0	1,751,532			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		97,241	0	97,241			21.00
22.00	Physician Part A - Administrative		600	0	600			22.00
22.01	Physician Part A - Teaching		13,806	0	13,806			22.01
23.00	Physician Part B		84,035	0	84,035			23.00
24.00	Wage-related costs (RHC/FQHC)		43,218	0	43,218			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet S-3
Part II
Date/Time Prepared:
1/13/2025 9:02 am

		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	8,000	0	8,000	200.00	40.00	26.00
27.00	Administrative & General	5.00	3,332,653	-84,077	3,248,576	65,071.49	49.92	27.00
28.00	Administrative & General under contract (see inst.)		662,149	0	662,149	2,180.00	303.74	28.00
29.00	Maintenance & Repairs	6.00	454,594	-3,372	451,222	17,463.86	25.84	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	77,606	-712	76,894	4,456.75	17.25	31.00
32.00	Housekeeping	9.00	361,199	0	361,199	19,773.59	18.27	32.00
33.00	Housekeeping under contract (see instructions)		390,934	0	390,934	20,178.74	19.37	33.00
34.00	Dietary	10.00	294,026	-238,776	55,250	2,520.93	21.92	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	236,368	236,368	11,004.00	21.48	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	267,759	-2,532	265,227	6,000.23	44.20	38.00
39.00	Central Services and Supply	14.00	78,971	-1,550	77,421	3,468.50	22.32	39.00
40.00	Pharmacy	15.00	542,118	-481,008	61,110	1,498.52	40.78	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet S-3
Part III
Date/Time Prepared:
1/13/2025 9:02 am

	Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	26,106,636	-285,383	25,821,253	603,202.36	42.81	1.00
2.00	Excluded area salaries (see instructions)	10,202,758	-32,137	10,170,621	178,805.66	56.88	2.00
3.00	Subtotal salaries (line 1 minus line 2)	15,903,878	-253,246	15,650,632	424,396.70	36.88	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,589,860	0	1,589,860	28,307.86	56.16	4.00
5.00	Subtotal wage-related costs (see inst.)	4,012,676	0	4,012,676	0.00	25.64	5.00
6.00	Total (sum of lines 3 thru 5)	21,506,414	-253,246	21,253,168	452,704.56	46.95	6.00
7.00	Total overhead cost (see instructions)	6,470,009	-575,659	5,894,350	153,816.61	38.32	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet S-3
Part IV
Date/Time Prepared:
1/13/2025 9:02 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	489,108	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,206,858	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	104,571	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	24,532	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	289,407	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	46,054	14.00
15.00	'Workers' Compensation Insurance	106,301	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	1,722,262	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	13,414	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,002,507	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet S-3
Part V
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,589,860	6,002,507	1.00
2.00	Hospital	1,589,860	5,946,346	2.00
3.00	SUBPROVIDER - IPF	0	0	3.00
4.00	SUBPROVIDER - IRF	0	56,161	4.00
5.00	Subprovider - (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	Hospital-Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice	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	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	0	18.00

Health Financial Systems		MEMORIAL HOSP & HEALTH CARE CTR		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0115 Component CCN: 15-8507		Period: From 07/01/2024 To 09/30/2024 Worksheet S-8 Date/Time Prepared: 1/13/2025 9:02 am	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification			522 SOUTH MAPLE STREET	
	Street			1.00	
	City			State	
	1.00			2.00	
2.00	City, State, ZIP Code, County			FRENCH LICK IN 47432	
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	
	Grant Award			Date	
	1.00			2.00	
	Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
				1.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N 0	
	Sunday			Monday	
	from to			from to	
	1.00 2.00			3.00 4.00	
	Tuesday			from	
				5.00	
11.00	Facility hours of operations (1)				
	CLINIC			08:00 17:00 07:00	
				1.00 2.00 3.00	
12.00	Have you received an approval for an exception to the productivity standard?			N	
13.00	Is this worksheet prepared for a consolidated group as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y, enter in column 2 the number of providers included in the group. List the name and provider number of each member in the consolidated group on line 14. If column 1 is Y, in column 3 enter G or N to identify the grouping as grandfathered or non-grandfathered, respectively.			N 0	
	Provider name			CCN	
	1.00			2.00	
14.00	RHC/FQHC name, CCN				
	Y/N V			XVIII XIX	
	1.00 2.00			3.00 4.00	
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)				
	County				
	4.00				
2.00	City, State, ZIP Code, County			ORANGE	
				2.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 15-0115 Component CCN: 15-8507		Period: From 07/01/2024 To 09/30/2024	Worksheet S-8 Date/Time Prepared: 1/13/2025 9:02 am
					RHC I	Cost
		Tuesday	Wednesday		Thursday	
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)						
11.00	CLINIC	16:00	07:00	16:00	07:00	16:00
		Friday		Saturday		
		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		MEMORIAL HOSP & HEALTH CARE CTR		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 15-0115 Component CCN: 15-8508		Period: From 07/01/2024 To 09/30/2024 Worksheet S-8 Date/Time Prepared: 1/13/2025 9:02 am		
		RHC II		Cost		
		1.00				
1.00	Clinic Address and Identification					1.00
	Street	105 COOPER STREET				1.00
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	LOOG00TEE		IN 47553		2.00
				1.00		
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0		3.00
		Grant Award		Date		
		1.00		2.00		
Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
		1.00		2.00		
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0		10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
Facility hours of operations (1)						
11.00	CLINIC	07:30		17:00		07:30
		1.00		2.00		3.00
12.00	Have you received an approval for an exception to the productivity standard?	N				12.00
13.00	Is this worksheet prepared for a consolidated group as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is Y, enter in column 2 the number of providers included in the group. List the name and provider number of each member in the consolidated group on line 14. If column 1 is Y, in column 3 enter G or N to identify the grouping as grandfathered or non-grandfathered, respectively.	N		0		13.00
		Provider name		CCN		
		1.00		2.00		
14.00	RHC/FQHC name, CCN					14.00
		Y/N	V	XVIII	XIX	Total Visits
		1.00	2.00	3.00	4.00	5.00
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)					15.00
		County				
		4.00				
2.00	City, State, ZIP Code, County	MARTIN				2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 15-0115 Component CCN: 15-8508		Period: From 07/01/2024 To 09/30/2024	Worksheet S-8 Date/Time Prepared: 1/13/2025 9:02 am
					RHC II	Cost
		Tuesday	Wednesday		Thursday	
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)						
11.00	CLINIC	17:00	07:30	16:00	07:30	17:00
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
Facility hours of operations (1)						
11.00	CLINIC	07:00	15:30			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 1/13/2025 9:02 am
				1.00
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.210970	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		4,663,272	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		23,562,132	6.00
7.00	Medicaid cost (line 1 times line 6)		4,970,903	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		307,631	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	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 CHIP (see instructions)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		307,631	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	2,232,335	166,018	2,398,353
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	470,956	166,018	636,974
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (see instructions)	470,956	166,018	636,974
				1.00
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
25.01	Charges for insured patients' liability (see instructions)		0	25.01
26.00	Bad debt amount (see instructions)		2,910,008	26.00
27.00	Medicare reimbursable bad debts (see instructions)		51,727	27.00
27.01	Medicare allowable bad debts (see instructions)		79,580	27.01
28.00	Non-Medicare bad debt amount (see instructions)		2,830,428	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		624,988	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		1,261,962	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,569,593	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet S-10 Parts I & II Date/Time Prepared: 1/13/2025 9:02 am
				1.00
PART II - HOSPITAL DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.205682	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			5.00
6.00	Medicaid charges			6.00
7.00	Medicaid cost (line 1 times line 6)			7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)			8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP			9.00
10.00	Stand-alone CHIP charges			10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)			12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			14.00
15.00	State or local indigent care program cost (line 1 times line 14)			15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)			16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care			17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	2,129,499	162,808	2,292,307
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	438,000	162,808	600,808
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (see instructions)	438,000	162,808	600,808
				1.00
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
25.01	Charges for insured patients' liability (see instructions)		0	25.01
26.00	Bad debt amount (see instructions)		2,863,621	26.00
27.00	Medicare reimbursable bad debts (see instructions)		51,727	27.00
27.01	Medicare allowable bad debts (see instructions)		79,580	27.01
28.00	Non-Medicare bad debt amount (see instructions)		2,784,041	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		600,480	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		1,201,288	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,201,288	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet A

Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,561,862	3,561,862	0	3,561,862 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,382,978	1,382,978	0	1,382,978 2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,000	5,750,425	5,758,425	0	5,758,425 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,332,653	9,704,424	13,037,077	-56,718	12,980,359 5.00
6.00	00600	MAINTENANCE & REPAIRS	454,594	1,784,711	2,239,305	0	2,239,305 6.00
8.00	00800	LAUNDRY & LINEN SERVICE	77,606	35,845	113,451	0	113,451 8.00
9.00	00900	HOUSEKEEPING	361,199	69,805	431,004	0	431,004 9.00
10.00	01000	DIETARY	294,026	165,852	459,878	-371,113	88,765 10.00
11.00	01100	CAFETERIA	0	0	0	369,696	369,696 11.00
13.00	01300	NURSING ADMINISTRATION	267,759	14,073	281,832	0	281,832 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,971	59,116	138,087	-5,218	132,869 14.00
15.00	01500	PHARMACY	542,118	4,717,470	5,259,588	-5,125,445	134,143 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	613,765	613,765	0	613,765 16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	388,617	388,617 21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	323,619	405,240	728,859	-388,617	340,242 22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,262,522	250,610	2,513,132	-626,197	1,886,935 30.00
31.00	03100	INTENSIVE CARE UNIT	805,870	93,435	899,305	-29,619	869,686 31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0 40.00
41.00	04100	SUBPROVIDER - IRF	278,743	25,985	304,728	-3,033	301,695 41.00
43.00	04300	NURSERY	0	0	0	192,888	192,888 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	3,000	3,000 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,295,123	3,140,527	4,435,650	-20,044	4,415,606 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	385,776	385,776 52.00
53.00	05300	ANESTHESIOLOGY	17,782	1,216,450	1,234,232	-24,639	1,209,593 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,278,760	499,178	2,777,938	-151,767	2,626,171 54.00
56.00	05600	RADIOISOTOPE	69,331	251,441	320,772	-142	320,630 56.00
60.00	06000	LABORATORY	1,011,131	1,583,815	2,594,946	-3,194	2,591,752 60.00
65.00	06500	RESPIRATORY THERAPY	354,080	187,775	541,855	-3,674	538,181 65.00
66.00	06600	PHYSICAL THERAPY	742,143	38,888	781,031	-19,024	762,007 66.00
69.00	06900	ELECTROCARDIOLOGY	750,136	674,278	1,424,414	-26,053	1,398,361 69.00
69.01	06901	PULMONARY	0	0	0	0	0 69.01
69.02	06902	CARDIOPULMONARY	28,822	17,043	45,865	0	45,865 69.02
69.03	06903	SLEEP LAB	74,124	5,271	79,395	0	79,395 69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	499,042	499,042 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,374,585	1,374,585	0	1,374,585 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,239,811	5,239,811 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0 77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0 78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	140,131	51,801	191,932	0	191,932 88.00
88.01	08801	RURAL HEALTH CLINIC II	167,703	3,308	171,011	0	171,011 88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00	09000	CLINIC	133,246	148,306	281,552	-41,495	240,057 90.00
90.01	09001	IMED	0	0	0	0	0 90.01
90.02	09002	ONCOLOGY	762,181	266,881	1,029,062	-24,564	1,004,498 90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0 90.03
90.04	09004	HBURG URGENT CARE CLINIC	338,020	174,615	512,635	-138,914	373,721 90.04
90.05	09005	DIABETES MGMT CLINIC	16,779	484	17,263	0	17,263 90.05
91.00	09100	EMERGENCY	2,599,794	192,109	2,791,903	-65,472	2,726,431 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	710,860	56,248	767,108	-5,614	761,494 95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0 102.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	0 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,577,826	38,518,599	59,096,425	-51,726	59,044,699 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,040,771	2,354,991	10,395,762	0	10,395,762 192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	261,964	2,032	263,996	0	263,996 192.01
194.00	07950	LODGE	158	3,509	3,667	0	3,667 194.00
194.01	07951	OTHER NRCC	0	0	0	0	0 194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	42,731	2,223	44,954	0	44,954 194.02
194.03	07953	MKT/PHY SERVICES	571,070	450,227	1,021,297	0	1,021,297 194.03
194.04	07954	COMMUNITY EDUCATION	109,123	21,127	130,250	0	130,250 194.04

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet A

Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
194.05	07955 VOLUNTEER	58,318	3,942	62,260	0	62,260	194.05
194.06	07956 MAB	0	0	0	0	0	194.06
194.07	07957 OFFSITE COVID SCREENING	0	0	0	51,726	51,726	194.07
194.08	07958 PUBLIC RELATIONS	105,801	67,581	173,382	0	173,382	194.08
194.09	07959 UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960 EMERGENCY PREPAREDNESS	23,219	-16,463	6,756	0	6,756	194.10
194.11	07961 HOME OFFICE	0	0	0	0	0	194.11
200.00	TOTAL (SUM OF LINES 118 through 199)	29,790,981	41,407,768	71,198,749	0	71,198,749	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet A

Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-518,191	3,043,671	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,382,978	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,653,429	7,411,854	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-828,210	12,152,149	5.00
6.00	00600	MAINTENANCE & REPAIRS	538,246	2,777,551	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	113,451	8.00
9.00	00900	HOUSEKEEPING	-2,100	428,904	9.00
10.00	01000	DIETARY	-120	88,645	10.00
11.00	01100	CAFETERIA	-143,500	226,196	11.00
13.00	01300	NURSING ADMINISTRATION	-4,687	277,145	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-645	132,224	14.00
15.00	01500	PHARMACY	-109,054	25,089	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,004	607,761	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	388,617	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	-123,678	216,564	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,417	1,885,518	30.00
31.00	03100	INTENSIVE CARE UNIT	0	869,686	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	-21,435	280,260	41.00
43.00	04300	NURSERY	0	192,888	43.00
44.00	04400	SKILLED NURSING FACILITY	0	3,000	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-307,552	4,108,054	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	385,776	52.00
53.00	05300	ANESTHESIOLOGY	-1,108,922	100,671	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,439,024	1,187,147	54.00
56.00	05600	RADIOISOTOPE	0	320,630	56.00
60.00	06000	LABORATORY	-37,500	2,554,252	60.00
65.00	06500	RESPIRATORY THERAPY	-542	537,639	65.00
66.00	06600	PHYSICAL THERAPY	-86,513	675,494	66.00
69.00	06900	ELECTROCARDIOLOGY	-43,787	1,354,574	69.00
69.01	06901	PULMONARY	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	45,865	69.02
69.03	06903	SLEEP LAB	0	79,395	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	499,042	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,374,585	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,239,811	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-1,000	190,932	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	171,011	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-61,108	178,949	90.00
90.01	09001	IMED	0	0	90.01
90.02	09002	ONCOLOGY	0	1,004,498	90.02
90.03	09003	OUTPATIENT CENTER	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	-67,309	306,412	90.04
90.05	09005	DIABETES MGMT CLINIC	0	17,263	90.05
91.00	09100	EMERGENCY	-1,420,629	1,305,802	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-26,959	734,535	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,168,211	54,876,488	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,395,762	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	263,996	192.01
194.00	07950	LODGE	0	3,667	194.00
194.01	07951	OTHER NRCC	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	44,954	194.02
194.03	07953	MKT/PHY SERVICES	0	1,021,297	194.03
194.04	07954	COMMUNITY EDUCATION	0	130,250	194.04
194.05	07955	VOLUNTEER	0	62,260	194.05

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet A Date/Time Prepared: 1/13/2025 9:02 am
---	--	-----------------------	---	---

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
194.06	07956 MAB	0	0	194.06
194.07	07957 OFFSITE COVID SCREENING	0	51,726	194.07
194.08	07958 PUBLIC RELATIONS	0	173,382	194.08
194.09	07959 UNUSED SPACE	0	0	194.09
194.10	07960 EMERGENCY PREPAREDNESS	0	6,756	194.10
194.11	07961 HOME OFFICE	0	0	194.11
200.00	TOTAL (SUM OF LINES 118 through 199)	-4,168,211	67,030,538	200.00

RECLASSIFICATIONS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet A-6
Date/Time Prepared:
1/13/2025 9:02 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - LABOR AND DELIVERY					
1.00	NURSERY	43.00	171,083	21,805		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	342,167	43,609		2.00
	0		513,250	65,414		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	236,368	133,328		1.00
	0		236,368	133,328		
	C - BILLABLE SUPPLES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	499,042		1.00
2.00	SKILLED NURSING FACILITY	44.00	0	3,001		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
	0		0	502,043		
	D - DRUGS RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,777,402		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
	0		0	4,777,402		
	E - INTERN AND RESIDENT RECLASS					
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	388,617		1.00
	0		0	388,617		
	F - DISABILITY LEAVE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	37,284		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	3,372		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	712		3.00
4.00	DIETARY	10.00	0	2,408		4.00
5.00	NURSING ADMINISTRATION	13.00	0	2,532		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,550		6.00
7.00	PHARMACY	15.00	0	18,599		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	27,764		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	15,828		9.00
11.00	SUBPROVIDER - IRF	41.00	0	915		11.00
12.00	OPERATING ROOM	50.00	0	22,081		12.00
13.00	ANESTHESIOLOGY	53.00	0	4,139		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,628		14.00
15.00	LABORATORY	60.00	0	5,256		15.00
16.00	RESPIRATORY THERAPY	65.00	0	9,267		16.00
17.00	PHYSICAL THERAPY	66.00	0	7,338		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	6,233		18.00
19.00	SLEEP LAB	69.03	0	1,894		19.00
20.00	RURAL HEALTH CLINIC	88.00	0	538		20.00
21.00	RURAL HEALTH CLINIC II	88.01	0	2,235		21.00
22.00	CLINIC	90.00	0	2,228		22.00

RECLASSIFICATIONS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet A-6

Date/Time Prepared:
1/13/2025 9:02 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
23.00	ONCOLOGY	90.02	0	21,592	23.00
24.00	HBURG URGENT CARE CLINIC	90.04	0	1,586	24.00
25.00	EMERGENCY	91.00	0	7,389	25.00
26.00	AMBULANCE SERVICES	95.00	0	2,962	26.00
28.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	69,062	28.00
29.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	192.01	0	5,991	29.00
			0	285,383	
G - PHARMACY RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	462,409	0	1.00
			462,409	0	
H - VOLUNTEER/GUEST SVC					
1.00	OFFSITE COVID SCREENING	194.07	46,793	4,933	1.00
			46,793	4,933	
500.00	Grand Total: Increases		1,258,820	6,157,120	500.00

RECLASSIFICATIONS

Provider CCN: 15-0115

Period:

From 07/01/2024

To 09/30/2024

Worksheet A-6

Date/Time Prepared:
1/13/2025 9:02 am

	Decreases						1/13/2025 9:02 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	513,250	65,414	0		1.00
2.00		0.00	0	0	0		2.00
	0		513,250	65,414			
	B - CAFETERIA						
1.00	DIETARY	10.00	236,368	133,328	0		1.00
	0		236,368	133,328			
	C - BILLABLE SUPPLES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,707	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,217	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	47,375	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	29,606	0		4.00
5.00	SUBPROVIDER - IRF	41.00	0	3,033	0		5.00
6.00	OPERATING ROOM	50.00	0	19,993	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	776	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	90,488	0		8.00
9.00	RADIOISOTOPE	56.00	0	142	0		9.00
10.00	LABORATORY	60.00	0	364	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	3,595	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	18,798	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	16,400	0		13.00
14.00	CLINIC	90.00	0	37,635	0		14.00
15.00	ONCOLOGY	90.02	0	24,564	0		15.00
16.00	HBURG URGENT CARE CLINIC	90.04	0	135,168	0		16.00
17.00	EMERGENCY	91.00	0	61,301	0		17.00
18.00	AMBULANCE SERVICES	95.00	0	2,881	0		18.00
	0		0	502,043			
	D - DRUGS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	285	0		1.00
2.00	DIETARY	10.00	0	1,417	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	1	0		3.00
4.00	PHARMACY	15.00	0	4,663,036	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	158	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	13	0		6.00
7.00	SKILLED NURSING FACILITY	44.00	0	1	0		7.00
8.00	OPERATING ROOM	50.00	0	51	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	23,863	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	61,279	0		10.00
11.00	LABORATORY	60.00	0	2,830	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	79	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	226	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	9,653	0		14.00
15.00	CLINIC	90.00	0	3,860	0		15.00
16.00	HBURG URGENT CARE CLINIC	90.04	0	3,746	0		16.00
17.00	EMERGENCY	91.00	0	4,171	0		17.00
18.00	AMBULANCE SERVICES	95.00	0	2,733	0		18.00
	0		0	4,777,402			
	E - INTERN AND RESIDENT RECLASS						
1.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	388,617	0		1.00
	0		0	388,617			
	F - DISABILITY LEAVE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	37,284	0	0		1.00
2.00	MAINTENANCE & REPAIRS	6.00	3,372	0	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	712	0	0		3.00
4.00	DIETARY	10.00	2,408	0	0		4.00
5.00	NURSING ADMINISTRATION	13.00	2,532	0	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	1,550	0	0		6.00
7.00	PHARMACY	15.00	18,599	0	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	27,764	0	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	15,828	0	0		9.00
11.00	SUBPROVIDER - IRF	41.00	915	0	0		11.00
12.00	OPERATING ROOM	50.00	22,081	0	0		12.00
13.00	ANESTHESIOLOGY	53.00	4,139	0	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	4,628	0	0		14.00
15.00	LABORATORY	60.00	5,256	0	0		15.00
16.00	RESPIRATORY THERAPY	65.00	9,267	0	0		16.00
17.00	PHYSICAL THERAPY	66.00	7,338	0	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	6,233	0	0		18.00
19.00	SLEEP LAB	69.03	1,894	0	0		19.00
20.00	RURAL HEALTH CLINIC	88.00	538	0	0		20.00
21.00	RURAL HEALTH CLINIC II	88.01	2,235	0	0		21.00
22.00	CLINIC	90.00	2,228	0	0		22.00
23.00	ONCOLOGY	90.02	21,592	0	0		23.00

RECLASSIFICATIONS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet A-6

Date/Time Prepared:
1/13/2025 9:02 am

Decreases						
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
24.00	HBURG URGENT CARE CLINIC	90.04	1,586	0	0	24.00
25.00	EMERGENCY	91.00	7,389	0	0	25.00
26.00	AMBULANCE SERVICES	95.00	2,962	0	0	26.00
28.00	PHYSICIANS' PRIVATE OFFICES	192.00	69,062	0	0	28.00
29.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	192.01	5,991	0	0	29.00
			285,383	0		
	G - PHARMACY RECLASS					
1.00	PHARMACY	15.00	462,409	0	0	1.00
			462,409	0		
	H - VOLUNTEER/GUEST SVC					
1.00	ADMINISTRATIVE & GENERAL	5.00	46,793	4,933	0	1.00
			46,793	4,933		
500.00	Grand Total: Decreases		1,544,203	5,871,737		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet A-7
Part I
Date/Time Prepared:
1/13/2025 9:02 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
			1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	11,219,373	0	0	0	9,105,214	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	124,644,697	0	0	0	9,060,779	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	125,475,631	0	0	0	85,238,856	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	261,339,701	0	0	0	103,404,849	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	261,339,701	0	0	0	103,404,849	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	2,114,159	0					1.00
2.00	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	115,583,918	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	40,236,775	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	157,934,852	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	157,934,852	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet A-7
Part II
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,763,027	215,938	512,191	70,706	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,382,978	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,146,005	215,938	512,191	70,706	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	3,561,862				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,382,978				2.00
3.00	Total (sum of lines 1-2)	0	4,944,840				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet A-7
Part III
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized 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 CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	117,698,077	0	117,698,077	0.745232	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	40,236,775	0	40,236,775	0.254768	0	2.00
3.00	Total (sum of lines 1-2)	157,934,852	0	157,934,852	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,757,027	215,938	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,382,978	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,140,005	215,938	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	70,706	0	0	3,043,671	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,382,978	2.00
3.00	Total (sum of lines 1-2)	0	70,706	0	0	4,426,649	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet A-8

Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-512,191	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-4,191	CAP REL COSTS-BLDG & FIXT	1.00	9	7.00
8.00	Television and radio service (chapter 21)	A	-1,752	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,214,915			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-245	ADMINISTRATIVE & GENERAL	5.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	4,233,019			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-143,500	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-109,054	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,004	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet A-8

Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ADVERTISING - FRENCH LICK	A	-1,000	RURAL HEALTH CLINIC	88.00	0	33.00
33.01	ADVERTISING - AMBULANCE	A	-4,459	AMBULANCE SERVICES	95.00	0	33.01
33.02	MISCELLANEOUS REVENUE	B	-16,710	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	MISCELLANEOUS REVENUE	B	-40,403	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.05	MISCELLANEOUS REVENUE	B	-2,057	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	MISCELLANEOUS REVENUE	B	-2,100	HOUSEKEEPING	9.00	0	33.06
33.08	MISCELLANEOUS REVENUE	B	-120	DIETARY	10.00	0	33.08
33.09	MISCELLANEOUS REVENUE	B	-4,687	NURSING ADMINISTRATION	13.00	0	33.09
33.10	MISCELLANEOUS REVENUE	B	-645	CENTRAL SERVICES & SUPPLY	14.00	0	33.10
33.11	MISCELLANEOUS REVENUE	B	-1,268	SUBPROVIDER - IRF	41.00	0	33.11
33.12	MISCELLANEOUS REVENUE	B	-360	RADIOLOGY-DIAGNOSTIC	54.00	0	33.12
33.13	MISCELLANEOUS REVENUE	B	-86,513	PHYSICAL THERAPY	66.00	0	33.13
33.15	MISCELLANEOUS REVENUE	B	-22,500	AMBULANCE SERVICES	95.00	0	33.15
33.16	CRNA EXPENSE	A	-1,108,922	ANESTHESIOLOGY	53.00	0	33.16
33.18	ADVERTISING - A&G	A	-1,902	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	HAF	A	-3,106,914	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	LOBBYING DUES	A	-4,180	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	TELEPHONE SERVICES - PATIENT PHONE C	A	-1,567	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.26	TELEPHONE SERVICES - PATIENT SWITCHB	A	-1,262	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	MARKETING & PR - DEPR	A	-1,809	CAP REL COSTS-BLDG & FIXT	1.00	9	33.27
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,168,211				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet A-8-1

Date/Time Prepared:
1/13/2025 9:02 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	AMBULATORY SURGERY CENTER	1,016,585	1,324,023	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,670,139	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,332,072	0	3.00
4.00	6.00	MAINTENANCE & REPAIRS	HOME OFFICE	538,246	0	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,557,042	1,324,023	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.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
	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	C	MHHCC	0.00	MEM HOS OP SURG	40.00	6.00
7.00	B	DEACONESS	0.00	MEMORIAL HOME O	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet A-8-1

Date/Time Prepared:
1/13/2025 9:02 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-307,438	0		1.00
2.00	1,670,139	0		2.00
3.00	2,332,072	0		3.00
4.00	538,246	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
5.00	4,233,019			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	
Type of Business	
6.00	

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	SURGERY CENTER		6.00
7.00	HOME OFFICE		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet A-8-2

Date/Time Prepared:
1/13/2025 9:02 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider 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. COSTS APPRVD	255,092	0	255,092	197,500	1,384	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,417	1,417	0	181,300	0	2.00
3.00	41.00	SUBPROVIDER - IRF	20,167	20,167	0	179,000	0	3.00
4.00	50.00	OPERATING ROOM	114	114	0	246,400	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	1,438,664	1,438,664	0	271,900	0	5.00
6.00	60.00	LABORATORY	37,500	37,500	0	271,900	0	6.00
7.00	65.00	RESPIRATORY THERAPY	542	542	0	211,500	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	43,787	43,787	0	211,500	0	8.00
9.00	90.00	CLINIC	61,108	61,108	0	211,500	0	9.00
10.00	90.04	HBURG URGENT CARE CLINIC	67,309	67,309	0	211,500	0	10.00
11.00	91.00	EMERGENCY	1,420,629	1,420,629	0	211,500	0	11.00
200.00			3,346,329	3,091,237	255,092		1,384	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	131,414	6,571	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	90.04	HBURG URGENT CARE CLINIC	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
200.00			131,414	6,571	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	131,414	123,678	123,678		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,417		2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	20,167		3.00
4.00	50.00	OPERATING ROOM	0	0	0	114		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,438,664		5.00
6.00	60.00	LABORATORY	0	0	0	37,500		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	542		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	43,787		8.00
9.00	90.00	CLINIC	0	0	0	61,108		9.00
10.00	90.04	HBURG URGENT CARE CLINIC	0	0	0	67,309		10.00
11.00	91.00	EMERGENCY	0	0	0	1,420,629		11.00
200.00			0	131,414	123,678	3,214,915		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet B
Part I
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,043,671	3,043,671				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,382,978		1,382,978			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,411,854	0	0	7,411,854		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,152,149	272,327	123,739	816,270	13,364,485	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,777,551	958,450	435,499	113,379	4,284,879	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	113,451	9,157	4,161	19,321	146,090	8.00
9.00	00900	HOUSEKEEPING	428,904	10,714	4,868	90,758	535,244	9.00
10.00	01000	DIETARY	88,645	8,232	3,740	13,883	114,500	10.00
11.00	01100	CAFETERIA	226,196	28,956	13,157	59,392	327,701	11.00
13.00	01300	NURSING ADMINISTRATION	277,145	6,810	3,094	66,644	353,693	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	132,224	5,310	2,413	19,454	159,401	14.00
15.00	01500	PHARMACY	25,089	16,697	7,587	15,355	64,728	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	607,761	7,265	3,301	0	618,327	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	388,617	0	0	0	388,617	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	216,564	23,542	10,697	81,316	332,119	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,885,518	231,876	105,359	432,563	2,655,316	30.00
31.00	03100	INTENSIVE CARE UNIT	869,686	65,686	29,846	198,514	1,163,732	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	280,260	27,073	12,302	69,810	389,445	41.00
43.00	04300	NURSERY	192,888	16,988	7,719	42,988	260,583	43.00
44.00	04400	SKILLED NURSING FACILITY	3,000	1,617	735	0	5,352	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,108,054	188,102	85,470	319,877	4,701,503	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	385,776	33,975	15,438	85,976	521,165	52.00
53.00	05300	ANESTHESIOLOGY	100,671	0	0	3,428	104,099	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,187,147	65,133	29,595	571,421	1,853,296	54.00
56.00	05600	RADIOISOTOPE	320,630	4,457	2,025	17,421	344,533	56.00
60.00	06000	LABORATORY	2,554,252	31,657	14,384	252,746	2,853,039	60.00
65.00	06500	RESPIRATORY THERAPY	537,639	17,348	7,882	86,641	649,510	65.00
66.00	06600	PHYSICAL THERAPY	675,494	28,154	12,792	184,634	901,074	66.00
69.00	06900	ELECTROCARDIOLOGY	1,354,574	61,807	28,084	186,921	1,631,386	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	45,865	7,417	3,370	7,242	63,894	69.02
69.03	06903	SLEEP LAB	79,395	8,825	4,010	18,149	110,379	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	499,042	0	0	0	499,042	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,374,585	0	0	0	1,374,585	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,239,811	0	0	116,190	5,356,001	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	190,932	9,075	4,123	35,076	239,206	88.00
88.01	08801	RURAL HEALTH CLINIC II	171,011	20,459	9,296	41,577	242,343	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	178,949	26,540	12,059	32,921	250,469	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	1,004,498	57,350	26,059	186,088	1,273,995	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	306,412	25,219	11,459	84,536	427,626	90.04
90.05	09005	DIABETES MGMT CLINIC	17,263	2,603	1,183	4,216	25,265	90.05
91.00	09100	EMERGENCY	1,305,802	50,773	23,070	651,394	2,031,039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	734,535	10,651	4,840	177,874	927,900	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,876,488	2,340,245	1,063,356	5,103,975	51,545,561	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	0	4,703	2,137	0	6,840	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,395,762	485,095	220,417	2,003,041	13,104,315	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	263,996	12,016	5,460	64,318	345,790	192.01
194.00	07950	LODGE	3,667	136,441	61,996	40	202,144	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet B
Part I
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	44,954	7,183	3,264	10,737	66,138	194.02
194.03	07953	MKT/PHY SERVICES	1,021,297	27,658	12,567	143,493	1,205,015	194.03
194.04	07954	COMMUNITY EDUCATION	130,250	23,340	10,605	27,419	191,614	194.04
194.05	07955	VOLUNTEER	62,260	0	0	14,654	76,914	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	51,726	0	0	11,758	63,484	194.07
194.08	07958	PUBLIC RELATIONS	173,382	6,990	3,176	26,585	210,133	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	6,756	0	0	5,834	12,590	194.10
194.11	07961	HOME OFFICE	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers					0	201.00
202.00		TOTAL (sum lines 118 through 201)	67,030,538	3,043,671	1,382,978	7,411,854	67,030,538	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet B
Part I
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
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	13,364,485					5.00
6.00	00600	MAINTENANCE & REPAIRS	1,067,068	5,351,947				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	36,381	27,033	209,504			8.00
9.00	00900	HOUSEKEEPING	133,292	31,631	0	700,167		9.00
10.00	01000	DIETARY	28,514	24,301	945	3,214	171,474	10.00
11.00	01100	CAFETERIA	81,608	85,483	0	11,307	0	11.00
13.00	01300	NURSING ADMINISTRATION	88,081	20,105	0	2,659	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	39,696	15,675	5,347	2,073	0	14.00
15.00	01500	PHARMACY	16,119	49,292	0	6,520	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	153,983	21,448	0	2,837	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	96,778	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	82,708	69,500	0	9,193	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	661,256	684,534	37,863	90,546	97,952	30.00
31.00	03100	INTENSIVE CARE UNIT	289,805	193,914	13,411	25,650	38,244	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	96,984	79,925	5,719	10,572	18,126	41.00
43.00	04300	NURSERY	64,893	50,150	104	6,634	16,688	43.00
44.00	04400	SKILLED NURSING FACILITY	1,333	4,774	13	632	464	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,170,820	555,307	28,722	73,453	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	129,786	100,300	10,272	13,267	0	52.00
53.00	05300	ANESTHESIOLOGY	25,924	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	461,528	192,283	32,728	25,434	0	54.00
56.00	05600	RADIOISOTOPE	85,799	13,158	0	1,740	0	56.00
60.00	06000	LABORATORY	710,495	93,456	660	12,362	0	60.00
65.00	06500	RESPIRATORY THERAPY	161,748	51,213	0	6,774	0	65.00
66.00	06600	PHYSICAL THERAPY	224,395	83,114	9,010	10,994	0	66.00
69.00	06900	ELECTROCARDIOLOGY	406,266	182,463	14,233	24,135	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	15,912	21,895	130	2,896	0	69.02
69.03	06903	SLEEP LAB	27,488	26,054	1,983	3,446	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	124,277	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	342,314	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,333,810	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	59,570	26,791	0	3,544	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	60,351	60,398	0	7,989	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	62,375	78,349	450	10,364	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	317,264	169,306	5,645	22,395	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	106,492	74,451	147	9,848	0	90.04
90.05	09005	DIABETES MGMT CLINIC	6,292	7,684	0	1,016	0	90.05
91.00	09100	EMERGENCY	505,792	149,891	29,645	19,827	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	231,076	31,444	784	4,159	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,508,273	3,275,322	197,811	425,480	171,474	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,703	13,885	0	1,837	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,263,355	1,432,077	11,693	189,429	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	86,112	35,473	0	4,692	0	192.01
194.00	07950	LODGE	50,340	402,796	0	53,280	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	16,470	21,205	0	2,805	0	194.02
194.03	07953	MKT/PHY SERVICES	300,086	81,650	0	10,800	0	194.03
194.04	07954	COMMUNITY EDUCATION	47,718	68,903	0	9,114	0	194.04
194.05	07955	VOLUNTEER	19,154	0	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet B
Part I
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
194.07	07957	OFFSITE COVID SCREENING	15,809	0	0	0	0	194.07
194.08	07958	PUBLIC RELATIONS	52,330	20,636	0	2,730	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	3,135	0	0	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)	13,364,485	5,351,947	209,504	700,167	171,474	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet B
Part I
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			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	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	506,099					11.00
13.00	01300	NURSING ADMINISTRATION	6,208	470,746				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,615	0	225,807			14.00
15.00	01500	PHARMACY	2,085	0	901	139,645		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	68	0	796,663	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	2,806	0	14	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	40,935	257,842	6,230	0	28,956	30.00
31.00	03100	INTENSIVE CARE UNIT	21,059	132,643	1,374	0	8,169	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	6,183	38,948	184	0	2,792	41.00
43.00	04300	NURSERY	5,428	34,192	0	0	1,822	43.00
44.00	04400	SKILLED NURSING FACILITY	1,131	7,121	0	0	15	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,745	0	63,352	0	81,940	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,857	0	0	0	3,242	52.00
53.00	05300	ANESTHESIOLOGY	565	0	4,796	0	7,466	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,188	0	3,156	0	121,945	54.00
56.00	05600	RADIOISOTOPE	1,449	0	44	0	21,608	56.00
60.00	06000	LABORATORY	24,338	0	56,180	0	94,780	60.00
65.00	06500	RESPIRATORY THERAPY	10,480	0	8,718	0	8,937	65.00
66.00	06600	PHYSICAL THERAPY	21,841	0	933	0	17,715	66.00
69.00	06900	ELECTROCARDIOLOGY	15,193	0	26,295	0	76,764	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	948	0	98	0	1,646	69.02
69.03	06903	SLEEP LAB	2,010	0	274	0	3,427	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	32,905	0	14,822	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	24,213	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,806	0	0	139,645	132,502	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,729	0	623	0	1,013	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,511	0	0	0	1,228	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	4,146	0	703	0	5,693	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	23,019	0	2,204	0	35,006	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	9,230	0	796	0	4,396	90.04
90.05	09005	DIABETES MGMT CLINIC	488	0	32	0	162	90.05
91.00	09100	EMERGENCY	33,287	0	3,240	0	87,645	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	24,098	0	924	0	8,759	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	347,378	470,746	214,044	139,645	796,663	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	125,502	0	10,656	0	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,145	0	11	0	0	192.01
194.00	07950	LODGE	7	0	88	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	1,114	0	3	0	0	194.02
194.03	07953	MKT/PHY SERVICES	13,850	0	268	0	0	194.03
194.04	07954	COMMUNITY EDUCATION	5,083	0	628	0	0	194.04
194.05	07955	VOLUNTEER	1,447	0	11	0	0	194.05

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet B
Part I
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
194.06	07956	MAB	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	2,214	0	0	0	194.07
194.08	07958	PUBLIC RELATIONS	2,749	0	45	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	610	0	53	0	194.10
194.11	07961	HOME OFFICE	0	0	0	0	194.11
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	506,099	470,746	225,807	139,645	796,663 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet B
Part I
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM. COSTS				
			21.00	22.00	24.00	25.00	26.00	
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	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	485,395					21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD		496,340				22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	175,510	179,468	4,916,408	-354,978	4,561,430	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	1,888,001	0	1,888,001	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	648,878	0	648,878	41.00
43.00	04300	NURSERY	0	0	440,494	0	440,494	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	20,835	0	20,835	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,568	21,031	6,748,441	-41,599	6,706,842	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	788,889	0	788,889	52.00
53.00	05300	ANESTHESIOLOGY	0	0	142,850	0	142,850	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,716,558	0	2,716,558	54.00
56.00	05600	RADIOISOTOPE	0	0	468,331	0	468,331	56.00
60.00	06000	LABORATORY	0	0	3,845,310	0	3,845,310	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	897,380	0	897,380	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,269,076	0	1,269,076	66.00
69.00	06900	ELECTROCARDIOLOGY	2,742	2,804	2,382,281	-5,546	2,376,735	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	2,742	2,804	112,965	-5,546	107,419	69.02
69.03	06903	SLEEP LAB	0	0	175,061	0	175,061	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	671,046	0	671,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,741,112	0	1,741,112	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	6,972,764	0	6,972,764	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	334,476	0	334,476	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	375,820	0	375,820	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	412,549	0	412,549	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	8,227	8,413	1,865,474	-16,640	1,848,834	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	10,969	11,217	655,172	-22,186	632,986	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	40,939	0	40,939	90.05
91.00	09100	EMERGENCY	10,969	11,217	2,882,552	-22,186	2,860,366	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	1,229,144	0	1,229,144	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE			0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	231,727	236,954	44,642,806	-468,681	44,174,125	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	0	0	24,265	0	24,265	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	37,022	37,856	18,211,905	-74,878	18,137,027	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	478,223	0	478,223	192.01
194.00	07950	LODGE	0	0	708,655	0	708,655	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet B
Part I
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM. COSTS				
			21.00	22.00				
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	0	107,735	0	107,735	194.02
194.03	07953	MKT/PHY SERVICES	0	0	1,611,669	0	1,611,669	194.03
194.04	07954	COMMUNITY EDUCATION	216,646	221,530	761,236	-438,176	323,060	194.04
194.05	07955	VOLUNTEER	0	0	97,526	0	97,526	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	81,507	0	81,507	194.07
194.08	07958	PUBLIC RELATIONS	0	0	288,623	0	288,623	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	0	16,388	0	16,388	194.10
194.11	07961	HOME OFFICE	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	485,395	496,340	67,030,538	-981,735	66,048,803	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet B
Part II
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
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	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	272,327	123,739	396,066	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	958,450	435,499	1,393,949	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,157	4,161	13,318	8.00
9.00	00900	HOUSEKEEPING	0	10,714	4,868	15,582	9.00
10.00	01000	DIETARY	0	8,232	3,740	11,972	10.00
11.00	01100	CAFETERIA	0	28,956	13,157	42,113	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,810	3,094	9,904	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,310	2,413	7,723	14.00
15.00	01500	PHARMACY	0	16,697	7,587	24,284	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,265	3,301	10,566	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	23,542	10,697	34,239	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	231,876	105,359	337,235	30.00
31.00	03100	INTENSIVE CARE UNIT	0	65,686	29,846	95,532	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	27,073	12,302	39,375	41.00
43.00	04300	NURSERY	0	16,988	7,719	24,707	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,617	735	2,352	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	188,102	85,470	273,572	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	33,975	15,438	49,413	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	65,133	29,595	94,728	54.00
56.00	05600	RADIOISOTOPE	0	4,457	2,025	6,482	56.00
60.00	06000	LABORATORY	0	31,657	14,384	46,041	60.00
65.00	06500	RESPIRATORY THERAPY	0	17,348	7,882	25,230	65.00
66.00	06600	PHYSICAL THERAPY	0	28,154	12,792	40,946	66.00
69.00	06900	ELECTROCARDIOLOGY	0	61,807	28,084	89,891	69.00
69.01	06901	PULMONARY	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	7,417	3,370	10,787	69.02
69.03	06903	SLEEP LAB	0	8,825	4,010	12,835	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. 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
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	9,075	4,123	13,198	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	20,459	9,296	29,755	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	26,540	12,059	38,599	90.00
90.01	09001	IMED	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	57,350	26,059	83,409	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	25,219	11,459	36,678	90.04
90.05	09005	DIABETES MGMT CLINIC	0	2,603	1,183	3,786	90.05
91.00	09100	EMERGENCY	0	50,773	23,070	73,843	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	10,651	4,840	15,491	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,340,245	1,063,356	3,403,601	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,703	2,137	6,840	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	485,095	220,417	705,512	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	12,016	5,460	17,476	192.01
194.00	07950	LODGE	0	136,441	61,996	198,437	194.00
194.01	07951	OTHER NRCC	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	7,183	3,264	10,447	194.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet B
Part II
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
194.03	07953	MKT/PHY SERVICES	0	27,658	12,567	40,225	0 194.03
194.04	07954	COMMUNITY EDUCATION	0	23,340	10,605	33,945	0 194.04
194.05	07955	VOLUNTEER	0	0	0	0	0 194.05
194.06	07956	MAB	0	0	0	0	0 194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	0	0	0 194.07
194.08	07958	PUBLIC RELATIONS	0	6,990	3,176	10,166	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	0	0	0	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	3,043,671	1,382,978	4,426,649	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet B
Part II
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
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	396,066					5.00
6.00	00600	MAINTENANCE & REPAIRS	31,622	1,425,571				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,078	7,201	21,597			8.00
9.00	00900	HOUSEKEEPING	3,950	8,425	0	27,957		9.00
10.00	01000	DIETARY	845	6,473	97	128	19,515	10.00
11.00	01100	CAFETERIA	2,418	22,770	0	451	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,610	5,355	0	106	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,176	4,175	551	83	0	14.00
15.00	01500	PHARMACY	478	13,130	0	260	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,563	5,713	0	113	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,868	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	2,451	18,512	0	367	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,596	182,336	3,905	3,615	11,148	30.00
31.00	03100	INTENSIVE CARE UNIT	8,588	51,652	1,382	1,024	4,352	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	2,874	21,289	590	422	2,063	41.00
43.00	04300	NURSERY	1,923	13,358	11	265	1,899	43.00
44.00	04400	SKILLED NURSING FACILITY	39	1,272	1	25	53	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	34,697	147,914	2,961	2,933	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,846	26,716	1,059	530	0	52.00
53.00	05300	ANESTHESIOLOGY	768	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,677	51,217	3,374	1,016	0	54.00
56.00	05600	RADIOISOTOPE	2,543	3,505	0	69	0	56.00
60.00	06000	LABORATORY	21,055	24,893	68	494	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,793	13,641	0	270	0	65.00
66.00	06600	PHYSICAL THERAPY	6,650	22,139	929	439	0	66.00
69.00	06900	ELECTROCARDIOLOGY	12,040	48,602	1,467	964	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	472	5,832	13	116	0	69.02
69.03	06903	SLEEP LAB	815	6,940	204	138	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,683	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,144	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,527	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,765	7,136	0	141	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,788	16,088	0	319	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,848	20,869	46	414	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	9,402	45,097	582	894	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	3,156	19,831	15	393	0	90.04
90.05	09005	DIABETES MGMT CLINIC	186	2,047	0	41	0	90.05
91.00	09100	EMERGENCY	14,989	39,926	3,056	792	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	6,848	8,376	81	166	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	281,771	872,430	20,392	16,988	19,515	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	50	3,698	0	73	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	96,725	381,456	1,205	7,566	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,552	9,449	0	187	0	192.01
194.00	07950	LODGE	1,492	107,291	0	2,127	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	488	5,648	0	112	0	194.02
194.03	07953	MKT/PHY SERVICES	8,893	21,749	0	431	0	194.03
194.04	07954	COMMUNITY EDUCATION	1,414	18,353	0	364	0	194.04
194.05	07955	VOLUNTEER	568	0	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet B
Part II
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
194.07	07957	OFFSITE COVID SCREENING	469	0	0	0	0	194.07
194.08	07958	PUBLIC RELATIONS	1,551	5,497	0	109	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	93	0	0	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)	396,066	1,425,571	21,597	27,957	19,515	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet B
Part II
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			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	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	67,752					11.00
13.00	01300	NURSING ADMINISTRATION	831	18,806				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	484	0	14,192			14.00
15.00	01500	PHARMACY	279	0	57	38,488		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	4	0	20,959	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	376	0	1	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,480	10,301	392	0	761	30.00
31.00	03100	INTENSIVE CARE UNIT	2,819	5,299	86	0	215	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	828	1,556	12	0	73	41.00
43.00	04300	NURSERY	727	1,366	0	0	48	43.00
44.00	04400	SKILLED NURSING FACILITY	151	284	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,250	0	3,981	0	2,153	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,453	0	0	0	85	52.00
53.00	05300	ANESTHESIOLOGY	76	0	301	0	196	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,506	0	198	0	3,205	54.00
56.00	05600	RADIOISOTOPE	194	0	3	0	568	56.00
60.00	06000	LABORATORY	3,258	0	3,531	0	2,491	60.00
65.00	06500	RESPIRATORY THERAPY	1,403	0	548	0	235	65.00
66.00	06600	PHYSICAL THERAPY	2,924	0	59	0	466	66.00
69.00	06900	ELECTROCARDIOLOGY	2,034	0	1,653	0	2,017	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	127	0	6	0	43	69.02
69.03	06903	SLEEP LAB	269	0	17	0	90	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,068	0	390	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	636	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,447	0	0	38,488	3,505	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	499	0	39	0	27	88.00
88.01	08801	RURAL HEALTH CLINIC II	470	0	0	0	32	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	555	0	44	0	150	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	3,082	0	138	0	920	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	1,236	0	50	0	116	90.04
90.05	09005	DIABETES MGMT CLINIC	65	0	2	0	4	90.05
91.00	09100	EMERGENCY	4,456	0	204	0	2,303	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	3,226	0	58	0	230	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,505	18,806	13,452	38,488	20,959	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,800	0	670	0	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	823	0	1	0	0	192.01
194.00	07950	LODGE	1	0	6	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	149	0	0	0	0	194.02
194.03	07953	MKT/PHY SERVICES	1,854	0	17	0	0	194.03
194.04	07954	COMMUNITY EDUCATION	680	0	39	0	0	194.04
194.05	07955	VOLUNTEER	194	0	1	0	0	194.05

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet B
Part II
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
194.06	07956	MAB	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	296	0	0	0	194.07
194.08	07958	PUBLIC RELATIONS	368	0	3	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	82	0	3	0	194.10
194.11	07961	HOME OFFICE	0	0	0	0	194.11
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	67,752	18,806	14,192	38,488	20,959 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet B
Part II
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM. COSTS				
			21.00	22.00	24.00	25.00	26.00	
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	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,868					21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD		55,946				22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS			574,769	0	574,769	30.00
31.00	03100	INTENSIVE CARE UNIT			170,949	0	170,949	31.00
40.00	04000	SUBPROVIDER - IPF			0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF			69,082	0	69,082	41.00
43.00	04300	NURSERY			44,304	0	44,304	43.00
44.00	04400	SKILLED NURSING FACILITY			4,177	0	4,177	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM			472,461	0	472,461	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM			83,102	0	83,102	52.00
53.00	05300	ANESTHESIOLOGY			1,341	0	1,341	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			170,921	0	170,921	54.00
56.00	05600	RADIOISOTOPE			13,364	0	13,364	56.00
60.00	06000	LABORATORY			101,831	0	101,831	60.00
65.00	06500	RESPIRATORY THERAPY			46,120	0	46,120	65.00
66.00	06600	PHYSICAL THERAPY			74,552	0	74,552	66.00
69.00	06900	ELECTROCARDIOLOGY			158,668	0	158,668	69.00
69.01	06901	PULMONARY			0	0	0	69.01
69.02	06902	CARDIOPULMONARY			17,396	0	17,396	69.02
69.03	06903	SLEEP LAB			21,308	0	21,308	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY			0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS			6,141	0	6,141	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			10,780	0	10,780	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			82,967	0	82,967	73.00
74.00	07400	RENAL DIALYSIS			0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION			0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY			0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC			22,805	0	22,805	88.00
88.01	08801	RURAL HEALTH CLINIC II			48,452	0	48,452	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	89.00
90.00	09000	CLINIC			62,525	0	62,525	90.00
90.01	09001	IMED			0	0	0	90.01
90.02	09002	ONCOLOGY			143,524	0	143,524	90.02
90.03	09003	OUTPATIENT CENTER			0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC			61,475	0	61,475	90.04
90.05	09005	DIABETES MGMT CLINIC			6,131	0	6,131	90.05
91.00	09100	EMERGENCY			139,569	0	139,569	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES			34,476	0	34,476	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED			0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY			0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM			0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE			0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	2,643,190	0	2,643,190	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN			10,661	0	10,661	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES			1,209,934	0	1,209,934	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES			30,488	0	30,488	192.01
194.00	07950	LODGE			309,354	0	309,354	194.00
194.01	07951	OTHER NRCC			0	0	0	194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet B
Part II
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM. COSTS				
			21.00	22.00				
194.02	07952	MEMORIAL HOSPITAL FOUNDATION			16,844	0	16,844	194.02
194.03	07953	MKT/PHY SERVICES			73,169	0	73,169	194.03
194.04	07954	COMMUNITY EDUCATION			54,795	0	54,795	194.04
194.05	07955	VOLUNTEER			763	0	763	194.05
194.06	07956	MAB			0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING			765	0	765	194.07
194.08	07958	PUBLIC RELATIONS			17,694	0	17,694	194.08
194.09	07959	UNUSED SPACE			0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS			178	0	178	194.10
194.11	07961	HOME OFFICE			0	0	0	194.11
200.00		Cross Foot Adjustments	2,868	55,946	58,814	0	58,814	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,868	55,946	4,426,649	0	4,426,649	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet B-1

Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	963,575					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		963,575				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	29,497,598			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	86,214	86,214	3,248,576	-13,364,485	53,666,053	5.00
6.00	00600	MAINTENANCE & REPAIRS	303,429	303,429	451,222	0	4,284,879	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,899	2,899	76,894	0	146,090	8.00
9.00	00900	HOUSEKEEPING	3,392	3,392	361,199	0	535,244	9.00
10.00	01000	DIETARY	2,606	2,606	55,250	0	114,500	10.00
11.00	01100	CAFETERIA	9,167	9,167	236,368	0	327,701	11.00
13.00	01300	NURSING ADMINISTRATION	2,156	2,156	265,227	0	353,693	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,681	1,681	77,421	0	159,401	14.00
15.00	01500	PHARMACY	5,286	5,286	61,110	0	64,728	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,300	2,300	0	0	618,327	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	388,617	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	7,453	7,453	323,619	0	332,119	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	73,408	73,408	1,721,508	0	2,655,316	30.00
31.00	03100	INTENSIVE CARE UNIT	20,795	20,795	790,042	0	1,163,732	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	8,571	8,571	277,828	0	389,445	41.00
43.00	04300	NURSERY	5,378	5,378	171,083	0	260,583	43.00
44.00	04400	SKILLED NURSING FACILITY	512	512	0	0	5,352	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	59,550	59,550	1,273,042	0	4,701,503	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,756	10,756	342,167	0	521,165	52.00
53.00	05300	ANESTHESIOLOGY	0	0	13,643	0	104,099	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,620	20,620	2,274,132	0	1,853,296	54.00
56.00	05600	RADIOISOTOPE	1,411	1,411	69,331	0	344,533	56.00
60.00	06000	LABORATORY	10,022	10,022	1,005,875	0	2,853,039	60.00
65.00	06500	RESPIRATORY THERAPY	5,492	5,492	344,813	0	649,510	65.00
66.00	06600	PHYSICAL THERAPY	8,913	8,913	734,805	0	901,074	66.00
69.00	06900	ELECTROCARDIOLOGY	19,567	19,567	743,903	0	1,631,386	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	2,348	2,348	28,822	0	63,894	69.02
69.03	06903	SLEEP LAB	2,794	2,794	72,230	0	110,379	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	499,042	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,374,585	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	462,409	0	5,356,001	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,873	2,873	139,593	0	239,206	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,477	6,477	165,468	0	242,343	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	8,402	8,402	131,018	0	250,469	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	18,156	18,156	740,589	0	1,273,995	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	7,984	7,984	336,434	0	427,626	90.04
90.05	09005	DIABETES MGMT CLINIC	824	824	16,779	0	25,265	90.05
91.00	09100	EMERGENCY	16,074	16,074	2,592,405	0	2,031,039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	3,372	3,372	707,898	0	927,900	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	740,882	740,882	20,312,703	-13,364,485	38,181,076	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	1,489	1,489	0	0	6,840	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	153,573	153,573	7,971,709	0	13,104,315	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,804	3,804	255,973	0	345,790	192.01
194.00	07950	LODGE	43,195	43,195	158	0	202,144	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet B-1

Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	2,274	2,274	42,731	0	66,138	194.02
194.03	07953	MKT/PHY SERVICES	8,756	8,756	571,070	0	1,205,015	194.03
194.04	07954	COMMUNITY EDUCATION	7,389	7,389	109,123	0	191,614	194.04
194.05	07955	VOLUNTEER	0	0	58,318	0	76,914	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	46,793	0	63,484	194.07
194.08	07958	PUBLIC RELATIONS	2,213	2,213	105,801	0	210,133	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	0	23,219	0	12,590	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						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,043,671	1,382,978	7,411,854		13,364,485	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.158728	1.435257	0.251270		0.249031	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		396,066	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.007380	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet B-1

Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (HOURS)	
		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	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	573,932				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,899	201,044			8.00
9.00	00900	HOUSEKEEPING	3,392	0	567,641		9.00
10.00	01000	DIETARY	2,606	907	2,606	3,699	10.00
11.00	01100	CAFETERIA	9,167	0	9,167	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,156	0	2,156	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,681	5,131	1,681	0	14.00
15.00	01500	PHARMACY	5,286	0	5,286	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,300	0	2,300	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	7,453	0	7,453	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	73,408	36,336	73,408	2,113	30.00
31.00	03100	INTENSIVE CARE UNIT	20,795	12,869	20,795	825	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	8,571	5,488	8,571	391	41.00
43.00	04300	NURSERY	5,378	100	5,378	360	43.00
44.00	04400	SKILLED NURSING FACILITY	512	12	512	10	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	59,550	27,562	59,550	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,756	9,857	10,756	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,620	31,406	20,620	0	54.00
56.00	05600	RADIOISOTOPE	1,411	0	1,411	0	56.00
60.00	06000	LABORATORY	10,022	633	10,022	0	60.00
65.00	06500	RESPIRATORY THERAPY	5,492	0	5,492	0	65.00
66.00	06600	PHYSICAL THERAPY	8,913	8,646	8,913	0	66.00
69.00	06900	ELECTROCARDIOLOGY	19,567	13,658	19,567	0	69.00
69.01	06901	PULMONARY	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	2,348	125	2,348	0	69.02
69.03	06903	SLEEP LAB	2,794	1,903	2,794	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. 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	10,706	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,873	0	2,873	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,477	0	6,477	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	8,402	432	8,402	0	90.00
90.01	09001	IMED	0	0	0	0	90.01
90.02	09002	ONCOLOGY	18,156	5,417	18,156	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	7,984	141	7,984	0	90.04
90.05	09005	DIABETES MGMT CLINIC	824	0	824	0	90.05
91.00	09100	EMERGENCY	16,074	28,448	16,074	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,372	752	3,372	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	351,239	189,823	344,948	3,699	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,489	0	1,489	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	153,573	11,221	153,573	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,804	0	3,804	0	192.01
194.00	07950	LODGE	43,195	0	43,195	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	2,274	0	2,274	0	194.02
194.03	07953	MKT/PHY SERVICES	8,756	0	8,756	0	194.03
194.04	07954	COMMUNITY EDUCATION	7,389	0	7,389	0	194.04

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet B-1

Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (HOURS)	
			6.00	8.00	9.00	10.00	11.00	
194.05	07955	VOLUNTEER	0	0	0	0	1,434	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	0	0	2,193	194.07
194.08	07958	PUBLIC RELATIONS	2,213	0	2,213	0	2,723	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	0	0	0	604	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						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,351,947	209,504	700,167	171,474	506,099	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.325054	1.042080	1.233468	46.356853	1.009382	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,425,571	21,597	27,957	19,515	67,752	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.483867	0.107424	0.049251	5.275750	0.135127	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet B-1

Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	INTERNS & RESIDENTS SERVICES-SALA RY & FRINGES (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	21.00	
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	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	74,042					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,424,607				14.00
15.00	01500	PHARMACY	0	13,660	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,036	0	209,385,968		16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	354	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	206	0	0		22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	40,555	94,491	0	7,609,933	128	30.00
31.00	03100	INTENSIVE CARE UNIT	20,863	20,843	0	2,146,999	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	6,126	2,785	0	733,774	0	41.00
43.00	04300	NURSERY	5,378	0	0	478,716	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,120	0	0	3,900	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	960,819	0	21,534,718	15	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	852,022	0	52.00
53.00	05300	ANESTHESIOLOGY	0	72,743	0	1,962,186	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,860	0	32,048,523	0	54.00
56.00	05600	RADIOISOTOPE	0	664	0	5,678,799	0	56.00
60.00	06000	LABORATORY	0	852,022	0	24,909,461	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	132,214	0	2,348,700	0	65.00
66.00	06600	PHYSICAL THERAPY	0	14,156	0	4,655,668	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	398,796	0	20,174,429	2	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	1,479	0	432,527	2	69.02
69.03	06903	SLEEP LAB	0	4,159	0	900,592	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	499,042	0	3,895,436	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,363,469	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	34,836,869	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	9,448	0	266,213	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	322,671	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	10,667	0	1,496,211	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	33,421	0	9,200,029	6	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	12,071	0	1,155,279	8	90.04
90.05	09005	DIABETES MGMT CLINIC	0	484	0	42,679	0	90.05
91.00	09100	EMERGENCY	0	49,133	0	23,034,104	8	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	14,017	0	2,302,061	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,042	3,246,216	100	209,385,968	169	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	161,606	0	0	27	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	168	0	0	0	192.01
194.00	07950	LODGE	0	1,336	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet B-1

Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			NURSING ADMINISTRATIO N (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	INTERNS & RESIDENTS SERVICES-SALA RY & FRINGES (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	21.00	
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	40	0	0	0	194.02
194.03	07953	MKT/PHY SERVICES	0	4,064	0	0	0	194.03
194.04	07954	COMMUNITY EDUCATION	0	9,525	0	0	158	194.04
194.05	07955	VOLUNTEER	0	165	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.07	07957	OFFSITE COVID SCREENING	0	0	0	0	0	194.07
194.08	07958	PUBLIC RELATIONS	0	677	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
194.10	07960	EMERGENCY PREPAREDNESS	0	810	0	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						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	470,746	225,807	139,645	796,663	485,395	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.357824	0.065937	1,396.450000	0.003805	1,371.172316	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	18,806	14,192	38,488	20,959	2,868	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.253991	0.004144	384.880000	0.000100	8.101695	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet B-1

Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description		INTERNS & RESIDENTS		
		SERVICES-OTHE		
		R PRGM. COSTS		
		(ASSIGNED TIME)		
		22.00		
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	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	354	22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	128	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	15	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
56.00	05600	RADIOISOTOPE	0	56.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2	69.00
69.01	06901	PULMONARY	0	69.01
69.02	06902	CARDIOPULMONARY	2	69.02
69.03	06903	SLEEP LAB	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	78.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	0	90.00
90.01	09001	IMED	0	90.01
90.02	09002	ONCOLOGY	6	90.02
90.03	09003	OUTPATIENT CENTER	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	8	90.04
90.05	09005	DIABETES MGMT CLINIC	0	90.05
91.00	09100	EMERGENCY	8	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	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
102.00	10200	OPIOID TREATMENT PROGRAM	0	102.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	169	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	27	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	192.01
194.00	07950	LODGE	0	194.00
194.01	07951	OTHER NRCC	0	194.01
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	194.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet B-1
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description		INTERNS & RESIDENTS		
		SERVICES-OTHE R PRGM. COSTS (ASSIGNED TIME)		
		22.00		
194.03	07953	MKT/PHY SERVICES	0	194.03
194.04	07954	COMMUNITY EDUCATION	158	194.04
194.05	07955	VOLUNTEER	0	194.05
194.06	07956	MAB	0	194.06
194.07	07957	OFFSITE COVID SCREENING	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 OFFICE	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)	496,340	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,402.090395	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	55,946	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	158.039548	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet C
Part I
Date/Time Prepared:
1/13/2025 9:02 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,561,430		4,561,430	0	4,561,430	30.00
31.00	03100	INTENSIVE CARE UNIT	1,888,001		1,888,001	0	1,888,001	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	648,878		648,878	0	648,878	41.00
43.00	04300	NURSERY	440,494		440,494	0	440,494	43.00
44.00	04400	SKILLED NURSING FACILITY	20,835		20,835	0	20,835	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,706,842		6,706,842	0	6,706,842	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	788,889		788,889	0	788,889	52.00
53.00	05300	ANESTHESIOLOGY	142,850		142,850	0	142,850	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,716,558		2,716,558	0	2,716,558	54.00
56.00	05600	RADIOISOTOPE	468,331		468,331	0	468,331	56.00
60.00	06000	LABORATORY	3,845,310		3,845,310	0	3,845,310	60.00
65.00	06500	RESPIRATORY THERAPY	897,380	0	897,380	0	897,380	65.00
66.00	06600	PHYSICAL THERAPY	1,269,076	0	1,269,076	0	1,269,076	66.00
69.00	06900	ELECTROCARDIOLOGY	2,376,735		2,376,735	0	2,376,735	69.00
69.01	06901	PULMONARY	0		0	0	0	69.01
69.02	06902	CARDIOPULMONARY	107,419		107,419	0	107,419	69.02
69.03	06903	SLEEP LAB	175,061		175,061	0	175,061	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	671,046		671,046	0	671,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,741,112		1,741,112	0	1,741,112	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,972,764		6,972,764	0	6,972,764	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	334,476		334,476	0	334,476	88.00
88.01	08801	RURAL HEALTH CLINIC II	375,820		375,820	0	375,820	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	412,549		412,549	0	412,549	90.00
90.01	09001	IMED	0		0	0	0	90.01
90.02	09002	ONCOLOGY	1,848,834		1,848,834	0	1,848,834	90.02
90.03	09003	OUTPATIENT CENTER	0		0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	632,986		632,986	0	632,986	90.04
90.05	09005	DIABETES MGMT CLINIC	40,939		40,939	0	40,939	90.05
91.00	09100	EMERGENCY	2,860,366		2,860,366	0	2,860,366	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,547,579		1,547,579	0	1,547,579	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,229,144		1,229,144	0	1,229,144	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0		0	0	0	116.00
200.00		Subtotal (see instructions)	45,721,704	0	45,721,704	0	45,721,704	200.00
201.00		Less Observation Beds	1,547,579		1,547,579	0	1,547,579	201.00
202.00		Total (see instructions)	44,174,125	0	44,174,125	0	44,174,125	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet C
Part I
Date/Time Prepared:
1/13/2025 9:02 am

			Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,072,194		4,072,194			30.00
31.00	03100	INTENSIVE CARE UNIT	2,146,999		2,146,999			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	733,774		733,774			41.00
43.00	04300	NURSERY	478,716		478,716			43.00
44.00	04400	SKILLED NURSING FACILITY	3,900		3,900			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,820,325	18,714,393	21,534,718	0.311443	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	840,232	11,790	852,022	0.925902	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	853,638	1,108,548	1,962,186	0.072801	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,034,605	29,013,918	32,048,523	0.084764	0.000000	54.00
56.00	05600	RADIOISOTOPE	121,708	5,557,091	5,678,799	0.082470	0.000000	56.00
60.00	06000	LABORATORY	3,277,312	21,632,149	24,909,461	0.154371	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	574,632	1,774,068	2,348,700	0.382075	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,359,281	3,296,387	4,655,668	0.272587	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	5,033,813	15,140,616	20,174,429	0.117809	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0.000000	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0	432,527	432,527	0.248352	0.000000	69.02
69.03	06903	SLEEP LAB	0	900,592	900,592	0.194384	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	868,870	3,026,566	3,895,436	0.172265	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,142,681	4,220,788	6,363,469	0.273611	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,352,484	29,484,385	34,836,869	0.200155	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	266,213	266,213			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	322,671	322,671			88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	42,917	1,453,294	1,496,211	0.275729	0.000000	90.00
90.01	09001	IMED	0	0	0	0.000000	0.000000	90.01
90.02	09002	ONCOLOGY	104,756	9,095,273	9,200,029	0.200960	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0.000000	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	1,300	1,153,979	1,155,279	0.547907	0.000000	90.04
90.05	09005	DIABETES MGMT CLINIC	0	42,679	42,679	0.959231	0.000000	90.05
91.00	09100	EMERGENCY	2,912,157	20,121,947	23,034,104	0.124180	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	472,300	3,065,439	3,537,739	0.437449	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,180	2,300,881	2,302,061	0.533932	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
	SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	37,249,774	172,136,194	209,385,968			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	37,249,774	172,136,194	209,385,968			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet C
Part I
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.311443			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.925902			52.00
53.00	05300	ANESTHESIOLOGY	0.072801			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084764			54.00
56.00	05600	RADIOISOTOPE	0.082470			56.00
60.00	06000	LABORATORY	0.154371			60.00
65.00	06500	RESPIRATORY THERAPY	0.382075			65.00
66.00	06600	PHYSICAL THERAPY	0.272587			66.00
69.00	06900	ELECTROCARDIOLOGY	0.117809			69.00
69.01	06901	PULMONARY	0.000000			69.01
69.02	06902	CARDIOPULMONARY	0.248352			69.02
69.03	06903	SLEEP LAB	0.194384			69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.172265			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.273611			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200155			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000			77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000			78.00
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	CLINIC	0.275729			90.00
90.01	09001	IMED	0.000000			90.01
90.02	09002	ONCOLOGY	0.200960			90.02
90.03	09003	OUTPATIENT CENTER	0.000000			90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.547907			90.04
90.05	09005	DIABETES MGMT CLINIC	0.959231			90.05
91.00	09100	EMERGENCY	0.124180			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.437449			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.533932			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
101.00	10100	HOME HEALTH AGENCY				101.00
102.00	10200	OPIOID TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE				116.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet C
Part I
Date/Time Prepared:
1/13/2025 9:02 am

			Title XIX	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,561,430		4,561,430	30.00
31.00	03100	INTENSIVE CARE UNIT	1,888,001		1,888,001	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	40.00
41.00	04100	SUBPROVIDER - IRF	648,878		648,878	41.00
43.00	04300	NURSERY	440,494		440,494	43.00
44.00	04400	SKILLED NURSING FACILITY	20,835		20,835	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,706,842		6,706,842	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	788,889		788,889	52.00
53.00	05300	ANESTHESIOLOGY	142,850		142,850	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,716,558		2,716,558	54.00
56.00	05600	RADIOISOTOPE	468,331		468,331	56.00
60.00	06000	LABORATORY	3,845,310		3,845,310	60.00
65.00	06500	RESPIRATORY THERAPY	897,380	0	897,380	65.00
66.00	06600	PHYSICAL THERAPY	1,269,076	0	1,269,076	66.00
69.00	06900	ELECTROCARDIOLOGY	2,376,735		2,376,735	69.00
69.01	06901	PULMONARY	0		0	69.01
69.02	06902	CARDIOPULMONARY	107,419		107,419	69.02
69.03	06903	SLEEP LAB	175,061		175,061	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	671,046		671,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,741,112		1,741,112	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,972,764		6,972,764	73.00
74.00	07400	RENAL DIALYSIS	0		0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	78.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	334,476		334,476	88.00
88.01	08801	RURAL HEALTH CLINIC II	375,820		375,820	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	89.00
90.00	09000	CLINIC	412,549		412,549	90.00
90.01	09001	IMED	0		0	90.01
90.02	09002	ONCOLOGY	1,848,834		1,848,834	90.02
90.03	09003	OUTPATIENT CENTER	0		0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	632,986		632,986	90.04
90.05	09005	DIABETES MGMT CLINIC	40,939		40,939	90.05
91.00	09100	EMERGENCY	2,860,366		2,860,366	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,547,579		1,547,579	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,229,144		1,229,144	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	96.00
101.00	10100	HOME HEALTH AGENCY	0		0	101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	102.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0	116.00
200.00		Subtotal (see instructions)	45,721,704	0	45,721,704	200.00
201.00		Less Observation Beds	1,547,579		1,547,579	201.00
202.00		Total (see instructions)	44,174,125	0	44,174,125	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet C
Part I
Date/Time Prepared:
1/13/2025 9:02 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,072,194		4,072,194		30.00
31.00	03100	INTENSIVE CARE UNIT	2,146,999		2,146,999		31.00
40.00	04000	SUBPROVIDER - IPF	0		0		40.00
41.00	04100	SUBPROVIDER - IRF	733,774		733,774		41.00
43.00	04300	NURSERY	478,716		478,716		43.00
44.00	04400	SKILLED NURSING FACILITY	3,900		3,900		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,820,325	18,714,393	21,534,718	0.311443	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	840,232	11,790	852,022	0.925902	0.000000
53.00	05300	ANESTHESIOLOGY	853,638	1,108,548	1,962,186	0.072801	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,034,605	29,013,918	32,048,523	0.084764	0.000000
56.00	05600	RADIOISOTOPE	121,708	5,557,091	5,678,799	0.082470	0.000000
60.00	06000	LABORATORY	3,277,312	21,632,149	24,909,461	0.154371	0.000000
65.00	06500	RESPIRATORY THERAPY	574,632	1,774,068	2,348,700	0.382075	0.000000
66.00	06600	PHYSICAL THERAPY	1,359,281	3,296,387	4,655,668	0.272587	0.000000
69.00	06900	ELECTROCARDIOLOGY	5,033,813	15,140,616	20,174,429	0.117809	0.000000
69.01	06901	PULMONARY	0	0	0	0.000000	0.000000
69.02	06902	CARDIOPULMONARY	0	432,527	432,527	0.248352	0.000000
69.03	06903	SLEEP LAB	0	900,592	900,592	0.194384	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	868,870	3,026,566	3,895,436	0.172265	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,142,681	4,220,788	6,363,469	0.273611	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	5,352,484	29,484,385	34,836,869	0.200155	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	266,213	266,213	1.256422	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	322,671	322,671	1.164716	0.000000
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000
90.00	09000	CLINIC	42,917	1,453,294	1,496,211	0.275729	0.000000
90.01	09001	IMED	0	0	0	0.000000	0.000000
90.02	09002	ONCOLOGY	104,756	9,095,273	9,200,029	0.200960	0.000000
90.03	09003	OUTPATIENT CENTER	0	0	0	0.000000	0.000000
90.04	09004	HBURG URGENT CARE CLINIC	1,300	1,153,979	1,155,279	0.547907	0.000000
90.05	09005	DIABETES MGMT CLINIC	0	42,679	42,679	0.959231	0.000000
91.00	09100	EMERGENCY	2,912,157	20,121,947	23,034,104	0.124180	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	472,300	3,065,439	3,537,739	0.437449	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,180	2,300,881	2,302,061	0.533932	0.000000
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		102.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	37,249,774	172,136,194	209,385,968		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	37,249,774	172,136,194	209,385,968		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet C
Part I
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
69.01	06901	PULMONARY	0.000000			69.01
69.02	06902	CARDIOPULMONARY	0.000000			69.02
69.03	06903	SLEEP LAB	0.000000			69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			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
74.00	07400	RENAL DIALYSIS	0.000000			74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000			77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000			78.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000			88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	IMED	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
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
101.00	10100	HOME HEALTH AGENCY				101.00
102.00	10200	OPIOID TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE				116.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet D
Part I
Date/Time Prepared:
1/13/2025 9:02 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	574,769	0	574,769	3,198	179.73	30.00
31.00	INTENSIVE CARE UNIT	170,949		170,949	825	207.21	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	69,082	0	69,082	391	176.68	41.00
43.00	NURSERY	44,304		44,304	360	123.07	43.00
44.00	SKILLED NURSING FACILITY	4,177		4,177	10	417.70	44.00
200.00	Total (lines 30 through 199)	863,281		863,281	4,784		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	706	126,889				30.00
31.00	INTENSIVE CARE UNIT	388	80,397				31.00
40.00	SUBPROVIDER - IPF	0	0				40.00
41.00	SUBPROVIDER - IRF	198	34,983				41.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	10	4,177				44.00
200.00	Total (lines 30 through 199)	1,302	246,446				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet D
Part II
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			Title XVIII		Hospital	PPS		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	472,461	21,534,718	0.021940	1,536,531	33,711	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	83,102	852,022	0.097535	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,341	1,962,186	0.000683	92,386	63	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	170,921	32,048,523	0.005333	1,584,264	8,449	54.00
56.00	05600	RADIOISOTOPE	13,364	5,678,799	0.002353	89,570	211	56.00
60.00	06000	LABORATORY	101,831	24,909,461	0.004088	1,318,139	5,389	60.00
65.00	06500	RESPIRATORY THERAPY	46,120	2,348,700	0.019636	245,564	4,822	65.00
66.00	06600	PHYSICAL THERAPY	74,552	4,655,668	0.016013	394,622	6,319	66.00
69.00	06900	ELECTROCARDIOLOGY	158,668	20,174,429	0.007865	2,075,948	16,327	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	17,396	432,527	0.040219	0	0	69.02
69.03	06903	SLEEP LAB	21,308	900,592	0.023660	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,141	3,895,436	0.001576	468,379	738	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,780	6,363,469	0.001694	1,506,306	2,552	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,967	34,836,869	0.002382	2,060,827	4,909	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	22,805	266,213	0.085664	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	48,452	322,671	0.150159	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	62,525	1,496,211	0.041789	24,177	1,010	90.00
90.01	09001	IMED	0	0	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	143,524	9,200,029	0.015600	49,272	769	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	61,475	1,155,279	0.053212	368	20	90.04
90.05	09005	DIABETES MGMT CLINIC	6,131	42,679	0.143654	0	0	90.05
91.00	09100	EMERGENCY	139,569	23,034,104	0.006059	1,559,202	9,447	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	195,004	3,537,739	0.055121	199,054	10,972	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50 through 199)	1,940,437	199,648,324		13,204,609	105,708	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 15-0115		Period: From 07/01/2024 To 09/30/2024		Worksheet D Part III Date/Time Prepared: 1/13/2025 9:02 am		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
	INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	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										
30.00	03000	ADULTS & PEDIATRICS	0	0	3,198	0.00	706	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	825	0.00	388	31.00			
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00			
41.00	04100	SUBPROVIDER - IRF	0	0	391	0.00	198	41.00			
43.00	04300	NURSERY	0	0	360	0.00	0	43.00			
44.00	04400	SKILLED NURSING FACILITY	0	0	10	0.00	10	44.00			
200.00		Total (lines 30 through 199)	0	0	4,784		1,302	200.00			
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
	INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
41.00	04100	SUBPROVIDER - IRF	0								41.00
43.00	04300	NURSERY	0								43.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet D
Part IV
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			Title XVIII			Hospital		PPS
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	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	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	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	DIABETES MGMT CLINIC	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	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	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet D
Part IV
Date/Time Prepared:
1/13/2025 9:02 am

			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	21,534,718	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	852,022	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,962,186	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,048,523	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	5,678,799	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	24,909,461	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,348,700	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,655,668	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	20,174,429	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	432,527	0.000000	69.02
69.03	06903	SLEEP LAB	0	0	0	900,592	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	3,895,436	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,363,469	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	34,836,869	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	266,213	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	322,671	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	1,496,211	0.000000	90.00
90.01	09001	IMED	0	0	0	0	0.000000	90.01
90.02	09002	ONCOLOGY	0	0	0	9,200,029	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	1,155,279	0.000000	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	42,679	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	23,034,104	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,537,739	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
200.00		Total (lines 50 through 199)	0	0	0	199,648,324		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet D
Part IV
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description			Title XVIII		Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	1,536,531	0	4,606,853	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	92,386	0	216,194	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,584,264	0	7,474,794	0
56.00	05600	RADIOISOTOPE	0.000000	89,570	0	2,100,827	0
60.00	06000	LABORATORY	0.000000	1,318,139	0	2,559,577	0
65.00	06500	RESPIRATORY THERAPY	0.000000	245,564	0	383,744	0
66.00	06600	PHYSICAL THERAPY	0.000000	394,622	0	55,321	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,075,948	0	5,977,151	0
69.01	06901	PULMONARY	0.000000	0	0	0	0
69.02	06902	CARDIOPULMONARY	0.000000	0	0	243,867	0
69.03	06903	SLEEP LAB	0.000000	0	0	299,383	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	468,379	0	740,261	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,506,306	0	1,339,704	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,060,827	0	10,495,254	0
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0
90.00	09000	CLINIC	0.000000	24,177	0	483,585	0
90.01	09001	IMED	0.000000	0	0	0	0
90.02	09002	ONCOLOGY	0.000000	49,272	0	4,580,845	0
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0
90.04	09004	HBURG URGENT CARE CLINIC	0.000000	368	0	142,692	0
90.05	09005	DIABETES MGMT CLINIC	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	1,559,202	0	4,497,848	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	199,054	0	296,023	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0	0
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0
200.00		Total (lines 50 through 199)		13,204,609	0	46,493,923	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet D
Part V
Date/Time Prepared:
1/13/2025 9:02 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.311443	4,606,853	0	0	1,434,772	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.925902	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.072801	216,194	0	0	15,739	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084764	7,474,794	0	0	633,593	54.00
56.00	05600	RADIOISOTOPE	0.082470	2,100,827	0	0	173,255	56.00
60.00	06000	LABORATORY	0.154371	2,559,577	0	0	395,124	60.00
65.00	06500	RESPIRATORY THERAPY	0.382075	383,744	0	0	146,619	65.00
66.00	06600	PHYSICAL THERAPY	0.272587	55,321	0	0	15,080	66.00
69.00	06900	ELECTROCARDIOLOGY	0.117809	5,977,151	0	0	704,162	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.248352	243,867	0	0	60,565	69.02
69.03	06903	SLEEP LAB	0.194384	299,383	0	0	58,195	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.172265	740,261	0	0	127,521	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.273611	1,339,704	0	0	366,558	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200155	10,495,254	0	1,117	2,100,678	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
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	CLINIC	0.275729	483,585	0	0	133,338	90.00
90.01	09001	IMED	0.000000	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.200960	4,580,845	0	0	920,567	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.547907	142,692	0	0	78,182	90.04
90.05	09005	DIABETES MGMT CLINIC	0.959231	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.124180	4,497,848	0	0	558,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.437449	296,023	0	0	129,495	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.533932		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		46,493,923	0	1,117	8,051,986	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		46,493,923	0	1,117	8,051,986	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 15-0115		Period: From 07/01/2024 To 09/30/2024		Worksheet D Part V Date/Time Prepared: 1/13/2025 9:02 am	
				Title XVIII		Hospital		PPS	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
56.00	05600	RADIOISOTOPE	0	0					56.00
60.00	06000	LABORATORY	0	0					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
69.01	06901	PULMONARY	0	0					69.01
69.02	06902	CARDIOPULMONARY	0	0					69.02
69.03	06903	SLEEP LAB	0	0					69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	224					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0					77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0					78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
88.01	08801	RURAL HEALTH CLINIC II							88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER							89.00
90.00	09000	CLINIC	0	0					90.00
90.01	09001	IMED	0	0					90.01
90.02	09002	ONCOLOGY	0	0					90.02
90.03	09003	OUTPATIENT CENTER	0	0					90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0					90.04
90.05	09005	DIABETES MGMT CLINIC	0	0					90.05
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0					96.00
200.00		Subtotal (see instructions)	0	224					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	224					202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS					Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet D Part II Date/Time Prepared: 1/13/2025 9:02 am	
					Component CCN: 15-T115			
					Title XVIII		Subprovider - IRF	PPS
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	472,461	21,534,718	0.021940	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	83,102	852,022	0.097535	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,341	1,962,186	0.000683	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	170,921	32,048,523	0.005333	4,185	22	54.00
56.00	05600	RADIOISOTOPE	13,364	5,678,799	0.002353	0	0	56.00
60.00	06000	LABORATORY	101,831	24,909,461	0.004088	22,483	92	60.00
65.00	06500	RESPIRATORY THERAPY	46,120	2,348,700	0.019636	3,020	59	65.00
66.00	06600	PHYSICAL THERAPY	74,552	4,655,668	0.016013	322,956	5,171	66.00
69.00	06900	ELECTROCARDIOLOGY	158,668	20,174,429	0.007865	2,533	20	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	17,396	432,527	0.040219	0	0	69.02
69.03	06903	SLEEP LAB	21,308	900,592	0.023660	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,141	3,895,436	0.001576	1,994	3	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,780	6,363,469	0.001694	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,967	34,836,869	0.002382	61,035	145	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	22,805	266,213	0.085664	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	48,452	322,671	0.150159	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	62,525	1,496,211	0.041789	0	0	90.00
90.01	09001	IMED	0	0	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	143,524	9,200,029	0.015600	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	61,475	1,155,279	0.053212	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	6,131	42,679	0.143654	0	0	90.05
91.00	09100	EMERGENCY	139,569	23,034,104	0.006059	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,537,739	0.000000	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50 through 199)	1,745,433	199,648,324		418,206	5,512	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0115 Component CCN: 15-T115		Period: From 07/01/2024 To 09/30/2024		Worksheet D Part IV Date/Time Prepared: 1/13/2025 9:02 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0115 Component CCN: 15-T115		Period: From 07/01/2024 To 09/30/2024		Worksheet D Part IV Date/Time Prepared: 1/13/2025 9:02 am	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	21,534,718	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	852,022	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,962,186	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	32,048,523	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	5,678,799	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	24,909,461	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,348,700	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,655,668	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	20,174,429	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	432,527	0.000000	69.02
69.03	06903	SLEEP LAB	0	0	0	900,592	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	3,895,436	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,363,469	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	34,836,869	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	266,213	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	322,671	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	1,496,211	0.000000	90.00
90.01	09001	IMED	0	0	0	0	0.000000	90.01
90.02	09002	ONCOLOGY	0	0	0	9,200,029	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	1,155,279	0.000000	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	42,679	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	23,034,104	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,537,739	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0.000000	96.00
200.00		Total (lines 50 through 199)	0	0	0	199,648,324		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0115 Component CCN: 15-T115		Period: From 07/01/2024 To 09/30/2024		Worksheet D Part IV Date/Time Prepared: 1/13/2025 9:02 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	4,185	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	22,483	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,020	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	322,956	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,533	0	0	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.000000	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0.000000	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,994	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	61,035	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09001	IMED	0.000000	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.000000	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.000000	0	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.000000	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)			418,206	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0115 Component CCN: 15-5305		Period: From 07/01/2024 To 09/30/2024		Worksheet D Part IV Date/Time Prepared: 1/13/2025 9:02 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0	0	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0115 Component CCN: 15-5305		Period: From 07/01/2024 To 09/30/2024		Worksheet D Part IV Date/Time Prepared: 1/13/2025 9:02 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	21,534,718	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	852,022	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	1,962,186	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	32,048,523	0.000000	54.00
56.00	05600	RADIOISOTOPE		0	0	0	5,678,799	0.000000	56.00
60.00	06000	LABORATORY		0	0	0	24,909,461	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	2,348,700	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	4,655,668	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	20,174,429	0.000000	69.00
69.01	06901	PULMONARY		0	0	0	0	0.000000	69.01
69.02	06902	CARDIOPULMONARY		0	0	0	432,527	0.000000	69.02
69.03	06903	SLEEP LAB		0	0	0	900,592	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	3,895,436	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	6,363,469	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	34,836,869	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	266,213	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	322,671	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	0.000000	89.00
90.00	09000	CLINIC		0	0	0	1,496,211	0.000000	90.00
90.01	09001	IMED		0	0	0	0	0.000000	90.01
90.02	09002	ONCOLOGY		0	0	0	9,200,029	0.000000	90.02
90.03	09003	OUTPATIENT CENTER		0	0	0	0	0.000000	90.03
90.04	09004	HBURG URGENT CARE CLINIC		0	0	0	1,155,279	0.000000	90.04
90.05	09005	DIABETES MGMT CLINIC		0	0	0	42,679	0.000000	90.05
91.00	09100	EMERGENCY		0	0	0	23,034,104	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	3,537,739	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		0	0	0	0	0.000000	96.00
200.00		Total (lines 50 through 199)		0	0	0	199,648,324		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 15-0115 Component CCN: 15-5305		Period: From 07/01/2024 To 09/30/2024		Worksheet D Part IV Date/Time Prepared: 1/13/2025 9:02 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0.000000	2,265	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	10,967	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.000000	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0.000000	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,502	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09001	IMED	0.000000	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.000000	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.000000	0	0	0	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.000000	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)			15,734	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet D
Part V
Date/Time Prepared:
1/13/2025 9:02 am

			Title XIX		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.311443	0	160,238	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.925902	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.072801	0	10,042	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084764	0	316,435	0	0	54.00
56.00	05600	RADIOISOTOPE	0.082470	0	25,938	0	0	56.00
60.00	06000	LABORATORY	0.154371	0	345,988	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.382075	0	24,817	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.272587	0	9,354	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.117809	0	160,858	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.248352	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0.194384	0	4,585	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.172265	0	28,143	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.273611	0	8,263	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200155	0	117,755	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
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	CLINIC	0.275729	0	34,235	0	0	90.00
90.01	09001	IMED	0.000000	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.200960	0	30,490	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.547907	0	15,729	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.959231	0	267	0	0	90.05
91.00	09100	EMERGENCY	0.124180	0	511,807	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.437449	0	52,413	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.533932	0	85,834			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	1,943,191	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	1,943,191	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:15-0115		Period: From 07/01/2024 To 09/30/2024	Worksheet D Part V Date/Time Prepared: 1/13/2025 9:02 am
			Title XIX		Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	49,905	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	731	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,822	0		54.00
56.00	05600	RADIOISOTOPE	2,139	0		56.00
60.00	06000	LABORATORY	53,411	0		60.00
65.00	06500	RESPIRATORY THERAPY	9,482	0		65.00
66.00	06600	PHYSICAL THERAPY	2,550	0		66.00
69.00	06900	ELECTROCARDIOLOGY	18,951	0		69.00
69.01	06901	PULMONARY	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	0		69.02
69.03	06903	SLEEP LAB	891	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,848	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,261	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,569	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	9,440	0		90.00
90.01	09001	IMED	0	0		90.01
90.02	09002	ONCOLOGY	6,127	0		90.02
90.03	09003	OUTPATIENT CENTER	0	0		90.03
90.04	09004	HBURG URGENT CARE CLINIC	8,618	0		90.04
90.05	09005	DIABETES MGMT CLINIC	256	0		90.05
91.00	09100	EMERGENCY	63,556	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	22,928	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	45,830			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	352,315	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	352,315	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet D-1 Date/Time Prepared: 1/13/2025 9:02 am	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,198	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,198	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			2,113	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 reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-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)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			706	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
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)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			4,561,430	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)			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)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			4,561,430	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
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	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 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 27 minus line 36)			4,561,430	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,426.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,006,996	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,006,996	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet D-1

Date/Time Prepared:
1/13/2025 9:02 am

		Title XVIII		Hospital		PPS
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,888,001	825	2,288.49	388	887,934
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,479,164
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					4,374,094
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					207,286
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					105,708
52.00	Total Program excludable cost (sum of lines 50 and 51)					312,994
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,061,100
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
55.01	Permanent adjustment amount per discharge					0.00
55.02	Adjustment amount per discharge (contractor use only)					0.00
55.03	CAR T-cell amount paid as an interim payment					0
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					1,085

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0115		Period: From 07/01/2024 To 09/30/2024		Worksheet D-1 Date/Time Prepared: 1/13/2025 9:02 am	
				Title XVIII		Hospital		PPS	
Cost Center Description								1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)							1,426.34	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)							1,547,579	89.00
Cost Center Description			Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
			1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost	574,769	4,561,430	0.126006	1,547,579	195,004	90.00		
91.00	Nursing Program cost	0	4,561,430	0.000000	1,547,579	0	91.00		
92.00	Allied health cost	0	4,561,430	0.000000	1,547,579	0	92.00		
93.00	All other Medical Education	0	4,561,430	0.000000	1,547,579	0	93.00		

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2024 To 09/30/2024	Worksheet D-1 Date/Time Prepared: 1/13/2025 9:02 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		391	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		391	2.00	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00	
4.00	Semi-private room days (excluding swing-bed and observation bed days)		391	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 reporting period (if calendar year, enter 0 on this line)		0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00	
8.00	Total swing-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)		0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		198	9.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00	
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)		0	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00	
15.00	Total nursery days (title V or XIX only)		0	15.00	
16.00	Nursery days (title V or XIX only)		0	16.00	
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00	
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00	
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00	
21.00	Total general inpatient routine service cost (see instructions)		648,878	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)		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)		0	23.00	
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00	
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00	
26.00	Total swing-bed cost (see instructions)		0	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		648,878	27.00	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
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	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00	
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00	
34.00	Average per diem private room charge differential (line 32 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 27 minus line 36)		648,878	37.00	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,659.53	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		328,587	39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		328,587	41.00	

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2024 To 09/30/2024	Worksheet D-1 Date/Time Prepared: 1/13/2025 9:02 am		
				Title XVIII		Subprovider - IRF	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description								
							1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						105,871	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)						0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)						434,458	49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						34,983	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						5,512	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						40,495	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						393,963	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
55.01	Permanent adjustment amount per discharge						0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)						0.00	55.02
55.03	CAR T-cell amount paid as an interim payment							55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)						0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2024 To 09/30/2024	Worksheet D-1 Date/Time Prepared: 1/13/2025 9:02 am	
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description						1.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	69,082	648,878	0.106464	0	0	90.00
91.00	Nursing Program cost	0	648,878	0.000000	0	0	91.00
92.00	Allied health cost	0	648,878	0.000000	0	0	92.00
93.00	All other Medical Education	0	648,878	0.000000	0	0	93.00

Health Financial Systems		MEMORIAL HOSP & HEALTH CARE CTR		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0115	Period: From 07/01/2024	Worksheet D-1	
		Component CCN: 15-5305	To 09/30/2024	Date/Time Prepared: 1/13/2025 9:02 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description					
					1.00
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			10	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			10	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			10	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 reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-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)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			10	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
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)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			20,835	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)			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)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			20,835	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
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	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 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 27 minus line 36)			20,835	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)				38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)				39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)				40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)				41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2024 To 09/30/2024	Worksheet D-1 Date/Time Prepared: 1/13/2025 9:02 am	
				Title XVIII		Skilled Nursing Facility	PPS
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)						48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)						49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
55.01	Permanent adjustment amount per discharge						55.01
55.02	Adjustment amount per discharge (contractor use only)						55.02
55.03	CAR T-cell amount paid as an interim payment						55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)						59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						20,835 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						2,083.50 71.00
72.00	Program routine service cost (line 9 x line 71)						20,835 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						20,835 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)						0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						0 80.00
81.00	Inpatient routine service cost per diem limitation						0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)						20,835 83.00
84.00	Program inpatient ancillary services (see instructions)						3,840 84.00
85.00	Utilization review - physician compensation (see instructions)						0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						24,675 86.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:15-0115 Component CCN:15-5305		Period: From 07/01/2024 To 09/30/2024		Worksheet D-1 Date/Time Prepared: 1/13/2025 9:02 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description								1.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
87.00	Total observation bed days (see instructions)							0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)							0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)							0	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
		1.00	2.00	3.00	4.00	5.00			
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost	0	0	0.000000	0	0			
91.00	Nursing Program cost	0	0	0.000000	0	0			
92.00	Allied health cost	0	0	0.000000	0	0			
93.00	All other Medical Education	0	0	0.000000	0	0			

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet D-1 Date/Time Prepared: 1/13/2025 9:02 am	
		Title XIX	Hospital	Cost	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,198	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,198	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			2,113	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 reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-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)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			27	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
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)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			360	15.00
16.00	Nursery days (title V or XIX only)			21	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			4,561,430	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)			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)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			4,561,430	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
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	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 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 27 minus line 36)			4,561,430	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,426.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			38,511	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			38,511	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet D-1

Date/Time Prepared:
1/13/2025 9:02 am

		Title XIX		Hospital	Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	440,494	360	1,223.59	21	25,695
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,888,001	825	2,288.49	28	64,078
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					84,443
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					212,727
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
55.01	Permanent adjustment amount per discharge					0.00
55.02	Adjustment amount per discharge (contractor use only)					0.00
55.03	CAR T-cell amount paid as an interim payment					0
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)					0.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00	Program routine service cost (line 9 x line 71)					
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00	Per diem capital-related costs (line 75 ÷ line 2)					
77.00	Program capital-related costs (line 9 x line 76)					
78.00	Inpatient routine service cost (line 74 minus line 77)					
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					
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					
82.00	Inpatient routine service cost limitation (line 9 x line 81)					
83.00	Reasonable inpatient routine service costs (see instructions)					
84.00	Program inpatient ancillary services (see instructions)					
85.00	Utilization review - physician compensation (see instructions)					
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					1,085

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0115		Period: From 07/01/2024 To 09/30/2024		Worksheet D-1 Date/Time Prepared: 1/13/2025 9:02 am	
				Title XIX		Hospital		Cost	
Cost Center Description								1.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,426.34		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						1,547,579		89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
		1.00	2.00	3.00	4.00	5.00			
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost	574,769	4,561,430	0.126006	1,547,579	195,004		90.00	
91.00	Nursing Program cost	0	4,561,430	0.000000	1,547,579	0		91.00	
92.00	Allied health cost	0	4,561,430	0.000000	1,547,579	0		92.00	
93.00	All other Medical Education	0	4,561,430	0.000000	1,547,579	0		93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2024 To 09/30/2024	Worksheet D-1 Date/Time Prepared: 1/13/2025 9:02 am
		Title XIX	Subprovider - IRF	Cost
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		391	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		391	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		391	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 reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-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)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
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)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		360	15.00
16.00	Nursery days (title V or XIX only)		21	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		648,878	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)		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)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		648,878	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
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	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 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 27 minus line 36)		648,878	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,659.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2024 To 09/30/2024	Worksheet D-1 Date/Time Prepared: 1/13/2025 9:02 am		
				Title XIX		Subprovider - IRF	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description								
							1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)						0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)						0	49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						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 excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
55.01	Permanent adjustment amount per discharge						0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)						0.00	55.02
55.03	CAR T-cell amount paid as an interim payment							55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)						0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2024 To 09/30/2024	Worksheet D-1 Date/Time Prepared: 1/13/2025 9:02 am	
				Title XIX	Subprovider - IRF	Cost	
Cost Center Description						1.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	69,082	648,878	0.106464	0	0	90.00
91.00	Nursing Program cost	0	648,878	0.000000	0	0	91.00
92.00	Allied health cost	0	648,878	0.000000	0	0	92.00
93.00	All other Medical Education	0	648,878	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2024 To 09/30/2024	Worksheet D-1 Date/Time Prepared: 1/13/2025 9:02 am
		Title XIX	Skilled Nursing Facility	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		10	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 reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-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)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
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)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		360	15.00
16.00	Nursery days (title V or XIX only)		21	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		20,835	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)		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)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		20,835	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
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	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 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 27 minus line 36)		20,835	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2024 To 09/30/2024	Worksheet D-1 Date/Time Prepared: 1/13/2025 9:02 am	
				Title XIX		Skilled Nursing Facility	Cost
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)						48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
55.01	Permanent adjustment amount per discharge						55.01
55.02	Adjustment amount per discharge (contractor use only)						55.02
55.03	CAR T-cell amount paid as an interim payment						55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)						59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					20,835	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					2,083.50	71.00
72.00	Program routine service cost (line 9 x line 71)					0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					4,177	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					417.70	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					0	83.00
84.00	Program inpatient ancillary services (see instructions)					0	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					0	86.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:15-0115 Component CCN:15-5305		Period: From 07/01/2024 To 09/30/2024		Worksheet D-1 Date/Time Prepared: 1/13/2025 9:02 am	
				Title XIX		Skilled Nursing Facility		Cost	
Cost Center Description								1.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
87.00	Total observation bed days (see instructions)							0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)							0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)							0	89.00
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
		1.00	2.00	3.00	4.00	5.00			
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost	0	0	0.000000	0	0			
91.00	Nursing Program cost	0	0	0.000000	0	0			
92.00	Allied health cost	0	0	0.000000	0	0			
93.00	All other Medical Education	0	0	0.000000	0	0			

Health Financial Systems		MEMORIAL HOSP & HEALTH CARE CTR		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet D-3 Date/Time Prepared: 1/13/2025 9:02 am
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,238,560	30.00
31.00	03100	INTENSIVE CARE UNIT		974,785	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.311443	1,536,531	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.925902	0	52.00
53.00	05300	ANESTHESIOLOGY	0.072801	92,386	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084764	1,584,264	54.00
56.00	05600	RADIOISOTOPE	0.082470	89,570	56.00
60.00	06000	LABORATORY	0.154371	1,318,139	60.00
65.00	06500	RESPIRATORY THERAPY	0.382075	245,564	65.00
66.00	06600	PHYSICAL THERAPY	0.272587	394,622	66.00
69.00	06900	ELECTROCARDIOLOGY	0.117809	2,075,948	69.00
69.01	06901	PULMONARY	0.000000	0	69.01
69.02	06902	CARDIOPULMONARY	0.248352	0	69.02
69.03	06903	SLEEP LAB	0.194384	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.172265	468,379	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.273611	1,506,306	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200155	2,060,827	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.275729	24,177	90.00
90.01	09001	IMED	0.000000	0	90.01
90.02	09002	ONCOLOGY	0.200960	49,272	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.547907	368	90.04
90.05	09005	DIABETES MGMT CLINIC	0.959231	0	90.05
91.00	09100	EMERGENCY	0.124180	1,559,202	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.437449	199,054	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
200.00		Total (sum of lines 50 through 94 and 96 through 98)		13,204,609	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		13,204,609	202.00

Health Financial Systems			MEMORIAL HOSP & HEALTH CARE CTR		In Lieu of Form CMS-2552-10				
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 15-0115		Period: From 07/01/2024 To 09/30/2024		Worksheet D-3		
			Component CCN: 15-T115				Date/Time Prepared: 1/13/2025 9:02 am		
			Title XVIII		Subprovider - IRF		PPS		
Cost Center Description			Ratio of Cost To Charges		Inpatient Program Charges		Inpatient Program Costs (col. 1 x col. 2)		
			1.00		2.00		3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS							30.00
31.00	03100	INTENSIVE CARE UNIT							31.00
40.00	04000	SUBPROVIDER - IPF							40.00
41.00	04100	SUBPROVIDER - IRF			318,180				41.00
43.00	04300	NURSERY							43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.311443		0		0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.925902		0		0		52.00
53.00	05300	ANESTHESIOLOGY	0.072801		0		0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084764		4,185		355		54.00
56.00	05600	RADIOISOTOPE	0.082470		0		0		56.00
60.00	06000	LABORATORY	0.154371		22,483		3,471		60.00
65.00	06500	RESPIRATORY THERAPY	0.382075		3,020		1,154		65.00
66.00	06600	PHYSICAL THERAPY	0.272587		322,956		88,034		66.00
69.00	06900	ELECTROCARDIOLOGY	0.117809		2,533		298		69.00
69.01	06901	PULMONARY	0.000000		0		0		69.01
69.02	06902	CARDIOPULMONARY	0.248352		0		0		69.02
69.03	06903	SLEEP LAB	0.194384		0		0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		0		0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.172265		1,994		343		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.273611		0		0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200155		61,035		12,216		73.00
74.00	07400	RENAL DIALYSIS	0.000000		0		0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		0		0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		0		0		78.00
OUTPATIENT SERVICE COST CENTERS									
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		89.00
90.00	09000	CLINIC	0.275729		0		0		90.00
90.01	09001	IMED	0.000000		0		0		90.01
90.02	09002	ONCOLOGY	0.200960		0		0		90.02
90.03	09003	OUTPATIENT CENTER	0.000000		0		0		90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.547907		0		0		90.04
90.05	09005	DIABETES MGMT CLINIC	0.959231		0		0		90.05
91.00	09100	EMERGENCY	0.124180		0		0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.437449		0		0		92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		0		0		96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)			418,206		105,871		200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)			0				201.00
202.00		Net charges (line 200 minus line 201)			418,206				202.00

Health Financial Systems			MEMORIAL HOSP & HEALTH CARE CTR		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN:15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet D-3	
			Component CCN:15-5305		Date/Time Prepared: 1/13/2025 9:02 am	
			Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.311443	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.925902	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.072801	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084764	0	0	54.00
56.00	05600	RADIOISOTOPE	0.082470	0	0	56.00
60.00	06000	LABORATORY	0.154371	2,265	350	60.00
65.00	06500	RESPIRATORY THERAPY	0.382075	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.272587	10,967	2,989	66.00
69.00	06900	ELECTROCARDIOLOGY	0.117809	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.248352	0	0	69.02
69.03	06903	SLEEP LAB	0.194384	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.172265	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.273611	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200155	2,502	501	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
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	89.00
90.00	09000	CLINIC	0.275729	0	0	90.00
90.01	09001	IMED	0.000000	0	0	90.01
90.02	09002	ONCOLOGY	0.200960	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.547907	0	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.959231	0	0	90.05
91.00	09100	EMERGENCY	0.124180	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.437449	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		15,734	3,840	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		15,734		202.00

Health Financial Systems		MEMORIAL HOSP & HEALTH CARE CTR		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet D-3 Date/Time Prepared: 1/13/2025 9:02 am
			Title XIX	Hospital	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		190,981	30.00
31.00	03100	INTENSIVE CARE UNIT		98,153	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		46,170	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.311443	33,782	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.925902	0	52.00
53.00	05300	ANESTHESIOLOGY	0.072801	36,530	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084764	39,822	54.00
56.00	05600	RADIOISOTOPE	0.082470	7,848	56.00
60.00	06000	LABORATORY	0.154371	87,983	60.00
65.00	06500	RESPIRATORY THERAPY	0.382075	46,773	65.00
66.00	06600	PHYSICAL THERAPY	0.272587	16,940	66.00
69.00	06900	ELECTROCARDIOLOGY	0.117809	103,545	69.00
69.01	06901	PULMONARY	0.000000	0	69.01
69.02	06902	CARDIOPULMONARY	0.248352	0	69.02
69.03	06903	SLEEP LAB	0.194384	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.172265	4,556	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.273611	6,396	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200155	52,168	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1.256422	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.164716	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.275729	821	90.00
90.01	09001	IMED	0.000000	0	90.01
90.02	09002	ONCOLOGY	0.200960	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.547907	92	90.04
90.05	09005	DIABETES MGMT CLINIC	0.959231	0	90.05
91.00	09100	EMERGENCY	0.124180	46,050	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.437449	0	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
200.00		Total (sum of lines 50 through 94 and 96 through 98)		483,306	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		483,306	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2024 To 09/30/2024	Worksheet D-3 Date/Time Prepared: 1/13/2025 9:02 am	
		Title XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.311443	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.925902	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.072801	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.084764	0	0	54.00
56.00	05600 RADIOISOTOPE	0.082470	0	0	56.00
60.00	06000 LABORATORY	0.154371	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.382075	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.272587	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.117809	0	0	69.00
69.01	06901 PULMONARY	0.000000	0	0	69.01
69.02	06902 CARDIOPULMONARY	0.248352	0	0	69.02
69.03	06903 SLEEP LAB	0.194384	0	0	69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.172265	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.273611	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.200155	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.256422	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	1.164716	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000 CLINIC	0.275729	0	0	90.00
90.01	09001 IMED	0.000000	0	0	90.01
90.02	09002 ONCOLOGY	0.200960	0	0	90.02
90.03	09003 OUTPATIENT CENTER	0.000000	0	0	90.03
90.04	09004 HBURG URGENT CARE CLINIC	0.547907	0	0	90.04
90.05	09005 DIABETES MGMT CLINIC	0.959231	0	0	90.05
91.00	09100 EMERGENCY	0.124180	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.437449	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)			0	201.00
202.00	Net charges (line 200 minus line 201)			0	202.00

Health Financial Systems		MEMORIAL HOSP & HEALTH CARE CTR		In Lieu of Form CMS-2552-10	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 15-0115	Period: From 07/01/2024	Worksheet D-3
			Component CCN: 15-5305	To 09/30/2024	Date/Time Prepared: 1/13/2025 9:02 am
			Title XIX	Skilled Nursing Facility	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.311443	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.925902	0	52.00
53.00	05300	ANESTHESIOLOGY	0.072801	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084764	0	54.00
56.00	05600	RADIOISOTOPE	0.082470	0	56.00
60.00	06000	LABORATORY	0.154371	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.382075	0	65.00
66.00	06600	PHYSICAL THERAPY	0.272587	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.117809	0	69.00
69.01	06901	PULMONARY	0.000000	0	69.01
69.02	06902	CARDIOPULMONARY	0.248352	0	69.02
69.03	06903	SLEEP LAB	0.194384	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.172265	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.273611	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200155	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1.256422	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.164716	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.275729	0	90.00
90.01	09001	IMED	0.000000	0	90.01
90.02	09002	ONCOLOGY	0.200960	0	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	0	90.03
90.04	09004	HBURG URGENT CARE CLINIC	0.547907	0	90.04
90.05	09005	DIABETES MGMT CLINIC	0.959231	0	90.05
91.00	09100	EMERGENCY	0.124180	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.437449	0	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
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet E Part A Date/Time Prepared: 1/13/2025 9:02 am
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		3,620,686	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		0	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2.04
3.00	Managed Care Simulated Payments		1,226,404	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		93.92	4.00
Indirect Medical Education Adjustment				
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)		13.95	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
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	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		13.95	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		14.80	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		13.95	12.00
13.00	Total allowable FTE count for the prior year.		14.54	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		14.47	14.00
15.00	Sum of lines 12 through 14 divided by 3.		14.32	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		14.32	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.152470	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.171665	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.152470	21.00
22.00	IME payment adjustment (see instructions)		289,152	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		97,942	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C) .		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.85	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		289,152	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		97,942	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.53	30.00
31.00	Percentage of Medicaid patient days (see instructions)		23.88	31.00
32.00	Sum of lines 30 and 31		26.41	32.00
33.00	Allowable disproportionate share percentage (see instructions)		11.00	33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet E Part A Date/Time Prepared: 1/13/2025 9:02 am
		Title XVIII	Hospital	PPS
				1.00
34.00	Disproportionate share adjustment (see instructions)			99,569 34.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Payment Adjustment				
35.00	Total uncompensated care amount (see instructions)	0		0 35.00
35.01	Factor 3 (see instructions)	0.000000000		0.000000000 35.01
35.02	Hospital UCP, including supplemental UCP (see instructions)	723,116		0 35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	181,767		0 35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	181,767		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	4,191,174		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)	4,289,116		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	315,229		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	87,866		52.00
53.00	Nursing and Allied Health Managed Care payment	0		53.00
54.00	Special add-on payments for new technologies	0		54.00
54.01	Islet isolation add-on payment	0		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0		55.00
55.01	Cellular therapy acquisition cost (see instructions)	0		55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0		58.00
59.00	Total (sum of amounts on lines 49 through 58)	4,692,211		59.00
60.00	Primary payer payments	8,105		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	4,684,106		61.00
62.00	Deductibles billed to program beneficiaries	465,120		62.00
63.00	Coinsurance billed to program beneficiaries	9,792		63.00
64.00	Allowable bad debts (see instructions)	33,634		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	21,862		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,896		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	4,231,056		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)	0		70.50
70.75	N95 respirator payment adjustment amount (see instructions)	0		70.75
70.87	Demonstration payment adjustment amount before sequestration	0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0		70.91
70.92	Bundled Model 1 discount amount (see instructions)	0		70.92
70.93	HVBP payment adjustment amount (see instructions)	892		70.93
70.94	HRR adjustment amount (see instructions)	-2,173		70.94
70.95	Recovery of accelerated depreciation	0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet E Part A Date/Time Prepared: 1/13/2025 9:02 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2024	196,035	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,425,810	71.00
71.01	Sequestration adjustment (see instructions)		88,516	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		4,310,052	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)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		27,242	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		379,515	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		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 instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/13/2025 9:02 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,620,686	0	3,620,686		3,620,686
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0		0	0
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	1,226,404	0	1,226,404	0	1,226,404
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.152470	0.152470	0.152470	0.152470	
6.00	IME payment adjustment (see instructions)	22.00	289,152	0	289,152	0	289,152
6.01	IME payment adjustment for managed care (see instructions)	22.01	97,942	0	97,942	0	97,942
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	289,152	0	289,152	0	289,152
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	97,942	0	97,942	0	97,942
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1100	0.1100	0.1100	0.1100	
11.00	Disproportionate share adjustment (see instructions)	34.00	99,569	0	99,569	0	99,569
11.01	Uncompensated care payments	36.00	181,767	0	181,767	0	181,767
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	4,191,174	0	4,191,174	0	4,191,174
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,289,116	0	4,289,116	0	4,289,116

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/13/2025 9:02 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	315,229	0	315,229	0	315,229	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	4,604,345	0	4,604,345	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	278,939	0	278,939	0	278,939	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.1301	0.1301	0.1301	0.1301		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	36,290	0	36,290	0	36,290	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	315,229	0	315,229	0	315,229	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.042576	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			196,035		196,035	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/13/2025 9:02 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,620,686	3,620,686		3,620,686	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,226,404	1,226,404	0	1,226,404	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.152470	0.152470	0.152470		5.00
6.00	IME payment adjustment (see instructions)	22.00	289,152	289,152	0	289,152	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	97,942	97,942	0	97,942	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	289,152	289,152	0	289,152	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	97,942	97,942	0	97,942	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1100	0.1100	0.1100		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	99,569	99,569	0	99,569	11.00
11.01	Uncompensated care payments	36.00	181,767	181,767	0	181,767	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,191,174	4,191,174	0	4,191,174	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,289,116	4,289,116	0	4,289,116	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	315,229	315,229	0	315,229	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			4,604,345	0	4,604,345	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/13/2025 9:02 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	278,939	278,939	0	278,939	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.1301	0.1301	0.1301		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	36,290	36,290	0	36,290	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	315,229	315,229	0	315,229	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	196,035	196,035		196,035	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	892	892	0	892	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-2,173	-2,173	0	-2,173	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet E Part B Date/Time Prepared: 1/13/2025 9:02 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		224	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		8,051,986	2.00
3.00	OPPS or REH payments		7,477,322	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		224	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,117	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		1,117	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
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)		1,117	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		893	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		224	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		7,477,322	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,349,758	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		6,127,788	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		148,555	28.00
28.50	REH facility payment amount (see instructions)			28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)		6,276,343	30.00
31.00	Primary payer payments		1,090	31.00
32.00	Subtotal (line 30 minus line 31)		6,275,253	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		45,946	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		29,865	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		19,814	36.00
37.00	Subtotal (see instructions)		6,305,118	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		6,305,118	40.00
40.01	Sequestration adjustment (see instructions)		126,102	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		6,144,109	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		34,907	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		97,726	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00

Health Financial Systems		MEMORIAL HOSP & HEALTH CARE CTR		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT			Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet E Part B Date/Time Prepared: 1/13/2025 9:02 am
			Title XVIII	Hospital	PPS
					1.00
94.00	Total (sum of lines 91 and 93)				0 94.00
					1.00
200.00	MEDICARE PART B ANCILLARY COSTS Part B Combined Billed Days				0 200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet E-1
Part I
Date/Time Prepared:
1/13/2025 9:02 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part 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		4,310,052		6,144,109	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,310,052		6,144,109	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE 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		27,242		34,907	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		4,337,294		6,179,016	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 15-0115 Component CCN: 15-T115		Period: From 07/01/2024 To 09/30/2024		Worksheet E-1 Part I Date/Time Prepared: 1/13/2025 9:02 am	
		Title XVIII		Subprovider - IRF		PPS	
		Inpatient Part A		Part 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		416,992		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		416,992		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE 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		204		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		417,196		0	7.00	
		0		Contractor Number	NPR Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0115

Period:

Worksheet E-1

Component CCN: 15-5305

From 07/01/2024

Part I

To 09/30/2024

Date/Time Prepared:
1/13/2025 9:02 am

Title XVIII

Skilled Nursing
Facility

PPS

		Inpatient Part A		Part 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		3,734		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,734		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE 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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,734		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet E-1
Part II
Date/Time Prepared:
1/13/2025 9:02 am

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2024 To 09/30/2024	Worksheet E-3 Part III Date/Time Prepared: 1/13/2025 9:02 am
		Title XVIII	Subprovider - IRF	PPS
		1.00		
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)	416,797	1.00	
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2.00	
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	10,545	3.00	
4.00	Outlier Payments	0	4.00	
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00	
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01	
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00	
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00	
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00	
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00	
10.00	Average Daily Census (see instructions)	4.250000	10.00	
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00	
12.00	Teaching Adjustment (see instructions)	0	12.00	
13.00	Total PPS Payment (see instructions)	427,342	13.00	
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00	
15.00	Organ acquisition (DO NOT USE THIS LINE)	0	15.00	
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00	
17.00	Subtotal (see instructions)	427,342	17.00	
18.00	Primary payer payments	0	18.00	
19.00	Subtotal (line 17 less line 18).	427,342	19.00	
20.00	Deductibles	1,632	20.00	
21.00	Subtotal (line 19 minus line 20)	425,710	21.00	
22.00	Coinsurance	0	22.00	
23.00	Subtotal (line 21 minus line 22)	425,710	23.00	
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00	
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00	
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00	
27.00	Subtotal (sum of lines 23 and 25)	425,710	27.00	
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00	
29.00	Other pass through costs (see instructions)	0	29.00	
30.00	Outlier payments reconciliation	0	30.00	
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00	
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50	
31.98	Recovery of accelerated depreciation.	0	31.98	
31.99	Demonstration payment adjustment amount before sequestration	0	31.99	
32.00	Total amount payable to the provider (see instructions)	425,710	32.00	
32.01	Sequestration adjustment (see instructions)	8,514	32.01	
32.02	Demonstration payment adjustment amount after sequestration	0	32.02	
33.00	Interim payments	416,992	33.00	
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)	204	35.00	
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00	
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	0	50.00	
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00	
52.00	The rate used to calculate the Time Value of Money	0.00	52.00	
53.00	Time Value of Money (see instructions)	0	53.00	
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00	
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2024 To 09/30/2024	Worksheet E-3 Part VI Date/Time Prepared: 1/13/2025 9:02 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		5,850	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		5,850	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		2,040	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		3,810	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.98	Recovery of accelerated depreciation.		0	14.98
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		3,810	15.00
15.01	Sequestration adjustment (see instructions)		76	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)		0	15.75
16.00	Interim payments		3,734	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet E-3 Part VII Date/Time Prepared: 1/13/2025 9:02 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	212,727			1.00
2.00	Medical and other services			352,315	2.00
3.00	Organ acquisition (certified transplant programs only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	212,727		352,315	4.00
5.00	Inpatient primary payer payments	0			5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	212,727		352,315	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	0			8.00
9.00	Ancillary service charges	483,306		1,943,191	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)	483,306		1,943,191	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0		0	13.00
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)	0		0	14.00
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)	483,306		1,943,191	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	270,579		1,590,876	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0		0	18.00
19.00	Interns and Residents (see instructions)	0		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	212,727		352,315	21.00
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	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)	212,727		352,315	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	0		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	212,727		352,315	31.00
32.00	Deductibles	0		0	32.00
33.00	Coinurance	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)	212,727		352,315	36.00
37.00	OTHER ADJUSTMENTS (ZERO SETTLEMENT)	-212,727		-352,315	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, chapter 1, §115.2	0		0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0115 Component CCN: 15-T115	Period: From 07/01/2024 To 09/30/2024	Worksheet E-3 Part VII Date/Time Prepared: 1/13/2025 9:02 am
		Title XIX	Subprovider - IRF	Cost
			Inpatient 1.00	Outpatient 2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		0	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	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
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)		0	14.00
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)		0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		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	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
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	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		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	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		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	40.00
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, chapter 1, §115.2		0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0115 Component CCN: 15-5305	Period: From 07/01/2024 To 09/30/2024	Worksheet E-3 Part VII Date/Time Prepared: 1/13/2025 9:02 am
		Title XIX	Skilled Nursing Facility	Cost
		Inpatient	Outpatient	
		1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
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)	0	0	14.00
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)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be 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	0	24.00
25.00	Capital exception payments (see instructions)	0	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)	0	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	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	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	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, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet E-4 Date/Time Prepared: 1/13/2025 9:02 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			14.19	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)			0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			0.00	2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			0.00	3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			0.00	4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27			14.19	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			3.74	6.00
7.00	Enter the lesser of line 5 or line 6			3.74	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	3.49	0.25	3.74	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	3.49	0.25	3.74	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	3.49	0.25		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	3.61	0.13		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	3.59	0.13		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	3.56	0.17		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	3.56	0.17		17.00
18.00	Per resident amount	127,158.99	127,158.99		18.00
18.01	Per resident amount under §131 of the CAA 2021	0.00	0.00		18.01
19.00	Approved amount for resident costs	452,686	21,617	474,303	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			474,303	25.00

Health Financial Systems		MEMORIAL HOSP & HEALTH CARE CTR		In Lieu of Form CMS-2552-10	
DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet E-4 Date/Time Prepared: 1/13/2025 9:02 am	
		Title XVIII	Hospital	PPS	
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	1,292	430		26.00
27.00	Total Inpatient Days (see instructions)	3,431	3,431		27.00
28.00	Ratio of inpatient days to total inpatient days	0.376567	0.125328		28.00
29.00	Program direct GME amount	178,607	59,443	238,050	29.00
29.01	Percent reduction for MA DGME		2.74		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		1,629	1,629	30.00
31.00	Net Program direct GME amount			236,421	31.00
				1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)					
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	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 (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			4,835,237	37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			8,105	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			4,827,132	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			8,162,437	42.00
43.00	Primary payer payments (see instructions)			1,264	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			8,161,173	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			12,988,305	45.00
46.00	Ratio of Part A reasonable cost to total reasonable costs (line 41 ÷ line 45)			0.371652	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.628348	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			236,421	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			87,866	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			148,555	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet E-5 Date/Time Prepared: 1/13/2025 9:02 am
		Title XVIII		PPS
				1.00
TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0 1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0 2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)			0 3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)			0 4.00
5.00	The rate used to calculate the time value of money (see instructions)			0.00 5.00
6.00	Time value of money for operating expenses (see instructions)			0 6.00
7.00	Time value of money for capital related expenses (see instructions)			0 7.00

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

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet G

Date/Time Prepared:
1/13/2025 9:02 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	34,805,835	0	0	0	1.00
2.00	Temporary investments	82,410,837	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	20,415,126	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	-572,139	0	0	0	8.00
9.00	Other current assets	9,951,563	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	147,011,222	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,114,159	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	115,583,918	0	0	0	15.00
16.00	Accumulated depreciation	-3,347,526	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	40,236,775	0	0	0	19.00
20.00	Accumulated depreciation	-8,927,871	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	145,659,455	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	75,828,770	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	16,654,638	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	92,483,408	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	385,154,085	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	10,836,946	0	0	0	37.00
38.00	Salaries, wages, and fees payable	22,383,121	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,627,375	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	-1,651,828	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,269,376	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	34,464,990	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	62,253,302	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	62,253,302	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	96,718,292	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	288,435,793				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	288,435,793	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	385,154,085	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet G-1

Date/Time Prepared:
1/13/2025 9:02 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		206,940,322		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,725,412				2.00
3.00	Total (sum of line 1 and line 2)		213,665,734		0		3.00
4.00	FREESTANDING RHC DEPARTMENTS	-22,482		0		0	4.00
5.00	CHANGES IN CAPITAL BALANCES	74,792,541		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		74,770,059		0		10.00
11.00	Subtotal (line 3 plus line 10)		288,435,793		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		288,435,793		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	FREESTANDING RHC DEPARTMENTS		0				4.00
5.00	CHANGES IN CAPITAL BALANCES		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024Worksheet G-2
Parts I & II
Date/Time Prepared:
1/13/2025 9:02 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	8,307,651		8,307,651	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	733,795		733,795	3.00
4.00	SUBPROVIDER				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	3,900		3,900	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)	9,045,346		9,045,346	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,355,206		3,355,206	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,355,206		3,355,206	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	12,400,552		12,400,552	17.00
18.00	Ancillary services	24,980,981	116,793,409	141,774,390	18.00
19.00	Outpatient services	3,045,098	49,275,001	52,320,099	19.00
20.00	RURAL HEALTH CLINIC	0	266,213	266,213	20.00
20.01	RURAL HEALTH CLINIC II	0	322,671	322,671	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	1,180	2,300,881	2,302,061	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (PHYSICIANS)	0	28,429,536	28,429,536	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	40,427,811	197,387,711	237,815,522	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		71,198,749		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		71,198,749		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet G-3

Date/Time Prepared:
1/13/2025 9:02 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	237,815,522	1.00
2.00	Less contractual allowances and discounts on patients' accounts	167,545,575	2.00
3.00	Net patient revenues (line 1 minus line 2)	70,269,947	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	71,198,749	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-928,802	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	6,233,645	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	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	143,620	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	109,054	17.00
18.00	Revenue from sale of medical records and abstracts	6,004	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	11,406	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	41,633	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (MISC)	1,108,852	24.00
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	7,654,214	25.00
26.00	Total (line 5 plus line 25)	6,725,412	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,725,412	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet L Parts I-III Date/Time Prepared: 1/13/2025 9:02 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		278,939	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		33.04	3.00
4.00	Number of interns & residents (see instructions)		14.32	4.00
5.00	Indirect medical education percentage (see instructions)		13.01	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		36,290	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		315,229	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 circumstances (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 instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

Health Financial Systems		MEMORIAL HOSP & HEALTH CARE CTR			In Lieu of Form CMS-2552-10		
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS				Provider CCN: 15-0115		Period: From 07/01/2024	Worksheet M-1
				Component CCN: 15-8507		To 09/30/2024	Date/Time Prepared: 1/13/2025 9:02 am
						RHC I	Cost
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	140,131	0	140,131	-133,924	6,207	1.00
2.00	Physician Assistant	0	0	0	1,232	1,232	2.00
3.00	Nurse Practitioner	0	0	0	79,501	79,501	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
7.10	Marriage and Family Therapist	0	0	0	0	0	7.10
7.11	Mental Health Counselor	0	0	0	0	0	7.11
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	16,997	16,997	9.00
10.00	Subtotal (sum of lines 1 through 9)	140,131	0	140,131	-36,194	103,937	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	6,390	6,390	0	6,390	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	6,390	6,390	0	6,390	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	140,131	6,390	146,521	-36,194	110,327	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	6,299	6,299	0	6,299	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	6,299	6,299	0	6,299	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	25,400	25,400	0	25,400	29.00
30.00	Administrative Costs	0	13,712	13,712	36,194	49,906	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	39,112	39,112	36,194	75,306	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	140,131	51,801	191,932	0	191,932	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0115

Period:

Worksheet M-1

Component CCN: 15-8507

From 07/01/2024
To 09/30/2024Date/Time Prepared:
1/13/2025 9:02 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	6,207	1.00
2.00	Physician Assistant	0	1,232	2.00
3.00	Nurse Practitioner	0	79,501	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
7.10	Marriage and Family Therapist	0	0	7.10
7.11	Mental Health Counselor	0	0	7.11
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	16,997	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	103,937	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	6,390	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	6,390	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	110,327	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	6,299	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	6,299	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	25,400	29.00
30.00	Administrative Costs	-1,000	48,906	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,000	74,306	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,000	190,932	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0115

Period:

Worksheet M-1

Component CCN: 15-8508

From 07/01/2024
To 09/30/2024Date/Time Prepared:
1/13/2025 9:02 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	167,703	0	167,703	-106,042	61,661
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	0	0	0	50,787	50,787
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
7.10	Marriage and Family Therapist	0	0	0	0	0
7.11	Mental Health Counselor	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	18,173	18,173
10.00	Subtotal (sum of lines 1 through 9)	167,703	0	167,703	-37,082	130,621
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	-8,697	-8,697	0	-8,697
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	-8,697	-8,697	0	-8,697
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	167,703	-8,697	159,006	-37,082	121,924
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	3,297	3,297	0	3,297
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	3,297	3,297	0	3,297
FACILITY OVERHEAD						
29.00	Facility Costs	0	670	670	0	670
30.00	Administrative Costs	0	8,038	8,038	37,082	45,120
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	8,708	8,708	37,082	45,790
32.00	Total facility costs (sum of lines 22, 28 and 31)	167,703	3,308	171,011	0	171,011

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-0115

Period:

Worksheet M-1

Component CCN: 15-8508

From 07/01/2024
To 09/30/2024Date/Time Prepared:
1/13/2025 9:02 am

RHC II

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	61,661	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	50,787	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
7.10	Marriage and Family Therapist	0	0	7.10
7.11	Mental Health Counselor	0	0	7.11
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	18,173	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	130,621	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	-8,697	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	-8,697	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	121,924	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	3,297	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	3,297	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	670	29.00
30.00	Administrative Costs	0	45,120	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	45,790	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	171,011	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0115

Period:

Worksheet M-2

Component CCN: 15-8507

From 07/01/2024
To 09/30/2024Date/Time Prepared:
1/13/2025 9:02 am

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.01	21	4,200	42	1.00
2.00	Physician Assistant	0.01	0	2,100	21	2.00
3.00	Nurse Practitioner	0.43	1,046	2,100	903	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.45	1,067		966	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
7.03	Marriage and Family Therapist	0.00	0		0	7.03
7.04	Mental Health Counselor	0.00	0		0	7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.45	1,067		1,067	8.00
9.00	Physician Services Under Agreements		0		0	9.00
						1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				110,327	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				6,299	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				116,626	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.945990	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				74,306	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				143,544	15.00
16.00	Total overhead (sum of lines 14 and 15)				217,850	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				217,850	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				206,084	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				316,411	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-0115

Period:

Worksheet M-2

Component CCN: 15-8508

From 07/01/2024
To 09/30/2024Date/Time Prepared:
1/13/2025 9:02 am

		RHC II		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.23	755	4,200	966	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.18	573	2,100	378	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.41	1,328		1,344	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
7.03	Marriage and Family Therapist	0.00	0		0	7.03
7.04	Mental Health Counselor	0.00	0		0	7.04
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.41	1,328		1,344	8.00
9.00	Physician Services Under Agreements		0		0	9.00
						1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				121,924	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				3,297	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				125,221	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.973671	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				45,790	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				204,809	15.00
16.00	Total overhead (sum of lines 14 and 15)				250,599	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				250,599	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				244,001	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				365,925	20.00

Health Financial Systems		MEMORIAL HOSP & HEALTH CARE CTR		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0115	Period: From 07/01/2024 To 09/30/2024	Worksheet M-3	
		Component CCN: 15-8507		Date/Time Prepared: 1/13/2025 9:02 am	
		Title XVIII	RHC I	Cost	
			1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			316,411	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			63	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			316,348	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,067	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			1,067	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			296.48	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (07/01/2024 through 09/30/2024)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	139.00	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	139.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	307	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	42,673	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	42,673	16.00
16.01	Total program charges (see instructions)(from contractor's records)			69,251	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			3,478	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			2,143	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			31,140	16.04
16.05	Total program cost (see instructions)		0	33,283	16.05
17.00	Primary payer amounts			5	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			1,605	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			12,658	19.00
20.00	Net program cost excluding injections/infusions (see instructions)			33,278	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			42	21.00
21.50	Total program IOP OPPS payments (see instructions)			0	21.50
			Program IOP Visits	Program IOP Cost	
			1.00	2.00	
21.55	Total program IOP visits and cost (see instructions)		0	0	21.55
21.60	Program IOP deductible and coinsurance (see instructions)			0	21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)			33,320	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			33,320	26.00
26.01	Sequestration adjustment (see instructions)			666	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			32,432	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			222	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 15-0115 Component CCN: 15-8508	Period: From 07/01/2024 To 09/30/2024	Worksheet M-3 Date/Time Prepared: 1/13/2025 9:02 am	
		Title XVIII	RHC II	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			365,925	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			156	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			365,769	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,344	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			1,344	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			272.15	7.00
			Calculation of Limit (1)		
			Rate Period N/A	Rate Period 1 (07/01/2024 through 09/30/2024)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	139.00	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	139.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	486	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	67,554	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	67,554	16.00
16.01	Total program charges (see instructions)(from contractor's records)			109,329	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			29,700	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			18,352	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			37,603	16.04
16.05	Total program cost (see instructions)		0	55,955	16.05
17.00	Primary payer amounts			169	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			2,198	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			15,442	19.00
20.00	Net program cost excluding injections/infusions (see instructions)			55,786	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			104	21.00
21.50	Total program IOP OPPS payments (see instructions)			0	21.50
			Program IOP Visits	Program IOP Cost	
			1.00	2.00	
21.55	Total program IOP visits and cost (see instructions)		0	0	21.55
21.60	Program IOP deductible and coinsurance (see instructions)			0	21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, minus line 21.60)			55,890	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			55,890	26.00
26.01	Sequestration adjustment (see instructions)			1,118	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			53,170	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			1,602	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0115

Period:

Worksheet M-4

Component CCN: 15-8507

From 07/01/2024
To 09/30/2024Date/Time Prepared:
1/13/2025 9:02 am

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	103,937	103,937	103,937	103,937	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000211	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	22	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	0	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	22	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	110,327	110,327	110,327	110,327	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	206,084	206,084	206,084	206,084	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000199	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	41	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	63	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	3	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	21.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	2	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)	0	42	0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1.00	2.00	
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)				63	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)				42	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 15-0115

Period:

Worksheet M-4

Component CCN: 15-8508

From 07/01/2024
To 09/30/2024Date/Time Prepared:
1/13/2025 9:02 am

		Title XVIII		RHC II	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	130,621	130,621	130,621	130,621	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000395	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	52	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	0	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	52	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	121,924	121,924	121,924	121,924	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	244,001	244,001	244,001	244,001	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000426	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	104	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	156	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	6	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	26.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	4	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)	0	104	0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
				1.00	2.00	
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)				156	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)				104	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-0115 Component CCN: 15-8507	Period: From 07/01/2024 To 09/30/2024	Worksheet M-5 Date/Time Prepared: 1/13/2025 9:02 am	
			RHC I	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		32,432	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		32,432		4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01			0		5.01
5.02			0		5.02
5.03			0		5.03
Provider to Program					
5.50			0		5.50
5.51			0		5.51
5.52			0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		222		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		32,654		7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-0115 Component CCN: 15-8508	Period: From 07/01/2024 To 09/30/2024	Worksheet M-5 Date/Time Prepared: 1/13/2025 9:02 am	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			53,170	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			53,170	4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			1,602	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			54,772	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION
AND SETTLEMENT SUMMARY

Provider CCN:15-0115

Period:
From 07/01/2024
To 09/30/2024

Worksheet S
Parts I-III
Date/Time Prepared:
1/13/2025 9:02 am

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 1/13/2025	Time: 9:02 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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 07/01/2024 and ending 09/30/2024 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	ELECTRONIC SIGNATURE STATEMENT	
1	1	2		
		☒	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

Encryption Information

ECR: Date: 1/13/2025 Time: 9:02 am
xo3:4.Cx9gYLbrMD:UBQ5XCplaswx0
wy08y0Fmjp:00u1G:pvr0lL3vp2A7Q
T03P14QP6e0s..ZI

		Title V		Title XVIII		HIT	Title XIX	
		1.00	2.00	Part A	Part B			
						4.00	5.00	
1.00	HOSPITAL	0	27,242		34,907	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0		0		0	2.00
3.00	SUBPROVIDER - IRF	0	204		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		0		0	9.00
10.00	RURAL HEALTH CLINIC I	0			222		0	10.00
10.01	RURAL HEALTH CLINIC II	0			1,602		0	10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0			0		0	11.00
200.00	TOTAL	0	27,446		36,731	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

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