This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1330 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 3/2/2024 10:07 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 3/2/2024 Time: 10:07 am] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Contractor use only (3) Settled with Audit 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 ADAMS MEMORIAL HOSPITAL (15-1330) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

| | SIGNATURE OF CHIEF FINA | NCIAL OFFICER OR ADMINISTRATOR | CHECKBOX | ELECTRONI C | |
|---|-------------------------|--------------------------------|----------|---|---|
| | | 1 | 2 | SI GNATURE STATEMENT | |
| 1 | Dar | ne Wheeler | Y | I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature. | 1 |
| 2 | Signatory Printed Name | Dane Wheeler | | | 2 |
| 3 | Signatory Title | CF0 | | | 3 |
| 4 | Date | 03/04/2024 04: 11: 48 AM (PT) | | | 4 |

Encryption Information

(4) Reopened (5) Amended

ECR: Date: 3/2/2024 Time: 10:07 am lje:yD4Kzz7VDwuqQX2bRZHXSKxHoO 29XrBOZ:GgzgHPWr9piDYOpJKFfT4J XqwmOomZOQOTzXQn

| | | | Title | XVIII | | | |
|--------|-------------------------------|---------|----------|-----------|-------|-----------|--------|
| | | Title V | Part A | Part B | HIT | Title XIX | |
| | | 1. 00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| | PART III - SETTLEMENT SUMMARY | | | | | | |
| 1.00 | HOSPI TAL | 0 | -2, 493 | -480, 947 | 0 | 0 | 1.00 |
| 2.00 | SUBPROVI DER - I PF | 0 | 0 | 0 | | 0 | 2. 00 |
| 3.00 | SUBPROVI DER - I RF | 0 | 0 | 0 | | 0 | 3. 00 |
| 5.00 | SWING BED - SNF | 0 | 121, 133 | 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 | MONROE FAMILY MEDICINE I | 0 | | 213, 717 | | 0 | 10.00 |
| 10. 01 | WOODCREST II | 0 | | 113, 913 | | 0 | 10. 01 |
| 10. 02 | STAT CARE III | 0 | | 22, 521 | | 0 | 10. 02 |
| 10. 03 | BERNE FAMILY MEDICINE IV | 0 | | 139, 908 | | 0 | 10. 03 |
| 10. 04 | HIGH STREET V | 0 | | 22, 477 | | 0 | 10.04 |
| 200.00 | TOTAL | 0 | 118, 640 | 31, 589 | 0 | 0 | 200.00 |

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

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

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA

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

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

| HOSPI 1 | Financial Systems -AL AND HOSPITAL HEALTH CARE COMPLEX | ADAMS MEMORIA IDENTIFICATION DATA | _ | der CCN: 1 | | Period: From 01/01/ To 12/31/ | 2022 | Workshe Part I Date/Ti 3/2/202 | et S-2 me Pre | pared: |
|----------------------------|--|--|--|--|------------|-------------------------------------|-------|---|------------------|--------------------------------------|
| | 1.00 | 2. 00 | | 3. 00 | | 4 | 1. 00 | 0, 2, 202 | 1 10.0 | , diii |
| 1. 00 | Hospital and Hospital Health Care Co Street: 1100 MERCER AVENEUE | omplex Address: PO Box: | | | | | | | | 1.00 |
| 2. 00 | City: DECATUR | State: IN | Zin Cod | e: 46733 | Count | y: ADAMS | | | | 2.00 |
| 2.00 | jer ty. Beamen | Component Name | CCN | CBSA | Provi der | 1 | Payme | nt Syst | em (P, | 2.00 |
| | | · | Number | Number | Type | Certi fi ed | | 0, or | | |
| | | 1.00 | | 2 22 | 1.00 | 5.00 | V | XVIII | | |
| | Hospital and Hospital-Based Compone | 1.00 | 2. 00 | 3. 00 | 4.00 | 5. 00 | 6. 00 | 7. 00 | 8. 00 | |
| 3. 00 | Hospi tal | ADAMS MEMORIAL HOSPITAL | 151330 | 99915 | 1 | 11/01/2005 | N | 0 | Р | 3.00 |
| 4.00 | Subprovi der - IPF | | | | | | | | | 4.00 |
| 5.00 | Subprovi der - IRF | | | | | | | | | 5.00 |
| 6.00 | Subprovider - (Other) Swing Beds - SNF ADAMS MEMORIAL HOSPITAL 1 | | | 99915 | | 11 /01 /2005 | N. | | P | 6.00 |
| 7. 00 8. 00 | Swing Beds - SNF | ADAMS MEMORIAL HOSPITAL | 15Z330 | 99915 | | 11/01/2005 | N | 0 | P | 7. 00 8. 00 |
| 9. 00 | Hospi tal -Based SNF | | | | | | | | | 9.00 |
| 10.00 | Hospi tal -Based NF | | | | | | | | | 10.00 |
| 11.00 | Hospi tal -Based OLTC | | | | | | | | | 11.00 |
| 12. 00 13. 00 | Hospi tal -Based HHA Separately Certified ASC | | | | | | | | | 12. 00 13. 00 |
| 14. 00 | Hospi tal -Based Hospi ce | | | | | | | | | 14.00 |
| 15. 00 | Hospital -Based Health Clinic - RHC | MONROE FAMILY MEDICINE | 158526 | 99915 | | 10/25/2017 | N | 0 | N | 15.00 |
| 15. 01 | Hospital-Based Health Clinic - RHC | DECATUR FAMILY | 158536 | 99915 | | 12/26/2018 | N | 0 | N | 15. 01 |
| 15. 02 | Henrital Recod Health Clinic PUC | MEDICINE-WOODCREST | 150527 | 99915 | | 12/10/2010 | N | 0 | N. | 15 00 |
| 15. 02 | Hospital-Based Health Clinic - RHC | STAT CARE & PRIMARY CARE CLINIC | 158537 | 99915 | | 12/18/2018 | IN | 0 | N | 15. 02 |
| 15. 03 | Hospital-Based Health Clinic - RHC | BERNE FAMILY MEDICINE | 158559 | 99915 | | 07/01/2020 | N | 0 | N | 15. 03 |
| 15. 04 | Hospital-Based Health Clinic - RHC | | 158555 | 99915 | | 01/24/2020 | N | 0 | N | 15. 04 |
| 16. 00 | Hospital-Based Health Clinic - FQHC | MEDI CI NE | | | | | | | | 16. 00 |
| 17. 00 | Hospital -Based (CMHC) I | | | | | | | | | 17. 00 |
| 18. 00 | Renal Dialysis | | | | | | | | | 18. 00 |
| 19. 00 | Other | | | | | | | | | 19. 00 |
| | | | | | | 1.00 | | To | | |
| 20. 00 | Cost Reporting Period (mm/dd/yyyy) | | | | | 01/01/20 | 022 | 12/31/ | | 20.00 |
| 21. 00 | | | | | | | | | | |
| | Type of control (see Thisti detrolls) | | | | | 9 | | | | 21.00 |
| | Type of control (see This rue trolls) | | | | 1. 00 | 2.00 | | 3. 0 | 00 | 21.00 |
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| 22. 00 | Inpatient PPS Information Does this facility qualify and is is disproportionate share hospital adju | ustment, in accordance wi | th 42 CF | | | | | 3. (| 00 | |
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| 22. 01 22. 02 22. 03 | Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adjugate. S412.106? In column 1, enter "Y" for facility subject to 42 CFR Section ! hospital?) In column 2, enter "Y" for Did this hospital receive interim Ut this cost reporting period? Enter infor the portion of the cost reporting. Enter in column 2, "Y" for yes on cost reporting period occurring on a instructions) Is this a newly merged hospital that determined at cost report settlemen. "Y" for yes or "N" for no, for the period prior to October 1. Enter in for the portion of the cost reporting Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or af Does this hospital contain at least counted in accordance with 42 CFR 4 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMI adopted by CMS in FY 2021? Enter in for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or af the cost reporting and period occurring on or "N" for reporting period occurring on or af the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or af the cost reporting period occurring on or "N" for reporting period occurring on or af the cost reporting of the cost reporting period occurring on or af the cost reporting on or af the cost reporting of the cost reporting of the cost reporting on or af the cost reporting of the | ustment, in accordance with a contract of the portion of the cost of the portion of the cost of the portion of | th 42 CF this endment cal UCPs, or "N" for to Octo cion of t be ter in co eporting "N" for cober 1. n urban t stical a "N" for er 1. Ent ne cost ructions) a urban t stical ar ructions t cost cost cost cost cost cost cost cos | for r no ber he l umn no, o reas no er as or o eas no er | N N | 2.00 N | | | | 22. 00 22. 01 22. 02 22. 03 |
| 22. 01 22. 02 22. 03 | Inpatient PPS Information Does this facility qualify and is indisproportionate share hospital adjugate. S412. 106? In column 1, enter "Y" for facility subject to 42 CFR Section ! hospital?) In column 2, enter "Y" for Jid this hospital receive interim Ut this cost reporting period? Enter in for the portion of the cost reporting. Enter in column 2, "Y" for yes on cost reporting period occurring on a instructions) Is this a newly merged hospital than determined at cost reports settlement, "Y" for yes or "N" for no, for the period prior to October 1. Enter in for the portion of the cost reporting of the cost reporting of the took and adopted by CMS in FY2015? Enter in a for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afformation of the cost reporting that contain at least counted in accordance with 42 CFR 4 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMI adopted by CMS in FY 2021? Enter in for the portion of the cost reporting for the portion of the cost reporting as a result of the revised OMI adopted by CMS in FY 2021? Enter in for the portion of the cost reporting for the portion of the cost reporting nepriod occurring on or afformation of the cost reporting period occurring on or afformation of the cost reporting nepriod occurring on or afformation of the cost reporting nepriod occurring on or afformation of the cost reporting nepriod occurring on or afformation of the cost reporting nepriod occurring on or afformation of the cost reporting nepriod occurring on or afformation of the cost reporting nepriod occurring on or afformation of the cost reporting nepriod occurring on or afformation of the cost reporting nepriod occurring on or afformation of the cost reporting nepriod occurring on or afformation of the cost reporting nepriod occurring on or afformation of the cost reporting nepriod occurring on or afformation of the cost reporting nepriod occurring on or afformation of the cost reporting nepriod oc | ustment, in accordance with a system of the portion of the cost reclassification from for the portion of the cost recolumn 1, "Y" for yes on the portion of the cost recolumn 2, "Y" for yes on the portion of the cost recolumn 2, "Y" for yes on the portion of the cost recolumn 1, "Y" for yes on the portion of the portion | th 42 CF this endment cal UCPs, or "N" for to Octo cion of t be ter in co endment "N" for to be to co endment "N" for to co endment "N | for r no ber he l umn no, o reas no er as or o eas no er | N N | 2.00 N | | | | 22. 00 22. 01 22. 02 22. 03 |
| 22. 01 22. 02 22. 03 | Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adjugate. S412.106? In column 1, enter "Y" for facility subject to 42 CFR Section ! hospital?) In column 2, enter "Y" for Did this hospital receive interim Ut this cost reporting period? Enter infor the portion of the cost reporting. Enter in column 2, "Y" for yes on cost reporting period occurring on a instructions) Is this a newly merged hospital that determined at cost report settlemen. "Y" for yes or "N" for no, for the period prior to October 1. Enter in for the portion of the cost reporting Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or af Does this hospital contain at least counted in accordance with 42 CFR 4 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMI adopted by CMS in FY 2021? Enter in for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or af the cost reporting and period occurring on or "N" for reporting period occurring on or af the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or af the cost reporting period occurring on or "N" for reporting period occurring on or af the cost reporting of the cost reporting period occurring on or af the cost reporting on or af the cost reporting of the cost reporting of the cost reporting on or af the cost reporting of the | ustment, in accordance with a system of the portion of the cost reclassification from for the portion of the cost recolumn 1, "Y" for yes on the portion of the cost recolumn 2, "Y" for yes on the portion of the cost recolumn 2, "Y" for yes on the portion of the cost recolumn 1, "Y" for yes on the portion of the portion | th 42 CF this endment cal UCPs, or "N" for to Octo cion of t be ter in co endment "N" for to be to co endment "N" for to co endment "N | for r no ber he l umn no, o reas no er as or o eas no er | N N | 2.00 N | | | | 22. 00 22. 01 22. 02 22. 03 |

Health Financial Systems ADAMS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1330 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 3/2/2024 10: 07 am | XVIII | XIX 1. 00 2.00 3.00 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, 57.00 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. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Qual i fi cati on Line # Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60 00 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. IME Direct GME IME Direct GME 2.00 4.00 1.00 3.00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61 05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 2.00 1 00 3 00 4 00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,

the direct GME FTE unweighted count.

| | AL AND HOSPITAL HEALTH CARE COMP | LEX IDENTIFICATION DA | ATA Provider CO | | <u>In Lie</u> Period: From 01/01/2022 | Worksheet S-2 Part I | |
|------|--|--|--|--|---|---|---------------|
| | | | | | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | pared 7 am |
| | | | | | | 1. 00 | |
| | ACA Provisions Affecting the Hea | | | | | | |
| | Enter the number of FTE resident your hospital received HRSA PCRE | | | reporting pe | riod for which | 0.00 | 62. |
| | Enter the number of FTE resident during in this cost reporting po | eriod of HRSA THC pro | gram. (see instructio | | o your hospital | 0.00 | 62. |
| | Teaching Hospitals that Claim Re Has your facility trained reside "Y" for yes or "N" for no in col | ents in nonprovider s | ettings during this c | | | N | 63. |
| | To yes of N To no Th con | unii i. ii yes, compi | ete i i nes 04 tili ougii | Unwei ghted | Unweighted | Ratio (col. | |
| | | | | FTEs Nonprovider Site | FTEs in Hospital | 1/ (col . 1 + col . 2)) | |
| | | | | 1. 00 | 2. 00 | 3. 00 | |
| | Section 5504 of the ACA Base Yea | | | This base yea | ır is your cost | reporti ng | |
| | period that begins on or after. Enter in column 1, if line 63 is | | | 0.0 | 0.00 | 0. 000000 | 64. |
| | in the base year period, the num | nber of unweighted no | n-primary care | | | | |
| | resident FTEs attributable to resettings. Enter in column 2 the | | | | | | |
| | resident FTEs that trained in yo | our hospital. Enter i | n column 3 the ratio | | | | |
| | of (column 1 divided by (column | 1 + column 2)). (see Program Name | Program Code | Unweighted | Unwei ghted | Ratio (col. | |
| | | 3 | 3 | FTEs | FTEs in | 3/ (col. 3 + | |
| | | | | Nonprovider Site | Hospi tal | col. 4)) | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | 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) | | | Unweighted | Unweighted FTFs in | Ratio (col. | |
| | | | | FTEs Nonprovider Site | FTEs in Hospital | 1/ (col. 1 + col. 2)) | |
| | 4)). (see instructions) Section 5504 of the ACA Current | | n Nonprovider Setting | FTEs Nonprovider Site 1.00 | FTES in Hospi tal | 1/ (col . 1 + col . 2)) | |
| . 00 | 4)). (see instructions) | 010 unweighted non-prima occurring in all nonp | ry care resident rovider settings. | FTEs Nonprovider Site 1.00 | FTES in Hospital 2.00 for cost report | 1/ (col. 1 + col. 2)) 3.00 ing periods | 66. |
| . 00 | Section 5504 of the ACA Current beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit | ono unweighted non-prima occurring in all nonpo unweighted non-prima al. Enter in column | ry care resident rovider settings. ry care resident 3 the ratio of | FTEs Nonprovider Site 1.00 gsEffective | FTES in Hospital 2.00 for cost report | 1/ (col. 1 + col. 2)) 3.00 ing periods | 66. |
| . 00 | Section 5504 of the ACA Current beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations center in column 2 the number of | ono unweighted non-prima occurring in all nonpo unweighted non-prima al. Enter in column | ry care resident rovider settings. ry care resident 3 the ratio of | FTEs Nonprovider Site 1.00 gsEffective | FTES in Hospital 2.00 for cost report | 1/ (col. 1 + col. 2)) 3.00 ing periods | 66 |

Health Financial Systems ADAMS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1330 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 3/2/2024 10:07 am Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ (col. 3 + FTEs FTEs in col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4. 00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0. 00 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) 1.00 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 N 68.00 68.00 (August 10, 2022)? 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 N 70.00 Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no. Ν 75 00 76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80 00 N 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 'Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85 00 N 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Permanent Adjustment (Y/N) Adjustments 1.00 2.00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target 0 88.00 amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line

89. (see instructions)

Column 2: Enter the number of approved permanent adjustments.

| SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provi der Co | CN: 15-1330 | Peri od: From 01/01/2022 To 12/31/2022 | | |
|--|--------------------------------------|--------------------|--|---|------|
| | | Wkst. A Lir No. | | 3/2/2024 10:0 Approved Permanent Adjustment Amount Per Discharge | |
| | | 1.00 | 2. 00 | 3. 00 | |
| .00 Column 1: If line 88, column 1 is Y, enter the Worksheet A I on which the per discharge permanent adjustment approval was Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA taper discharge. Column 3: Enter the amount of the approved permanent adjustment adjus | s based. g period arget amount | 0. | 00 | C | 89. |
| | | | V | XIX | - |
| Title V and XIX Services | | | 1. 00 | 2. 00 | |
| .00 Does this facility have title V and/or XIX inpatient hospita | al services? E | nter "Y" for | N | Υ | 90. |
| yes or "N" for no in the applicable column. .00 Is this hospital reimbursed for title V and/or XIX through 1 | the cost roper | t oithor in | N | N | 91. |
| full or in part? Enter "Y" for yes or "N" for no in the appl | | | IN . | IN IN | 71. |
| .00 Are title XIX NF patients occupying title XVIII SNF beds (duinstructions) Enter "Y" for yes or "N" for no in the applications. | | ion)? (see | | N | 92. |
| .00 Does this facility operate an ICF/IID facility for purposes | | d XIX? Enter | N | N | 93. |
| "Y" for yes or "N" for no in the applicable column. | I HAIH G | | | | |
| .00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column. | and N TOFF | o in the | N | N | 94. |
| .00 If line 94 is "Y", enter the reduction percentage in the app | | | 0.00 | 0.00 | 95. |
| .00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column. | s or "N" for r | o in the | N | N | 96. |
| .00 $ f $ line 96 is "Y", enter the reduction percentage in the app | | | 0. 00 | 0.00 | 97. |
| .00 Does title V or XIX follow Medicare (title XVIII) for the ir stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f | | | Y | Y | 98. |
| column 1 for title V, and in column 2 for title XIX. | ioi yes oi ii | 101 110 111 | | | |
| .01 Does title V or XIX follow Medicare (title XVIII) for the re | | | | Υ | 98. |
| C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX. | tie v, and ir | COLUMN 2 FO | or | | |
| .02 Does title V or XIX follow Medicare (title XVIII) for the ca | | | Y | Υ | 98. |
| bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of for title V, and in column 2 for title XIX. | or "N" for no | in column 1 | | | |
| .03 Does title V or XIX follow Medicare (title XVIII) for a crit | | | | N | 98. |
| reimbursed 101% of inpatient services cost? Enter "Y" for ye for title V, and in column 2 for title XIX. | es or "N" for | no in column | 1 | | |
| .04 Does title V or XIX follow Medicare (title XVIII) for a CAH | reimbursed 10 | 1% of | N | N | 98. |
| outpatient services cost? Enter "Y" for yes or "N" for no ir | n column 1 for | title V, an | d | | |
| in column 2 for title XIX. .05 Does title V or XIX follow Medicare (title XVIII) and add ba | ack the RCF di | sallowance o | ın Y | Y | 98. |
| Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in o | | | | | |
| column 2 for title XIX. .06 Does title V or XIX follow Medicare (title XVIII) when cost | reimbursed fo | r Wkst D | Y | Y | 98. |
| Pts. I through IV? Enter "Y" for yes or "N" for no in column | | | · | | ,0. |
| column 2 for title XIX. Rural Providers | | | | | |
| 5.00 Does this hospital qualify as a CAH? | | | Y | | 105 |
| 6.00 If this facility qualifies as a CAH, has it elected the all- | -inclusive met | hod of payme | nt Y | | 106. |
| for outpatient services? (see instructions) 7.00 Column 1: If line 105 is Y, is this facility eligible for co | ost reimbursem | ent for I&R | N | | 107. |
| training programs? Enter "Y" for yes or "N" for no in column | n 1. (see ins | tructions) | | | |
| Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IF | | | | | |
| Enter "Y" for yes or "N" for no in column 2. (see instructi | ons) | • • | | | |
| 8.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no. | CRNA fee sche | dul e? See 4 | 2 N | | 108. |
| 1 101 905 01 11 101 100 | Physi cal | Occupati ona | | Respi ratory | |
| 9.00 f this hospital qualifies as a CAH or a cost provider, are | 1. 00 | 2.00 | 3. 00 | 4. 00 | 100 |
| A THILL THE BUCKLEST MUSILIFIED SE STAND OF SCHOOL BEDATAR SEE | N | l N | l N | l N | 109. |

| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider C | | | u of Form CMS | |
|--|---|--|---------------|---|
| | | eriod: rom 01/01/2022 o 12/31/2022 | | |
| | | | 3/2/2024 10: | |
| | | | 1. 00 | |
| 110.00 Did this hospital participate in the Rural Community Hospital Demonstration Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, I applicable. | "N" for no. I | f yes, | N | 110. 00 |
| | | 1.00 | 2.00 | |
| 111.00 If this facility qualifies as a CAH, did it participate in the Frontier (Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services. | period? Enter enter the column 2. | 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. Miscellaneous Cost Reporting Information | N | | | 112. 00 |
| 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 s this facility classified as a referral center? Enter "Y" for yes or "N" for no. | N | | | 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 s 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 |
| | Premiums | Losses | Insurance | |
| 118.01 List amounts of malpractice premiums and paid losses: | 1. 00 575, 003 | 2.00 | 3. 00 | 0118.01 |
| The or Least amounts of marpraetice premitums and part 1035es. | 373,000 | | | 0110.01 |
| 118.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing condemnate centained therein | | 1.00 N | 2.00 | 118. 02 |
| and amounts contained therein. | | | | |
| 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro \$3121 and applicable amendments? (see instructions) Enter in column 1, "N" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) | /" for yes or the Outpatient | N | N | |
| 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "\"\"\" for no. Is this a rural hospital with < 100 beds that qualifies for 1 Hold Harmless provision in ACA §3121 and applicable amendments? (see inst Enter in column 2, "Y" for yes or "\" for no. 121.00 Did this facility incur and report costs for high cost implantable devices | /" for yes or the Outpatient tructions) | N Y | N | 120.00 |
| 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prosports \$3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instance in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the column of the column 1 is "Y", enter the column 1 | /" for yes or the Outpatient tructions) es charged to $3(w)(3)$ of the | N Y Y | N 5. 00 | 120.00 |
| 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instender in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain heal theare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater that professional services expenses, for services purchased from unrelated org located in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. | (" for yes or the Outpatient tructions) es charged to ((a) (3) of the er in column 2 ((b) (a) of the er in column 2 ((c) (a) of the er in column 2 ((c) (a) of total ganizations | | N 5. 00 | 120. 00 121. 00 122. 00 |
| 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "\"\"\"\" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instenter in column 2, "Y" for yes or "\" for no. 121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "\" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "\" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "\" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater that professional services expenses, for services purchased from unrelated organization a CBSA outside of the main hospital CBSA? In column 2, enter "\"\" for no. Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center? Enter | "" for yes or the Outpatient tructions) es charged to B(w)(3) of the er in column 2 sional and/or 1, enter "Y" 1, 50% of total ganizations Y" for yes or | | N 5. 00 | 120. 00 121. 00 122. 00 123. 00 |
| 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless programs (saling and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for thold Harmless provision in ACA §3121 and applicable amendments? (see instance in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain heal thcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater that professional services expenses, for services purchased from unrelated organizated in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. 125.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare-certified kidney transplant program, enter the certification. | "" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 sional and/or 1, enter "Y" n 50% of total ganizations "Y" for yes or | Y | 5. 00 | 120. 00 121. 00 122. 00 123. 00 |
| 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "\"n" for no. Is this a rural hospital with < 100 beds that qualifies for thold Harmless provision in ACA §3121 and applicable amendments? (see instender in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain heal thcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enterthe Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater that professional services expenses, for services purchased from unrelated organizated in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. 125.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. | "" for yes or the Outpatient tructions) es charged to B(w)(3) of the er in column 2 sional and/or 1, enter "Y" 1 50% of total panizations "Y" for yes or "Y" for yes tification date | Y | N 5. 00 | 120. 00 121. 00 122. 00 123. 00 125. 00 126. 00 |
| 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for thold Harmless provision in ACA §3121 and applicable amendments? (see instender in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than professional services expenses, for services purchased from unrelated organization? In column 2 in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. 125.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare-certified kidney transplant program, enter the certific olumn 1 and termination date, if applicable, in column 2. | "" for yes or the Outpatient tructions) es charged to B(w)(3) of the er in column 2 sional and/or 1, enter "Y" 150% of total ganizations "Y" for yes or "Y" for yes tification date | Y | 5. 00 | 121. 00 122. 00 123. 00 125. 00 126. 00 127. 00 |
| 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro \$3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA \$3121 and applicable amendments? (see instended that the Interior of the Hold Harmless provision in ACA \$3121 and applicable amendments? (see instended that the Interior of Interior | "" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 sional and/or 1, enter "Y" 150% of total ganizations "Y" for yes or "Y" for yes tification date fication date | Y | N 5. 00 | 121. 00 122. 00 123. 00 125. 00 126. 00 127. 00 128. 00 |

| Health Financial Systems | ADAMS MEMO | RIAL HOSPITAL | | | In Lie | u of Form CMS | -2552-10 |
|---|--|---------------------------------------|----------------|----------|------------------------|-------------------|--------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLE | EX IDENTIFICATION DATA | Provi der CC | CN: 15-1330 | | 1/01/2022 2/31/2022 | | epared: |
| | | | | | 1 00 | | |
| 131.00 If this is a Medicare-certified in | | | certi fi cati | | 1. 00 | 2. 00 | 131. 00 |
| date in column 1 and termination of 132.00 If this is a Medicare-certified is | slet transplant program | , enter the certi | fication da | te | | | 132. 00 |
| in column 1 and termination date, 133.00 Removed and reserved | it applicable, in colu | mn 2. | | | | | 133. 00 |
| 134.00 If this is a hospital-based organ in column 1 and termination date, All Providers | | | he OPO numb | er | | | 134. 00 |
| 140.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the | "N" for no in column 1. e home office chain num | If yes, and home ber. (see instruc | office cos | ts | Υ | 15H060 | 140.00 |
| 1.00 If this facility is part of a cha | | 2.00 on lines 141 thro | ugh 1/3 the | name an | 3.00 | of the home | _ |
| office and enter the home office | contractor name and con | tractor number. | | | | | |
| 141.00 Name: ADAMS HEALTH NETWORK 142.00 Street: 1100 MERCER AVE | Contractor's Name: PO Box: | WPS | Contrac | tor's Nu | mber: 0810 |)1 | 141. 00 142. 00 |
| 143. 00 Ci ty: DECATUR | State: | IN | Zi p Cod | e: | 4673 | 33 | 143. 00 |
| | | | | | | 1. 00 | 4 |
| 144.00 Are provider based physicians' com | sts included in Workshe | et A? | | | | Y Y | 144. 00 |
| | | | | | 1. 00 | 2.00 | - |
| 145.00 If costs for renal services are c inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" | " for yes or "N" for no clude Medicare utilizat | in column 1. If | column 1 is | | 1.00 | 2.00 | 145. 00 |
| 146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/ | gy changed from the pre n column 1. (See CMS Pu | | | lf | N | | 146. 00 |
| | | | | | | 1. 00 | |
| 147.00 Was there a change in the statist 148.00 Was there a change in the order o | | | | | | N N | 147. 00 148. 00 |
| 149.00 Was there a change to the simplif | | | | or no. | | N N | 149. 00 |
| | | Part A 1.00 | Part B 2.00 | | itle V 3.00 | Title XIX 4.00 | 4 |
| Does this facility contain a prov or charges? Enter "Y" for yes or | | an exemption fro | m the appli | cation o | f the low | er of costs | |
| 155.00 Hospi tal 156.00 Subprovi der - IPF | | Y N | Y N | | N N | N N | 155. 00 156. 00 |
| 157.00 Subprovi der - IRF | | N | N N | | N | N N | 157. 00 |
| 158. 00 SUBPROVI DER 159. 00 SNF | | N | N | | N | N | 158. 00 159. 00 |
| 160.00HOME HEALTH AGENCY | | N N | N N | | N | N N | 160.00 |
| 161. 00 CMHC | | | N | | N | N | 161.00 |
| | | | | | | 1. 00 | |
| Multicampus 165.00 s this hospital part of a Multical | ampus hospital that has | one or more camp | uses in dif | ferent C | BSAs? | N | 165. 00 |
| Enter "Y" for yes or "N" for no. | Name | County | | ip Code | CBSA | FTE/Campus | |
| 166.00 If line 165 is yes, for each | 0 | 1. 00 | 2. 00 | 3. 00 | 4.00 | 5.00 | 0166.00 |
| campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) | | | | | | 0.0 | 0100.00 |
| | | | | | | 1. 00 | |
| Health Information Technology (HI | | | | ent Act | | | 147.00 |
| 167.00 Is this provider a meaningful use 168.00 If this provider is a CAH (line 1) reasonable cost incurred for the | 05 is "Y") and is a mea | ningful user (line | | "), ente | r the | Y | 167. 00 168. 00 |
| 168.01 If this provider is a CAH and is | not a meaningful user, | does this provide | | | dshi p | | 168. 01 |
| exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful transition factor. (see instruction | user (line 167 is "Y") | | | | enter the | 0.0 | 169.00 |

| Health Financial Systems | ADAMS MEMORIAL | HOSPI TAL | In Lie | In Lieu of Form CMS-25 | | |
|---|---|-----------------------|-----------------|------------------------|-------------|--|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX | IDENTIFICATION DATA | Provider CCN: 15-1330 | Peri od: | Worksheet S-2 |) | |
| | | | From 01/01/2022 | | | |
| | | | To 12/31/2022 | Date/Time Pre | eparea: | |
| | | | | 3/2/2024 10:0 | <u>/ am</u> | |
| | | | Begi nni ng | Endi ng | | |
| | | | 1. 00 | 2. 00 | | |
| 170.00 Enter in columns 1 and 2 the EHR be period respectively (mm/dd/yyyy) | | | 170. 00 | | | |
| | | | | | | |
| | | | 1. 00 | 2. 00 | | |
| 171.00 If line 167 is "Y", does this provi | | | N | C | 171.00 | |
| section 1876 Medicare cost plans re | section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter | | | | | |
| "Y" for ves and "N" for no in colum | "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. (se | | | | | | |
| | | | | (| 1 | |

Health Financial Systems ADAMS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1330 Peri od: Worksheet S-2 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 3/2/2024 10:07 am Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column $\hat{\textbf{3}},$ "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Ν 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5.00 Ν those on the filed financial statements? If yes, submit reconciliation Legal Oper. Y/N 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider N 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 N 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? N N 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for 04/25/2023 17.00 Υ 04/25/2023 Υ 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 Ν 18.00 N Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

| | Financial Systems ADAMS MEMORI | | | | u of Form CM | |
|-------------------|---|------------------|----------------|--|--|----------|
| HOSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provi der (| CCN: 15-1330 | Peri od: From 01/01/2022 To 12/31/2022 | Worksheet S Part II Date/Time F 3/2/2024 10 | repared: |
| | | Descr | iption | Y/N | Y/N | |
| | 1611 17 18 18 18 18 18 18 18 18 18 18 18 18 18 | | 0 | 1.00 | 3. 00 | |
| 20. 00 | If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: | | | N | N | 20. 00 |
| | neport data for other; beserred the other day detilients. | Y/N | Date | Y/N | Date | |
| | | 1.00 | 2.00 | 3.00 | 4. 00 | |
| 21. 00 | Was the cost report prepared only using the provider's records? If yes, see instructions. | N | | N | | 21. 00 |
| | | | | | 1. 00 | |
| | COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC | CEPT CHILDRENS | HOSPI TALS) | | 1.00 | |
| | Capital Related Cost | | , | | | |
| | Have assets been relifed for Medicare purposes? If yes, se | | | | N | 22. 00 |
| 23. 00 | Have changes occurred in the Medicare depreciation expense | e due to apprai | sals made du | ring the cost | N | 23. 00 |
| 24. 00 | reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter If yes, see instructions | eporting period? | N | 24. 00 | | |
| 25. 00 | Have there been new capitalized leases entered into during | ? If yes, see | N | 25. 00 | | |
| 26. 00 | instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t | f yes, see | N | 26. 00 | | |
| 27. 00 | instructions. Has the provider's capitalization policy changed during th | f yes, submit | N | 27. 00 | | |
| | copy. Interest Expense | | | | | |
| 28. 00 | Were new Loans, mortgage agreements or letters of credit eperiod? If yes, see instructions. | t reporting | N | 28. 00 | | |
| 29. 00 | Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst | Reserve Fund) | Υ | 29. 00 | | |
| 30. 00 | Has existing debt been replaced prior to its scheduled mat | | debt? If yes | s, see | N | 30.00 |
| 31. 00 | <pre>instructions. Has debt been recalled before scheduled maturity without i instructions.</pre> | ssuance of new | w debt? If yes | s, see | N | 31.00 |
| | Purchased Services | | | | | |
| 32. 00 | Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr | | ned through co | ontractual | N | 32. 00 |
| 33. 00 | | | ng to competi | tive bidding? If | N | 33.00 |
| | Provi der-Based Physi ci ans | | | | | |
| 34.00 | Were services furnished at the provider facility under an | arrangement wi | th provider-l | pased physicians? | Y | 34.00 |
| 35 00 | If yes, see instructions. If line 34 is yes, were there new agreements or amended ex | disting agreeme | ents with the | provi der-based | Υ | 35.00 |
| | physicians during the cost reporting period? If yes, see i | | | · | | 00.00 |
| | | | | Y/N | Date | |
| | Home Office Costs | | | 1.00 | 2. 00 | |
| 36, 00 | Were home office costs claimed on the cost report? | | | Υ | | 36.00 |
| | If line 36 is yes, has a home office cost statement been p | prepared by the | e home office | | | 37. 00 |
| 38. 00 | | | | f N | | 38. 00 |
| 39. 00 | the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth | | | s, Y | | 39. 00 |
| 40. 00 | see instructions. If line 36 is yes, did the provider render services to the | e home office? | If yes, see | N | | 40.00 |
| | i nstructi ons. | | | | | |
| | | 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, reportively. | ANDREW | | MCCABE | | 41.00 |
| 42. 00 | respectively. Enter the employer/company name of the cost report | WI PFLI | | | | 42.00 |
| 43 OO | preparer. Enter the telephone number and email address of the cost | 715-858-6660 | | AMCCABE@WI PFLI | COM | 43.00 |
| 4 5.00 | report preparer in columns 1 and 2, respectively. | , 13-030-0000 | | MINICOADLEWIFILI | . GOIVI | 43.00 |

| Health Financial Systems ADA | MS MEMORIAL HOSPITAL | In Lie | u of Form CMS-2 | 2552-10 |
|--|------------------------------|----------------------|-----------------|---------|
| HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION | NAIRE Provi der CCN: 15-1330 | rovider CCN: 15-1330 | | pared: |
| | | | | |
| | 3.00 | | | |
| Cost Report Preparer Contact Information | | | | |
| 41.00 Enter the first name, last name and the title/pos | | | | 41.00 |
| held by the cost report preparer in columns 1, 2, | and 3, | | | |
| respecti vel y. | | | | |
| 42.00 Enter the employer/company name of the cost repor | t | | | 42.00 |
| preparer. | | | | |
| 43.00 Enter the telephone number and email address of t | ne cost | | | 43.00 |
| report preparer in columns 1 and 2, respectively. | | | | |

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:
 Health Financial
 Systems
 ADAMS N

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 15-1330

| | | | | | T | o 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
|------------------|--|-------------|--------|------|--------------|---------------|-----------------------------|------------------|
| | | | | | | | 1/P Days / | / alli |
| | | | | | | | 0/P Vi si ts / | |
| | | | | | | | Trips | |
| | Component | Worksheet A | No. of | Beds | Bed Days | CAH/REH Hours | Title V | |
| | | Li ne No. | | | Avai I abl e | | | |
| | | 1. 00 | 2.0 | 00 | 3. 00 | 4. 00 | 5. 00 | |
| 4 00 | PART I - STATISTICAL DATA | | | 0.4 | 7.45 | 54.040.00 | | 4.00 |
| 1. 00 | Hospital Adults & Peds. (columns 5, 6, 7 and | 30. 00 | | 21 | 7, 665 | 54, 312. 00 | 0 | 1. 00 |
| | 8 exclude Swing Bed, Observation Bed and | | | | | | | |
| | Hospice days) (see instructions for col. 2 | | | | | | | |
| 2.00 | for the portion of LDP room available beds) 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 | | | 21 | 7, 665 | 54, 312. 00 | 0 | 7. 00 |
| 7.00 | beds) (see instructions) | | | - ' | ,, 555 | 01/012100 | · · | 7.00 |
| 8.00 | INTENSIVE CARE UNIT | 31.00 | | 4 | 1, 460 | 9, 648. 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) | | | 25 | 9, 125 | 63, 960. 00 | 0 | 14.00 |
| 15.00 | CAH visits | | | | | | 0 | 15.00 |
| 15. 10 | REH hours and visits | | | | | | | 15. 10 |
| 16. 00 | SUBPROVIDER - IPF | 40. 00 | | 0 | 2, 730 | | 0 | 16.00 |
| 17. 00 | SUBPROVI DER - I RF | | | | | | | 17. 00 |
| 18.00 | SUBPROVI DER | | | | | | | 18.00 |
| 19.00 | SKILLED NURSING FACILITY | 44. 00 | | 0 | C | | 0 | 19.00 |
| 20.00 | NURSING FACILITY | | | | | | | 20.00 |
| 21.00 | OTHER LONG TERM CARE | 404.00 | | | | | 0 | 21.00 |
| 22. 00 | HOME HEALTH AGENCY | 101. 00 | | | | | 0 | 22. 00 23. 00 |
| 23. 00 24. 00 | AMBULATORY SURGICAL CENTER (D. P.) HOSPICE | 116. 00 | | 0 | C | | | 23.00 |
| 24. 00 | HOSPICE (non-distinct part) | 30.00 | | ٥ | C | | | 24. 00 |
| 25. 00 | CMHC - CMHC | 30.00 | | | | | | 25. 00 |
| 26. 00 | MONROE FAMILY MEDICINE | 88. 00 | | | | | 0 | 26.00 |
| 26. 01 | WOODCREST | 88. 01 | | | | | 0 | 26. 01 |
| 26. 02 | STAT CARE | 88. 02 | | | | | 0 | 26. 02 |
| 26. 03 | BERNE FAMILY MEDICINE | 88. 03 | | | | | 0 | 26. 03 |
| 26. 04 | HI GH STREET | 88. 04 | | | | | 0 | 26. 04 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 89. 00 | | | | | 0 | 26. 25 |
| 27.00 | Total (sum of lines 14-26) | | | 25 | | | | 27. 00 |
| 28.00 | Observation Bed Days | | | | | | 0 | 28. 00 |
| 29.00 | Ambul ance Trips | | | | | | | 29. 00 |
| 30.00 | Employee discount days (see instruction) | | | ļ | | | | 30.00 |
| 31.00 | Employee discount days - IRF | | | | | | | 31.00 |
| 32.00 | Labor & delivery days (see instructions) | | | 0 | C | | | 32.00 |
| 32. 01 | Total ancillary labor & delivery room | | | | | | | 32. 01 |
| 00 - | outpatient days (see instructions) | | | | | | | |
| 33.00 | LTCH non-covered days | | | | | | | 33.00 |
| 33. 01 | LTCH site neutral days and discharges | 20.00 | | ر | _ | | 0 | 33. 01 |
| 34. UU | Temporary Expansion COVID-19 PHE Acute Care | 30. 00 | l | 0 | C | 'I I | 0 | 34.00 |

Health Financial Systems ADAMS MOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-1330

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

| | | | | ' | 0 12/01/2022 | 3/2/2024 10: 0 | 7 am |
|--------|--|-------------|--------------|-----------|---------------|----------------|--------|
| | · | I/P Days | / O/P Visits | / Tri ps | Full Time | Equi val ents | |
| | | | | | | | |
| | | | | | | | |
| | Component | Title XVIII | Title XIX | Total All | Total Interns | Employees On | |
| | | | | Pati ents | & Residents | Payrol I | |
| | | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| | PART I - STATISTICAL DATA | | | | | | |
| 1.00 | Hospital Adults & Peds. (columns 5, 6, 7 and | 827 | 0 | 2, 263 | 3 | | 1.00 |
| | 8 exclude Swing Bed, Observation Bed and | | | | | | |
| | Hospice days) (see instructions for col. 2 | | | | | | |
| | for the portion of LDP room available beds) | | | | | | |
| 2.00 | HMO and other (see instructions) | 749 | 205 | | | | 2.00 |
| 3.00 | HMO IPF Subprovider | 0 | 0 | | | | 3.00 |
| 4.00 | HMO IRF Subprovider | 0 | 0 | | | | 4.00 |
| 5.00 | Hospital Adults & Peds. Swing Bed SNF | 541 | 0 | 1, 036 | b | | 5.00 |
| 6.00 | Hospital Adults & Peds. Swing Bed NF | | 0 | 114 | ļ. | | 6.00 |
| 7.00 | Total Adults and Peds. (exclude observation | 1, 368 | 0 | 3, 413 | 3 | | 7.00 |
| | beds) (see instructions) | | | | | | |
| 8.00 | INTENSIVE CARE UNIT | 249 | 114 | 880 |) | | 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 | | 90 | 239 | | | 13.00 |
| 14.00 | Total (see instructions) | 1, 617 | 204 | 4, 532 | 0.00 | 404. 85 | |
| 15.00 | CAH visits | 0 | 0 | C |) | | 15.00 |
| 15. 10 | REH hours and visits | | | | | | 15. 10 |
| 16.00 | SUBPROVIDER - IPF | 0 | 0 | (| 0.00 | 0.00 | 16.00 |
| 17. 00 | SUBPROVI DER - I RF | | | | | | 17. 00 |
| 18.00 | SUBPROVI DER | | | | | | 18. 00 |
| 19. 00 | SKILLED NURSING FACILITY | 0 | 0 | (| 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 | (| 0.00 | 0.00 | 22. 00 |
| 23.00 | | | | | | | 23. 00 |
| 24.00 | | 0 | 0 | (| 0.00 | 0.00 | 24.00 |
| 24. 10 | HOSPICE (non-distinct part) | | | (|) | | 24. 10 |
| 25.00 | | | | | | | 25.00 |
| 26.00 | MONROE FAMILY MEDICINE | 3, 705 | 0 | 9, 915 | | l | |
| 26. 01 | WOODCREST | 1, 366 | 0 | 7, 815 | | | |
| 26. 02 | | 789 | 0 | 11, 748 | 0. 00 | | |
| 26. 03 | BERNE FAMILY MEDICINE | 1, 296 | 0 | 7, 960 | 0.00 | 11. 42 | 26. 03 |
| 26. 04 | HI GH STREET | 1, 849 | 0 | 7, 510 | 0.00 | 7. 87 | 26. 04 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 0 | 0 | (| 0.00 | 0.00 | 26. 25 |
| 27. 00 | | | | | 0. 00 | 461. 58 | 27.00 |
| 28. 00 | | | 0 | 1, 847 | ' | | 28. 00 |
| 29. 00 | | 712 | | | | | 29. 00 |
| 30.00 | , | | | C | | | 30.00 |
| 31.00 | 1 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | | C | | | 31.00 |
| 32.00 | | 0 | 0 | C | | | 32.00 |
| 32. 01 | Total ancillary labor & delivery room | | | 80 |) | | 32. 01 |
| | outpatient days (see instructions) | | | | | | 1 |
| 33.00 | 1 | 0 | | | | | 33.00 |
| 33. 01 | | 0 | | | | | 33. 01 |
| 34. 00 | Temporary Expansion COVID-19 PHE Acute Care | 0 | 0 | (|) | | 34.00 |
| | | | | | | | |

 Health Financial
 Systems
 ADAMS N

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 | Peri od: | Worksheet S-3 | From 01/01/2022 | Part I | | Date/Time Prepared: | Date/Time Prepared: | Part | Provi der CCN: 15-1330

| | | | | 10 |) 12/31/2022 | Date/IIme Pre 3/2/2024 10:0 | |
|------------------|--|--------------------------|----------|-------------|--------------|----------------------------------|------------------|
| | | Full Time Equivalents | | Di sch | arges | 107272021 10.0 | 7 dill |
| | Component | Nonpai d | Title V | Title XVIII | Title XIX | Total All | |
| | Component | Workers | 11 110 1 | THE WITT | THE WIX | Pati ents | |
| | | 11. 00 | 12. 00 | 13.00 | 14. 00 | 15. 00 | |
| | PART I - STATISTICAL DATA | | | | | | |
| 1. 00 | Hospital Adults & Peds. (columns 5, 6, 7 and | | C | 312 | 0 | 957 | 1.00 |
| | 8 exclude Swing Bed, Observation Bed and | | | | | | |
| | Hospice days) (see instructions for col. 2 | | | | | | |
| 2. 00 | for the portion of LDP room available beds) HMO and other (see instructions) | | | 190 | 179 | | 2. 00 |
| 3. 00 | HMO IPF Subprovider | | | 190 | 0 | | 3.00 |
| 4. 00 | HMO IRF Subprovider | | | | 0 | | 4.00 |
| 5. 00 | Hospital Adults & Peds. Swing Bed SNF | | | | Ĭ | | 5.00 |
| 6. 00 | Hospital Adults & Peds. Swing Bed NF | | | | | | 6.00 |
| 7.00 | Total Adults and Peds. (exclude observation | | | | | | 7.00 |
| | beds) (see instructions) | | | | | | |
| 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 13. 00 | OTHER SPECIAL CARE (SPECIFY) NURSERY | | | | | | 12. 00 13. 00 |
| 14. 00 | Total (see instructions) | 0.00 | C | 312 | 0 | 957 | 14.00 |
| 15. 00 | CAH visits | 0.00 | | 312 | J | 757 | 15.00 |
| 15. 10 | REH hours and visits | | | | | | 15. 10 |
| 16.00 | SUBPROVIDER - IPF | 0.00 | C | o | 0 | 0 | 16.00 |
| 17.00 | SUBPROVI DER - I RF | | | | | | 17.00 |
| 18. 00 | SUBPROVI DER | | | | | | 18. 00 |
| 19. 00 | SKILLED NURSING FACILITY | 0.00 | | | | | 19.00 |
| 20.00 | NURSING FACILITY | | | | | | 20.00 |
| 21.00 | OTHER LONG TERM CARE | 0.00 | | | | | 21.00 |
| 22. 00 23. 00 | HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) | 0.00 | | | | | 22. 00 23. 00 |
| 24. 00 | HOSPICE | 0.00 | | | | | 24.00 |
| 24. 10 | HOSPICE (non-distinct part) | 0.00 | | | | | 24. 10 |
| 25. 00 | CMHC - CMHC | | | | | | 25. 00 |
| 26.00 | MONROE FAMILY MEDICINE | 0.00 | | | | | 26.00 |
| 26. 01 | WOODCREST | 0.00 | | | | | 26. 01 |
| 26. 02 | STAT CARE | 0.00 | | | | | 26. 02 |
| 26. 03 | BERNE FAMILY MEDICINE | 0.00 | | | | | 26. 03 |
| 26. 04 | HI GH STREET | 0.00 | | | | | 26.04 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 0.00 | | | | | 26. 25 |
| 27. 00 28. 00 | Total (sum of lines 14-26) Observation Bed Days | 0.00 | | | | | 27. 00 28. 00 |
| 29. 00 | Ambul ance Trips | | | | | | 29.00 |
| 30. 00 | Employee discount days (see instruction) | | | | | | 30.00 |
| 31. 00 | Employee discount days - IRF | | | | | | 31.00 |
| 32.00 | Labor & delivery days (see instructions) | | | | | | 32.00 |
| 32. 01 | Total ancillary labor & delivery room | | | | | | 32. 01 |
| | outpatient days (see instructions) | | | | | | |
| 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 | l l | | | ļ | | 34.00 |

| | n Financial Systems TAL-BASED RHC/FQHC STATISTICAL DATA | ADAMS MEMORIA | | CN: 15-1330 | Peri od: | worksheet S-8 | |
|----------------------------|---|---|---|--|----------------------------------|---|-----------------|
| | | | | CCN: 15-8526 | From 01/01/2022 To 12/31/2022 | Date/Time Pre | epared |
| | | | | | RHC I | 3/2/2024 10: 0 Cost |)/ am |
| | | | | | KIIC I | COST | |
| | | | | | 1. | 00 | |
| | Clinic Address and Identification | | | | | | |
| . 00 | Street | | | | 205 TOWER DRIV | | 1. |
| | | | | ty | State 2.00 | ZIP Code 3.00 | |
| . 00 | City, State, ZIP Code, County | | MONROE I. | 00 | | 3.00 | 2. |
| 00 | orty, state, zir code, codity | | MONTOL | | 111 | 40772 | - 2. |
| | | | | | | 1. 00 | |
| 00 | HOSPITAL-BASED FQHCs ONLY: Designation - Ent | er "R" for rur | al or "U" for | | | 0 | 3. |
| | | | | | nt Award | Date | |
| | Course of Endoral Funds | | | | 1. 00 | 2. 00 | |
| . 00 | Source of Federal Funds Community Health Center (Section 330(d), PHS | Act) | | | | I | 4. |
| . 00 | Migrant Health Center (Section 329(d), PHS A | | | | | | 5. |
| 00 | Health Services for the Homeless (Section 34 | | | | | | 6. |
| 00 | Appalachian Regional Commission | | | | | | 7. |
| 00 | Look-Alikes | | | | | | 8. |
| 00 | OTHER (SPECIFY) | | | | | | 9. |
| | | | | | 1. 00 | 2. 00 | |
| 0. 00 | Does this facility operate as other than a h | ospi tal -based | RHC or FQHC? E | nter "Y" for | Y | 1 | 10. |
| | yes or "N" for no in column 1. If yes, indic | | | | | | |
| | 2. (Enter in subscripts of line 11 the type o | f other operat | ion(s) and the | operati ng | | | |
| | hours.) | Cum | dov | I M | andau | Tuesday | |
| | | Sun from | to | from | onday to | from | |
| | | 1, 00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| | Facility hours of operations (1) | | | | | 2.22 | |
| | CLINIC | | | 08: 00 | 20: 00 | 08: 00 | 11. |
| 1.00 | | | | | | | _ |
| 1.00 | | | | | | | |
| | Have you received an approval for an excepti | on to the prod | uctivity stand | and? | 1.00 | 2. 00 | |
| 2. 00 | | | | | Y | 2.00 | 12. |
| 2. 00 3. 00 | Is this a consolidated cost report as define | d in CMS Pub. | 100-04, chapte | r 9, section | | | 12. |
| 2. 00 | | d in CMS Pub. umn 1. If yes, | 100-04, chapte enter in colu | r 9, section mn 2 the | Y | 2.00 | 12. |
| 2. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col | d in CMS Pub. umn 1. If yes, | 100-04, chapte enter in colu | r 9, section mn 2 the ders and | Y N | 2.00 | 12. |
| 2. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. | d in CMS Pub. umn 1. If yes, | 100-04, chapte enter in colu | r 9, section mn 2 the ders and | Y N der name | 2. 00 0 | 12. |
| 2. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. | d in CMS Pub. umn 1. If yes, | 100-04, chapte enter in colu | r 9, section mn 2 the ders and | Y N | 2.00 | 12. |
| 2. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. | d in CMS Pub. umn 1. If yes, | 100-04, chapte enter in colu | r 9, section mn 2 the ders and | Y N der name | 2. 00 0 | 12. |
| 2. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. | d in CMS Pub. umn 1. If yes, List the name: | 100-04, chapte enter in colu s of all provi | r 9, section mn 2 the ders and Provi | Y N der name 1.00 | 2. 00 CCN 2. 00 | 12. |
| 2. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FOHC name, CCN Have you provided all or substantially all | d in CMS Pub. umn 1. If yes, List the name: | 100-04, chapte enter in colu s of all provi | r 9, section mn 2 the ders and Provi | Y N der name 1.00 | 2.00 CCN 2.00 | 12. 13. |
| 2. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FOHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in | d in CMS Pub. umn 1. If yes, List the name: | 100-04, chapte enter in colu s of all provi | r 9, section mn 2 the ders and Provi | Y N der name 1.00 | 2.00 CCN 2.00 | 12. 13. |
| 2. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN 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 | d in CMS Pub. umn 1. If yes, List the name: | 100-04, chapte enter in colu s of all provi | r 9, section mn 2 the ders and Provi | Y N der name 1.00 | 2.00 CCN 2.00 | 12. 13. |
| 2. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN 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 | d in CMS Pub. umn 1. If yes, List the name: | 100-04, chapte enter in colu s of all provi | r 9, section mn 2 the ders and Provi | Y N der name 1.00 | 2.00 CCN 2.00 | 12. 13. |
| 2. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN 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 | d in CMS Pub. umn 1. If yes, List the name: | 100-04, chapte enter in colu s of all provi | r 9, section mn 2 the ders and Provi | Y N der name 1.00 | 2.00 CCN 2.00 | 12. 13. |
| 2. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN 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. | d in CMS Pub. umn 1. If yes, List the name: | 100-04, chapte enter in colu s of all provi | r 9, section mn 2 the ders and Provi | Y N der name 1.00 | 2.00 CCN 2.00 | 12. 13. |
| 2. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN 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 | d in CMS Pub. umn 1. If yes, List the name: | 100-04, chapte enter in colus of all provi | r 9, section mn 2 the ders and Provi XVIII 3.00 | Y N der name 1.00 | 2.00 CCN 2.00 | 12. 13. |
| 2. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN 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. | d in CMS Pub. umn 1. If yes, List the name: | 100-04, chapte enter in colus of all provi | r 9, section mn 2 the ders and Provi XVIII 3.00 | Y N der name 1.00 | 2.00 CCN 2.00 | 12. 13. |
| 22. 00 33. 00 44. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FOHC name, CCN 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) | d in CMS Pub. umn 1. If yes, List the name: Y/N 1.00 | V 2.00 | r 9, section mn 2 the ders and Provi XVIII 3.00 | Y N der name 1.00 | 2.00 CCN 2.00 | 12. 13. 14. 15. |
| 22. 00 33. 00 44. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN 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. | d in CMS Pub. umn 1. If yes, List the name: Y/N 1.00 | 100-04, chapte enter in colus of all provi | r 9, section mn 2 the ders and Provi XVIII 3.00 Inty 00 | Y N N der name 1.00 XIX 4.00 | 2.00 CCN 2.00 Total Visits 5.00 | 12. 13. 14. 15. |
| 2. 00 3. 00 4. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FOHC name, CCN 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) | d in CMS Pub. umn 1. If yes, List the name: Y/N 1.00 | V 2.00 | r 9, section mn 2 the ders and Provi XVIII 3.00 | Y N N der name 1.00 XIX 4.00 | 2.00 CCN 2.00 | 12. 13. 14. 15. |
| 22. 00 33. 00 44. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FOHC name, CCN 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) | d in CMS Pub. umn 1. If yes, List the name: Y/N 1.00 | V 2.00 Cou ADAMS Wedn | r 9, section mn 2 the ders and Provi XVIII 3.00 unty 00 esday | Y N der name 1.00 XIX 4.00 | 2.00 CCN 2.00 Total Visits 5.00 | 12. |

| Health Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|--|---------------|-------------|--------------|-----------------|-----------------|---------|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | | Provi der C | CN: 15-1330 | Peri od: | Worksheet S-8 | |
| | | | | From 01/01/2022 | | |
| | | Component | CCN: 15-8526 | To 12/31/2022 | | |
| | | | | | 3/2/2024 10:0 | 7 am |
| | | | | RHC I | Cost | |
| | Fri | day | Sa | turday | | |
| | from | to | from | to | | |
| | 11. 00 | 12. 00 | 13.00 | 14. 00 | | |
| Facility hours of operations (1) | | | | | | |
| 11. 00 CLINIC | 08: 00 | 17: 00 | | | | 11.00 |

| Heal th | n Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS- | 2552-10 |
|------------------|--|-----------------|----------------|--------------|-----------------------------|--------------------------------|----------------|
| HOSPI 7 | TAL-BASED RHC/FQHC STATISTICAL DATA | | Provi der C | CN: 15-1330 | Peri od: From 01/01/2022 | Worksheet S-8 | 3 |
| | | | Component | CCN: 15-8536 | To 12/31/2022 | Date/Time Pro 3/2/2024 10:0 | |
| | | | | | RHC II | Cost | |
| | | | | | 1 | 00 | - |
| | Clinic Address and Identification | | | | | 00 | |
| 1. 00 | Street | | 1 | | 1300 MERCER AV | | 1.00 |
| | | | | 00 | 2. 00 | ZIP Code 3.00 | |
| 2. 00 | City, State, ZIP Code, County | | DECATUR 1. | 00 | | 46733 | 2.00 |
| | 1 | | | | | | |
| 2 00 | HOSPITAL-BASED FQHCs ONLY: Designation - Ent | on "D" for run | al as "II" fas | ushon | | 1.00 | 2 00 |
| 3. 00 | THOSPITAL-BASED FUNCS UNLY: DESIGNATION - ENT | er k for rur | al of U for | | nt Award | Date | 3.00 |
| | | | | | 1. 00 | 2. 00 | |
| | Source of Federal Funds | | | | | | |
| 4. 00 5. 00 | Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A | | | | | | 4. 00 5. 00 |
| 6. 00 | Health Services for the Homeless (Section 34 | | | | | | 6.00 |
| 7. 00 | Appal achi an Regi onal Commi ssi on | (4), | | | | | 7. 00 |
| 8. 00 | Look-Alikes | | | | | | 8. 00 |
| 9. 00 | OTHER (SPECIFY) | | | | | | 9. 00 |
| | | | | | 1.00 | 2. 00 | |
| 10. 00 | | | | | N | | 10.00 |
| | yes or "N" for no in column 1. If yes, indic | | | | | | |
| | 2. (Enter in subscripts of line 11 the type o hours.) | of other operat | ion(s) and the | operating | | | |
| | Tiour s.) | Sun | ıday | l N | Monday | Tuesday | |
| | | from | to | from | to | from | |
| | F: : t., b 6t: (1) | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| 11 00 | Facility hours of operations (1) | | | 08: 00 | 17: 00 | 08: 00 | 11. 00 |
| | Joenn 9 | l. | | 100.00 | | 00.00 | 111.00 |
| | To the second se | | | | 1. 00 | 2. 00 | |
| 12. 00 13. 00 | | | | | Y | 0 | 12.00 |
| 13.00 | 30. 8? Enter "Y" for yes or "N" for no in col | | | | IN | | 13.00 |
| | number of providers included in this report. | | | | | | |
| | numbers below. | | | D | : | CCN | |
| | | | | Prov | ider name 1.00 | 2. 00 | |
| 14. 00 | RHC/FQHC name, CCN | | | | 1. 00 | 2.00 | 14.00 |
| | | Y/N | V | XVIII | XIX | Total Visits | |
| 15.00 | Hove you provided all an autotantial all | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | 15.00 |
| 15. 00 | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in | | | | | | 15. 00 |
| | column 1. If yes, enter in columns 2, 3 and | | | | | | |
| | 4 the number of program visits performed by | | | | | | |
| | Intern & Residents for titles V, XVIII, and | | | | | | |
| | XIX, as applicable. Enter in column 5 the number of total visits for this provider. | | | | | | |
| | (see instructions) | | | | | | |
| | | | | unty | | | |
| 2 00 | City State 71D Code County | | ADAMS 4. | 00 | | | 2.00 |
| 2. 00 | City, State, ZIP Code, County | Tuesday | | esday | Thur | sday | 2.00 |
| | | to | from | to | from | to | |
| | | 6. 00 | 7. 00 | 8.00 | 9.00 | 10.00 | |
| 11 00 | Facility hours of operations (1) | 17. 00 | 00.00 | 17.00 | 00.00 | 17.00 | 11 00 |
| 11.00 | CLINIC | 17: 00 | 08: 00 | 17: 00 | 08: 00 | 17: 00 | 11.00 |

| Health Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|--|---------------|-------------|--------------|-----------------|-----------------|---------|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | | Provi der 0 | CCN: 15-1330 | Peri od: | Worksheet S-8 | |
| | | | | From 01/01/2022 | | |
| | | Component | CCN: 15-8536 | To 12/31/2022 | | |
| | | · | | | 3/2/2024 10:0 | 7 am |
| | | | | RHC II | Cost | |
| | Fri | day | Sa | turday | | |
| | from | to | from | to | | |
| | 11. 00 | 12. 00 | 13.00 | 14. 00 | | |
| Facility hours of operations (1) | | | | | | |
| 11. 00 CLINIC | 08: 00 | 17: 00 | | | | 11.00 |

| Heal th | Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS- | -2552-10 |
|----------------|--|---------------------------------|---------------------------------|--|--|-----------------------------|----------------|
| HOSPI T | AL-BASED RHC/FQHC STATISTICAL DATA | | | CN: 15-1330 CCN: 15-8537 | Peri od: From 01/01/2022 To 12/31/2022 | Worksheet S-8 Date/Time Pre | |
| | | | | | | 3/2/2024 10:0 | |
| | | | | | RHC III | Cost | |
| | | | | | 1. | 00 | |
| 4 00 | Clinic Address and Identification | | | | 1400 UEDOED 414 | | 1 |
| 1. 00 | Street | | Ci | ty | 1100 MERCER AV State | ZIP Code | 1.00 |
| | | | | 00 | 2. 00 | 3. 00 | |
| 2. 00 | City, State, ZIP Code, County | | DECATUR | | | 46733 | 2.00 |
| | | | | | | 1. 00 | |
| 3. 00 | HOSPITAL-BASED FQHCs ONLY: Designation - Ent | er "R" for rur | al or "U" for | | | C | 3.00 |
| | | | | | nt Award | Date | |
| | Source of Federal Funds | | | | 1. 00 | 2. 00 | |
| 4.00 | Community Health Center (Section 330(d), PHS | Act) | | | | | 4.00 |
| 5.00 | Migrant Health Center (Section 329(d), PHS A | | | | | I | 5.00 |
| 6.00 | Health Services for the Homeless (Section 34 | O(d), PHS Act) | | | | l | 6.00 |
| 7. 00 8. 00 | Appalachian Regional Commission Look-Alikes | | | | | I | 7. 00 8. 00 |
| 9. 00 | OTHER (SPECIFY) | | | | | I | 9.00 |
| | | | | • | | | |
| 10.00 | Describes Coultry and the state of the state | | DUO - FOUGO F | 11.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1 | 1.00 | 2. 00 | 10.00 |
| 10.00 | Does this facility operate as other than a hyes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.) | ate number of | other operatio | ns in column | | | 10.00 |
| | Thour 3.) | Sun | day | N | londay | Tuesday | |
| | | from | to | from | to | from | |
| | [5 | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| 11 00 | Facility hours of operations (1) | 09: 00 | 17: 00 | 07: 30 | 20: 30 | 07: 30 | 11.00 |
| | OZ. 111 O | 07.00 | 1.7.00 | Jo. 7. 00 | 20.00 | | 111.00 |
| | I | | | | 1.00 | 2. 00 | |
| | Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. | d in CMS Pub. umn 1. If yes, | 100-04, chapte enter in colu | r 9, section mn 2 the | N N | C | 12.00 |
| | | | | | ider name | CCN | |
| 14.00 | DUO (FOUG TOWN CON | | | | 1. 00 | 2. 00 | 14.00 |
| 14.00 | RHC/FQHC name, CCN | Y/N | V | XVIII | XIX | Total Visits | 14. 00 |
| | | 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 | | | | | | 15.00 |
| | XIX, as applicable. Enter in column 5 the number of total visits for this provider. | | | | | | |
| | (see instructions) | | | | | | |
| | | | | unty | | | |
| 2. 00 | City, State, ZIP Code, County | | ADAMS 4. | 00 | | | 2.00 |
| 2.00 | orty, State, 211 code, county | Tuesday | | esday | Thur | sday | 2.00 |
| | | to | from | to | from | to | |
| | | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10. 00 | |
| 11 00 | Facility hours of operations (1) CLINIC | 20. 20 | 07. 20 | 20: 20 | 07. 20 | 20. 20 | 11 00 |
| 11.00 | OLI INI C | 20: 30 | 07: 30 | 20: 30 | 07: 30 | 20: 30 | 11.00 |

| Health Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|--|---------------|-------------|--------------|-----------------|-----------------|---------|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | | Provi der (| CCN: 15-1330 | Peri od: | Worksheet S-8 | |
| | | | | From 01/01/2022 | | |
| | | Component | CCN: 15-8537 | To 12/31/2022 | | |
| | | | | | 3/2/2024 10:0 | 7 am |
| | | | | RHC III | Cost | |
| | Fri | day | Sa | turday | | |
| | from | to | from | to | | |
| | 11. 00 | 12. 00 | 13.00 | 14. 00 | | |
| Facility hours of operations (1) | | | | | | |
| 11. 00 CLINIC | 07: 30 | 20: 30 | 09: 00 | 17: 00 | | 11.00 |

| Heal th | n Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS- | 2552-10 |
|----------------|--|-------------------|----------------|--------------|----------------------------------|--------------------------------|---------|
| HOSPI | TAL-BASED RHC/FQHC STATISTICAL DATA | | Provi der C | CN: 15-1330 | Peri od: | Worksheet S-8 | 3 |
| | | | Component | CCN: 15-8559 | From 01/01/2022 To 12/31/2022 | Date/Time Pro 3/2/2024 10:0 | |
| | | | | | RHC I V | Cost | |
| | | | | | 1 | 00 | - |
| | Clinic Address and Identification | | | | | 00 | |
| 1. 00 | Street | | 0.1 | | 1521 WEST MAIN | | 1.00 |
| | | | | 00 | State 2.00 | ZI P Code 3. 00 | |
| 2. 00 | City, State, ZIP Code, County | | BERNE | 00 | | 46711 | 2.00 |
| | 1 | | | | | | |
| 2 00 | HOSPITAL-BASED FQHCs ONLY: Designation - Ent | on "D" for run | al as "II" for | urban | | 1. 00 | 2.00 |
| 3. 00 | HOSPITAL-BASED FUNCS UNLY: DESIGNATION - ENT | er k for rura | al or u ror | | nt Award | Date | 3.00 |
| | | | | | 1. 00 | 2. 00 | |
| | Source of Federal Funds | | | | | | |
| 4. 00 5. 00 | Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A | | | | | | 4.00 |
| 6. 00 | Health Services for the Homeless (Section 34 | | | | | | 6.00 |
| 7. 00 | Appal achi an Regi onal Commi ssi on | (4), | | | | | 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 h | ospi tal -based l | RHC or FQHC? E | nter "Y" for | | | 10.00 |
| | yes or "N" for no in column 1. If yes, indic | | | | | | |
| | 2. (Enter in subscripts of line 11 the type o hours.) | of other operati | ion(s) and the | operati ng | | | |
| | Tiour S.) | Sun | dav | I | l Nonday | Tuesday | |
| | | from | to | from | to | from | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| 11 00 | Facility hours of operations (1) | | | 07: 30 | 17: 00 | 07: 30 | 11.00 |
| 11.00 | CLINIC | | | 07. 30 | 17.00 | 07. 30 | 11.00 |
| | | | | | 1.00 | 2. 00 | |
| 12.00 | | | | | | | 12.00 |
| 13. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col | | | | N | C | 13.00 |
| | number of providers included in this report. | | | | | | |
| | numbers below. | | | | | | |
| | | | | Prov | ider name 1.00 | 2. 00 | |
| 14. 00 | RHC/FQHC name, CCN | | | | 1.00 | 2.00 | 14.00 |
| | | Y/N | V | XVIII | XI X | Total Visits | |
| 45. | The state of the s | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | 1.5 |
| 15. 00 | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in | | | | | | 15.00 |
| | column 1. If yes, enter in columns 2, 3 and | | | | | | |
| | 4 the number of program visits performed by | | | | | | |
| | Intern & Residents for titles V, XVIII, and | | | | | | |
| | XIX, as applicable. Enter in column 5 the number of total visits for this provider. | | | | | | |
| | (see instructions) | | | | | | |
| | · · · · · · · · · · · · · · · · · · · | | | inty | | | |
| 2.00 | City Ctata 71D Cada Co | | | 00 | | | 0.00 |
| 2. 00 | City, State, ZIP Code, County | Tuesday | ADAMS Wedn | esday | Thur | sday | 2.00 |
| | | to | from | to | from | to | |
| | | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10. 00 | |
| | Facility hours of operations (1) | | | | | | |
| | | 17: 00 | 07: 00 | 17: 00 | 07: 30 | 17: 00 | 11.00 |

| Health Financial Systems | ADAMS MEMORI | AL HOSPITAL | | In Lie | u of Form CMS- | 2552-10 |
|--|--------------|-------------|-------|----------------------------------|----------------|---------|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | | Provi der C | | Peri od: | Worksheet S-8 | |
| | | Component | | From 01/01/2022 To 12/31/2022 | | |
| | | | | RHC IV | Cost | |
| | Fri | day | Sa | turday | | |
| | from | to | from | to | | |
| | 11. 00 | 12. 00 | 13.00 | 14. 00 | | |
| Facility hours of operations (1) | | | | | | |
| 11. 00 CLINIC | 07: 00 | 17: 00 | | | | 11. 00 |

| Heal th | n Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS- | 2552-10 |
|----------------|---|-----------------|----------------|--------------|----------------------------------|-----------------|----------------|
| HOSPI 7 | TAL-BASED RHC/FQHC STATISTICAL DATA | | Provi der 0 | CN: 15-1330 | Peri od: | Worksheet S-8 | 3 |
| | | | Component | CCN: 15-8555 | From 01/01/2022 To 12/31/2022 | | |
| | | | | | RHC V | Cost | |
| | | | | | | | |
| | Clinic Address and Identification | | | | | 00 | |
| 1. 00 | Street | | | | 955 HI GH STREE | T | 1.00 |
| | 1000 | | Ci | ty | State | ZIP Code | 11.00 |
| | | | | 00 | 2.00 | 3. 00 | |
| 2. 00 | City, State, ZIP Code, County | | DECATUR | | IN | 46733 | 2.00 |
| | | | | | | 1.00 | |
| 3. 00 | HOSPITAL-BASED FQHCs ONLY: Designation - Ent | er "R" for rur | al or "U" for | urban | | 1.00 | 3.00 |
| | <u>,</u> | | | | nt Award | Date | |
| | | | | | 1. 00 | 2. 00 | |
| 4 00 | Source of Federal Funds | ` ^ - + ` | | T | | I | 4 00 |
| 4. 00 5. 00 | Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A | | | | | | 4. 00 5. 00 |
| 6. 00 | Health Services for the Homeless (Section 34 | | | | | | 6.00 |
| 7. 00 | Appal achi an Regi onal Commi ssi on | | | | | | 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 h | ospi tal -based | RHC or FQHC? E | nter "Y" for | | | 10.00 |
| | yes or "N" for no in column 1. If yes, indic | | | | | | |
| | 2. (Enter in subscripts of line 11 the type o | of other operat | ion(s) and the | operating | | | |
| | hours.) | Com | ala | | An and an a | Torradao | |
| | | from | day to | from | Monday to | Tuesday from | |
| | | 1. 00 | 2.00 | 3.00 | 4.00 | 5. 00 | |
| | Facility hours of operations (1) | | | | | | |
| 11.00 | CLINIC | | | 08: 00 | 17: 00 | 08: 00 | 11. 00 |
| | | | | | 1.00 | 2.00 | |
| 12. 00 | Have you received an approval for an excepti | on to the prod | uctivity stand | lard? | 1.00 | 2. 00 | 12. 00 |
| 13. 00 | | | | | N | 0 | |
| | 30.8? Enter "Y" for yes or "N" for no in col | | | | | | |
| | number of providers included in this report. | List the name | s of all provi | ders and | | | |
| | numbers below. | | | Prov | ider name | CCN | |
| | | | | 1100 | 1. 00 | 2.00 | |
| 14. 00 | RHC/FQHC name, CCN | | , | | | | 14.00 |
| | | Y/N | V | XVIII | XI X | Total Visits | |
| 15.00 | | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | 15.00 |
| 15. 00 | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in | | | | | | 15. 00 |
| | column 1. If yes, enter in columns 2, 3 and | | | | | | |
| | 4 the number of program visits performed by | | | | | | |
| | Intern & Residents for titles V, XVIII, and | | | | | | |
| | XIX, as applicable. Enter in column 5 the | | | | | | |
| | number of total visits for this provider. (see instructions) | | | | | | |
| | TOOC THISTI WOLLDING | 1 | Cou | unty | | | |
| | | | 4. | 00 | | | |
| 2. 00 | City, State, ZIP Code, County | | ADAMS | | | | 2.00 |
| | | Tuesday | | esday | | sday L +- | |
| | | 6. 00 | 7.00 | 8. 00 | 9.00 | to 10.00 | |
| | Facility hours of operations (1) | 0.00 | 7.00 | 0.00 | 7.00 | 10.00 | |
| 11. 00 | CLINIC | 17: 00 | 08: 00 | 17: 00 | 08: 00 | 17: 00 | 11.00 |
| | | * | • | • | • | • | • |

| Health Financial Systems | ADAMS MEMORI | AL HOSPITAL | | In Lie | u of Form CMS-: | 2552-10 |
|--|--------------|-------------|-------|----------------------------------|-----------------|---------|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | | Provi der C | | Peri od: | Worksheet S-8 | } |
| | | Component | | From 01/01/2022 To 12/31/2022 | | |
| | | | | RHC V | Cost | |
| | Fri | day | Sa | turday | | |
| | from | to | from | to | | |
| | 11. 00 | 12. 00 | 13.00 | 14. 00 | | |
| Facility hours of operations (1) | | | | | | |
| 11. 00 CLINIC | 08: 00 | 17: 00 | | | - | 11. 00 |

| HUSPI | Financial Systems ADAMS MEMORIAL HOSP | | N. 15 1000 | | u of Form CMS-2 | |
|--|---|--|------------------------------------|-----------------------------|---|--|
| | TAL UNCOMPENSATED AND INDIGENT CARE DATA Pro | ovider CC | N: 15-1330 | Peri od: From 01/01/2022 | Worksheet S-1 | U |
| | | | | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | pared: 7 am |
| | | | | | 1. 00 | |
| | Uncompensated and indigent care cost computation | | | | 1.00 | |
| 1. 00 | Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid | ded by li | ne 202 colum | n 8) | 0. 558606 | 1.0 |
| | Medicaid (see instructions for each line) | | | | | |
| 2. 00 | Net revenue from Medicaid | | | | 5, 933, 138 | |
| 3. 00 | Did you receive DSH or supplemental payments from Medicaid? | | | | Y | 3.0 |
| 1. 00 | If line 3 is yes, does line 2 include all DSH and/or supplemental | | | ai d? | Υ | 4.0 |
| 5. 00 | If line 4 is no, then enter DSH and/or supplemental payments from | n Medicai | a | | 0 21, 787, 257 | 5.0 |
| 5. 00 7. 00 | Medicaid charges Medicaid cost (line 1 times line 6) | | | | 12, 170, 492 | 6. 0 7. 0 |
| 3. 00 | Difference between net revenue and costs for Medicaid program (li | ne 7 min | us sum of Li | nes 2 and 5 if | 6, 237, 354 | |
| , 00 | < zero then enter zero) | 7 1111 11 | us sum or ir | nes z una e, i i | 0, 207, 001 | 0.0 |
| | Children's Health Insurance Program (CHIP) (see instructions for | each lin | e) | | | ĺ |
| 9. 00 | Net revenue from stand-alone CHIP | | | | 0 | 9.0 |
| | Stand-alone CHIP charges | | | | 0 | 10.0 |
| 11.00 | | | | | 0 | 11.0 |
| 2. 00 | · · | ne 11 mi | nus line 9; | if < zero then | 0 | 12.0 |
| | enter zero) Other state or local government indigent care program (see instru | ictions f | or each line |) | | |
| 3. 00 | | | | | 0 | 13. C |
| 4. 00 | | | | | 0 | 14. 0 |
| | 10) | g (| | | _ | |
| 5.00 | State or local indigent care program cost (line 1 times line 14) | | | | 0 | 15. C |
| 16. 00 | | gent care | program (li | ne 15 minus line | . 0 | 16.0 |
| | 13; if < zero then enter zero) | 1 | . / | | | ļ |
| | Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) | and Stat | e/rocar rndi | gent care progra | ms (see | |
| 17.00 | Private grants, donations, or endowment income restricted to fund | ding char | ity care | | 0 | 17.0 |
| | Government grants, appropriations or transfers for support of hos | | | | 0 | |
| 19. 00 | Total unreimbursed cost for Medicaid , CHIP and state and local i | ndi gent | care program | s (sum of lines | 6, 237, 354 | 19.0 |
| | 8, 12 and 16) | | Uni nsured | Insured | Total (col. 1 | |
| | | | patients | patients | + col . 2) | |
| | | | 1. 00 | 2.00 | 3. 00 | |
| | Uncompensated Care (see instructions for each line) | | | | | |
| 20. 00 | Charity care charges and uninsured discounts for the entire facil (see instructions) | ity | 117, 54 | 61, 491 | 179, 034 | 20.0 |
| 21. 00 | Cost of patients approved for charity care and uninsured discount | ts (see | 65, 66 | 61, 491 | 127, 151 | 21.0 |
| | instructions) | (| | 3., | , | |
| 22. 00 | Payments received from patients for amounts previously written of | ff as | | 0 0 | 0 | 22.0 |
| | charity care | | | | | 1 |
| | | | 65, 66 | 61, 491 | 127 151 | |
| 23.00 | Cost of charity care (line 21 minus line 22) | | | | 127, 101 | 23. 0 |
| 23. 00 | cost of charity care (fine 2) minus fine 22) | | | · | | 23. 0 |
| | | days hov | ond a Length | of stay limit | 1. 00 | |
| | Does the amount on line 20 column 2, include charges for patient | | ond a Length | of stay limit | | |
| 24. 00 | Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the | rogram? | · · | | 1. 00 | 24.0 |
| 24. 00 25. 00 | Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit | rogram? i ndi gent | · · | | 1. 00 N | 24. 0 |
| 24. 00 25. 00 26. 00 | Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instr | rogram? indigent ructions) | care progra | | 1. 00 N 0 5, 706, 904 | 24. 0 25. 0 26. 0 |
| 24. 00 25. 00 26. 00 27. 00 | Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instr Medicare reimbursable bad debts for the entire hospital complex (| rogram? indigent ructions) (see inst | care progra | | 1. 00 N 0 5, 706, 904 159, 281 | 24. 0 25. 0 26. 0 27. 0 |
| 24. 00 25. 00 26. 00 27. 00 27. 01 | Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (Medicare allowable bad debts for the entire hospital complex (see | rogram? indigent ructions) (see inst | care progra | | 1. 00 N 0 5, 706, 904 159, 281 245, 048 | 24. 0 25. 0 26. 0 27. 0 27. 0 |
| 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 | Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instruedicare reimbursable bad debts for the entire hospital complex (Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions) | rogram? indigent ructions) (see inst e instruc | care progra ructions) tions) | m's length of | 1. 00 N 0 5, 706, 904 159, 281 245, 048 5, 461, 856 | 24. 0 25. 0 26. 0 27. 0 27. 0 28. 0 |
| 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00 30. 00 | Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instruedicare reimbursable bad debts for the entire hospital complex (Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense | rogram? indigent ructions) (see inst e instruc | care progra ructions) tions) | m's length of | 1. 00 N 0 5, 706, 904 159, 281 245, 048 | 26. 00 27. 00 27. 00 28. 00 29. 00 |

| | Financial Systems | ADAMS MEMORIAL | HOSPI TAL | | In Lie | u of Form CMS- | 2552-10 |
|------------------|---|----------------------------|-------------------------|---------------|----------------------------------|------------------|------------------|
| RECLAS | SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O | F EXPENSES | Provi der C | CN: 15-1330 F | Peri od: | Worksheet A | |
| | | | | | From 01/01/2022 Fo 12/31/2022 | Date/Time Pre | nared: |
| | | | | | 10 12/31/2022 | 3/2/2024 10: 0 | |
| | Cost Center Description | Sal ari es | Other | Total (col. 1 | Recl assi fi cat | Recl assi fi ed | |
| | · | | | + col . 2) | ions (See | Trial Balance | |
| | | | | | A-6) | (col. 3 +- | |
| | | | | | | col. 4) | |
| | OFNEDAL CERVILOE COCT OFNEEDO | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| 1 00 | GENERAL SERVICE COST CENTERS | | 2 010 001 | 2 010 001 | 72 254 | 2 004 225 | 1 00 |
| 1. 00 2. 00 | 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP | | 2, 010, 881 | 2, 010, 88 | 73, 354 | 2, 084, 235 0 | |
| 3. 00 | 00300 OTHER CAP REL COSTS | | 0 | | | 0 | 2.00 |
| 4. 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 154, 942 | 139, 226 | 294, 168 | 3 0 | 294, 168 | 1 |
| 5. 00 | 00500 ADMINISTRATIVE & GENERAL | 3, 397, 762 | 8, 822, 982 | 1 | | | 1 |
| 7. 00 | 00700 OPERATION OF PLANT | 0 | 1, 876, 310 | | | | |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 70, 782 | 175, 000 | | | | |
| 9.00 | 00900 HOUSEKEEPI NG | 493, 421 | 296, 658 | 790, 079 | 3, 598 | 793, 677 | 9. 00 |
| 10.00 | 01000 DI ETARY | 623, 816 | 639, 970 | 1, 263, 786 | 0 | 1, 263, 786 | 10.00 |
| 11. 00 | O1100 CAFETERI A | 0 | 0 |) (| 0 | 0 | 11.00 |
| 13.00 | 01300 NURSING ADMINISTRATION | 879, 369 | 224, 082 | 1, 103, 451 | 0 | 1, 103, 451 | 1 |
| 14. 00 | 01400 CENTRAL SERVICES & SUPPLY | 0 | 0 |) (| 0 | 0 | 14.00 |
| 15.00 | 01500 PHARMACY | 868, 295 | 453, 070 | | | , . , | 1 |
| 16. 00 | 01600 MEDI CAL RECORDS & LI BRARY | 310, 582 | 286, 325 | 596, 907 | 7 0 | 596, 907 | 16.00 |
| 30. 00 | INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS | 3, 833, 159 | 3, 415, 170 | 7, 248, 329 | -29, 893 | 7, 218, 436 | 30.00 |
| 31. 00 | 03100 INTENSIVE CARE UNIT | 686, 935 | 1, 306, 697 | 1 | | | 1 |
| 40. 00 | 04000 SUBPROVI DER - I PF | 000, 739 | 1, 300, 077 |) 1, 775, 652 | | 0 | 1 |
| 43. 00 | 04300 NURSERY | 0 | 0 | 1 | 8, 815 | | |
| 44. 00 | 04400 SKILLED NURSING FACILITY | ol | 0 | 1 | 0 0 | 1 | 1 |
| | ANCILLARY SERVICE COST CENTERS | · | | | | | |
| 50.00 | 05000 OPERATING ROOM | 2, 307, 270 | 2, 550, 224 | 4, 857, 494 | 1 0 | 4, 857, 494 | 50.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | | 21, 078 | 21, 078 | 52.00 |
| 53.00 | 05300 ANESTHESI OLOGY | 0 | 0 |) (| 0 | 0 | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 1, 164, 702 | 1, 633, 737 | | | _, , | |
| 60.00 | 06000 LABORATORY | 1, 246, 838 | 3, 482, 806 | | | | 1 |
| 65.00 | 06500 RESPI RATORY THERAPY | 512, 669 | 516, 412 | | | , | |
| 66.00 | 06600 PHYSI CAL THERAPY | 1, 780, 676 | 547, 725 | 1 | | , | 1 |
| 67. 00 68. 00 | 06700 OCCUPATI ONAL THERAPY | 557, 815 | 139, 897 | | | | |
| 69.00 | 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY | 248, 450 | 49, 245 | 297, 695 | | 297, 695 0 | 68. 00 69. 00 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | | · - | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 1, 080, 859 | 1, 080, 859 | | | |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS | ō | 1, 256, 810 | 1 | | 1 | 1 |
| 76.00 | 03020 OP PSYCH | 901, 924 | 240, 321 | 1 | | | |
| 76. 01 | 03030 WOUND CARE | 193, 378 | 94, 724 | 288, 102 | 0 | 288, 102 | 76. 01 |
| | OUTPATIENT SERVICE COST CENTERS | | | | _ | | |
| 88. 00 | 08800 MONROE FAMILY MEDICINE | 1, 358, 085 | 535, 768 | | | | 1 |
| 88. 01 | 08801 WOODCREST | 1, 221, 305 | 483, 367 | | | | 1 |
| 88. 02 | 08802 STAT CARE | 1, 139, 784 | 474, 323 | 1 | | | |
| | 08803 BERNE FAMILY MEDICINE | 978, 281 | 589, 153 | | | | |
| | 08804 HI GH STREET | 1, 052, 129 | 438, 078 | | | ., ., 0, 20, | |
| 90.00 | 09000 | 2, 693, 747 1, 997, 376 | 1, 463, 212 439, 488 | | | | |
| 90.01 | 1 1 | 699, 873 | 94, 937 | | | | 1 |
| 90. 03 | 09003 GENERAL SURGERY OFFICE | 1, 185, 291 | 1, 228, 874 | 1 | | | |
| | 04950 INTENSIVE OP BEHAVIORAL HEALTH | 0 | 0 | | 0 20,000 | | 1 |
| 91. 00 | 09100 EMERGENCY | 2, 557, 248 | 1, 392, 701 | 3, 949, 949 | | | |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | |] |
| | 09500 AMBULANCE SERVICES | 1, 436, 128 | 767, 876 | 2, 204, 004 | 1 0 | 2, 204, 004 | 95. 00 |
| | 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 |) (| | l | 97.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 0 | 0 |) (| 0 | 0 | 101.00 |
| 444.00 | SPECIAL PURPOSE COST CENTERS | | | | | _ | |
| | 11600 HOSPI CE | 0 0 | 20 147 000 | 75 (00 04) | 0 | | 116.00 |
| 118. 00 | 5 / | 36, 552, 032 | 39, 146, 908 | 75, 698, 940 | 10, 939 | 75, 709, 879 |]118.00 |
| 100 00 | NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | ٥ | | | | | 190. 00 |
| | 07950 TITLE XX | 0 | 0 | | | | 194.00 |
| | 07951 OTHER NRCC | 318, 567 | 325, 662 | 644, 229 | -23, 923 | | |
| | 07952 OTHER MOBS | 0.5,557 | 020, 002 |) | 12, 984 | | 194. 02 |
| 194. 03 | 07953 I DLE SPACE | ol | 0 | | 0 | | 194. 03 |
| | 07954 OTHER NONREIMBURSABLE COST CENTERS | o | 55, 292 | | | 55, 292 | 194. 04 |
| 200.00 | | 36, 870, 599 | 39, 527, 862 | 76, 398, 46 | 0 | 76, 398, 461 | 200.00 |
| | | | | | | | |

Provi der CCN: 15-1330

Period: Worksheet A From 01/01/2022 To 12/31/2022 Date/Time Prepared: 3/2/2024 10:07 am

| | | | | 3/2/2024 10:07 am |
|--|---|--------------|--|-------------------|
| Cost Center Description | Adjustments | Net Expenses | | |
| | (See A-8) | For | | |
| | | Allocation | | |
| | 6. 00 | 7. 00 | | |
| GENERAL SERVICE COST CENTERS | | | | |
| 1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT | -89, 159 | 1, 995, 076 | | 1.00 |
| 2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP | 0 | 0 | | 2. 00 |
| 3.00 00300 0THER CAP REL COSTS | 0 | 0 | | 3.00 |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT | 0 | 294, 168 | | 4.00 |
| 5. 00 00500 ADMINI STRATI VE & GENERAL | 1, 312, 677 | 13, 447, 083 | | 5. 00 |
| 7.00 00700 OPERATION OF PLANT | 321, 359 | 2, 198, 742 | | 7. 00 |
| 8. 00 00800 LAUNDRY & LINEN SERVICE | 0 | 245, 782 | | 8. 00 |
| 9. 00 00900 HOUSEKEEPI NG | 0 | 793, 677 | | 9. 00 |
| 10. 00 01000 DI ETARY | -338, 849 | 924, 937 | | 10.00 |
| 11. 00 01100 CAFETERI A | 0 | 0 | | 11.00 |
| 13.00 01300 NURSING ADMINISTRATION | 0 | 1, 103, 451 | | 13.00 |
| 14.00 01400 CENTRAL SERVICES & SUPPLY | 0 | 0 | | 14. 00 |
| 15. 00 01500 PHARMACY | -137, 722 | 1, 183, 643 | | 15. 00 |
| 16.00 O1600 MEDICAL RECORDS & LIBRARY | -25, 911 | 570, 996 | | 16. 00 |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | -765, 926 | 6, 452, 510 | | 30.00 |
| 31. 00 03100 INTENSIVE CARE UNIT | -30, 769 | 1, 962, 863 | | 31.00 |
| 40. 00 04000 SUBPROVI DER - I PF | 0 | 0 | | 40.00 |
| 43. 00 04300 NURSERY | 0 | 8, 815 | | 43.00 |
| 44. 00 O4400 SKILLED NURSING FACILITY | 0 | 0 | | 44. 00 |
| ANCILLARY SERVICE COST CENTERS | 1 000 (75 | 0.7// 040 | | |
| 50. 00 05000 OPERATING ROOM | -1, 090, 675 | | | 50.00 |
| 52. 00 05200 DELI VERY ROOM & LABOR ROOM | 0 | 21, 078 | | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 2, 798, 439 | | 54.00 |
| 60. 00 06000 LABORATORY | -34, 732 | 4, 701, 350 | | 60.00 |
| 65. 00 06500 RESPIRATORY THERAPY | -81, 609 | 947, 472 | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 2, 328, 401 | | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0 | 697, 712 | | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0 | 297, 695 | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 69.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 1 000 050 | | 71.00 |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT | 200, 150 | 1, 080, 859 | | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | -209, 159 | 1, 047, 651 | | 73.00 |
| 76. 00 03020 OP PSYCH 76. 01 03030 WOUND CARE | -277, 178 0 | 865, 067 | | 76. 00 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | | 288, 102 | | 76.01 |
| 88. 00 08800 MONROE FAMILY MEDICINE | 0 | 1, 893, 853 | | 88.00 |
| 88. 01 08801 WOODCREST | 0 | 1, 704, 672 | | 88. 01 |
| 88. 02 08802 STAT CARE | 0 | 1, 614, 107 | | 88. 02 |
| 88. 03 08803 BERNE FAMILY MEDICINE | -53, 859 | | | 88. 03 |
| 88. 04 08804 HI GH STREET | -6, 912 | 1, 483, 295 | | 88. 04 |
| 90. 00 09000 CLI NI C | -1, 904, 028 | | | 90.00 |
| 90. 01 09001 CLI NI C - AMO | -1, 792, 838 | | | 90.00 |
| 90. 02 09002 CLINIC - AMH NEURO | -643, 104 | 175, 629 | | 90.02 |
| 90. 03 09003 GENERAL SURGERY OFFICE | -1, 906, 672 | | | 90. 03 |
| 90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH | 1, 700, 072 | · | | 90.04 |
| 91. 00 09100 EMERGENCY | -813, 490 | | | 91.00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 013, 470 | 3, 130, 437 | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | 72.00 |
| 95. 00 09500 AMBULANCE SERVI CES | 0 | 2, 204, 004 | | 95. 00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | | 97.00 |
| 101.00 10100 HOME HEALTH AGENCY | 0 | | | 101.00 |
| SPECIAL PURPOSE COST CENTERS | | 9 | | 101.00 |
| 116. 00 11600 HOSPI CE | 0 | 0 | | 116. 00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117 | | | | 118.00 |
| NONREI MBURSABLE COST CENTERS | ,, 5,555,550 | 3., 711, 020 | | 1.13.00 |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | | 190. 00 |
| 194. 00 07950 TITLE XX | 0 | n | | 194. 00 |
| 194. 01 07951 OTHER NRCC | 0 | 620, 306 | | 194. 01 |
| 194. 02 07952 OTHER MOBS | n | 12, 984 | | 194. 02 |
| 194. 03 07953 I DLE SPACE | 0 | 0 | | 194. 03 |
| 194. 04 07954 OTHER NONREIMBURSABLE COST CENTERS | 0 | 55, 292 | | 194. 04 |
| 200.00 TOTAL (SUM OF LINES 118 through 199) | -8, 568, 556 | | | 200. 00 |
| , , , , , , , , , , , , , , , , , , , | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | 1=33.00 |

Heal th Financial Systems

ADAMS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

RECLASSIFICATIONS

Provider CCN: 15-1330
Period: From 01/01/2022 To 12/31/2022 Date/Time Prepared:

| | | | | To 12/31/2022 Date/Time Pi 3/2/2024 10: | repared: :07 am | |
|--------|-------------------------------|-----------------|------------------|--|--------------------|--------|
| | | Increases | | • | 0, 2, 202 , 10 | |
| | Cost Center | Li ne # | Sal ary | 0ther | | |
| | 2. 00 | 3.00 | 4. 00 | 5. 00 | | |
| | A - OB, NURSERY AND L&D | | | | | |
| 1.00 | NURSERY | 43. 00 | 6, 679 | 2, 136 | | 1.00 |
| 2.00 | DELIVERY ROOM & LABOR ROOM _ | <u>52.</u> 00 | 1 <u>5, 9</u> 70 | <u>5, 1</u> 08 | | 2.00 |
| | 0 | | 22, 649 | 7, 244 | | |
| | B - INSURANCE | | | | | |
| 1. 00 | NEW CAP REL COSTS-BLDG & | 1. 00 | 0 | 73, 354 | | 1. 00 |
| | FI XT | | | | | |
| 2.00 | OTHER MOBS | 1 <u>94.</u> 02 | 0 | 1 <u>2, 9</u> 84 | | 2. 00 |
| | 0 | | 0 | 86, 338 | | |
| | K - RECLASS MOC BUILDING MAIN | | | | | |
| 1. 00 | OPERATION OF PLANT | 7. 00 | 0 | 1, 073 | | 1. 00 |
| 2. 00 | HOUSEKEEPI NG | 9. 00 | 0 | 3, 598 | | 2. 00 |
| 3. 00 | LABORATORY | 60. 00 | 0 | 6, 438 | | 3. 00 |
| 4. 00 | CLINIC | 90. 00 | 0 | 66, 104 | | 4. 00 |
| 5. 00 | CLINIC - AMO | 90. 01 | 0 | 19, 224 | | 5. 00 |
| 6. 00 | GENERAL SURGERY OFFICE | 90.03 | 0 | 2 <u>3, 3</u> 36 | | 6. 00 |
| | TOTALS | | 0 | 119, 773 | | |
| | L - RECLASS NEURO CLINIC BUIL | | | | | |
| 1. 00 | CLINIC - AMH NEURO | 90.02 | 0 | 2 <u>3, 9</u> 23 | | 1. 00 |
| | TOTALS | | 0 | 23, 923 | | |
| 500.00 | Grand Total: Increases | | 22, 649 | 237, 278 | | 500.00 |

Heal th Financial SystemsADAMS MEMORIAL HOSPITALIn Lieu of Form CMS-2552-10RECLASSIFICATIONSProvider CCN: 15-1330Period: From 01/01/2022Worksheet A-6

| | | | | | | To 12/31/2022 | Date/Time Pro 3/2/2024 10: | |
|--------|-------------------------------|-----------|---------|-----------------|---------------|---------------|-------------------------------|--------|
| | | Decreases | | | | | | |
| | Cost Center | Li ne # | Sal ary | 0ther | Wkst. A-7 Ref | | | |
| | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | | | |
| | A - OB, NURSERY AND L&D | | | | | | | |
| 1.00 | ADULTS & PEDIATRICS | 30. 00 | 22, 649 | 7, 244 | | 0 | | 1.00 |
| 2.00 | | 0.00 | 0 | 0 | | o | | 2.00 |
| | 0 | | 22, 649 | 7, 244 | | | | |
| | B - I NSURANCE | | | | | | | |
| 1.00 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 86, 338 | 1 | 2 | | 1.00 |
| 2.00 | | 0.00 | 0 | 0 | | <u>o</u> | | 2.00 |
| | 0 | | 0 | 86, 338 | | | | |
| | K - RECLASS MOC BUILDING MAIN | | | | | | | |
| 1.00 | CLINIC | 90.00 | 0 | 119, 773 | | 0 | | 1.00 |
| 2.00 | | 0.00 | 0 | 0 | | 0 | | 2.00 |
| 3.00 | | 0.00 | 0 | 0 | | 0 | | 3.00 |
| 4.00 | | 0.00 | 0 | 0 | | 0 | | 4. 00 |
| 5.00 | | 0.00 | 0 | 0 | | 0 | | 5. 00 |
| 6.00 | | 0.00 | 0 | 0 | | ol | | 6. 00 |
| | TOTALS | | 0 | 119, 773 | | | | |
| | L - RECLASS NEURO CLINIC BUIL | | | | | | | |
| 1.00 | OTHER NRCC | 194. 01 | 0 | 2 <u>3,</u> 923 | | <u> </u> | | 1.00 |
| | TOTALS | | 0 | 23, 923 | | | | 1 |
| 500.00 | Grand Total: Decreases | | 22, 649 | 237, 278 | | | | 500.00 |

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS ADAMS MEMORIAL HOSPITAL

| Peri od: | Worksheet A-7 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-1330

| | | | | 10 | 12/31/2022 | Date/lime Pre 3/2/2024 10:0 | |
|--------|--|--------------|-------------|-----------------|-------------|--------------------------------|------------|
| | | | | Acqui si ti ons | | 0,2,2021 1010 | , <u>u</u> |
| | | Begi nni ng | Purchases | Donati on | Total | Disposals and | |
| | | Bal ances | | | | Retirements | |
| | | 1.00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE | | | | | | |
| 1. 00 | Land | 363, 119 | 110, 000 | | 110, 000 | | 1.00 |
| 2.00 | Land Improvements | 2, 234, 502 | 32, 686 | | 32, 686 | | 2.00 |
| 3.00 | Buildings and Fixtures | 42, 572, 075 | 202, 110 | 0 | 202, 110 | 0 | 3.00 |
| 4.00 | Building Improvements | 0 | 0 | 0 | 0 | 0 | 4.00 |
| 5. 00 | Fi xed Equipment | 9, 266, 812 | 452, 925 | 0 | 452, 925 | | 5.00 |
| 6. 00 | Movable Equipment | 19, 999, 333 | 930, 002 | 0 | 930, 002 | 163, 646 | 6.00 |
| 7.00 | HIT designated Assets | 0 | 0 | 0 | 0 | 0 | 7. 00 |
| 8.00 | Subtotal (sum of lines 1-7) | 74, 435, 841 | 1, 727, 723 | 0 | 1, 727, 723 | 163, 646 | 8. 00 |
| 9.00 | Reconciling Items | 0 | 0 | 0 | 0 | 0 | 9. 00 |
| 10.00 | Total (line 8 minus line 9) | 74, 435, 841 | 1, 727, 723 | 0 | 1, 727, 723 | 163, 646 | 10.00 |
| | | Endi ng | Fully | | | | |
| | | Bal ance | Depreciated | | | | |
| | | | Assets | | | | |
| | DART I ANNUALO OF GUANGES IN CARLEY AGOS | 6. 00 | 7. 00 | | | | |
| 4 00 | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE | | al | | | | |
| 1.00 | Land | 473, 119 | 0 | | | | 1.00 |
| 2. 00 | Land Improvements | 2, 267, 188 | 0 | | | | 2.00 |
| 3.00 | Buildings and Fixtures | 42, 774, 185 | 0 | | | | 3.00 |
| 4.00 | Building Improvements | 0 | 0 | | | | 4.00 |
| 5.00 | Fi xed Equi pment | 9, 719, 737 | 0 | | | | 5.00 |
| 6.00 | Movabl e Equi pment | 20, 765, 689 | 0 | | | | 6.00 |
| 7.00 | HIT designated Assets | 75 000 010 | 0 | | | | 7.00 |
| 8.00 | Subtotal (sum of lines 1-7) | 75, 999, 918 | 0 | | | | 8.00 |
| 9.00 | Reconciling Items | 75 000 010 | 0 | | | | 9.00 |
| 10. 00 | Total (line 8 minus line 9) | 75, 999, 918 | 0 | | | | 10. 00 |

| Heal th | Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|--|------------------|------------------------|---------------|--|-----------------|---------|
| RECONCILIATION OF CAPITAL COSTS CENTERS | | | Provi der CCN: 15-1330 | | Peri od: From 01/01/2022 To 12/31/2022 | | pared: |
| | | | SL | JMMARY OF CAP | I TAL | | |
| | Cost Center Description | Depreciation | Lease | Interest | Insurance | Taxes (see | |
| | | | | | (see instructions) | instructions) | |
| | | 9. 00 | 10. 00 | 11. 00 | 12.00 | 13. 00 | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WOR | KSHEET A, COLUI | MN 2, LINES 1 a | and 2 | | | |
| 1.00 | NEW CAP REL COSTS-BLDG & FIXT | 1, 581, 281 | 0 | 429, 6 | 00 0 | 0 | 1.00 |
| 2.00 | NEW CAP REL COSTS-MVBLE EQUIP | 0 | 0 | | 0 0 | 0 | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 1, 581, 281 | 0 | 429, 6 | 00 0 | 0 | 3.00 |
| | | SUMMARY 0 | F CAPITAL | | | | |
| | Cost Center Description | Other | Total (1) | | | | |
| | | Capi tal -Rel at | (sum of cols. | | | | |
| | | ed Costs (see | 9 through 14) | | | | |
| | | instructions) | | | | | |
| | | 14. 00 | 15. 00 | | | | |

| | | 9. 00 | 10.00 | 11.00 | 12.00 | 13. 00 | |
|-------|--|----------------|-----------------|----------|-------|--------|-------|
| · · | PART II - RECONCILIATION OF AMOUNTS FROM WOR | KSHEET A, COLU | MN 2, LINES 1 a | and 2 | | | |
| 1.00 | NEW CAP REL COSTS-BLDG & FIXT | 1, 581, 281 | 0 | 429, 600 | 0 | 0 | 1.00 |
| 2.00 | NEW CAP REL COSTS-MVBLE EQUIP | 0 | 0 | 0 | 0 | 0 | 2. 00 |
| 3.00 | Total (sum of lines 1-2) | 1, 581, 281 | 0 | 429, 600 | 0 | 0 | 3.00 |
| | | SUMMARY C | F CAPI TAL | | | | |
| | | | | | | | |
| | Cost Center Description | 0ther | Total (1) | | | | |
| | | | (sum of cols. | | | | |
| | | | 9 through 14) | | | | |
| | | instructions) | | | | | |
| | | 14. 00 | 15. 00 | | | | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WOR | KSHEET A, COLU | | | | | |
| 1. 00 | NEW CAP REL COSTS-BLDG & FLXT | 0 | 2, 010, 881 | | | | 1.00 |
| 2.00 | NEW CAP REL COSTS-MVBLE EQUIP | 0 | 0 | | | | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 0 | 2, 010, 881 | | | | 3.00 |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

| Heal th | n Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|--|---------------|--|----------------|---|-----------------|---------|
| RECONCILIATION OF CAPITAL COSTS CENTERS | | | Provi der Co | | Period: From 01/01/2022 To 12/31/2022 | | pared: |
| | | COM | COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPI | | | | |
| | Cost Center Description | Gross Assets | Capi tal i zed | Gross Assets | Ratio (see | Insurance | |
| | | | Leases | for Ratio | instructions) | | |
| | | | | (col. 1 - | | | |
| | | 1.00 | 0.00 | col . 2) | 4.00 | 5.00 | |
| | DART III DECONCILIATION OF CARLTAL COSTS C | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| 1. 00 | PART III - RECONCILIATION OF CAPITAL COSTS C | 54, 761, 110 | | 54, 761, 11 | 0. 725055 | 0 | 1.00 |
| 2. 00 | NEW CAP REL COSTS-BLDG & FIXT | 20, 765, 689 | | 20, 765, 68 | | | 2.00 |
| 3. 00 | Total (sum of lines 1-2) | 75, 526, 799 | | 75, 526, 79 | | | 3.00 |
| 3.00 | Total (Saill of Triles 1 2) | | TION OF OTHER (| | | F CAPITAL | 3.00 |
| | | ALLOCA | TION OF OTHER C | JAI I IAL | 30WWWATET C | OALLIAE | |
| | Cost Center Description | Taxes | Other | Total (sum o | f Depreciation | Lease | |
| | | | Capi tal -Rel at | cols. 5 | | | |
| | | | ed Costs | through 7) | | | |
| | | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| | PART III - RECONCILIATION OF CAPITAL COSTS C | | | | | | |
| 1. 00 | NEW CAP REL COSTS-BLDG & FIXT | 0 | - | | 0 1, 550, 715 | | 1.00 |
| 2.00 | NEW CAP REL COSTS-MVBLE EQUIP | 0 | - | | 0 0 | 0 | 2.00 |
| 3. 00 | Total (sum of lines 1-2) | 0 | | IMMARDY OF CAR | 0 1, 550, 715 | 0 | 3.00 |
| | | | SL | JMMARY OF CAPI | IAL | | |
| | Cost Center Description | Interest | Insurance | Taxes (see | Other | Total (2) | |
| | 555t 5511tol | 111101 001 | (see | instructions | | | |
| | | | instructions) | | ed Costs (see | | |
| | | | ĺ | | instructions) | | |
| | | 11. 00 | 12. 00 | 13.00 | 14.00 | 15. 00 | |
| | PART III - RECONCILIATION OF CAPITAL COSTS C | | | | | | |
| 1.00 | NEW CAP REL COSTS-BLDG & FIXT | 371, 007 | 73, 354 | | 0 0 | 1, 995, 076 | 1.00 |
| 2.00 | NEW CAP REL COSTS-MVBLE EQUIP | 0 | ı | | 0 | | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 371, 007 | 73, 354 | | 0 | 1, 995, 076 | 3.00 |
| | | | | | | | |

Health Financial Systems ADAMS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-1330 Peri od: Worksheet A-8 From 01/01/2022 12/31/2022 Date/Time Prepared: 3/2/2024 10:07 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Cost Center Description Amount Wkst. A-7 (2) Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP -64,546 NEW CAP REL COSTS-BLDG & 1.00 1.00 REL COSTS-BLDG & FIXT (chapter lfi xt 2.00 Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.00 2.00 REL COSTS-MVBLE EQUIP (chapter EQUI P 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0 0.00 4.00 discounts (chapter 8) Refunds and rebates of 5.00 0.00 5.00 expenses (chapter 8) 6 00 Rental of provider space by 0 00 6 00 suppliers (chapter 8) 7.00 Tel ephone services (pay 0.00 7.00 stations excluded) (chapter 21) 8.00 Tel evi si on and radi o servi ce -7, 445 ADMINISTRATIVE & GENERAL 8.00 5.00 0 Α (chapter 21) Parking lot (chapter 21) 9.00 0.00 9.00 10.00 Provi der-based physi ci an A-8-2 -9, 134, 200 10.00

| Health Financial Systems | | | ADAMS MEMORIA | AL HOSPITAL | In Lie | In Lieu of Form CMS-2552-10 | | | |
|------------------------------|---------------|-----------|---------------|--------------------------|----------------------------------|-----------------------------|--------|--|--|
| ADJUSTMENTS TO EXPENSES | | | | Provider CCN: 15-1330 | Peri od: | Worksheet A-8 | | | |
| | | | | | From 01/01/2022 To 12/31/2022 | Date/Time Pre | nared· | | |
| | | | | | | 3/2/2024 10: 0 | | | |
| | | | | Expense Classification | | | | | |
| | | | | To/From Which the Amount | is to be Adjusted | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| Cost Center Des | scription Bas | si s/Code | Amount | Cost Center | Li ne # | Wkst. A-7 | | | |
| | | 1. 00 | 2. 00 | 3.00 | 4.00 | Ref. | | | |
| 31.00 Adjustment for speed | h | A-8-3 | | SPEECH PATHOLOGY | 4. 00 | 5. 00 | 31. 00 | | |
| pathology costs in e | | H-0-3 | U | SPEECH PATHOLOGY | 00.00 | | 31.00 | | |
| limitation (chapter | | | | | | | | | |
| 32.00 CAH HIT Adjustment f | | | 0 | | 0.00 | 0 | 32.00 | | |
| Depreciation and Int | | | · | | | - | | | |
| 33.00 I HA DUES | | Α | -1, 747 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33.00 | | |
| 33. 01 AHA DUES | | Α | -3, 914 | ADMINISTRATIVE & GENERAL | 5. 00 | o | 33. 01 | | |
| 33.02 MISC AMBULANCE REVEN | UE | В | 0 | AMBULANCE SERVICES | 95.00 | o | 33.02 | | |
| 33.03 340B CONTRACT EXPENS | ES | Α | | PHARMACY | 15. 00 | o | 33.03 | | |
| 33.04 WORTHMAN FITNESS CEN | TER | В | -81, 609 | RESPIRATORY THERAPY | 65. 00 | 0 | 33.04 | | |
| 33.05 MISC INCOME | | В | · | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33.05 | | |
| 33. 06 EDUCATIONAL SERVICES | | В | · | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33.06 | | |
| 33. 07 HOSPITAL PROVIDER TA | X | Α | 0 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33. 07 | | |
| SHORTFALL | | | 045 400 | | | | | | |
| 33. 09 MARKETI NG | | A | · | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33. 09 | | |
| 33. 10 PHYSICIAN RECRUITING | | A | · | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33. 10 | | |
| 33. 11 VALUE ASSI GNMENT/MIS | C IESTING | В | · | LABORATORY | 60.00 | 0 | 33. 11 | | |
| 33. 12 MISC PSYCH INCOME | | В | | OP PSYCH | 76. 00 | 0 | 33. 12 | | |
| 34. 00 RENTAL INCOME | | В | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 34.00 | | |

-53, 859 BERNE FAMILY MEDICINE

5, 953 NEW CAP REL COSTS-BLDG &

-37, 750 CLINIC - AMH NEURO

-6, 912 HI GH STREET

-8, 568, 556

88. 03

88.04

90. 02

1.00

34.01

34.02

34.03

34.04

50.00

11

В

В

В

TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,

LAPSE LOSS ON REFINANCING

34. 01 RENTAL INCOME

RENTAL INCOME

RENTAL INCOME

34.02

34.03

34.04

50.00

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

| | | | | _ | 3/2/2024 10:0 | 07 am | |
|-------|---|------------------------------|------------------------------|----------------|----------------|-------|--|
| | Li ne No. | Cost Center | Expense Items | Amount of | Amount | | |
| | | | | Allowable Cost | Included in | | |
| | | | | | Wks. A, column | | |
| | | | | | 5 | | |
| | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | | |
| | A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME | | | | | | |
| | OFFICE COSTS: | | | | | | |
| 1.00 | 1.00 | NEW CAP REL COSTS-BLDG & FIX | HOME OFFICE CAPITAL ALLOCATI | 50, 001 | 80, 567 | 1.00 | |
| 2.00 | 5. 00 | ADMINISTRATIVE & GENERAL | HOME OFFICE AND IT COSTS | 5, 211, 287 | 3, 447, 963 | 2.00 | |
| 3.00 | 7. 00 | OPERATION OF PLANT | MAINTENANCE AND GROUNDS | 829, 846 | 508, 487 | 3.00 | |
| 3. 01 | 0.00 | | | 0 | 0 | 3.01 | |
| 3.02 | 0.00 | | | 0 | O | 3.02 | |
| 3.03 | 0.00 | | | 0 | o | 3.03 | |
| 3.04 | 0.00 | | | 0 | o | 3.04 | |
| 3.05 | 0.00 | | | 0 | o | 3.05 | |
| 3.06 | 0.00 | | | 0 | o | 3.06 | |
| 4.00 | 0.00 | | | 0 | o | 4.00 | |
| 5.00 | 0 | | 0 | 6, 091, 134 | 4, 037, 017 | 5.00 | |

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

| | · | | | Related Organization(s) and/ | or Home Office | |
|---|------------|-------|---------------|------------------------------|----------------|--|
| | | | | | | |
| | | | | | | |
| | Symbol (1) | Name | Percentage of | Name | Percentage of | |
| | | | Ownershi p | | Ownershi p | |
| | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: | | | | | | |

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

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

| 6. 00 B | O. OO ADAMS HEALTH NETWORK | 0. 00 | 6. 00 |
|-------------------------------|----------------------------|-------|--------|
| 7. 00 | 0.00 | 0.00 | 7.00 |
| 8. 00 | 0.00 | 0.00 | 8. 00 |
| 9. 00 | 0.00 | 0.00 | 9. 00 |
| 10.00 | 0.00 | 0.00 | 10.00 |
| 100.00 G. Other (financial or | | | 100.00 |
| non-fi nanci al) speci fy: | | | |

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

 F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

| Heal th | Financial Syst | ems | ADAMS MEMORIAL HOSPITAL In Lie | u of Form CMS-2552-10 |
|---------|----------------|-----------------|--|-----------------------|
| STATEME | | SERVICES FROM | RELATED ORGANIZATIONS AND HOME Provider CCN: 15-1330 Period: From 01/01/2022 | Worksheet A-8-1 |
| OTTTOL | 00313 | | To 12/31/2022 | |
| | Net | Wkst. A-7 Ref. | | |
| | Adjustments | | | |
| | (col. 4 minus | | | |
| | col. 5)* | | | |
| | 6. 00 | 7. 00 | | |
| | A. COSTS INCUR | RED AND ADJUSTI | MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OF | CLAIMED HOME |
| | OFFICE COSTS: | | | |
| 1.00 | -30, 566 | 9 | | 1.00 |
| 2.00 | 1, 763, 324 | 0 | | 2. 00 |
| 3.00 | 321, 359 | 0 | | 3.00 |
| 3. 01 | 0 | 0 | | 3. 01 |
| 3.02 | 0 | 0 | | 3. 02 |
| 3.03 | 0 | 0 | | 3. 03 |
| 3.04 | l 0 | 0 | | 3.04 |
| 3. 05 | 0 | 0 | | 3. 05 |
| 3.06 | 0 | 0 | | 3.06 |
| 4.00 | 0 | 0 | | 4.00 |

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

5.00

| Related Organization(s) and/or Home Office | | |
|---|---|--|
| | | |
| Type of Business | | |
| 6. 00 | | |
| B. INTERRELATIONSHIP TO RELA | TED ORGANIZATION(S) AND/OR HOME OFFICE: | |

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

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

| Termbar Sement ander title AVIII. | | | | | | | |
|-----------------------------------|------------|--|--------|--|--|--|--|
| 6. 00 | MANAGEMENT | | 6. 00 | | | | |
| 7.00 | | | 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.

5.00

| Period: | Worksheet A-8-2 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 15-1330

| | | | | | - | To 12/31/2022 | 2 Date/Time Pre 3/2/2024 10:0 | |
|---------|----------------|------------------------|----------------|----------------|-----------------|----------------|----------------------------------|--------|
| | Wkst. A Line # | Cost Center/Physician | Total | Professi onal | Provi der | RCE Amount | Physi ci an/Prov | |
| | | I denti fi er | Remuneration | Component | Component | Troc 7 miodire | ider Component | |
| | | | | | | | Hours | |
| | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | 6. 00 | 7. 00 | |
| 1.00 | 30.00 | ADULTS & PEDIATRICS | 765, 926 | 765, 926 | 0 | 0 | 0 | 1. 00 |
| 2.00 | 31.00 | INTENSIVE CARE UNIT | 30, 769 | 30, 769 | 0 | 0 | o | 2.00 |
| 3.00 | 50.00 | OPERATING ROOM | 1, 090, 675 | | | 0 | 0 | 3. 00 |
| 4.00 | | OP PSYCH | 224, 448 | | | 0 | 0 | 4.00 |
| 5. 00 | | CLINIC | 1, 985, 111 | 1, 904, 028 | | 0 | 0 | 5. 00 |
| 6.00 | | CLINIC - AMO | 1, 792, 838 | | | 0 | 0 | 6. 00 |
| 7. 00 | | CLINIC - AMH NEURO | 605, 354 | | | 0 | 0 | 7. 00 |
| 8. 00 | | GENERAL SURGERY OFFICE | 1, 936, 672 | | | 0 | 0 | 8. 00 |
| 9. 00 | | EMERGENCY | 1, 926, 788 | | | | 0 | 9. 00 |
| 10.00 | 0.00 | | 0 | 0 | | 0 | 0 | 10.00 |
| 200.00 | | | 10, 358, 581 | 9, 134, 200 | 1, 224, 381 | | 0 | 200.00 |
| | Wkst. A Line # | Cost Center/Physician | Unadjusted RCE | | Cost of | Provi der | Physician Cost | |
| | | I denti fi er | | Unadjusted RCE | | Component | of Mal practice | |
| | | | | Limit | Conti nui ng | Share of col. | Insurance | |
| | | | | | Educati on | 12 | | |
| | 1.00 | 2. 00 | 8. 00 | 9. 00 | 12.00 | 13. 00 | 14.00 | |
| 1.00 | 30.00 | ADULTS & PEDIATRICS | 0 | 0 | 0 | 0 | 0 | 1.00 |
| 2.00 | 31.00 | INTENSIVE CARE UNIT | 0 | 0 | 0 | 0 | 0 | 2.00 |
| 3.00 | 50.00 | OPERATING ROOM | 0 | 0 | 0 | 0 | 0 | 3.00 |
| 4.00 | 76. 00 | OP PSYCH | 0 | 0 | 0 | 0 | 0 | 4.00 |
| 5.00 | 90. 00 | CLI NI C | 0 | 0 | 0 | 0 | 0 | 5.00 |
| 6.00 | 90. 01 | CLINIC - AMO | 0 | 0 | 0 | 0 | 0 | 6.00 |
| 7.00 | | CLINIC - AMH NEURO | 0 | 0 | 0 | 0 | 0 | 7.00 |
| 8.00 | 90. 03 | GENERAL SURGERY OFFICE | 0 | 0 | 0 | 0 | 0 | 8.00 |
| 9.00 | 91.00 | EMERGENCY | 0 | 0 | 0 | 0 | 0 | 9.00 |
| 10.00 | 0.00 | | 0 | 0 | 0 | 0 | 0 | 10.00 |
| 200.00 | | | 0 | 0 | 0 | 0 | 0 | 200.00 |
| | Wkst. A Line # | | Provi der | Adjusted RCE | RCE | Adjustment | | |
| | | Identifier | Component | Limit | Di sal I owance | | | |
| | | | Share of col. | | | | | |
| | | | 14 | | | | | |
| 4 00 | 1.00 | 2.00 | 15. 00 | 16. 00 | 17. 00 | 18.00 | | 1.00 |
| 1.00 | | ADULTS & PEDIATRICS | 0 | ľ | | | | 1.00 |
| 2.00 | | INTENSIVE CARE UNIT | 0 | 0 | _ | , | | 2.00 |
| 3.00 | | OPERATING ROOM | 0 | | - | ., | | 3.00 |
| 4.00 | | OP PSYCH | 0 | 0 | _ | , | | 4.00 |
| 5. 00 | • | CLINIC AMO | | 0 | - | ., , | | 5.00 |
| 6. 00 | • | CLINIC - AMO | 0 | 0 | _ | 1, 792, 838 | | 6.00 |
| 7.00 | | CLINIC - AMH NEURO | | 0 | - | 000,00. | | 7.00 |
| 8. 00 | | GENERAL SURGERY OFFICE | | 0 | | ., | | 8. 00 |
| 9.00 | | EMERGENCY | | 0 | - | | | 9.00 |
| 10.00 | 0.00 | | | 0 | _ | _ | | 10.00 |
| 200. 00 | I | I | 0 | 0 | 0 | 9, 134, 200 | | 200.00 |

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-1330

| | | | | Т | o 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | | |
|--------------------|----------------|--|----------------------------|--------------------|--------------|-----------------------------|----------------------------|--------------------|
| | | | | CAPI TAL REL | _ATED COSTS | | 37272024 10.0 | / dill |
| | | | | | | | | |
| | | Cost Center Description | Net Expenses | NEW BLDG & | NEW MVBLE | EMPLOYEE | Subtotal | |
| | | | for Cost Allocation | FLXT | EQUI P | BENEFITS DEPARTMENT | | |
| | | | (from Wkst A | | | DEPARTMENT | | |
| | | | col. 7) | | | | | |
| | | | 0 | 1.00 | 2.00 | 4. 00 | 4A | |
| | | AL SERVICE COST CENTERS | | | | 1 | | |
| 1.00 | | NEW CAP REL COSTS-BLDG & FIXT | 1, 995, 076 | 1, 995, 076 | | | | 1.00 |
| 2.00 | | NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT | 294, 168 | 0 | | | | 2.00 4.00 |
| 4. 00 5. 00 | | ADMINISTRATIVE & GENERAL | 13, 447, 083 | 181, 074 | | · | 13, 655, 380 | 5.00 |
| 7. 00 | | OPERATION OF PLANT | 2, 198, 742 | 273, 125 | | | 2, 471, 867 | 7.00 |
| 8.00 | | LAUNDRY & LINEN SERVICE | 245, 782 | 31, 736 | | 567 | 278, 085 | 8.00 |
| 9. 00 | 1 | HOUSEKEEPI NG | 793, 677 | 52, 514 | | | 850, 144 | 9. 00 |
| 10.00 | 1 | DI ETARY | 924, 937 | 125, 237 | | | 1, 055, 172 | |
| 11. 00 13. 00 | | CAFETERI A | 1 102 451 | 0 F 200 | | | 0 | 11.00 |
| 14.00 | | NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY | 1, 103, 451 | 5, 800 0 | | 7, 046 | 1, 116, 297 0 | 13. 00 14. 00 |
| 15. 00 | | PHARMACY | 1, 183, 643 | 40, 969 | | | 1, 231, 569 | |
| | | MEDICAL RECORDS & LIBRARY | 570, 996 | 46, 604 | | | 620, 088 | |
| | | ENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | | ADULTS & PEDIATRICS | 6, 452, 510 | 293, 717 | | | | |
| 31.00 | 1 | INTENSIVE CARE UNIT | 1, 962, 863 | 52, 753 | | | 2, 021, 120 | |
| 40. 00 43. 00 | | SUBPROVI DER – I PF NURSERY | 0 015 | 0 27 479 | | - | 0 | 40. 00 43. 00 |
| 44.00 | 1 | SKILLED NURSING FACILITY | 8, 815 0 | 27, 478 0 | | | 36, 347 0 | |
| 44.00 | | LARY SERVICE COST CENTERS | <u></u> | <u> </u> | | | | 1 44.00 |
| 50.00 | | OPERATI NG ROOM | 3, 766, 819 | 201, 264 | C | 18, 486 | 3, 986, 569 | 50.00 |
| 52.00 | | DELIVERY ROOM & LABOR ROOM | 21, 078 | 27, 478 | O | 128 | 48, 684 | 52.00 |
| 53.00 | 1 | ANESTHESI OLOGY | 0 | 0 | 1 | | 0 | 53.00 |
| 54.00 | | RADI OLOGY-DI AGNOSTI C | 2, 798, 439 | 162, 535 | | | 2, 970, 306 | |
| 60. 00 65. 00 | | LABORATORY RESPI RATORY THERAPY | 4, 701, 350 947, 472 | 72, 062 75, 054 | | | 4, 783, 402 1, 026, 634 | 60. 00 65. 00 |
| 66. 00 | | PHYSI CAL THERAPY | 2, 328, 401 | 167, 546 | | | 2, 510, 214 | |
| 67. 00 | | OCCUPATI ONAL THERAPY | 697, 712 | 1, 836 | | | 704, 017 | |
| 68.00 | | SPEECH PATHOLOGY | 297, 695 | 918 | | | 300, 604 | |
| 69. 00 | | ELECTROCARDI OLOGY | 0 | 0 | | _ | 0 | 69. 00 |
| 71.00 | | MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | 71.00 |
| 72. 00 73. 00 | | IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS | 1, 080, 859 1, 047, 651 | 0 | i o | 0 | 1, 080, 859 1, 047, 651 | |
| 76.00 | | OP PSYCH | 865, 067 | 0 | | | 872, 293 | |
| 76. 01 | | WOUND CARE | 288, 102 | 0 | | · | 289, 651 | |
| | OUTPA | TIENT SERVICE COST CENTERS | · | | | · | · | |
| 88. 00 | | MONROE FAMILY MEDICINE | 1, 893, 853 | 0 | | · | 1, 904, 734 | |
| 88. 01 | | WOODCREST | 1, 704, 672 | 0 | | • | 1, 714, 457 | |
| 88. 02 88. 03 | | STAT CARE BERNE FAMILY MEDICINE | 1, 614, 107 | 41, 317 | | 9, 132 | 1, 664, 556 | |
| 88. 04 | | HIGH STREET | 1, 513, 575 1, 483, 295 | 0 | | 7, 838 8, 430 | 1, 521, 413 1, 491, 725 | |
| 90.00 | | CLINIC | 2, 199, 262 | 0 | | 21, 582 | | |
| | | CLINIC - AMO | 663, 250 | 0 | O | | 679, 253 | |
| 90. 02 | 09002 | CLINIC - AMH NEURO | 175, 629 | 0 | O | 5, 607 | 181, 236 | 90. 02 |
| 90. 03 | | GENERAL SURGERY OFFICE | 530, 829 | 0 | · · | 9, 497 | 540, 326 | |
| 90.04 | | INTENSIVE OP BEHAVIORAL HEALTH | 0 | 100.055 | | | 0 | 90.04 |
| 91. 00 92. 00 | | EMERGENCY | 3, 136, 459 | 102, 055 | O | 20, 489 | 3, 259, 003 | |
| 92.00 | 09200 0THER | OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS | | | | | 0 | 92.00 |
| 95. 00 | | AMBULANCE SERVICES | 2, 204, 004 | 0 | С | 11, 506 | 2, 215, 510 | 95.00 |
| | | DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | | · | 0 | |
| 101.00 | | HOME HEALTH AGENCY | O | 0 | 0 | 0 | 0 | 101.00 |
| | | AL PURPOSE COST CENTERS | | _ | T | T | | |
| | 1 | HOSPICE | 0 | 1 002 072 | | | | 116.00 |
| 118. 00 | - | SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS | 67, 141, 323 | 1, 983, 072 | C | 291, 616 | 67, 126, 767 | 1118.00 |
| 190.00 | | GIFT, FLOWER, COFFEE SHOP & CANTEEN | O | 12, 004 | | 0 | 12, 004 | 190. 00 |
| | | TITLE XX | Ö | 0 | O | | | 194. 00 |
| 194. 01 | 07951 | OTHER NRCC | 620, 306 | 0 | 0 | 2, 552 | 622, 858 | 194. 01 |
| | | OTHER MOBS | 12, 984 | 0 | 0 | 0 | 12, 984 | |
| | | IDLE SPACE | 0 | 0 | 0 | 0 | | 194. 03 |
| 194. 04 200. 00 | | OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments | 55, 292 | O | | 0 | 55, 292 | 194. 04 200. 00 |
| 200.00 | | Negative Cost Centers | | n | O | n | | 200.00 |
| 202.00 | | TOTAL (sum lines 118 through 201) | 67, 829, 905 | 1, 995, 076 | | | | |
| | • | | | | - | | | |

Provider CCN: 15-1330

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared: 3/2/2024 10: 07 am

| | | | | ' | 0 12/31/2022 | 3/2/2024 10:0 | |
|------------------|---|---------------------|--------------------|---------------|--------------------|-------------------------|--------------------|
| | Cost Center Description | ADMI NI STRATI V | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | |
| | | E & GENERAL | PLANT | LINEN SERVICE | | | |
| | OFWERN OFFILIAS ASST SENTERS | 5. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| 1 00 | GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT | | | 1 | | | 1 00 |
| 1. 00 2. 00 | 00200 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5. 00 | 00500 ADMINISTRATIVE & GENERAL | 13, 655, 380 | | | | | 5.00 |
| 7. 00 | 00700 OPERATION OF PLANT | 623, 066 | 3, 094, 933 | | | | 7.00 |
| 8. 00 | 00800 LAUNDRY & LI NEN SERVI CE | 70, 095 | 49, 534 | | | | 8.00 |
| 9. 00 | 00900 HOUSEKEEPI NG | 214, 290 | 81, 965 | 1 | 1 | | 9.00 |
| 10.00 | 01000 DI ETARY | 265, 970 | 195, 473 | 1 | 76, 099 | 1, 592, 714 | 10.00 |
| 11.00 | 01100 CAFETERI A | 0 | 0 | 0 | 0 | 0 | 11.00 |
| 13.00 | 01300 NURSING ADMINISTRATION | 281, 377 | 9, 053 | 0 | 3, 524 | 0 | 13.00 |
| 14. 00 | 01400 CENTRAL SERVICES & SUPPLY | 0 | 0 | 0 | 0 | 0 | 14.00 |
| 15. 00 | 01500 PHARMACY | 310, 433 | 63, 945 | 1 | | 0 | 15.00 |
| 16. 00 | 01600 MEDI CAL RECORDS & LI BRARY | 156, 301 | 72, 740 | 0 | 28, 318 | 0 | 16.00 |
| 20.00 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 1 700 155 | 450 440 | 222.004 | 170 47/ | 1 2/4 442 | 20.00 |
| 30. 00 31. 00 | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT | 1, 708, 155 | 458, 443 | 1 | | 1, 364, 442 228, 272 | 30.00 |
| 40.00 | 04000 SUBPROVI DER – I PF | 509, 450 0 | 82, 337 0 | 1 | 32, 055 | 228, 272 | 40.00 |
| 43. 00 | 04300 NURSERY | 9, 162 | 42, 888 | | 16, 697 | 0 | 43.00 |
| 44. 00 | 04400 SKILLED NURSING FACILITY | 7, 102 | 42,000 | 1 | | 0 | 44.00 |
| 00 | ANCILLARY SERVICE COST CENTERS | 91 | | | <u> </u> | | 1 00 |
| 50.00 | 05000 OPERATING ROOM | 1, 004, 867 | 567, 825 | 0 | 221, 060 | 0 | 50.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 12, 271 | 42, 888 | 4, 926 | 16, 697 | 0 | 52.00 |
| 53.00 | 05300 ANESTHESI OLOGY | 0 | 0 | 0 | 0 | 0 | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 748, 704 | 112, 476 | 0 | 43, 788 | 0 | 54.00 |
| 60.00 | 06000 LABORATORY | 1, 205, 719 | 117, 146 | 0 | 45, 606 | 0 | 60.00 |
| 65. 00 | 06500 RESPI RATORY THERAPY | 258, 776 | 261, 509 | 1 | 101, 808 | 0 | 65.00 |
| 66. 00 | 06600 PHYSI CAL THERAPY | 632, 732 | 2, 865 | 1 | ., | 0 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 177, 457 | 1, 432 | 0 | 558 | 0 | 67.00 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 75, 771 | 0 | | 0 | 0 | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 | 0 | 69.00 |
| 71. 00 72. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT | 272, 445 | 0 | 0 | 0 | 0 | 71. 00 72. 00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 264, 074 | 0 | | 0 | 0 | 73.00 |
| 76. 00 | 03020 OP PSYCH | 219, 873 | 0 | 0 | 0 | 0 | 76.00 |
| 76. 01 | 03030 WOUND CARE | 73, 010 | 0 | Ö | o | 0 | 76. 01 |
| | OUTPATIENT SERVICE COST CENTERS | · · · · · · | | | | | |
| 88. 00 | 08800 MONROE FAMILY MEDICINE | 480, 113 | 0 | 0 | 0 | 0 | 88. 00 |
| 88. 01 | 08801 WOODCREST | 432, 151 | 0 | 0 | 0 | 0 | 88. 01 |
| 88. 02 | 08802 STAT CARE | 419, 573 | 64, 489 | 0 | 25, 106 | 0 | 88. 02 |
| 88. 03 | 08803 BERNE FAMILY MEDICINE | 383, 492 | 0 | 0 | 0 | 0 | 88. 03 |
| 88. 04 | 08804 HI GH STREET | 376, 009 | 0 | 0 | 0 | 0 | 88. 04 |
| 90.00 | 09000 CLINIC | 559, 793 | 263, 915 | 1 | | 0 | 90.00 |
| 90. 01 90. 02 | 09001 CLINIC - AMO | 171, 215 | 61, 080 | 1 | 23, 779 | 0 | 90. 01 |
| 90. 02 | 09002 CLINIC - AMH NEURO 09003 GENERAL SURGERY OFFICE | 45, 683 136, 196 | 56, 009 74, 144 | 1 | 21, 805 28, 865 | 0 | 90. 02 90. 03 |
| 90. 04 | | 130, 170 | 74, 144 | 0 | 20, 003 | 0 | |
| | 1 | 821, 474 | 159, 289 | | 62, 013 | 0 | |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 021, 171 | 107, 207 | | 02,010 | Ü | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 95.00 | | 558, 448 | 0 | 0 | 0 | 0 | 95.00 |
| 97.00 | 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | 0 | 0 | 0 | 97.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 0 | 0 | 0 | 0 | 0 | 101.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| | 11600 HOSPI CE | 0 | 0 | 0 | | | 116. 00 |
| 118.00 | | 13, 478, 145 | 2, 841, 445 | 397, 714 | 1, 055, 008 | 1, 592, 714 | 118. 00 |
| 400.00 | NONREI MBURSABLE COST CENTERS | 1 0 00/1 | 10 707 | 1 | | | |
| | 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 3, 026 | 18, 737 | 1 | 0 | | 190.00 |
| | 07950 TITLE XX | 0 | 121 520 | 0 | F1 20F | | 194.00 |
| | 1 07951 OTHER NRCC | 156, 999 | 131, 528 | | 51, 205 | | 194. 01 |
| | 2 07952 0THER MOBS 3 07953 DLE SPACE | 3, 273 | 103, 223 | 0 | 40, 186 | | 194. 02 194. 03 |
| | 407954 OTHER NONREIMBURSABLE COST CENTERS | 13, 937 | 0 | | | | 194. 03 |
| 200. 00 | | 13, 73/ | Ü | | | 0 | 200.00 |
| 201.00 | , , | 0 | 0 | 0 | o | 0 | 201.00 |
| 202.00 | | 13, 655, 380 | 3, 094, 933 | 397, 714 | 1, 146, 399 | | |
| | | | | | | | |

Provider CCN: 15-1330

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

| | | | 10 | 12/31/2022 | Date/IIme Pre 3/2/2024 10:0 | |
|---|------------|------------------|-----------------|-------------|----------------------------------|------------------|
| Cost Center Description | CAFETERI A | NURSI NG | CENTRAL | PHARMACY | MEDI CAL | , diii |
| | | ADMI NI STRATI O | SERVICES & | | RECORDS & | |
| | 11. 00 | N 13. 00 | SUPPLY 14.00 | 15. 00 | 16. 00 | |
| GENERAL SERVICE COST CENTERS | 11.00 | 13.00 | 14.00 | 13.00 | 10.00 | |
| 1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT | | | | | | 1.00 |
| 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5. 00 00500 ADMINI STRATI VE & GENERAL | | | | | | 5. 00 |
| 7. 00 00700 OPERATION OF PLANT | | | | | | 7.00 |
| 8. 00 00800 LAUNDRY & LINEN SERVICE | | | | | | 8.00 |
| 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY | | | | | | 9. 00 10. 00 |
| 11. 00 01100 CAFETERI A | 0 | , | | | | 11.00 |
| 13. 00 01300 NURSI NG ADMI NI STRATI ON | | 1, 410, 251 | | | | 13.00 |
| 14. 00 01400 CENTRAL SERVICES & SUPPLY | C | 0 | 0 | | | 14.00 |
| 15. 00 01500 PHARMACY | C | o | 0 | 1, 630, 841 | | 15.00 |
| 16.00 01600 MEDICAL RECORDS & LIBRARY | C | 0 | 0 | 0 | 877, 447 | 16. 00 |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | C | | 0 | 0 | 83, 849 | 30.00 |
| 31. 00 03100 I NTENSI VE CARE UNI T | C | 97, 881 | 0 | 0 | 21, 979 | 31.00 |
| 40. 00 04000 SUBPROVI DER - I PF | | 0 0 0 | 0 | 0 | 1 201 | 40.00 |
| 43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY | C | | 0 | 0 | 1, 381 0 | 43. 00 44. 00 |
| ANCI LLARY SERVICE COST CENTERS | | <u>'</u> | 0 | <u> </u> | | 1 44.00 |
| 50. 00 05000 OPERATING ROOM | C | 328, 761 | 0 | 0 | 89, 245 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | C | 1 | 0 | 0 | 1, 378 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | C | o | 0 | o | 0 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | C | 이 | 0 | 0 | 181, 729 | 54.00 |
| 60. 00 06000 LABORATORY | C | 0 | 0 | 0 | 130, 365 | 60.00 |
| 65. 00 06500 RESPIRATORY THERAPY | C | 73, 050 | 0 | 0 | 30, 900 | 1 |
| 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY | | | 0 | U O | 38, 799 | 66. 00 67. 00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY | | | 0 | 0 | 15, 942 8, 748 | |
| 69. 00 06900 ELECTROCARDI OLOGY | | | 0 | 0 | 0, 740 | 69.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | ol ol | Ö | o | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | C | o | Ō | Ö | 30, 648 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | C | o | 0 | 1, 630, 841 | 66, 549 | 73.00 |
| 76. 00 03020 OP PSYCH | C | 0 | 0 | 0 | 721 | 76. 00 |
| 76. 01 03030 WOUND CARE | C | 0 | 0 | 0 | 3, 141 | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | | ا | | ام | 1/ 012 | 00.00 |
| 88. 00 08800 MONROE FAMILY MEDICINE 88. 01 08801 WOODCREST | C | | 0 | 0 | 16, 913 14, 609 | 88. 00 88. 01 |
| 88. 02 08802 STAT CARE | | | 0 | 0 | 16, 626 | ı |
| 88. 03 08803 BERNE FAMILY MEDICINE | | | 0 | 0 | 13, 678 | |
| 88. 04 08804 HI GH STREET | | ol ol | Ö | o | 16, 489 | 88. 04 |
| 90. 00 09000 CLI NI C | C | o | 0 | 0 | 17, 255 | |
| 90. 01 09001 CLINIC - AMO | C | 0 | 0 | 0 | 5, 029 | 90. 01 |
| 90. 02 09002 CLINIC - AMH NEURO | C | 0 | 0 | 0 | 1, 815 | 1 |
| 90. 03 09003 GENERAL SURGERY OFFICE | C | 0 | 0 | 0 | 3, 040 | |
| 90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH | C | 'I Y | 0 | 0 | 0 45 050 | |
| 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 364, 380 | U | ۷ | 65, 859 | 91. 00 92. 00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | 72.00 |
| 95. 00 09500 AMBULANCE SERVI CES | C | 0 | 0 | 0 | 0 | 95.00 |
| 97.00 09700 DURABLE MEDICAL EQUIP-SOLD | C | o | 0 | o | 0 | 97. 00 |
| 101.00 10100 HOME HEALTH AGENCY | C | 0 | 0 | 0 | 0 | 101.00 |
| SPECIAL PURPOSE COST CENTERS | T | T | | | | |
| 116. 00 11600 HOSPI CE | C | | 0 | 0 | 0 876, 687 | 116.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS | C | 1, 410, 251 | 0 | 1, 630, 841 | 876,687 | 1118.00 |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | | ol ol | 0 | 0 | 0 | 190. 00 |
| 194. 00 07950 TITLE XX | | l ől | o o | ol | | 194. 00 |
| 194. 01 07951 OTHER NRCC | C | o | 0 | O | | 194. 01 |
| 194.02 07952 OTHER MOBS | C | ol ol | 0 | О | | 194. 02 |
| 194. 03 07953 I DLE SPACE | C | 이 | 0 | o | | 194. 03 |
| 194. 04 07954 OTHER NONREIMBURSABLE COST CENTERS | C | 이 | 0 | 0 | 0 | 194. 04 |
| 200.00 Cross Foot Adjustments | _ | _ | _ | _ | _ | 200.00 |
| 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201) | 0 | | 0 | 1 (20 041 | | 201.00 |
| 202.00 TOTAL (sum lines 118 through 201) | [C | 1, 410, 251 | 0 | 1, 630, 841 | 877, 447 | ZUZ. UU |

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

| | OCATION - GENERAL SERVICE COSTS | ADAMS MEMORIA | Provider CC | CN: 15-1330 | Period: Worksheet E | |
|--------------------|--|----------------------------|--------------------------|--------------------------------------|--|--------------------|
| | | | | | From 01/01/2022 Part I To 12/31/2022 Date/Time F 3/2/2024 10 | |
| | Cost Center Description | Subtotal | Intern & | Total | 37272024 10 | 5. 07 aiii |
| | | | Residents Cost & Post | | | |
| | | | Stepdown | | | |
| | | 24. 00 | Adjustments 25.00 | 26. 00 | _ | |
| GE | ENERAL SERVICE COST CENTERS | 24. 00 | 25. 00 | 20.00 | | |
| 1 | 0100 NEW CAP REL COSTS-BLDG & FIXT | | | | | 1.00 |
| | 0200 NEW CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT | | | | | 2. 00 4. 00 |
| 5.00 00 | D500 ADMINISTRATIVE & GENERAL | | | | | 5. 00 |
| 1 | 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE | | | | | 7. 00 8. 00 |
| | 0900 HOUSEKEEPI NG | | | | | 9.00 |
| | 1000 DI ETARY | | | | | 10.00 |
| 1 | 100 CAFETERIA 1300 NURSING ADMINISTRATION | | | | | 11. 00 13. 00 |
| 14. 00 01 | 1400 CENTRAL SERVICES & SUPPLY | | | | | 14.00 |
| | 1500 PHARMACY | | | | | 15.00 |
| | 1600 MEDICAL RECORDS & LIBRARY IPATIENT ROUTINE SERVICE COST CENTERS | | | | | 16. 00 |
| 30.00 03 | 3000 ADULTS & PEDIATRICS | 11, 436, 959 | 0 | 11, 436, 9 | | 30.00 |
| | B100 INTENSIVE CARE UNIT H000 SUBPROVIDER - IPF | 3, 047, 280 0 | 0 | 3, 047, 28 | 80 0 | 31. 00 40. 00 |
| | 1300 NURSERY | 122, 143 | 0 | 122, 1 | | 43.00 |
| | 1400 SKILLED NURSING FACILITY | 0 | o | | 0 | 44. 00 |
| | ICILLARY SERVICE COST CENTERS 5000 OPERATING ROOM | 6, 198, 327 | O | 6, 198, 3 | 27 | 50.00 |
| | 5200 DELIVERY ROOM & LABOR ROOM | 129, 120 | Ö | | | 52.00 |
| | 5300 ANESTHESI OLOGY | 0 | 0 | 4 057 0 | 0 | 53.00 |
| | 5400 RADI OLOGY-DI AGNOSTI C 5000 LABORATORY | 4, 057, 003 6, 282, 238 | 0 | 4, 057, 00 6, 282, 23 | | 54. 00 60. 00 |
| 65.00 06 | 5500 RESPI RATORY THERAPY | 1, 752, 677 | ō | 1, 752, 6 | 77 | 65.00 |
| 1 | 5600 PHYSICAL THERAPY 5700 OCCUPATIONAL THERAPY | 3, 185, 725 899, 406 | 0 | 3, 185, 7: 899, 40 | | 66. 00 67. 00 |
| | 5800 SPEECH PATHOLOGY | 385, 123 | 0 | 385, 12 | | 68.00 |
| | 5900 ELECTROCARDI OLOGY | 0 | 0 | | 0 | 69.00 |
| | 7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 7200 IMPL. DEV. CHARGED TO PATIENT | 0 1, 383, 952 | 0 | 1, 383, 9 | 0 52 | 71. 00 72. 00 |
| 73.00 07 | 7300 DRUGS CHARGED TO PATIENTS | 3, 009, 115 | Ö | 3, 009, 1 | 15 | 73. 00 |
| | 3020 OP PSYCH | 1, 092, 887 365, 802 | 0 | 1, 092, 88 | | 76.00 |
| | 3030 WOUND CARE UTPATIENT SERVICE COST CENTERS | 300, 802 | U _I | 365, 80 | 02 | 76. 01 |
| | B800 MONROE FAMILY MEDICINE | 2, 401, 760 | 0 | | | 88. 00 |
| | 8801 WOODCREST 8802 STAT CARE | 2, 161, 217 2, 190, 350 | 0 | 2, 161, 2 ⁻ 2, 190, 3! | | 88. 01 88. 02 |
| | 3803 BERNE FAMILY MEDICINE | 1, 918, 583 | o | 1, 918, 5 | | 88. 03 |
| | 3804 HI GH STREET | 1, 884, 223 | | | | 88. 04 |
| | 2000 CLINIC 2001 CLINIC - AMO | 3, 164, 552 940, 356 | 0 | 3, 164, 5! 940, 3! | | 90. 00 90. 01 |
| 90. 02 09 | POO2 CLINIC - AMH NEURO | 306, 548 | O | 306, 5 | 48 | 90. 02 |
| | POO3 GENERAL SURGERY OFFICE 1950 INTENSIVE OP BEHAVIORAL HEALTH | 782, 571 0 | 0 | 782, 5 | 71 0 | 90. 03 90. 04 |
| | 9100 EMERGENCY | 4, 732, 018 | | 4, 732, 0° | | 91.00 |
| | 9200 OBSERVATION BEDS (NON-DISTINCT PART) | | 0 | | | 92. 00 |
| | THER REIMBURSABLE COST CENTERS PSOO AMBULANCE SERVICES | 2, 773, 958 | ol | 2, 773, 9 | 58 | 95. 00 |
| 97. 00 09 | 9700 DURABLE MEDICAL EQUIP-SOLD | 0 | О | | 0 | 97.00 |
| | 0100 HOME HEALTH AGENCY PECIAL PURPOSE COST CENTERS | 0 | 0 | | 0 | 101.00 |
| | 1600 HOSPI CE | 0 | 0 | | 0 | 116. 00 |
| 118. 00 | SUBTOTALS (SUM OF LINES 1 through 117) | 66, 603, 893 | 0 | 66, 603, 89 | 93 | 118. 00 |
| | ONREIMBURSABLE COST CENTERS OOOO GIFT, FLOWER, COFFEE SHOP & CANTEEN | 33, 767 | O | 33, 70 | 67 | 190. 00 |
| 194. 00 07 | 7950 TITLE XX | 0 | Ö | 337 7 | 0 | 194. 00 |
| | 7951 OTHER NRCC 7952 OTHER MOBS | 963, 350 159, 666 | 0 | 963, 3! 159, 66 | | 194. 01 194. 02 |
| | 7953 IDLE SPACE | 0 | 0 | 137, 00 | 0 | 194. 02 |
| 194. 04 07 | 7954 OTHER NONREIMBURSABLE COST CENTERS | 69, 229 | 0 | 69, 2 | | 194.04 |
| 200. 00 201. 00 | Cross Foot Adjustments Negative Cost Centers | 0 | 0 | | 0 | 200. 00 201. 00 |
| 202. 00 | TOTAL (sum lines 118 through 201) | 67, 829, 905 | | 67, 829, 90 | 05 | 202.00 |
| • | · · · · · · · · · · · · · · · · · · · | · | | | | |

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1330

| | | | | Io | 12/31/2022 | Date/lime Pre 3/2/2024 10:0 | pared: 7 am |
|------------------|--|--------------------------|---------------------|--------------------|---------------------|----------------------------------|--------------------|
| | | | CAPI TAL REL | ATED COSTS | | , | |
| | Occidence Described to the control of the control o | D: | NEW DIDO A | NEW ANDLE | 6 1 1 1 1 | EMBL OVEE | |
| | Cost Center Description | Directly Assigned New | NEW BLDG & FLXT | NEW MVBLE EQUIP | Subtotal | EMPLOYEE BENEFITS | |
| | | Capi tal | TIXI | EQUIT | | DEPARTMENT | |
| | | Related Costs | | | | | |
| | JOENEDAL OFFICE COOT OFFICE | 0 | 1. 00 | 2.00 | 2A | 4. 00 | |
| 1. 00 | GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2. 00 | 00200 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 2.00 |
| 4. 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | o | 0 | 0 | О | 0 | 4.00 |
| 5.00 | 00500 ADMINISTRATIVE & GENERAL | o | 181, 074 | 0 | 181, 074 | 0 | 5.00 |
| 7.00 | 00700 OPERATION OF PLANT | 0 | 273, 125 | 0 | 273, 125 | 0 | 7. 00 |
| 8. 00 | 00800 LAUNDRY & LINEN SERVICE | 0 | 31, 736 | 0 | 31, 736 | 0 | 8. 00 |
| 9. 00 10. 00 | 00900 HOUSEKEEPI NG | 0 | 52, 514 125, 237 | 0 | 52, 514 | 0 | 9. 00 10. 00 |
| 11. 00 | 01000 DI ETARY 01100 CAFETERI A | | 125, 257 | 0 | 125, 237 0 | 0 | 11.00 |
| 13. 00 | 01300 NURSI NG ADMI NI STRATI ON | o | 5, 800 | | 5, 800 | 0 | 13.00 |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 0 | 0 | 0 | 0 | 0 | 14.00 |
| 15.00 | 01500 PHARMACY | 0 | 40, 969 | 0 | 40, 969 | 0 | 15.00 |
| 16. 00 | 01600 MEDI CAL RECORDS & LI BRARY | 0 | 46, 604 | 0 | 46, 604 | 0 | 16.00 |
| 30. 00 | INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS | l ol | 293, 717 | 0 | 293, 717 | 0 | 30.00 |
| 31. 00 | 03100 INTENSIVE CARE UNIT | | 52, 753 | 0 | 52, 753 | 0 | 31.00 |
| 40.00 | 04000 SUBPROVI DER - I PF | 0 | 02, 700 | Ö | 02,700 | 0 | 40.00 |
| 43.00 | 04300 NURSERY | o | 27, 478 | 0 | 27, 478 | 0 | 43.00 |
| 44.00 | 04400 SKILLED NURSING FACILITY | 0 | 0 | 0 | 0 | 0 | 44.00 |
| EO 00 | ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM | l ol | 201 244 | | 201 244 | 0 | FO 00 |
| 50. 00 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | | 201, 264 27, 478 | 0 | 201, 264 27, 478 | 0 | 50.00 52.00 |
| 53.00 | 05300 ANESTHESI OLOGY | 0 | 27, 170 | O | 27, 170 | 0 | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0 | 162, 535 | 0 | 162, 535 | 0 | 54.00 |
| 60.00 | 06000 LABORATORY | 0 | 72, 062 | 0 | 72, 062 | 0 | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 0 | 75, 054 | 0 | 75, 054 | 0 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0 | 167, 546 | 0 | 167, 546 | 0 | 66.00 |
| 67. 00 68. 00 | 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY | 0 | 1, 836 918 | 0 | 1, 836 918 | 0 | 67. 00 68. 00 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | | 0 | 0 | 0 | 0 | 69.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | O | 0 | 0 | O | 0 | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | 0 | 0 | 0 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | 73.00 |
| 76. 00 76. 01 | 03020 OP PSYCH 03030 WOUND CARE | 0 | 0 | 0 | 0 | 0 | 76. 00 76. 01 |
| 70.01 | OUTPATIENT SERVICE COST CENTERS | <u> </u> | <u> </u> | <u> </u> | <u> </u> | | 70.01 |
| 88. 00 | 08800 MONROE FAMILY MEDICINE | 0 | 0 | 0 | 0 | 0 | 88. 00 |
| 88. 01 | 08801 WOODCREST | 0 | 0 | 0 | 0 | 0 | 88. 01 |
| 88. 02 | 08802 STAT CARE | 0 | 41, 317 | 0 | 41, 317 | 0 | 88. 02 |
| 88. 03 88. 04 | 08803 BERNE FAMILY MEDICINE 08804 HIGH STREET | 0 | 0 | 0 | U O | 0 | 88. 03 88. 04 |
| 90.00 | 09000 CLINIC | | 0 | 0 | 0 | 0 | 90.00 |
| | 09001 CLINIC - AMO | 0 | 0 | Ö | o | 0 | 90. 01 |
| | 09002 CLINIC - AMH NEURO | o | 0 | 0 | О | 0 | 90. 02 |
| 90. 03 | | 0 | 0 | 0 | 0 | 0 | 90. 03 |
| | 04950 INTENSIVE OP BEHAVIORAL HEALTH | 0 | 102.055 | 0 | 102.055 | 0 | 90.04 |
| 91. 00 92. 00 | O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART) | ٥ | 102, 055 | 0 | 102, 055 | 0 | 91. 00 92. 00 |
| 72.00 | OTHER REIMBURSABLE COST CENTERS | | | | <u> </u> | | 72.00 |
| 95.00 | 09500 AMBULANCE SERVICES | 0 | 0 | 0 | 0 | 0 | 95.00 |
| | 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | 0 | 0 | 0 | 97. 00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 0 | 0 | 0 | 0 | 0 | 101. 00 |
| 116 00 | SPECIAL PURPOSE COST CENTERS 011600 HOSPICE | l | 0 | 0 | ol | 0 | 116. 00 |
| 118. 00 | | 0 | 1, 983, 072 | | 1, 983, 072 | | 118.00 |
| | NONREI MBURSABLE COST CENTERS | | ., | - | ., | | |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 12, 004 | 0 | 12, 004 | | 190. 00 |
| | 07950 TITLE XX | 0 | 0 | 0 | 0 | | 194.00 |
| | O7951 OTHER NRCC 2 O7952 OTHER MOBS | 0 | 0 | | 0 | | 194. 01 194. 02 |
| | 3 07953 I DLE SPACE | | 0 | 0 | 0 | | 194. 02 |
| | 1 07954 OTHER NONREIMBURSABLE COST CENTERS | | Ö | o | o | | 194. 04 |
| 200.00 | Cross Foot Adjustments | | | | О | | 200. 00 |
| 201.00 | | _ | 0 | 0 | 0 | | 201.00 |
| 202. 00 | TOTAL (sum lines 118 through 201) | 0 | 1, 995, 076 | 0 | 1, 995, 076 | 0 | 202. 00 |
| | | | | | | | |

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1330

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

3/2/2024 10:07 am Cost Center Description ADMINISTRATIV OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY E & GENERAL PLANT LINEN SERVICE 5.00 9.00 10.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 00500 ADMINISTRATIVE & GENERAL 5.00 181,074 5.00 7.00 00700 OPERATION OF PLANT 8, 261 281, 386 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 929 4,504 37, 169 8.00 00900 HOUSEKEEPI NG 2 841 7, 452 62, 807 9 00 9 00 0 10.00 01000 DI ETARY 3,526 17, 772 0 4, 169 150, 704 10.00 01100 CAFETERI A 0 11.00 0 11.00 13.00 01300 NURSING ADMINISTRATION 3.731 823 0 193 0 13.00 01400 CENTRAL SERVICES & SUPPLY 0 14 00 Ω 0 0 14.00 0 15.00 01500 PHARMACY 4, 116 5, 814 1, 364 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 2,072 6,613 1,551 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 22.670 41, 681 03000 ADULTS & PEDIATRICS 30, 270 9.778 129, 105 30.00 31.00 03100 INTENSIVE CARE UNIT 6,755 7, 486 5,064 1, 756 21, 599 31.00 04000 SUBPROVI DER - I PF 40 00 40.00 04300 NURSERY 3, 899 43.00 1, 375 915 0 43.00 121 04400 SKILLED NURSING FACILITY 44.00 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 13, 323 0 12, 111 0 50.00 51, 628 05200 DELIVERY ROOM & LABOR ROOM 3, 899 52.00 163 460 915 0 52.00 53.00 05300 ANESTHESI OLOGY Ω 0 0 0 53.00 2, 399 54.00 05400 RADI OLOGY-DI AGNOSTI C 9, 927 10, 226 0 0 54.00 06000 LABORATORY 15.986 0 2.499 60.00 10,651 0 60.00 06500 RESPIRATORY THERAPY 0 65.00 3.431 23, 776 5, 578 0 65.00 06600 PHYSI CAL THERAPY 8, 389 0 0 66.00 260 61 66.00 06700 OCCUPATI ONAL THERAPY 67.00 2, 353 130 0 31 0 67.00 06800 SPEECH PATHOLOGY 1, 005 0 68.00 C 0 0 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 C 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 0 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 0 0 72.00 3.612 07300 DRUGS CHARGED TO PATIENTS 0 o 73.00 3.501 C 0 73.00 76.00 03020 OP PSYCH 2, 915 C 0 0 76.00 03030 WOUND CARE 0 76.01 968 0 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 MONROE FAMILY MEDICINE 6, 366 0 0 0 88.01 08801 WOODCREST 5,730 0 0 0 88.01 88.02 08802 STAT CARE 5, 563 5,863 0 1, 375 0 88.02 88 03 08803 BERNE FAMILY MEDICINE 5.085 0 Ω 88 03 0 0 88.04 08804 HI GH STREET 4, 985 0 0 88.04 90.00 09000 CLI NI C 7, 422 23, 995 5, 629 0 90.00 90.01 09001 CLINIC - AMO 2, 270 5, 553 0 1, 303 0 90.01 09002 CLINIC - AMH NEURO 5.092 0 90 02 90 02 606 1 195 0 6, 741 1, 581 90.03 09003 GENERAL SURGERY OFFICE 1,806 0 0 90.03 90.04 04950 INTENSIVE OP BEHAVIORAL HEALTH 0 0 90.04 91.00 09100 EMERGENCY 10, 892 0 3, 397 91.00 14, 482 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 7, 404 0 95.00 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 C 0 0 Ω 101.00 10100 HOME HEALTH AGENCY 0 C 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 116.00 C SUBTOTALS (SUM OF LINES 1 through 117) 57, 800 178, 724 258, 340 37, 169 150, 704 118. 00 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 40 1,703 0 0 194.00 07950 TITLE XX 0 194.00 0 0 0 0 194.01 194. 01 07951 OTHER NRCC 2.082 11, 958 0 2 805 194. 02 07952 OTHER MOBS 9, 385 0 2, 202 0 194.02 43 194. 03 07953 I DLE SPACE 0 0 194. 03 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 194.04 185 C 0 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 181, 074 281, 386 37, 169 62, 807 150, 704 202. 00

Provider CCN: 15-1330

| | | | | | 12/01/2022 | 3/2/2024 10: 0 | 7 am |
|--------------|--|------------|------------------|------------|------------|----------------|----------------|
| | Cost Center Description | CAFETERI A | NURSI NG | CENTRAL | PHARMACY | MEDI CAL | |
| | | | ADMI NI STRATI O | SERVICES & | | RECORDS & | |
| | | | N | SUPPLY | | LI BRARY | |
| OFNE | CDAL OFFICE OF SOUT OFFITTED | 11. 00 | 13. 00 | 14.00 | 15. 00 | 16. 00 | |
| | ERAL SERVICE COST CENTERS | | | | | | 1 00 |
| | OO NEW CAP REL COSTS-BLDG & FLXT | | | | | | 1.00 |
| | OO NEW CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| | OO EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| • | OO ADMINISTRATIVE & GENERAL | | | | | | 5.00 |
| | OO OPERATION OF PLANT | | | | | | 7.00 |
| | DO LAUNDRY & LI NEN SERVI CE DO HOUSEKEEPI NG | | | | | | 8. 00 9. 00 |
| | DO DI ETARY | | | | | | 10.00 |
| | DO CAFETERI A | 0 | | | | | 11.00 |
| | OO NURSING ADMINISTRATION | 0 | 10, 547 | | | | 13.00 |
| | 00 CENTRAL SERVICES & SUPPLY | 0 | 10, 547 | 0 | | | 14.00 |
| | DO PHARMACY | | 0 | 0 | 52, 263 | | 15.00 |
| | 00 MEDICAL RECORDS & LIBRARY | 0 | | 0 | 0 | 56, 840 | 16.00 |
| | ATIENT ROUTINE SERVICE COST CENTERS | | 0 | 0 | <u> </u> | 30, 040 | 10.00 |
| | OO ADULTS & PEDIATRICS | 0 | 4, 058 | 0 | n | 5, 434 | 30.00 |
| | OO INTENSIVE CARE UNIT | 0 | 1 | 0 | 0 | 1, 424 | 1 |
| | 00 SUBPROVI DER - I PF | 0 | 7.52 | 0 | 0 | 0 | 40.00 |
| | OO NURSERY | Ö | 7 | 0 | 0 | 89 | 43.00 |
| | OO SKILLED NURSING FACILITY | 0 | 1 | Ö | 0 | 0 | 44.00 |
| | LLARY SERVICE COST CENTERS | | | <u> </u> | ۷۱ | | 11.00 |
| | OO OPERATING ROOM | 0 | 2, 460 | 0 | ol | 5, 783 | 50.00 |
| | DO DELIVERY ROOM & LABOR ROOM | Ö | | ő | o | 89 | 52.00 |
| | OO ANESTHESI OLOGY | 0 | 1 | ő | 0 | 0 | 53.00 |
| • | DO RADI OLOGY-DI AGNOSTI C | 0 | 0 | Ő | 0 | 11, 756 | 54.00 |
| | DO LABORATORY | 0 | 0 | 0 | o | 8, 448 | 60.00 |
| • | 00 RESPI RATORY THERAPY | 0 | 547 | 0 | o | 2, 002 | 65.00 |
| | 00 PHYSI CAL THERAPY | 0 | 0 | 0 | 0 | 2, 514 | 1 |
| • | OO OCCUPATI ONAL THERAPY | Ö | l o | 0 | o | 1, 033 | 67.00 |
| • | OO SPEECH PATHOLOGY | 0 | 0 | 0 | o | 567 | 68.00 |
| • | DO ELECTROCARDI OLOGY | 0 | 0 | 0 | o | 0 | 69.00 |
| 71. 00 0710 | MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 0 | o | 0 | 71.00 |
| | DO IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | 0 | O | 1, 986 | 72.00 |
| | DO DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 52, 263 | 4, 313 | 73.00 |
| 76. 00 0302 | 20 OP PSYCH | 0 | 0 | 0 | 0 | 47 | 76.00 |
| 76. 01 0303 | BO WOUND CARE | 0 | 0 | 0 | 0 | 204 | 76. 01 |
| OUTF | PATIENT SERVICE COST CENTERS | | | | | | |
| 88. 00 0880 | DO MONROE FAMILY MEDICINE | 0 | 0 | 0 | 0 | 1, 096 | 88. 00 |
| 88. 01 0880 | 01 WOODCREST | 0 | 0 | 0 | 0 | 947 | 88. 01 |
| 88. 02 0880 | D2 STAT CARE | 0 | 0 | 0 | 0 | 1, 077 | 88. 02 |
| 88. 03 0880 | 03 BERNE FAMILY MEDICINE | 0 | 0 | 0 | 0 | 886 | 88. 03 |
| 88. 04 0880 | 04 HI GH STREET | 0 | 0 | 0 | 0 | 1, 069 | 88. 04 |
| | DO CLINIC | 0 | 0 | 0 | 0 | 1, 118 | 90.00 |
| 90. 01 0900 | D1 CLINIC - AMO | 0 | 0 | 0 | 0 | 326 | 90. 01 |
| | 02 CLINIC - AMH NEURO | 0 | 0 | 0 | 0 | 118 | 90. 02 |
| • | 03 GENERAL SURGERY OFFICE | 0 | 0 | 0 | 0 | 197 | 90. 03 |
| 1 | 50 INTENSIVE OP BEHAVIORAL HEALTH | 0 | 1 | 0 | 0 | 0 | 90. 04 |
| | DO EMERGENCY | 0 | 2, 726 | 0 | 0 | 4, 268 | 91.00 |
| | OO OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| | R REIMBURSABLE COST CENTERS | | 1 | .1 | | | |
| | OO AMBULANCE SERVICES | 0 | | 0 | 0 | 0 | 95.00 |
| • | DO DURABLE MEDICAL EQUIP-SOLD | 0 | | 0 | 0 | 0 | 97.00 |
| | DO HOME HEALTH AGENCY | 0 | 0 | 0 | 0 | 0 | 101. 00 |
| | CIAL PURPOSE COST CENTERS | | T | | | | |
| 116. 00 1160 | | 0 | | 0 | 0 | | 116. 00 |
| 118. 00 | SUBTOTALS (SUM OF LINES 1 through 117) | 0 | 10, 547 | 0 | 52, 263 | 56, 791 | 118.00 |
| | REIMBURSABLE COST CENTERS | _ | _ | _1 | | | |
| | OO GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | | 0 | 0 | | 190.00 |
| | 50 TITLE XX | 0 | 1 | 0 | 0 | | 194.00 |
| | 51 OTHER NRCC | 0 | 0 | 0 | 0 | | 194. 01 |
| | 52 OTHER MOBS | 0 | 0 | 0 | 0 | | 194. 02 |
| | 53 I DLE SPACE | 0 | 0 | 0 | 0 | | 194. 03 |
| | OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 194. 04 |
| 200.00 | Cross Foot Adjustments | _ | _ | _ | _ | _ | 200.00 |
| 201.00 | Negative Cost Centers | 0 | | 0 | 50.00 | | 201.00 |
| 202. 00 | TOTAL (sum lines 118 through 201) | 0 | 10, 547 | 0 | 52, 263 | 56, 840 | J2U2. UU |
| | | | | | | | |

Health Financial Systems ADAMS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1330 Period: Worksheet B

| ALLOCA | TION OF CAPITAL RELATED COSTS | | Provi der C | | Period: Workshee | et B |
|------------------|--|---------------------|-------------------------|-------------|---|--------------------|
| | | | | | From 01/01/2022 Part II Fo 12/31/2022 Date/Tim | me Prepared: |
| | | | | | | 4 10:07 am |
| | Cost Center Description | Subtotal | Intern & | Total | | |
| | | | Resi dents | | | |
| | | | Cost & Post | | | |
| | | | Stepdown Adjustments | | | |
| | | 24. 00 | 25. 00 | 26. 00 | + | |
| | GENERAL SERVICE COST CENTERS | 21100 | 20.00 | 20.00 | | |
| 1.00 | 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | 1.00 |
| 2.00 | 00200 NEW CAP REL COSTS-MVBLE EQUIP | | | | | 2. 00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | 4.00 |
| 5.00 | OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT | | | | | 5.00 |
| 7. 00 8. 00 | 00800 LAUNDRY & LINEN SERVICE | | | | | 7. 00 8. 00 |
| 9. 00 | 00900 HOUSEKEEPI NG | | | | | 9.00 |
| 10.00 | 01000 DI ETARY | | | | | 10.00 |
| 11.00 | 01100 CAFETERI A | | | | | 11.00 |
| 13.00 | 01300 NURSING ADMINISTRATION | | | | | 13. 00 |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | | | | | 14.00 |
| 15.00 | 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY | | | | | 15.00 |
| 16.00 | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | 16. 00 |
| 30. 00 | 03000 ADULTS & PEDIATRICS | 536, 713 | 0 | 536, 713 | 3 | 30.00 |
| 31. 00 | 03100 NTENSI VE CARE UNIT | 97, 569 | 0 | | | 31.00 |
| 40.00 | 04000 SUBPROVI DER - I PF | 0 | 0 | | | 40.00 |
| 43.00 | 04300 NURSERY | 33, 884 | 0 | | | 43.00 |
| 44. 00 | 04400 SKILLED NURSING FACILITY | 0 | 0 | (|) | 44. 00 |
| FO 00 | ANCILLARY SERVICE COST CENTERS | 20/ 5/0 | 0 | 20/ 5// | | |
| 50. 00 52. 00 | 05000 OPERATING ROOM | 286, 569 33, 021 | 0 | | | 50. 00 52. 00 |
| 53. 00 | 05300 ANESTHESI OLOGY | 33, 021 | 0 | 33,02 | | 53.00 |
| 54. 00 | 05400 RADI OLOGY-DI AGNOSTI C | 196, 843 | 0 | 196, 843 | 3 | 54.00 |
| 60.00 | 06000 LABORATORY | 109, 646 | 0 | 109, 646 | اٰو | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 110, 388 | 0 | 110, 388 | | 65. 00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 178, 770 | 0 | | | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 5, 383 | 0 | | | 67.00 |
| 68. 00 69. 00 | 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY | 2, 490 0 | 0 | | | 68. 00 69. 00 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | á | 71.00 |
| 72. 00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 5, 598 | 0 | 5, 598 | 3 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 60, 077 | 0 | | | 73. 00 |
| 76.00 | 03020 OP PSYCH | 2, 962 | 0 | | | 76. 00 |
| 76. 01 | 03030 WOUND CARE | 1, 172 | 0 | 1, 172 | 2 | 76. 01 |
| 88. 00 | OUTPATIENT SERVICE COST CENTERS 08800 MONROE FAMILY MEDICINE | 7, 462 | 0 | 7 14 | 2 | 88.00 |
| 88. 01 | 08801 WOODCREST | 6, 677 | 0 | | | 88. 01 |
| 88. 02 | 08802 STAT CARE | 55, 195 | 0 | | | 88. 02 |
| 88. 03 | 08803 BERNE FAMILY MEDICINE | 5, 971 | 0 | 5, 97 | | 88. 03 |
| 88. 04 | 08804 HI GH STREET | 6, 054 | 0 | | | 88. 04 |
| | 09000 CLI NI C | 38, 164 | 0 | 30, 10- | | 90.00 |
| | 09001 CLINIC - AMO | 9, 452 | 0 | | | 90. 01 |
| | 09002 CLINIC - AMH NEURO | 7, 011 | 0 | 7, 01 | | 90.02 |
| | 09003 GENERAL SURGERY OFFICE 04950 INTENSIVE OP BEHAVIORAL HEALTH | 10, 325 0 | 0 | | | 90. 03 90. 04 |
| | 09100 EMERGENCY | 137, 820 | 0 | | | 91.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 107,020 | 0 | | | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | |
| 95.00 | 09500 AMBULANCE SERVICES | 7, 404 | 0 | | 1 | 95.00 |
| | 09700 DURABLE MEDI CAL EQUI P-SOLD | 0 | 0 | • | | 97.00 |
| 101.00 | 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS | 0 | 0 | (|) | 101.00 |
| 116 00 | 11600 HOSPI CE | 0 | 0 | | J. | 116. 00 |
| 118.00 | l i | 1, 952, 620 | 0 | | - | 118.00 |
| | NONREI MBURSABLE COST CENTERS | .,,,,,,,,, | | ., ,,,,,,,, | ·1 | 1.10.00 |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 13, 747 | 0 | 13, 747 | 7 | 190. 00 |
| | 07950 TITLE XX | 0 | 0 | (| | 194. 00 |
| | 07951 OTHER NRCC | 16, 894 | 0 | 16, 894 | | 194. 01 |
| | 07952 OTHER MOBS | 11, 630 | 0 | 11, 630 | | 194. 02 |
| | 07953 DLE SPACE 07954 OTHER NONREIMBURSABLE COST CENTERS | 0 185 | 0 | 185 | | 194. 03 194. 04 |
| 200.00 | | 185 | 0 | 185 | | 200.00 |
| 201.00 | | 0 | 0 | | ,) | 201.00 |
| 202.00 | | 1, 995, 076 | | | اخ | 202.00 |
| | , , , , | | | | • | |

Heal<u>th</u> Financial Systems From 01/01/2022 To 12/31/2022 Date/Time Prepared: 3/2/2024 10:07 am CAPITAL RELATED COSTS Cost Center Description NEW BLDG & NEW MVBLE **EMPLOYEE** Reconciliatio ADMINISTRATIV E & GENERAL (ACCUM. COST) BENEFITS EQUI P FLXT n (SQUARE FEET) (SQUARE FEET) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 4.00 5A 5.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 1.00 108, 693 1.00 2.00 2.00 0 36, 715, 657 3, 397, 762 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5. 00 00500 ADMINISTRATIVE & GENERAL 9. 865 -13, 655, 380 54, 174, 525 5. 00

| 8. 00 0 9. 00 0 10. 00 0 11. 00 0 13. 00 0 14. 00 0 15. 00 0 | DOTOO OPERATION OF PLANT 108800 LAUNDRY & LINEN SERVICE 100900 HOUSEKEEPING 101000 DIETARY 11100 CAFETERIA | 14, 880 1, 729 2, 861 | 0 0 0 | 0 70, 782 493, 421 | 0 | 2, 471, 867 278, 085 | 8.00 |
|--|--|-----------------------------|-------------|--------------------------|---------------|-------------------------|---------|
| 9. 00 0 10. 00 0 11. 00 0 13. 00 0 14. 00 0 15. 00 0 | 00900 HOUSEKEEPI NG 01000 DI ETARY | 2, 861 | 0 | | 0 | | 1 |
| 10.00 (0 11.00 (0 13.00 (0 14.00 (0 15.00 (0 | D1000 DI ETARY | | 0 | 493, 421 | UI | | |
| 11. 00 0 13. 00 0 14. 00 0 15. 00 0 | | | _ | | 9 | 850, 144 | 1 |
| 13. 00 0 14. 00 0 15. 00 0 | 111001CAFFTERLA | 6, 823 | 0 | 623, 816 | 0 | 1, 055, 172 | 1 |
| 14. 00 (15. 00 (| | 0 | 0 | 0 | 0 | 0 | |
| 15.00 | D1300 NURSI NG ADMI NI STRATI ON | 316 | 0 | 879, 369 | 0 | 1, 116, 297 | |
| | 01400 CENTRAL SERVICES & SUPPLY | 0 | 0 | 0 | 0 | 0 | |
| | D1500 PHARMACY | 2, 232 | 0 | 868, 295 | 0 | 1, 231, 569 | 1 |
| | 01600 MEDICAL RECORDS & LIBRARY | 2, 539 | 0 | 310, 582 | 0 | 620, 088 | 16.00 |
| | NPATIENT ROUTINE SERVICE COST CENTERS | | | | | | 4 |
| | 03000 ADULTS & PEDI ATRI CS | 16, 002 | 0 | 3, 810, 510 | 0 | 6, 776, 757 | 1 |
| | 03100 INTENSIVE CARE UNIT | 2, 874 | 0 | 686, 935 | 0 | 2, 021, 120 | 1 |
| | 04000 SUBPROVI DER - I PF | 0 | 0 | 0 | 0 | 0 | |
| | 04300 NURSERY | 1, 497 | 0 | 6, 679 | 0 | 36, 347 | 1 |
| | 04400 SKILLED NURSING FACILITY | 0 | 0 | 0 | 0 | 0 | 44.00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | 4 |
| | D5000 OPERATING ROOM | 10, 965 | 0 | 2, 307, 270 | 0 | 3, 986, 569 | 1 |
| | D5200 DELIVERY ROOM & LABOR ROOM | 1, 497 | 0 | 15, 970 | 0 | 48, 684 | 1 |
| | D5300 ANESTHESI OLOGY | 0 | 0 | 0 | 0 | 0 | |
| | D5400 RADI OLOGY-DI AGNOSTI C | 8, 855 | 0 | 1, 164, 702 | 0 | 2, 970, 306 | 1 |
| | 06000 LABORATORY | 3, 926 | 0 | 1, 246, 838 | 0 | 4, 783, 402 | 1 |
| 1 | 06500 RESPI RATORY THERAPY | 4, 089 | 0 | 512, 669 | 0 | 1, 026, 634 | 1 |
| | 06600 PHYSI CAL THERAPY | 9, 128 | 0 | 1, 780, 676 | 0 | 2, 510, 214 | 66.00 |
| | 06700 OCCUPATI ONAL THERAPY | 100 | 0 | 557, 815 | 0 | 704, 017 | 67.00 |
| | 06800 SPEECH PATHOLOGY | 50 | 0 | 248, 450 | 0 | 300, 604 | 68.00 |
| | 06900 ELECTROCARDI OLOGY | 0 | 0 | 0 | 0 | 0 | 69.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | 0 | 0 | 1, 080, 859 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 1, 047, 651 | 73.00 |
| 76.00 | 03020 OP PSYCH | 0 | 0 | 901, 924 | 0 | 872, 293 | 76.00 |
| 76. 01 | 03030 WOUND CARE | 0 | 0 | 193, 378 | 0 | 289, 651 | 76. 01 |
| | DUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88. 00 | 08800 MONROE FAMILY MEDICINE | 0 | 0 | 1, 358, 085 | 0 | 1, 904, 734 | 88. 00 |
| | 08801 WOODCREST | 0 | 0 | 1, 221, 305 | 0 | 1, 714, 457 | 88. 01 |
| 88. 02 | 08802 STAT CARE | 2, 251 | 0 | 1, 139, 784 | 0 | 1, 664, 556 | 88. 02 |
| 88. 03 | 08803 BERNE FAMILY MEDICINE | 0 | 0 | 978, 281 | 0 | 1, 521, 413 | 88. 03 |
| 88. 04 | D8804 HI GH STREET | 0 | 0 | 1, 052, 129 | 0 | 1, 491, 725 | 88. 04 |
| 90.00 | 09000 CLI NI C | 0 | 0 | 2, 693, 747 | 0 | 2, 220, 844 | 90.00 |
| 90.01 | 09001 CLINIC - AMO | 0 | 0 | 1, 997, 376 | 0 | 679, 253 | 90. 01 |
| 90.02 | 09002 CLINIC - AMH NEURO | 0 | 0 | 699, 873 | 0 | 181, 236 | 90.02 |
| 90.03 | 09003 GENERAL SURGERY OFFICE | 0 | 0 | 1, 185, 291 | 0 | 540, 326 | 90.03 |
| | 04950 INTENSIVE OP BEHAVIORAL HEALTH | O | O | 0 | 0 | 0 | 90.04 |
| 91.00 | 09100 EMERGENCY | 5, 560 | O | 2, 557, 248 | 0 | 3, 259, 003 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| C | OTHER REIMBURSABLE COST CENTERS | | | | | | Ī |
| 95.00 | 09500 AMBULANCE SERVICES | 0 | 0 | 1, 436, 128 | 0 | 2, 215, 510 | 95.00 |
| 97.00 | 09700 DURABLE MEDICAL EQUIP-SOLD | o | O | 0 | O | 0 | |
| 101.00 | 10100 HOME HEALTH AGENCY | o | o | 0 | O | 0 | 101.00 |
| 5 | SPECIAL PURPOSE COST CENTERS | | | <u>.</u> | | | Ī |
| 116.00 | 11600 HOSPI CE | 0 | 0 | 0 | 0 | 0 | 116.00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) | 108, 039 | 0 | 36, 397, 090 | -13, 655, 380 | 53, 471, 387 | 118.00 |
| 1 | NONREI MBURSABLE COST CENTERS | | | | | | 1 |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 654 | 0 | 0 | 0 | 12, 004 | 190.00 |
| | 07950 TITLE XX | o | 0 | 0 | o | | 194.00 |
| | 07951 OTHER NRCC | ol | o | 318, 567 | ol | 622, 858 | 1 |
| | 07952 OTHER MOBS | 0 | 0 | 0 | 0 | | 194. 02 |
| | 07953 I DLE SPACE | ol | ol | Ö | o | | 194. 03 |
| | 07954 OTHER NONREIMBURSABLE COST CENTERS | 0 | 0 | 0 | 0 | 55, 292 | |
| 200.00 | Cross Foot Adjustments | ٩ | ٦ | ٩ | ٦ | | 200.00 |
| 201.00 | Negative Cost Centers | | | | | | 201.00 |
| 202.00 | Cost to be allocated (per Wkst. B, | 1, 995, 076 | o | 294, 168 | | 13, 655, 380 | |
| _52.00 | Part I) | ., ., 0, 0, 0 | 9 | 271,100 | | .0,000,000 | |
| 203. 00 | Unit cost multiplier (Wkst. B, Part I) | 18. 355147 | 0. 000000 | 0. 008012 | | 0. 252063 | 203.00 |
| _55.55 | [c 335ca. c. p. 151 (mat. b, 141 c 1) | . 5. 5551 77 | 3. 000000 | 3. 000012 | ı | 5. 202000 | 1-00.00 |

| Heal th Fir | nancial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|-------------|--|--------------------|--------------------|----------------------|----------------------------------|------------------------------|---------|
| COST ALLO | CATION - STATISTICAL BASIS | | Provi der Co | | Peri od: | Worksheet B-1 | |
| | | | | | From 01/01/2022 To 12/31/2022 | | |
| | | CAPI TAL REI | LATED COSTS | | | | |
| | Cost Center Description | NEW BLDG & FLXT | NEW MVBLE EQUIP | EMPLOYEE BENEFITS | Reconciliatio n | ADMINISTRATIV E & GENERAL | |
| | | (SQUARE FEET) | (SQUARE FEET) | DEPARTMENT (GROSS | | (ACCUM. COST) | |
| | | 1. 00 | 2.00 | SALARI ES) 4. 00 | 5A | 5. 00 | |
| 204.00 | Cost to be allocated (per Wkst. B, Part II) | | 27.00 | | 0 | 181, 074 | 204. 00 |
| 205. 00 | Unit cost multiplier (Wkst. B, Part | | | 0. 00000 | ס | 0. 003342 | 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 |

| Heal th | Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lieu | u of Form CMS- | 2552-10 |
|--|--|--|--|-------------------------------|--|---|--|
| COST A | NLLOCATION - STATISTICAL BASIS | | Provi der C | CN: 15-1330 Pe Fr To | eriod: com 01/01/2022 o 12/31/2022 | Worksheet B-1 Date/Time Pre 3/2/2024 10:0 | pared: |
| | Cost Center Description | OPERATION OF PLANT (SQUARE FEET) | LAUNDRY & LI NEN SERVI CE (PATI ENT DAYS) | HOUSEKEEPING (SQUARE FEET) | DI ETARY (PATI ENT DAYS) | CAFETERIA (NOT USED) | |
| | | 7. 00 | 8. 00 | 9.00 | 10.00 | 11. 00 | |
| 1 00 | GENERAL SERVICE COST CENTERS | | | | | | 1 00 |
| 1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 | OO100 NEW CAP REL COSTS-BLDG & FIXT OO200 NEW CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT OO500 ADMINISTRATIVE & GENERAL OO700 OPERATION OF PLANT OO800 LAUNDRY & LINEN SERVICE | 108, 029 1, 729 | 6, 459 | | | | 1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 |
| 9. 00 | 00900 HOUSEKEEPI NG | 2, 861 | 0 | , | | | 9. 00 |
| 10.00 | 01000 DI ETARY | 6, 823 | 0 | 6, 823 | 6, 140 | | 10.00 |
| 11.00 | 01100 CAFETERI A | 0 | 0 | 0 | 0 | 0 | |
| 13. 00 14. 00 | O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY | 316 | 0 | 316 | 0 | 0 | |
| 15. 00 | 01500 PHARMACY | 2, 232 | 0 | 1 | o | 0 | 1 |
| 16. 00 | 01600 MEDICAL RECORDS & LIBRARY | 2, 539 | 0 | | o | 0 | 1 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 03000 ADULTS & PEDI ATRI CS | 16, 002 | 5, 260 | 1 | 5, 260 | 0 | |
| 31.00 | 03100 INTENSI VE CARE UNI T | 2, 874 | 880 | | 880 | 0 | |
| 40.00 | 04000 SUBPROVI DER - I PF | 1 407 | 0 | - 1 | 0 | 0 | |
| 43. 00 44. 00 | 04300 NURSERY 04400 SKILLED NURSING FACILITY | 1, 497 | 239 0 | | 0 | 0 | |
| 44.00 | ANCI LLARY SERVICE COST CENTERS | <u> </u> | 0 | <u> </u> | O _I | | 44.00 |
| 50.00 | 05000 OPERATI NG ROOM | 19, 820 | 0 | 19, 820 | 0 | 0 | 50.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 1, 497 | 80 | 1, 497 | 0 | 0 | 52.00 |
| 53.00 | 05300 ANESTHESI OLOGY | 0 | 0 | · · | 0 | 0 | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 3, 926 | 0 | | 0 | 0 | |
| 60.00 | 06000 LABORATORY | 4, 089 | 0 | | 0 | 0 | 60.00 |
| 65. 00 66. 00 | 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY | 9, 128 100 | 0 | ., .=- | 0 | 0 | 65. 00 66. 00 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 50 | 0 | 50 | 0 | 0 | 67.00 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 0 | 0 | 1 | Ö | 0 | 1 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | o | 0 | 0 | 69. 00 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | 71.00 |
| 72.00 | 07200 I MPL. DEV. CHARGED TO PATIENT | 0 | 0 | 0 | 0 | 0 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | 73.00 |
| 76. 00 76. 01 | 03020 OP PSYCH 03030 WOUND CARE | 0 | 0 | 1 | 0 | 0 | |
| 70.01 | OUTPATIENT SERVICE COST CENTERS | <u> </u> | | <u> </u> | <u> </u> | | 70.01 |
| 88. 00 | 08800 MONROE FAMILY MEDICINE | 0 | 0 | 0 | 0 | 0 | 88. 00 |
| 88. 01 | 08801 WOODCREST | 0 | 0 | 1 | 0 | 0 | |
| 88. 02 | 08802 STAT CARE | 2, 251 | 0 | 2, 251 | 0 | 0 | 88. 02 |
| 88. 03 | O8803 BERNE FAMILY MEDICINE O8804 HIGH STREET | 0 | 0 | 0 | 0 | 0 | 88. 03 88. 04 |
| | 09000 CLI NI C | 9, 212 | 0 | 9, 212 | 0 | 0 | 1 |
| | 09001 CLINIC - AMO | 2, 132 | 0 | | Ō | 0 | |
| 90. 02 | 09002 CLINIC - AMH NEURO | 1, 955 | 0 | 1, 955 | 0 | 0 | |
| 90. 03 | 09003 GENERAL SURGERY OFFICE | 2, 588 | 0 | -, | 0 | 0 | |
| 90.04 | 04950 INTENSIVE OP BEHAVIORAL HEALTH | 0 | 0 | _ | 0 | 0 | |
| | O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART) | 5, 560 | U | 5, 560 | ٩ | U | 91.00 |
| 72.00 | OTHER REIMBURSABLE COST CENTERS | | | | | | 72.00 |
| | 09500 AMBULANCE SERVICES | 0 | 0 | 0 | 0 | 0 | |
| | 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | l . | 0 | 0 | |
| 101.00 | 10100 HOME HEALTH AGENCY | 0 | 0 | 0 | 0 | 0 | 101. 00 |
| 114 00 | SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE | O | 0 | ol | ol | 0 | 116. 00 |
| 118.00 | 1 1 | 99, 181 | 6, 459 | - 1 | 6, 140 | | 118.00 |
| 110.00 | NONREI MBURSABLE COST CENTERS | 77, 101 | 0, 437 | 74, 571 | 0, 140 | | 1110.00 |
| 190.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 654 | 0 | 0 | 0 | 0 | 190. 00 |
| | 07950 TITLE XX | 0 | 0 | 0 | 0 | | 194. 00 |
| 194. 01 | 07951 OTHER NRCC | 4, 591 | 0 | 4, 591 | 0 | | 194. 01 |
| | 07952 OTHER MOBS 07953 IDLE SPACE | 3, 603 | 0 | 3, 603 | 0 | | 194. 02 194. 03 |
| | 07954 OTHER NONREIMBURSABLE COST CENTERS | | 0 | | 0 | | 194. 03 |
| 200.00 | | | O | | J | O | 200.00 |
| 201.00 | 1 1 | | | | | | 201.00 |
| 202.00 | Cost to be allocated (per Wkst. B, | 3, 094, 933 | 397, 714 | 1, 146, 399 | 1, 592, 714 | 0 | 202. 00 |
| 000 - | Part I) | 00 / | /4 ===::: | | 050 055:5 | 0.0==== | 000 5- |
| 203.00 | | 28. 649094 | 61. 575166 | | 259. 399674 | 0. 000000 | 1 |
| 204.00 | Cost to be allocated (per Wkst. B, Part II) | 281, 386 | 37, 169 | 62, 807 | 150, 704 | Ü | 204. 00 |
| 205.00 | 1 1 | 2. 604727 | 5. 754606 | 0. 611052 | 24. 544625 | 0. 000000 | 205.00 |
| | | <u> </u> | | | | | <u> </u> |

| Heal th Finar | ncial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---------------|--|---------------|---------------|---------------|----------------------------------|-----------------|---------|
| COST ALLOCA | TION - STATISTICAL BASIS | | Provi der Co | | Peri od: | Worksheet B-1 | |
| | | | | | From 01/01/2022 To 12/31/2022 | Date/Time Pre | narad: |
| | | | | | 10 12/31/2022 | 3/2/2024 10:0 | 7 am |
| | Cost Center Description | OPERATION OF | LAUNDRY & | HOUSEKEEPI NO | DI ETARY | CAFETERI A | |
| | | PLANT | LINEN SERVICE | (SQUARE FEET) | (PATIENT | (NOT USED) | |
| | | (SQUARE FEET) | (PATI ENT | | DAYS) | | |
| | | | DAYS) | | | | |
| | | 7. 00 | 8. 00 | 9. 00 | 10.00 | 11. 00 | |
| 206.00 | NAHE adjustment amount to be allocated | | | | | | 206.00 |
| | (per Wkst. B-2) | | | | | | |
| 207. 00 | NAHE unit cost multiplier (Wkst. D, | | | | | | 207.00 |
| | Parts III and IV) | | | | | | |

| | | | | | rom 01/01/2022 o 12/31/2022 | Date/Time Prepared: 3/2/2024 10:07 am |
|---|--|---|--|--------------------------------------|---|---|
| | Cost Center Description | NURSI NG ADMI NI STRATI O N (GROSS SALARI ES) 13.00 | CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 14.00 | PHARMACY (COSTED REQUIS.) | MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00 | 0.2.202.10.0 |
| 4 00 | GENERAL SERVICE COST CENTERS | | | | | 4.00 |
| 1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 | 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MYBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS | 9, 897, 281 0 0 0 | 0 0 0 | 100 0 | | 1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 |
| 30. 00 | 03000 ADULTS & PEDIATRICS | 3, 810, 510 | ol | 0 | 11, 203, 776 | 30.00 |
| 31. 00 40. 00 43. 00 44. 00 | 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04300 NURSERY 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS | 686, 935 0 6, 679 | 0 0 0 0 | 0 0 0 | 2, 936, 838 0 184, 508 0 | 31.00 40.00 43.00 44.00 |
| 50.00 | 05000 OPERATING ROOM | 2, 307, 270 | 0 | 0 | 11, 924, 727 | 50.00 |
| 52. 00 53. 00 54. 00 60. 00 65. 00 | 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY | 15, 970 0 0 0 0 512, 669 | 0 0 0 0 | 0 0 0 0 | 184, 160 0 24, 277, 487 17, 419, 118 4, 128, 809 | 52. 00 53. 00 54. 00 60. 00 65. 00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0 | 0 | 0 | 5, 184, 297 | 66.00 |
| 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 01 | 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 03020 OP PSYCH 03030 WOUND CARE OUTPATIENT SERVICE COST CENTERS | 0 0 0 0 0 0 | 0 0 0 0 0 0 0 | 0 0 0 0 100 0 | 2, 130, 190 1, 168, 844 0 4, 095, 129 8, 892, 108 96, 383 419, 726 | 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 00 |
| 88. 00 | 08800 MONROE FAMILY MEDICINE | 0 | 0 | 0 | 2, 259, 889 | 88. 00 |
| 88. 01 88. 02 88. 03 88. 04 90. 00 90. 01 90. 02 90. 03 90. 04 91. 00 | 08801 WOODCREST 08802 STAT CARE 08803 BERNE FAMILY MEDICINE 08804 HIGH STREET 09000 CLINIC 09001 CLINIC - AMO 09002 CLINIC - AMH NEURO 09003 GENERAL SURGERY OFFICE 04950 INTENSIVE OP BEHAVIORAL HEALTH 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 0 0 0 0 0 0 0 0 0 0 0 2, 557, 248 | 0 0 0 0 0 0 0 | 0 0 0 0 0 0 0 0 | 1, 951, 988 2, 221, 560 1, 827, 639 2, 203, 202 2, 305, 617 672, 008 242, 497 406, 189 0 8, 800, 003 | 88. 01 88. 02 88. 03 88. 04 90. 00 90. 01 90. 02 90. 03 90. 04 91. 00 92. 00 |
| 95 00 | OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES | 0 | ol | 0 | O | 95. 00 |
| 97.00 | 09700 DURABLE MEDICAL EQUIP-SOLD 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS | 0 | 0 | 0 | 0 | 97. 00 101. 00 |
| | 11600 H0SPI CE | 0 | 0 | 0 | 0 | 116. 00 |
| 118. 00 | SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS | 9, 897, 281 | 0 | 100 | 117, 136, 692 | 118. 00 |
| 194. 00 194. 01 194. 02 194. 03 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 TITLE XX 07951 OTHER NRCC 07952 OTHER MOBS 07953 IDLE SPACE 07954 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments Negative Cost Centers | 0 0 0 0 0 0 0 | 0 0 0 0 0 0 | 0 0 0 0 0 0 0 | 0 0 101, 549 0 0 0 | 190.00 194.00 194.01 194.02 194.03 194.04 200.00 201.00 |
| | Part I) | | | | | |
| 203. 00 204. 00 | | 0. 142489 10, 547 | 0. 000000 0 | 16, 308. 410000 52, 263 | | 203. 00 204. 00 |

| Heal th Finar | ncial Systems | ADAMS MEMORIA | L HOSPITAL | | In Lie | u of Form CMS- | 2552-10 |
|---------------|--|------------------|--------------|------------|-----------------------------|--------------------------------|------------------|
| COST ALLOCA | TION - STATISTICAL BASIS | | Provi der Co | | Peri od: From 01/01/2022 | Worksheet B-1 | |
| | | | | | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | epared: 07 am |
| | Cost Center Description | NURSI NG | CENTRAL | PHARMACY | MEDI CAL | | |
| | | ADMI NI STRATI O | SERVICES & | (COSTED | RECORDS & | | |
| | | N | SUPPLY | REQUIS.) | LI BRARY | | |
| | | (GROSS | (COSTED | | (GROSS | | |
| | | SALARI ES) | REQUIS.) | | CHARGES) | | |
| | | 13. 00 | 14. 00 | 15. 00 | 16.00 | | |
| 205. 00 | Unit cost multiplier (Wkst. B, Part | 0. 001066 | 0. 000000 | 522. 63000 | 0. 000485 | | 205. 00 |
| 206. 00 | NAHE adjustment amount to be allocated (per Wkst. B-2) | | | | | | 206. 00 |
| 207. 00 | NAHE unit cost multiplier (Wkst. D, Parts III and IV) | | | | | | 207. 00 |

| Health Financial Systems | ADAMS MEMORIAL HOSPITAL | In Lieu of Form CMS-2552-10 |
|--|-------------------------|---|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-1330 | Period: Worksheet C From 01/01/2022 Part I |
| | | To 12/31/2022 Date/Time Prepared |

| | | | | o 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | pared: |
|--|---|-----------------------|--------------|------------------------|--------------------------------|---------|
| | | Title | XVIII | Hospi tal | Cost | , alli |
| | | 11 110 | XVIII | Costs | 0031 | |
| Cost Center Description | Total Cost (from Wkst. B, Part I, | Therapy Limit Adj. | Total Costs | RCE Di sal I owance | Total Costs | |
| | col . 26) | 2.00 | 2.00 | 4.00 | F 00 | |
| LAIDATI FAIT DOUTLAIF CERVILOF COCT OFATERS | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | 44 404 050 | | 11 10/ 05/ | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 11, 436, 959 | | 11, 436, 959 | | 0 | |
| 31. 00 03100 I NTENSI VE CARE UNI T | 3, 047, 280 | | 3, 047, 280 | | 0 | |
| 40. 00 04000 SUBPROVI DER - 1 PF | 0 | | (| 0 | 0 | |
| 43. 00 04300 NURSERY | 122, 143 | | 122, 143 | | 0 | 43.00 |
| 44.00 O4400 SKILLED NURSING FACILITY | 0 | | (| 0 | 0 | 44. 00 |
| ANCILLARY SERVICE COST CENTERS | | 1 | | | | |
| 50.00 05000 OPERATING ROOM | 6, 198, 327 | | 6, 198, 327 | | 0 | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 129, 120 | | 129, 120 | | 0 | |
| 53. 00 05300 ANESTHESI OLOGY | 0 | | (| 0 | 0 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 4, 057, 003 | | 4, 057, 003 | | 0 | 54.00 |
| 60. 00 06000 LABORATORY | 6, 282, 238 | | 6, 282, 238 | 0 | 0 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 1, 752, 677 | 0 | ., | | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 3, 185, 725 | 0 | 3, 185, 725 | 0 | 0 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 899, 406 | 0 | 899, 406 | 0 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 385, 123 | 0 | 385, 123 | 0 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | | (| 0 | 0 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | | (| 0 | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 1, 383, 952 | | 1, 383, 952 | 0 | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 3, 009, 115 | | 3, 009, 115 | 0 | 0 | 73.00 |
| 76.00 03020 OP PSYCH | 1, 092, 887 | | 1, 092, 887 | o o | 0 | 76.00 |
| 76. 01 03030 WOUND CARE | 365, 802 | | 365, 802 | 2 o | 0 | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | | | | | |] |
| 88.00 08800 MONROE FAMILY MEDICINE | 2, 401, 760 | | 2, 401, 760 | 0 | 0 | 88. 00 |
| 88. 01 08801 WOODCREST | 2, 161, 217 | | 2, 161, 217 | 0 | 0 | 88. 01 |
| 88. 02 08802 STAT CARE | 2, 190, 350 | | 2, 190, 350 | o | 0 | 88. 02 |
| 88.03 08803 BERNE FAMILY MEDICINE | 1, 918, 583 | | 1, 918, 583 | o o | 0 | 88. 03 |
| 88. 04 08804 HI GH STREET | 1, 884, 223 | | 1, 884, 223 | o o | 0 | 88. 04 |
| 90. 00 09000 CLI NI C | 3, 164, 552 | | 3, 164, 552 | 0 | 0 | 90.00 |
| 90. 01 09001 CLINIC - AMO | 940, 356 | | 940, 356 | o | 0 | 90. 01 |
| 90. 02 09002 CLINIC - AMH NEURO | 306, 548 | | 306, 548 | ol ol | 0 | 90. 02 |
| 90.03 09003 GENERAL SURGERY OFFICE | 782, 571 | | 782, 57° | | 0 | 90.03 |
| 90.04 04950 INTENSIVE OP BEHAVIORAL HEALTH | 0 | | | ol | 0 | 90.04 |
| 91. 00 09100 EMERGENCY | 4, 732, 018 | | 4, 732, 018 | sl ol | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 4, 099, 213 | | 4, 099, 213 | | 0 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | ., , | | ., ., | | | 1 |
| 95. 00 09500 AMBULANCE SERVI CES | 2, 773, 958 | | 2, 773, 958 | 8 0 | 0 | 95.00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | | (| | 0 | 97.00 |
| 101.00 10100 HOME HEALTH AGENCY | 0 | | (| | | 101.00 |
| SPECIAL PURPOSE COST CENTERS | | | | | | 1.01.00 |
| 116, 00 11600 HOSPI CE | 0 | | (| | 0 | 116. 00 |
| 200.00 Subtotal (see instructions) | 70, 703, 106 | l | | | | 200.00 |
| 201.00 Less Observation Beds | 4, 099, 213 |] | 4, 099, 213 | | | 201.00 |
| 202.00 Total (see instructions) | 66, 603, 893 | 0 | | | | 202.00 |
| | ,, 0,0 | | 1,, 0,, | ١ | · · | , .= |

| | | | Ť | 0 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | pared: |
|--|--------------|--------------|----------------------------|------------------------|--------------------------------|---------|
| | | Title | XVIII | Hospi tal | Cost | 7 alli |
| | | Charges | | | | |
| Cost Center Description | I npati ent | Outpati ent | Total (col. 6 + col. 7) | Cost or Other Ratio | TEFRA I npati ent Rati o | |
| | 6. 00 | 7.00 | 8. 00 | 9. 00 | 10.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 7, 446, 828 | | 7, 446, 828 | | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 2, 936, 838 | | 2, 936, 838 | | | 31.00 |
| 40. 00 04000 SUBPROVI DER - I PF | 0 | | 0 | | | 40.00 |
| 43. 00 04300 NURSERY | 184, 508 | | 184, 508 | | | 43.00 |
| 44.00 04400 SKILLED NURSING FACILITY | 0 | | 0 | | | 44.00 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50. 00 05000 OPERATING ROOM | 918, 753 | 11, 005, 974 | 11, 924, 727 | 0. 519788 | 0.000000 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 174, 525 | 9, 635 | 184, 160 | 0. 701129 | 0.000000 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | 0 | 0.000000 | 0.000000 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 1, 689, 361 | 22, 588, 126 | 24, 277, 487 | 0. 167110 | 0.000000 | 54.00 |
| 60. 00 06000 LABORATORY | 2, 170, 694 | 15, 248, 424 | 17, 419, 118 | 0. 360652 | 0.000000 | 60.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 1, 360, 949 | 2, 767, 860 | 4, 128, 809 | 0. 424499 | 0.000000 | 65.00 |
| 66.00 06600 PHYSI CAL THERAPY | 431, 965 | 4, 752, 332 | 5, 184, 297 | 0. 614495 | 0.000000 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 492, 792 | 1, 637, 398 | 2, 130, 190 | 0. 422219 | 0.000000 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 124, 281 | 1, 044, 563 | 1, 168, 844 | 0. 329491 | 0.000000 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | 0 | 0.000000 | 0.000000 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 0 | 0.000000 | 0.000000 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 477, 119 | 3, 618, 010 | 4, 095, 129 | 0. 337951 | 0.000000 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 3, 280, 018 | 5, 612, 090 | 8, 892, 108 | 0. 338403 | 0.000000 | 73.00 |
| 76.00 03020 OP PSYCH | 0 | 96, 383 | 96, 383 | 11. 339002 | 0.000000 | 76.00 |
| 76. 01 03030 WOUND CARE | 651 | 419, 075 | 419, 726 | 0. 871526 | 0.000000 | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 08800 MONROE FAMILY MEDICINE | 0 | 2, 259, 889 | 2, 259, 889 | | | 88. 00 |
| 88. 01 08801 WOODCREST | 0 | 1, 951, 988 | 1, 951, 988 | | | 88. 01 |
| 88. 02 08802 STAT CARE | 0 | 2, 221, 560 | 2, 221, 560 | | | 88. 02 |
| 88.03 08803 BERNE FAMILY MEDICINE | 0 | 1, 827, 639 | 1, 827, 639 | | | 88. 03 |
| 88. 04 08804 HI GH STREET | 0 | 2, 203, 202 | 2, 203, 202 | | | 88. 04 |
| 90. 00 09000 CLI NI C | 92 | 2, 305, 525 | 2, 305, 617 | 1. 372540 | 0.000000 | 90.00 |
| 90. 01 09001 CLINIC - AMO | 0 | 672, 008 | 672, 008 | 1. 399323 | 0.000000 | 90. 01 |
| 90. 02 09002 CLINIC - AMH NEURO | 0 | 242, 497 | 242, 497 | 1. 264131 | 0.000000 | 90. 02 |
| 90. 03 09003 GENERAL SURGERY OFFICE | 0 | 406, 189 | 406, 189 | 1. 926618 | 0.000000 | 90. 03 |
| 90.04 04950 INTENSIVE OP BEHAVIORAL HEALTH | 0 | 0 | 0 | 0.000000 | 0.000000 | 90. 04 |
| 91. 00 09100 EMERGENCY | 18, 072 | 8, 781, 931 | 8, 800, 003 | 0. 537729 | 0.000000 | 91.00 |
| 92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) | 257, 038 | 3, 499, 910 | 3, 756, 948 | 1. 091102 | 0.000000 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 95. 00 09500 AMBULANCE SERVI CES | 0 | 2, 095, 667 | 2, 095, 667 | 1. 323664 | 0.000000 | 95.00 |
| 97.00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | 0 | 0.000000 | 0.000000 | 97.00 |
| 101.00 10100 HOME HEALTH AGENCY | 0 | 0 | 0 | | | 101.00 |
| SPECIAL PURPOSE COST CENTERS | | | | | | |
| 116. 00 11600 H0SPI CE | 0 | 0 | | | | 116. 00 |
| 200.00 Subtotal (see instructions) | 21, 964, 484 | 97, 267, 875 | 119, 232, 359 | | | 200. 00 |
| 201.00 Less Observation Beds | | | | | | 201.00 |
| 202.00 Total (see instructions) | 21, 964, 484 | 97, 267, 875 | 119, 232, 359 | | | 202. 00 |

Heal th Financial Systems ADAMS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1330 Period: From 01/01/2022 To 12/31/2022 Date/Time Prepared: Date/Time Prepared: 2/2/2024 10: 07. am

| | | | | 12,01,2022 | 3/2/2024 10:0 | 07 am |
|--------|--|---------------|-------------|------------|---------------|---------|
| | | | Title XVIII | Hospi tal | Cost | |
| | Cost Center Description | PPS Inpatient | | | | |
| | | Ratio | | | | |
| | | 11. 00 | | | | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30.00 | 03000 ADULTS & PEDI ATRI CS | | | | | 30.00 |
| | 03100 INTENSIVE CARE UNIT | | | | | 31.00 |
| 40. 00 | 04000 SUBPROVI DER - I PF | | | | | 40.00 |
| 43.00 | 04300 NURSERY | | | | | 43.00 |
| 44. 00 | 04400 SKILLED NURSING FACILITY | | | | | 44. 00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | |
| 50.00 | 05000 OPERATING ROOM | 0. 000000 | | | | 50.00 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 0. 000000 | | | | 52.00 |
| 53.00 | 05300 ANESTHESI OLOGY | 0. 000000 | | | | 53.00 |
| 54. 00 | 05400 RADI OLOGY-DI AGNOSTI C | 0. 000000 | | | | 54.00 |
| 60.00 | 06000 LABORATORY | 0. 000000 | | | | 60.00 |
| 65. 00 | 06500 RESPI RATORY THERAPY | 0. 000000 | | | | 65. 00 |
| 66. 00 | 06600 PHYSI CAL THERAPY | 0. 000000 | | | | 66.00 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 0. 000000 | | | | 67.00 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 0. 000000 | | | | 68. 00 |
| | 06900 ELECTROCARDI OLOGY | 0. 000000 | | | | 69. 00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000 | | | | 71.00 |
| | 07200 IMPL. DEV. CHARGED TO PATIENT | 0. 000000 | | | | 72.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0. 000000 | | | | 73.00 |
| | 03020 OP PSYCH | 0. 000000 | | | | 76. 00 |
| 76. 01 | 03030 WOUND CARE | 0. 000000 | | | | 76. 01 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | |
| 88. 00 | 08800 MONROE FAMILY MEDICINE | | | | | 88. 00 |
| 88. 01 | 08801 WOODCREST | | | | | 88. 01 |
| 88. 02 | 08802 STAT CARE | | | | | 88. 02 |
| 88. 03 | 08803 BERNE FAMILY MEDICINE | | | | | 88. 03 |
| 88. 04 | 08804 HI GH STREET | | | | | 88. 04 |
| 90.00 | 09000 CLI NI C | 0. 000000 | | | | 90.00 |
| 90. 01 | 09001 CLINIC - AMO | 0. 000000 | | | | 90. 01 |
| | 09002 CLINIC - AMH NEURO | 0. 000000 | | | | 90.02 |
| | 09003 GENERAL SURGERY OFFICE | 0. 000000 | | | | 90.03 |
| | 04950 NTENSIVE OP BEHAVIORAL HEALTH | 0. 000000 | | | | 90.04 |
| 91.00 | 09100 EMERGENCY | 0. 000000 | | | | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000 | | | | 92.00 |
| 05.00 | OTHER REIMBURSABLE COST CENTERS | 0.00000 | | | | |
| | 09500 AMBULANCE SERVI CES | 0. 000000 | | | | 95.00 |
| | 09700 DURABLE MEDICAL EQUIP-SOLD | 0. 000000 | | | | 97.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | | | | | 101.00 |
| 11/ 00 | SPECIAL PURPOSE COST CENTERS | | | | | 11/ 00 |
| | 11600 HOSPI CE | | | | | 116.00 |
| 200.00 | | | | | | 200.00 |
| 201.00 | | | | | | 201.00 |
| 202.00 | Total (see instructions) | | | | | 202. 00 |

| Health Financial Systems | ADAMS MEMORIAL HOSPITAL | In Lieu of Form CMS-2552-10 |
|--|-------------------------|---|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-1330 | Period: Worksheet C From 01/01/2022 Part I |
| | | To 12/31/2022 Date/Time Prepared: |

| | | | Т | o 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | pared: 7 am |
|--|--------------|---------------|--------------|-----------------|-----------------------------|----------------|
| | | Ti tl | e XIX | Hospi tal | PPS | , <u>u</u> |
| | | | | Costs | | |
| Cost Center Description | Total Cost | Therapy Limit | Total Costs | RCE | Total Costs | |
| | (from Wkst. | Áďj. | | Di sal I owance | | |
| | B, Part I, | | | | | |
| | col . 26) | | | | | |
| | 1. 00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 11, 436, 959 | | 11, 436, 959 | 0 | 11, 436, 959 | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 3, 047, 280 | | 3, 047, 280 | o | 3, 047, 280 | 31.00 |
| 40. 00 04000 SUBPROVI DER - 1 PF | 0 | | [c | o | 0 | 40.00 |
| 43. 00 04300 NURSERY | 122, 143 | | 122, 143 | o | 122, 143 | 43.00 |
| 44.00 04400 SKILLED NURSING FACILITY | 0 | | C | 0 | 0 | 44.00 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 6, 198, 327 | | 6, 198, 327 | 0 | 6, 198, 327 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 129, 120 | | 129, 120 | 0 | 129, 120 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | | C | 0 | 0 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 4, 057, 003 | | 4, 057, 003 | 0 | 4, 057, 003 | 54.00 |
| 60. 00 06000 LABORATORY | 6, 282, 238 | | 6, 282, 238 | 0 | 6, 282, 238 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 1, 752, 677 | 0 | 1, 752, 677 | 0 | 1, 752, 677 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 3, 185, 725 | 0 | 3, 185, 725 | 0 | 3, 185, 725 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 899, 406 | 0 | 899, 406 | 0 | 899, 406 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 385, 123 | 0 | 385, 123 | 0 | 385, 123 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | | C | 0 | 0 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | | C | 0 | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 1, 383, 952 | | 1, 383, 952 | 0 | 1, 383, 952 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 3, 009, 115 | | 3, 009, 115 | 0 | 3, 009, 115 | 73.00 |
| 76. 00 03020 OP PSYCH | 1, 092, 887 | | 1, 092, 887 | 0 | 1, 092, 887 | 76.00 |
| 76. 01 03030 WOUND CARE | 365, 802 | | 365, 802 | 0 | 365, 802 | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 08800 MONROE FAMILY MEDICINE | 2, 401, 760 | | 2, 401, 760 | | 2, 401, 760 | 88.00 |
| 88. 01 08801 WOODCREST | 2, 161, 217 | | 2, 161, 217 | | 2, 161, 217 | 88. 01 |
| 88. 02 08802 STAT CARE | 2, 190, 350 | | 2, 190, 350 | 0 | 2, 190, 350 | 88. 02 |
| 88.03 08803 BERNE FAMILY MEDICINE | 1, 918, 583 | | 1, 918, 583 | 0 | 1, 918, 583 | 88. 03 |
| 88. 04 08804 HI GH STREET | 1, 884, 223 | | 1, 884, 223 | 0 | 1, 884, 223 | 88. 04 |
| 90. 00 09000 CLI NI C | 3, 164, 552 | | 3, 164, 552 | 0 | 3, 164, 552 | 90.00 |
| 90. 01 09001 CLINIC - AMO | 940, 356 | | 940, 356 | | 940, 356 | 90. 01 |
| 90. 02 09002 CLINIC - AMH NEURO | 306, 548 | | 306, 548 | | 306, 548 | 90.02 |
| 90. 03 09003 GENERAL SURGERY OFFICE | 782, 571 | | 782, 571 | 0 | 782, 571 | 90. 03 |
| 90.04 04950 INTENSIVE OP BEHAVIORAL HEALTH | 0 | | [C | 0 | 0 | 90.04 |
| 91. 00 09100 EMERGENCY | 4, 732, 018 | | 4, 732, 018 | | 4, 732, 018 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 4, 099, 213 | | 4, 099, 213 | | 4, 099, 213 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | 1 | | | | | |
| 95. 00 09500 AMBULANCE SERVICES | 2, 773, 958 | | 2, 773, 958 | | 2, 773, 958 | 95.00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | | C | | 0 | 97. 00 |
| 101.00 10100 HOME HEALTH AGENCY | 0 | | C |) | 0 | 101. 00 |
| SPECIAL PURPOSE COST CENTERS | T | | ı | | | |
| 116. 00 11600 HOSPI CE | 0 | | C | | | 116. 00 |
| 200.00 Subtotal (see instructions) | 70, 703, 106 | 0 | | | 70, 703, 106 | |
| 201.00 Less Observation Beds | 4, 099, 213 | _ | 4, 099, 213 | | 4, 099, 213 | |
| 202.00 Total (see instructions) | 66, 603, 893 | 0 | 66, 603, 893 | 0 | 66, 603, 893 | 202.00 |

| | | | | Т | o 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
|--------|--|--------------|--------------|---------------|---------------|--------------------------------|---------|
| | | | Ti tl | e XIX | Hospi tal | PPS | |
| | · | | Charges | <u> </u> | | | |
| | Cost Center Description | I npati ent | Outpati ent | Total (col. 6 | Cost or Other | TEFRA | |
| | | · | | + col. 7) | Ratio | I npati ent | |
| | | | | | | Ratio | |
| | | 6. 00 | 7.00 | 8. 00 | 9. 00 | 10.00 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 03000 ADULTS & PEDI ATRI CS | 7, 446, 828 | | 7, 446, 828 | | | 30.00 |
| 31.00 | 03100 INTENSIVE CARE UNIT | 2, 936, 838 | | 2, 936, 838 | 3 | | 31.00 |
| 40.00 | 04000 SUBPROVI DER - I PF | 0 | | (| | | 40.00 |
| 43.00 | 04300 NURSERY | 184, 508 | | 184, 508 | | | 43.00 |
| 44.00 | 04400 SKILLED NURSING FACILITY | 0 | | (|) | | 44.00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 05000 OPERATING ROOM | 918, 753 | 11, 005, 974 | | | 0. 000000 | 1 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 174, 525 | 9, 635 | | | 0. 000000 | 1 |
| 53.00 | 05300 ANESTHESI OLOGY | 0 | 0 | | | 0. 000000 | 1 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 1, 689, 361 | 22, 588, 126 | | | 0. 000000 | 1 |
| 60.00 | 06000 LABORATORY | 2, 170, 694 | 15, 248, 424 | 17, 419, 118 | 0. 360652 | 0.000000 | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 1, 360, 949 | 2, 767, 860 | 4, 128, 809 | 0. 424499 | 0.000000 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 431, 965 | 4, 752, 332 | 5, 184, 297 | 0. 614495 | 0.000000 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 492, 792 | 1, 637, 398 | 2, 130, 190 | 0. 422219 | 0.000000 | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 124, 281 | 1, 044, 563 | 1, 168, 844 | 0. 329491 | 0.000000 | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | C | 0. 000000 | 0.000000 | 69.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | C | 0. 000000 | 0.000000 | 71.00 |
| 72.00 | 07200 I MPL. DEV. CHARGED TO PATIENT | 477, 119 | 3, 618, 010 | 4, 095, 129 | 0. 337951 | 0.000000 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 3, 280, 018 | 5, 612, 090 | 8, 892, 108 | 0. 338403 | 0.000000 | 73.00 |
| 76.00 | 03020 OP PSYCH | 0 | 96, 383 | 96, 383 | 11. 339002 | 0.000000 | 76.00 |
| 76. 01 | 03030 WOUND CARE | 651 | 419, 075 | 419, 726 | 0. 871526 | 0.000000 | 76. 01 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88. 00 | 08800 MONROE FAMILY MEDICINE | 0 | 2, 259, 889 | 2, 259, 889 | 1. 062778 | 0.000000 | 88. 00 |
| 88. 01 | 08801 WOODCREST | 0 | 1, 951, 988 | 1, 951, 988 | 1. 107188 | 0.000000 | 88. 01 |
| 88. 02 | 08802 STAT CARE | 0 | 2, 221, 560 | 2, 221, 560 | 0. 985951 | 0.000000 | 88. 02 |
| 88. 03 | 08803 BERNE FAMILY MEDICINE | 0 | 1, 827, 639 | 1, 827, 639 | 1. 049760 | 0.000000 | 88. 03 |
| 88. 04 | 08804 HI GH STREET | 0 | 2, 203, 202 | 2, 203, 202 | 0. 855220 | 0.000000 | 88. 04 |
| 90.00 | 09000 CLI NI C | 92 | 2, 305, 525 | 2, 305, 617 | 1. 372540 | 0.000000 | 90.00 |
| 90. 01 | 09001 CLINIC - AMO | 0 | 672, 008 | 672, 008 | 1. 399323 | 0.000000 | 90. 01 |
| 90. 02 | 09002 CLINIC - AMH NEURO | 0 | 242, 497 | 242, 497 | 1. 264131 | 0.000000 | 90.02 |
| 90. 03 | 09003 GENERAL SURGERY OFFICE | o | 406, 189 | 406, 189 | 1. 926618 | 0.000000 | 90.03 |
| 90.04 | 04950 INTENSIVE OP BEHAVIORAL HEALTH | o | 0 | (| 0. 000000 | 0.000000 | 90.04 |
| 91.00 | 09100 EMERGENCY | 18, 072 | 8, 781, 931 | 8, 800, 003 | 0. 537729 | 0.000000 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 257, 038 | 3, 499, 910 | 3, 756, 948 | 1. 091102 | 0.000000 | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | • | | 1 |
| 95.00 | 09500 AMBULANCE SERVICES | 0 | 2, 095, 667 | 2, 095, 667 | 1. 323664 | 0.000000 | 95.00 |
| 97.00 | 09700 DURABLE MEDICAL EQUIP-SOLD | o | 0 | | 0. 000000 | 0.000000 | 97.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | o | 0 | l c | | | 101.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| 116.00 | 11600 H0SPI CE | 0 | 0 | C | | | 116. 00 |
| 200.00 | Subtotal (see instructions) | 21, 964, 484 | 97, 267, 875 | 119, 232, 359 |) | | 200.00 |
| 201.00 | Less Observation Beds | | | | | | 201.00 |
| 202.00 | Total (see instructions) | 21, 964, 484 | 97, 267, 875 | 119, 232, 359 |) | | 202.00 |
| | | | | | | | |

Health Financial Systems

ADAMS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1330
Feriod:
From 01/01/2022
To 12/31/2022
To 12/31/2022
Part I
Date/Time Prepared:
3/2/2024 10: 07 am

| | | | | | 3/2/2024 10:0 | 07 am |
|--------|--|---------------|-----------|-----------|---------------|--------------------|
| | | | Title XIX | Hospi tal | PPS | |
| | Cost Center Description | PPS Inpatient | | | | |
| | | Ratio | | | | |
| | | 11. 00 | | | | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30.00 | 03000 ADULTS & PEDI ATRI CS | | | | | 30.00 |
| 31.00 | 03100 INTENSIVE CARE UNIT | | | | | 31.00 |
| 40.00 | 04000 SUBPROVI DER - I PF | | | | | 40.00 |
| 43.00 | 04300 NURSERY | | | | | 43.00 |
| 44.00 | 04400 SKILLED NURSING FACILITY | | | | | 44.00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | |
| 50.00 | 05000 OPERATI NG ROOM | 0. 519788 | | | | 50.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0. 701129 | | | | 52.00 |
| | 05300 ANESTHESI OLOGY | 0. 000000 | | | | 53.00 |
| | 05400 RADI OLOGY-DI AGNOSTI C | 0. 167110 | | | | 54.00 |
| | 06000 LABORATORY | 0. 360652 | | | | 60.00 |
| | 06500 RESPI RATORY THERAPY | 0. 424499 | | | | 65.00 |
| | 06600 PHYSI CAL THERAPY | 0. 614495 | | | | 66.00 |
| | 06700 OCCUPATI ONAL THERAPY | 0. 422219 | | | | 67.00 |
| | 06800 SPEECH PATHOLOGY | 0. 329491 | | | | 68.00 |
| | 06900 ELECTROCARDI OLOGY | 0. 000000 | | | | 69.00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000 | | | | 71.00 |
| | 07200 I MPL. DEV. CHARGED TO PATIENT | 0. 337951 | | | | 72.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0. 338403 | | | | 73.00 |
| | 03020 OP PSYCH | 11. 339002 | | | | 76.00 |
| | 03030 WOUND CARE | 0. 871526 | | | | 76. 01 |
| 70.01 | OUTPATIENT SERVICE COST CENTERS | 0.071020 | | | | 70.01 |
| 88. 00 | 08800 MONROE FAMILY MEDICINE | 1. 062778 | | | | 88. 00 |
| | 08801 WOODCREST | 1. 107188 | | | | 88. 01 |
| | 08802 STAT CARE | 0. 985951 | | | | 88. 02 |
| | 08803 BERNE FAMILY MEDICINE | 1. 049760 | | | | 88. 03 |
| | 08804 HI GH STREET | 0. 855220 | | | | 88. 04 |
| | 09000 CLI NI C | 1. 372540 | | | | 90.00 |
| | 09001 CLINIC - AMO | 1. 399323 | | | | 90.01 |
| | 09002 CLINIC - AMH NEURO | 1. 264131 | | | | 90.02 |
| | 09003 GENERAL SURGERY OFFICE | 1. 926618 | | | | 90.03 |
| | 04950 INTENSIVE OP BEHAVIORAL HEALTH | 0. 000000 | | | | 90.03 |
| | 09100 EMERGENCY | 0. 537729 | | | | 91.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1. 091102 | | | | 92.00 |
| 72.00 | OTHER REIMBURSABLE COST CENTERS | 1. 091102 | | | | 72.00 |
| 05 00 | 09500 AMBULANCE SERVICES | 1. 323664 | | | | 95.00 |
| | 09700 DURABLE MEDICAL EQUIP-SOLD | 0. 000000 | | | | 97.00 |
| | 10100 HOME HEALTH AGENCY | 0.000000 | | | | 101.00 |
| 101.00 | | | | | | 1101.00 |
| 114 00 | SPECIAL PURPOSE COST CENTERS | T T | | | | 116.00 |
| | 11600 HOSPI CE | | | | | |
| 200.00 | , | | | | | 200.00 |
| 201.00 | | | | | | 201. 00 202. 00 |
| 202.00 | Total (see instructions) | | | | | J202.00 |

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

| | | | | | 10 12/31/2022 | 3/2/2024 10:0 | |
|--------|--|--------------|--------------|--------------|---------------|---------------|---------|
| | | | Ti tl | e XIX | Hospi tal | PPS | |
| | Cost Center Description | Total Cost | Capital Cost | Operating | Capi tal | Operating | |
| | | (Wkst. B, | (Wkst. B, | Cost Net of | Reducti on | Cost | |
| | | Part I, col. | Part II col. | Capital Cost | | Reduction | |
| | | 26) | 26) | (col. 1 - | | Amount | |
| | | | | col. 2) | | | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 05000 OPERATING ROOM | 6, 198, 327 | 286, 569 | | | 0 | 50.00 |
| 52.00 | | 129, 120 | 33, 021 | 96, 09 | 9 0 | 0 | 52.00 |
| 53.00 | 05300 ANESTHESI OLOGY | 0 | 0 | | 0 | 0 | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 4, 057, 003 | 196, 843 | | | 0 | 54.00 |
| 60.00 | 06000 LABORATORY | 6, 282, 238 | | | | 0 | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 1, 752, 677 | 110, 388 | | | 0 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 3, 185, 725 | 178, 770 | 3, 006, 95 | 5 0 | 0 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 899, 406 | 5, 383 | 894, 02 | 3 0 | 0 | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 385, 123 | 2, 490 | 382, 63 | 3 0 | 0 | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 | 0 | 69.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 | 0 | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 1, 383, 952 | 5, 598 | 1, 378, 35 | 4 0 | 0 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 3, 009, 115 | 60, 077 | 2, 949, 03 | 8 0 | 0 | 73.00 |
| 76.00 | 03020 OP PSYCH | 1, 092, 887 | 2, 962 | 1, 089, 92 | 5 0 | 0 | 76. 00 |
| 76. 01 | 03030 WOUND CARE | 365, 802 | 1, 172 | 364, 63 | 0 0 | 0 | 76. 01 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88. 00 | 08800 MONROE FAMILY MEDICINE | 2, 401, 760 | 7, 462 | 2, 394, 29 | 8 0 | 0 | 88. 00 |
| 88. 01 | 08801 WOODCREST | 2, 161, 217 | 6, 677 | 2, 154, 54 | 0 | 0 | 88. 01 |
| 88. 02 | 08802 STAT CARE | 2, 190, 350 | 55, 195 | 2, 135, 15 | 5 0 | 0 | 88. 02 |
| 88. 03 | 08803 BERNE FAMILY MEDICINE | 1, 918, 583 | 5, 971 | 1, 912, 61 | 2 0 | 0 | 88. 03 |
| 88. 04 | 08804 HI GH STREET | 1, 884, 223 | 6, 054 | 1, 878, 16 | 9 0 | 0 | 88. 04 |
| 90.00 | 09000 CLI NI C | 3, 164, 552 | 38, 164 | 3, 126, 38 | 8 0 | 0 | 90.00 |
| 90. 01 | 09001 CLINIC - AMO | 940, 356 | 9, 452 | 930, 90 | 4 0 | 0 | 90. 01 |
| 90. 02 | 09002 CLINIC - AMH NEURO | 306, 548 | 7, 011 | 299, 53 | 7 0 | 0 | 90. 02 |
| 90. 03 | 09003 GENERAL SURGERY OFFICE | 782, 571 | 10, 325 | 772, 24 | 6 0 | 0 | 90. 03 |
| 90.04 | 04950 INTENSIVE OP BEHAVIORAL HEALTH | 0 | 0 | | 0 | 0 | 90.04 |
| 91.00 | 09100 EMERGENCY | 4, 732, 018 | 137, 820 | 4, 594, 19 | 8 0 | 0 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 4, 099, 213 | 192, 368 | 3, 906, 84 | 5 0 | 0 | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 95.00 | 09500 AMBULANCE SERVICES | 2, 773, 958 | 7, 404 | 2, 766, 55 | 4 0 | 0 | 95.00 |
| 97.00 | 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | | 0 | 0 | 97.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 0 | 0 | | 0 | 0 | 101.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| | 11600 HOSPI CE | 0 | 0 | | 0 | | 116. 00 |
| 200.00 | | 56, 096, 724 | | | | | 200. 00 |
| 201.00 | | 4, 099, 213 | | | | | 201. 00 |
| 202.00 | Total (line 200 minus line 201) | 51, 997, 511 | 1, 284, 454 | 50, 713, 05 | 7 0 | 0 | 202. 00 |

Health Financial Systems ADAMS MEMORICALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF ADAMS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 15-1330

REDUCTIONS FOR MEDICALD ONLY

| | | | | | | 3/2/2024 TO: 07 am |
|--------|--|--------------|---------------|--------------|-----------|--------------------|
| | | | | e XIX | Hospi tal | PPS |
| | Cost Center Description | Cost Net of | Total Charges | | | |
| | | Capital and | (Worksheet C, | Cost to | | |
| | | | Part I, | Charge Ratio | | |
| | | Cost | column 8) | (col. 6 / | | |
| | | Reducti on | _ | col. 7) | | |
| | | 6. 00 | 7.00 | 8.00 | | |
| | ANCILLARY SERVICE COST CENTERS | | | | | |
| 50.00 | 05000 OPERATING ROOM | 6, 198, 327 | 11, 924, 727 | 0. 51978 | 3 | 50.00 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 129, 120 | | | | 52.00 |
| 53. 00 | 05300 ANESTHESI OLOGY | 127, 120 | | | | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 4, 057, 003 | | | | 54.00 |
| | | | | | | |
| 60.00 | 06000 LABORATORY | 6, 282, 238 | | | | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 1, 752, 677 | | | | 65.00 |
| 66. 00 | 06600 PHYSI CAL THERAPY | 3, 185, 725 | | | | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 899, 406 | | | | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 385, 123 | 1, 168, 844 | | | 68. 00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | | | 69.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 0. 000000 | O | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 1, 383, 952 | 4, 095, 129 | 0. 33795 | 1 | 72. 00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 3, 009, 115 | 8, 892, 108 | 0. 33840 | 3 | 73.00 |
| 76.00 | 03020 OP PSYCH | 1, 092, 887 | | 11. 33900 | 2 | 76.00 |
| 76. 01 | 03030 WOUND CARE | 365, 802 | | | | 76. 01 |
| | OUTPATIENT SERVICE COST CENTERS | 333,332 | ,.== | | - | |
| 88. 00 | 08800 MONROE FAMILY MEDICINE | 2, 401, 760 | 2, 259, 889 | 1. 062778 | 3 | 88.00 |
| 88. 01 | 08801 WOODCREST | 2, 161, 217 | | | | 88. 01 |
| 88. 02 | 08802 STAT CARE | 2, 190, 350 | | | | 88. 02 |
| 88. 03 | 08803 BERNE FAMILY MEDICINE | 1, 918, 583 | | | | 88. 03 |
| 88. 04 | 08804 HI GH STREET | 1, 884, 223 | | | | 88.04 |
| 90.00 | 09000 CLI NI C | 3, 164, 552 | | | | 90.00 |
| 90.00 | 09001 CLINIC - AMO | | | | | 90.00 |
| | | 940, 356 | | | | |
| 90. 02 | 09002 CLINIC - AMH NEURO | 306, 548 | | | | 90. 02 |
| 90. 03 | 09003 GENERAL SURGERY OFFICE | 782, 571 | | | | 90.03 |
| 90. 04 | 04950 INTENSIVE OP BEHAVIORAL HEALTH | 0 | 1 | | | 90.04 |
| | 09100 EMERGENCY | 4, 732, 018 | | | | 91.00 |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 4, 099, 213 | 3, 756, 948 | 1. 09110: | 2 | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | |
| | 09500 AMBULANCE SERVICES | 2, 773, 958 | 2, 095, 667 | | | 95.00 |
| 97.00 | 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | 0. 000000 | O | 97. 00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 0 | 0 | 0. 000000 | O | 101.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | |
| 116.00 | 11600 HOSPI CE | 0 | 0 | 0.00000 | O | 116. 00 |
| 200.00 | Subtotal (sum of lines 50 thru 199) | 56, 096, 724 | 108, 664, 185 | | | 200. 00 |
| 201.00 | | 4, 099, 213 | | | | 201.00 |
| 202.00 | | 51, 997, 511 | l . | | | 202. 00 |
| | 1 (| | | 1 | 1 | 1-32.00 |

| Health Financial Systems | ADAMS MEMORIAL HOSPITAL In Lie | | | | u of Form CMS-2 | 2552-10 |
|---|--------------------------------|---|------------|----------------------------------|-----------------------------|------------------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | AL COSTS | | | | Worksheet D | |
| | | | | From 01/01/2022 To 12/31/2022 | Part II | nonod. |
| | | | | 10 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | epareu: 17 am |
| | | Title | xVIII | Hospi tal | Cost | ,, aiii |
| Cost Center Description | Capi tal | Total Charges | | | Capital Costs | |
| 555t 5511t61 555511 pt. 511 | Related Cost | (from Wkst. | to Charges | Program | (column 3 x | |
| | (from Wkst. | C, Part I, | (col . 1 ÷ | Charges | column 4) | |
| | B, Part II, | col. 8) | col . 2) | 3 | 1 | |
| | col. 26) | | , | | | |
| | 1.00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 286, 569 | 11, 924, 727 | 0. 02403 | 1 247, 390 | 5, 945 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 33, 021 | 184, 160 | 0. 17930 | 6 0 | 0 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | 0. 00000 | 0 | 0 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 196, 843 | 24, 277, 487 | 0. 00810 | 8 427, 569 | 3, 467 | 54.00 |
| 60. 00 06000 LABORATORY | 109, 646 | 17, 419, 118 | 0. 00629 | 5 391, 292 | 2, 463 | 60.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 110, 388 | 4, 128, 809 | 0. 02673 | 6 353, 491 | 9, 451 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 178, 770 | 5, 184, 297 | 0. 03448 | 3 86, 024 | 2, 966 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 5, 383 | 2, 130, 190 | 0. 00252 | 7 92, 906 | 235 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 2, 490 | 1, 168, 844 | 0. 00213 | 0 28, 157 | 60 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | 0. 00000 | 0 | 0 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 0. 00000 | 0 | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 5, 598 | 4, 095, 129 | 0. 00136 | 7 82, 143 | 112 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 60, 077 | 8, 892, 108 | 0. 00675 | 6 765, 262 | 5, 170 | 73.00 |
| 76. 00 03020 OP PSYCH | 2, 962 | 96, 383 | 0. 03073 | 2 0 | 0 | 76.00 |
| 76. 01 03030 WOUND CARE | 1, 172 | 419, 726 | 0. 00279 | 2 651 | 2 | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 08800 MONROE FAMILY MEDICINE | 7, 462 | | | | 0 | |
| 88. 01 08801 WOODCREST | 6, 677 | | | | _ | |
| 88. 02 08802 STAT CARE | 55, 195 | , | | | 0 | |
| 88.03 08803 BERNE FAMILY MEDICINE | 5, 971 | 1, 827, 639 | | | 0 | |
| 88. 04 08804 HI GH STREET | 6, 054 | 2, 203, 202 | | | 0 | |
| 90. 00 09000 CLI NI C | 38, 164 | 2, 305, 617 | | | 2 | 90.00 |
| 90. 01 09001 CLINIC - AMO | 9, 452 | | | | 0 | |
| 90. 02 09002 CLINIC - AMH NEURO | 7, 011 | 242, 497 | | | 0 | |
| 90. 03 09003 GENERAL SURGERY OFFICE | 10, 325 | 406, 189 | | | 0 | |
| 90.04 04950 INTENSIVE OP BEHAVIORAL HEALTH | 0 | | 0.0000 | | 0 | |
| 91. 00 09100 EMERGENCY | 137, 820 | | | | 283 | |
| 92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) | 192, 368 | 3, 756, 948 | 0. 05120 | 3 13, 460 | 689 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | 1 |
| 95. 00 09500 AMBULANCE SERVICES | | | | | I | 95.00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | 0.0000 | | 0 | |
| 200.00 Total (lines 50 through 199) | 1, 469, 418 | 106, 568, 518 | I | 2, 506, 509 | 30, 845 | 200.00 |

| Health Financial Systems | ADAMS MEMORIAL | HOSPI TAL | In Lie | u of Form CMS-2552-10 |
|---------------------------------------|------------------------------|-----------|-----------------|-----------------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT | ANCILLARY SERVICE OTHER PASS | | Peri od: | Worksheet D |
| THROUGH COSTS | | | From 01/01/2022 | Part IV |

| 11111000 | 66515 | | | | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
|----------|--|---------------|---------------|----------|---------------|-----------------------------|---------|
| | | | Title | XVIII | Hospi tal | Cost | |
| | Cost Center Description | Non Physician | Nursi ng | Nursi ng | Allied Health | Allied Health | |
| | | Anestheti st | Program | Program | Post-Stepdown | | |
| | | Cost | Post-Stepdown | | Adjustments | | |
| | | | Adjustments | | | | |
| | | 1. 00 | 2A | 2.00 | 3A | 3. 00 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| | 05000 OPERATING ROOM | 0 | 0 |) | 0 | 0 | |
| | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 |) | 0 | 0 | 52.00 |
| 53.00 | 05300 ANESTHESI OLOGY | 0 | 0 |) | 0 | 0 | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | 0 0 | 0 | 54.00 |
| 60.00 | 06000 LABORATORY | 0 | 0 | | 0 0 | 0 | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 0 | 0 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 0 | 0 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 | 0 | 67.00 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 | 0 | 68. 00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 | 0 | 69.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 | 0 | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | | 0 | 0 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 |) | 0 | 0 | 73.00 |
| 76.00 | 03020 OP PSYCH | 0 | 0 | | 0 0 | 0 | 76.00 |
| 76. 01 | 03030 WOUND CARE | 0 | 0 | | 0 0 | 0 | 76. 01 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 | 08800 MONROE FAMILY MEDICINE | 0 | 0 |) | 0 0 | 0 | 88. 00 |
| 88. 01 | 08801 WOODCREST | 0 | 0 | | 0 | 0 | 88. 01 |
| 88. 02 | 08802 STAT CARE | 0 | 0 | | 0 | 0 | 88. 02 |
| 88. 03 | 08803 BERNE FAMILY MEDICINE | 0 | 0 | | 0 | 0 | 88. 03 |
| 88. 04 | 08804 HI GH STREET | 0 | 0 | | 0 | 0 | 88. 04 |
| 90.00 | 09000 CLI NI C | 0 | 0 | | 0 | 0 | 90.00 |
| 90. 01 | 09001 CLINIC - AMO | 0 | 0 | | 0 0 | 0 | 90. 01 |
| 90. 02 | 09002 CLINIC - AMH NEURO | 0 | 0 | | 0 0 | 0 | 90.02 |
| 90. 03 | 09003 GENERAL SURGERY OFFICE | 0 | 0 | | 0 0 | 0 | 90.03 |
| 90. 04 | 04950 INTENSIVE OP BEHAVIORAL HEALTH | 0 | 0 | | 0 0 | 0 | 90.04 |
| 91.00 | 09100 EMERGENCY | 0 | 0 | | 0 0 | 0 | 91.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | | | 0 | 0 | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | • | • | | |
| 95.00 | 09500 AMBULANCE SERVICES | | | | | | 95. 00 |
| 97.00 | 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | | 0 0 | 0 | 97.00 |
| 200.00 | Total (lines 50 through 199) | 0 | 0 |) | 0 0 | 0 | 200. 00 |

| Health Financial Systems | ADAMS MEMORIAL HOSPITAL | In Lieu of Form CMS-2552-10 |
|---------------------------------------|--|-----------------------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT | ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1330 | Peri od: Worksheet D |
| THROUGH COSTS | | From 01/01/2022 Part IV |

| TIROUGII CUSTS | | | j | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | pared: |
|--|------------|---------------|--------------|---------------|--------------------------------|--------|
| · | | Title | xVIII | Hospi tal | Cost | 7 alli |
| Cost Center Description | All Other | Total Cost | Total | Total Charges | | |
| | Medi cal | (sum of cols. | Outpati ent | (from Wkst. | to Charges | |
| | Educati on | 1, 2, 3, and | Cost (sum of | C, Part I, | (col. 5 ÷ | |
| | Cost | 4) | col s. 2, 3, | col. 8) | col. 7) | |
| | | ŕ | and 4) | , i | (see | |
| | | | | | instructions) | |
| | 4. 00 | 5. 00 | 6. 00 | 7. 00 | 8. 00 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 0 | 0 | (| 11, 924, 727 | 0.000000 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | (| 184, 160 | 0.000000 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | (| 0 | 0.000000 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | (| 24, 277, 487 | 0.000000 | 54.00 |
| 60. 00 06000 LABORATORY | 0 | 0 | (| 17, 419, 118 | 0.000000 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | (| 4, 128, 809 | 0.000000 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | (| 5, 184, 297 | 0.000000 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | (| 2, 130, 190 | 0.000000 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0 | 0 | | 1, 168, 844 | 0.000000 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | o | 0.000000 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | ol ol | 0.000000 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | | 4, 095, 129 | 0.000000 | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 8, 892, 108 | 0.000000 | 73.00 |
| 76. 00 03020 OP PSYCH | 0 | 0 | | 96, 383 | 0.000000 | 76.00 |
| 76. 01 03030 WOUND CARE | 0 | 0 | | 419, 726 | 0.000000 | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | - | | | | | |
| 88. 00 08800 MONROE FAMILY MEDICINE | 0 | 0 | (| 2, 259, 889 | 0.000000 | 88. 00 |
| 88. 01 08801 WOODCREST | 0 | 0 | (| 1, 951, 988 | 0.000000 | 88. 01 |
| 88. 02 08802 STAT CARE | 0 | 0 | (| 2, 221, 560 | 0.000000 | 88. 02 |
| 88.03 08803 BERNE FAMILY MEDICINE | 0 | 0 | | 1, 827, 639 | 0.000000 | 88. 03 |
| 88. 04 08804 HI GH STREET | 0 | 0 | | 2, 203, 202 | 0.000000 | 88. 04 |
| 90. 00 09000 CLI NI C | 0 | 0 | | 2, 305, 617 | 0.000000 | 90.00 |
| 90. 01 09001 CLINIC - AMO | 0 | 0 | | 672, 008 | 0.000000 | 90. 01 |
| 90. 02 09002 CLINIC - AMH NEURO | 0 | 0 | | 242, 497 | 0.000000 | 90. 02 |
| 90. 03 09003 GENERAL SURGERY OFFICE | 0 | 0 | | 406, 189 | 0.000000 | 90. 03 |
| 90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH | 0 | 0 | | ol o | 0.000000 | |
| 91. 00 09100 EMERGENCY | 0 | 0 | | 8, 800, 003 | 0.000000 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | | 0. 000000 | 1 |
| OTHER REIMBURSABLE COST CENTERS | <u> </u> | | | | | 1 |
| 95. 00 09500 AMBULANCE SERVICES | | | | | | 95.00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | | ol ol | 0.000000 | |
| 200.00 Total (lines 50 through 199) | 0 | 0 | (| 106, 568, 518 | | 200.00 |

| Heal th Financial | Systems | | ADA | MS MEMORIAL | HOSPI TAL | In Li | eu of Form CMS-2552-10 |
|--------------------------------|-------------------------|------------|----------|-------------|-----------|--|---|
| APPORTIONMENT OF THROUGH COSTS | I NPATI ENT/OUTPATI ENT | ANCI LLARY | SERVI CE | OTHER PASS | Provi der | Peri od: From 01/01/202 To 12/31/202 | Worksheet D Part IV Date/Time Prepared: |

| THROUG | GH COSTS | | | T | o 12/31/2022 | | pared: |
|--------|--|---------------|-------------|---------------|--------------|---------------|---------|
| | | | Title | xVIII | Hospi tal | Cost | 7 alli |
| | Cost Center Description | Outpati ent | Inpatient | Inpatient | Outpati ent | Outpati ent | |
| | , , , , , , , , , , , , , , , , , , , | Ratio of Cost | Program | Program | Program | Program | |
| | | to Charges | Charges | Pass-Through | Charges | Pass-Through | |
| | | (col. 6 ÷ | Ü | Costs (col. 8 | Ü | Costs (col. 9 | |
| | | col. 7) | | x col. 10) | | x col. 12) | |
| | | 9. 00 | 10. 00 | 11.00 | 12.00 | 13.00 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 05000 OPERATING ROOM | 0. 000000 | 247, 390 | 0 | 0 | 0 | 50.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0. 000000 | 0 | 0 | 0 | 0 | 52.00 |
| 53.00 | 05300 ANESTHESI OLOGY | 0. 000000 | 0 | 0 | 0 | 0 | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0. 000000 | 427, 569 | | 0 | 0 | 54.00 |
| 60.00 | 06000 LABORATORY | 0. 000000 | 391, 292 | 0 | 0 | 0 | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 0. 000000 | 353, 491 | 0 | 0 | 0 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0. 000000 | 86, 024 | 0 | 0 | 0 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0. 000000 | 92, 906 | | 0 | 0 | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 0. 000000 | 28, 157 | 0 | 0 | 0 | 68. 00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0. 000000 | 0 | 0 | 0 | 0 | 69.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000 | 0 | 0 | 0 | 0 | 71.00 |
| 72.00 | 07200 I MPL. DEV. CHARGED TO PATIENT | 0. 000000 | 82, 143 | 0 | 0 | 0 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0. 000000 | 765, 262 | 0 | 0 | 0 | 73.00 |
| 76.00 | 03020 OP PSYCH | 0. 000000 | 0 | 0 | 0 | 0 | 76.00 |
| 76. 01 | 03030 WOUND CARE | 0. 000000 | 651 | 0 | 0 | 0 | 76. 01 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 | 08800 MONROE FAMILY MEDICINE | 0. 000000 | 0 | 0 | 0 | 0 | 88. 00 |
| | 08801 WOODCREST | 0. 000000 | 0 | 0 | 0 | 0 | 88. 01 |
| 88. 02 | 08802 STAT CARE | 0. 000000 | 0 | 0 | 0 | 0 | 88. 02 |
| 88. 03 | 08803 BERNE FAMILY MEDICINE | 0. 000000 | 0 | 0 | 0 | 0 | 88. 03 |
| 88. 04 | 08804 HI GH STREET | 0. 000000 | 0 | | 0 | 0 | 88. 04 |
| 90.00 | 09000 CLI NI C | 0. 000000 | 92 | 0 | 0 | 0 | 90.00 |
| 90. 01 | 09001 CLINIC - AMO | 0. 000000 | 0 | 0 | 0 | 0 | 90. 01 |
| 90. 02 | 09002 CLINIC - AMH NEURO | 0. 000000 | 0 | 0 | 0 | 0 | 90. 02 |
| 90.03 | 09003 GENERAL SURGERY OFFICE | 0. 000000 | 0 | 0 | 0 | 0 | 90.03 |
| 90.04 | 04950 INTENSIVE OP BEHAVIORAL HEALTH | 0. 000000 | 0 | 0 | 0 | 0 | 90.04 |
| 91.00 | 09100 EMERGENCY | 0. 000000 | 18, 072 | 0 | 0 | 0 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000 | 13, 460 | 0 | 0 | 0 | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 95.00 | 09500 AMBULANCE SERVICES | | | | | | 95.00 |
| 97.00 | 09700 DURABLE MEDICAL EQUIP-SOLD | 0. 000000 | 0 | 0 | 0 | 0 | |
| 200.00 | Total (lines 50 through 199) | | 2, 506, 509 | 0 | 0 | 0 | 200. 00 |

| Peri od: | Worksheet D | From 01/01/2022 | Part V | To | 12/31/2022 | Date/Time Prepared: Provi der CCN: 15-1330

| | | | | | 10 12/31/2022 | 3/2/2024 10:0 | |
|---------|--|--------------|---------------|---------------|---------------|---------------|---------|
| | | | Title | : XVIII | Hospi tal | Cost | |
| | | | | Charges | | Costs | |
| | Cost Center Description | Cost to | PPS | Cost | Cost | PPS Services | |
| | ' | Charge Ratio | Rei mbursed | Rei mbursed | Rei mbursed | (see inst.) | |
| | | From | Services (see | Servi ces | Services Not | ` | |
| | | Worksheet C, | inst.) | Subject To | Subject To | | |
| | | Part I, col. | ĺ | Ded. & Coins. | Ded. & Coins. | | |
| | | 9 | | (see inst.) | (see inst.) | | |
| | | 1. 00 | 2.00 | 3.00 | 4.00 | 5. 00 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 05000 OPERATING ROOM | 0. 519788 | 0 | 2, 714, 76 | 9 0 | 0 | 50.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0. 701129 | 0 | | ol o | 0 | 52.00 |
| 53.00 | 05300 ANESTHESI OLOGY | 0. 000000 | 0 | | ol o | 0 | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0. 167110 | 0 | 5, 922, 09 | 4 0 | 0 | 54.00 |
| 60.00 | 06000 LABORATORY | 0. 360652 | 0 | 3, 673, 70 | 1, 228 | 0 | 60.00 |
| 65.00 | 06500 RESPIRATORY THERAPY | 0. 424499 | 0 | 634, 04 | | 0 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0. 614495 | 0 | 1, 531, 18 | | 0 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0. 422219 | 0 | 431, 11 | 1 | 0 | 67.00 |
| | 06800 SPEECH PATHOLOGY | 0. 329491 | 0 | 89, 62 | 1 | 0 | 68.00 |
| | 06900 ELECTROCARDI OLOGY | 0. 000000 | 0 | 1 | 0 | 0 | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000 | 0 | | | 0 | 1 |
| | 07200 I MPL. DEV. CHARGED TO PATIENT | 0. 337951 | 0 | 990, 90 | 4 0 | 0 | 72.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0. 338403 | 0 | 1, 445, 26 | | 0 | 73.00 |
| | 03020 OP PSYCH | 11. 339002 | 0 | 10, 76 | | 0 | 76.00 |
| | 03030 WOUND CARE | 0. 871526 | 0 | | | 0 | 76. 01 |
| 70.01 | OUTPATIENT SERVICE COST CENTERS | 0.071020 | | 02,00 | ٥, | | 70.01 |
| 88. 00 | 08800 MONROE FAMILY MEDICINE | | | | | | 88.00 |
| | 08801 WOODCREST | | | | | | 88. 01 |
| | 08802 STAT CARE | | | | | | 88. 02 |
| 88. 03 | 08803 BERNE FAMILY MEDICINE | | | | | | 88. 03 |
| | 08804 HI GH STREET | | | | | | 88. 04 |
| 90.00 | 09000 CLINIC | 1. 372540 | 0 | 297, 23 | 7 10, 557 | 0 | |
| | 09001 CLINIC - AMO | 1. 399323 | 0 | 296, 89 | | 0 | |
| | 09002 CLINIC - AMH NEURO | 1. 264131 | 0 | 70, 34 | | 0 | 90. 02 |
| | 09003 GENERAL SURGERY OFFICE | 1. 926618 | 0 | 106, 48 | 1 | 0 | |
| | 04950 INTENSIVE OP BEHAVIORAL HEALTH | 0. 000000 | 0 | | | 0 | 1 |
| 91. 00 | 09100 EMERGENCY | 0. 537729 | 0 | | ٦ ١ | 0 | 91.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1. 091102 | 0 | | 1 | 0 | 92.00 |
| 92.00 | OTHER REIMBURSABLE COST CENTERS | 1. 091102 | | 1, 410, 60. | 2 0 | 0 | 92.00 |
| 95. 00 | 09500 AMBULANCE SERVICES | 1. 323664 | | | | | 95.00 |
| | 09700 DURABLE MEDICAL EQUIP-SOLD | 0. 000000 | 0 | • | | 0 | |
| 200.00 | | 0.000000 | 0 | | ۷۱ ۲ | _ | 200.00 |
| 200.00 | | | U | | 0 40, 784 | U | 200.00 |
| 201.00 | Only Charges | | | ' | | | 201.00 |
| 202. 00 | | | 0 | 21, 228, 75 | 7 40, 784 | 0 | 202. 00 |
| 202.00 | I livet charges (Title 200 - Title 201) | ı l | U | 21,220,73 | 1 40, 704 | U | 1202.00 |

Peri od: Worksheet D From 01/01/2022 Part V To 12/31/2022 Date/Time Prepared:

| | | | | 10 12/01/2022 | 3/2/2024 10:07 am |
|---|-------------|---------------|-------|---------------|-------------------|
| | | Title | XVIII | Hospi tal | Cost |
| | Cos | | | <u> </u> | |
| Cost Center Description | Cost | Cost | | | |
| | Rei mbursed | Rei mbursed | | | |
| | Servi ces | Services Not | | | |
| | Subject To | Subject To | | | |
| | | Ded. & Coins. | | | |
| | (see inst.) | (see inst.) | | | |
| | 6. 00 | 7.00 | | | |
| ANCILLARY SERVICE COST CENTERS | • | | • | | |
| 50. 00 05000 OPERATING ROOM | 1, 411, 104 | 0 | | | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | | | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | | | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 989, 641 | 0 | | | 54.00 |
| 60. 00 06000 LABORATORY | 1, 324, 928 | 443 | | | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 269, 152 | 0 | | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 940, 908 | 0 | 1 | | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 182, 025 | 0 | | | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 29, 529 | 0 | | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | | 69.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0 | | | 71.00 |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENT | 334, 877 | 0 | | | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 489, 083 | 9, 813 | 1 | | 73.00 |
| 76. 00 03020 OP PSYCH | 122, 087 | 0,019 | i | | 76.00 |
| 76. 01 03030 WOUND CARE | 45, 614 | 0 | | | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | 43,014 | | l | | 70.01 |
| 88. 00 08800 MONROE FAMILY MEDICINE | | | | | 88. 00 |
| 88. 01 08801 WOODCREST | | | | | 88. 01 |
| 88. 02 08802 STAT CARE | | | | | 88. 02 |
| 88. 03 08803 BERNE FAMILY MEDICINE | | | | | 88. 03 |
| 88. 04 08804 HI GH STREET | | | | | 88. 04 |
| 90. 00 09000 CLI NI C | 407, 970 | 14, 490 | | | 90.00 |
| 90. 01 09001 CLI NI C - AMO | 415, 451 | 0 | 1 | | 90. 01 |
| 90. 02 09002 CLINIC - AMH NEURO | 88, 929 | 0 | | | 90. 02 |
| 90. 03 09003 GENERAL SURGERY OFFICE | 205, 164 | 0 | | | 90. 03 |
| 90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH | 203, 104 | 0 | | | 90.04 |
| 91. 00 09100 EMERGENCY | 829, 781 | 0 | | | 91.00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1, 548, 112 | 0 | | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | 1, 340, 112 | 0 | | | 92.00 |
| 95. 00 09500 AMBULANCE SERVI CES | 0 | | | | 95. 00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | | 0 | | | 97.00 |
| 200.00 Subtotal (see instructions) | 9, 634, 355 | 24, 746 | | | 200.00 |
| 201.00 Less PBP Clinic Lab. Services-Program | 7, 034, 333 | 24, 140 | | | 201.00 |
| Only Charges | ١ | | | | 201.00 |
| 202.00 Net Charges (line 200 - line 201) | 9, 634, 355 | 24, 746 | | | 202.00 |
| 202.00 | 7,007,000 | 24,740 | I | | 1202.00 |

| | | Component | CCN. 13-2330 1 | 0 12/31/2022 | 3/2/2024 10: 0 | |
|--|--------------|---------------|------------------|-----------------|----------------|---------|
| | | Title | XVIII Si | wing Beds - SNF | | |
| | | | Charges | | Costs | |
| Cost Center Description | Cost to | PPS | Cost | Cost | PPS Services | |
| | Charge Ratio | Rei mbursed | Rei mbursed | Rei mbursed | (see inst.) | |
| | From | Services (see | Servi ces | Services Not | | |
| | Worksheet C, | inst.) | Subject To | Subj ect To | | |
| | Part I, col. | | Ded. & Coins. | Ded. & Coins. | | |
| | 9 | | (see inst.) | (see inst.) | | |
| | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| ANCILLARY SERVICE COST CENTERS | | | 1 | _ | | |
| 50. 00 05000 OPERATI NG ROOM | 0. 519788 | | _ | _ | 0 | 50.00 |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM | 0. 701129 | 0 | 1 | | 0 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0. 000000 | 0 | 0 | 0 | 0 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 167110 | 0 | 0 | 0 | 0 | 54.00 |
| 60. 00 06000 LABORATORY | 0. 360652 | 0 | 0 | 0 | 0 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 424499 | 0 | 0 | 0 | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 614495 | 0 | 0 | 0 | 0 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0. 422219 | 0 | 0 | 0 | 0 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0. 329491 | 0 | 0 | 0 | 0 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 000000 | 0 | 0 | 0 | 0 | 69. 00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000 | 0 | 0 | 0 | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0. 337951 | 0 | 0 | 0 | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 338403 | 0 | 0 | 0 | 0 | 73.00 |
| 76. 00 03020 OP PSYCH | 11. 339002 | 0 | 1 | - | 0 | 76. 00 |
| 76. 01 03030 WOUND CARE | 0. 871526 | 0 | 0 | 0 | 0 | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | T | | T | | | |
| 88.00 08800 MONROE FAMILY MEDICINE | | | | | | 88. 00 |
| 88. 01 08801 WOODCREST | | | | | | 88. 01 |
| 88. 02 08802 STAT CARE | | | | | | 88. 02 |
| 88.03 08803 BERNE FAMILY MEDICINE | | | | | | 88. 03 |
| 88. 04 08804 HI GH STREET | | | | | | 88. 04 |
| 90. 00 09000 CLI NI C | 1. 372540 | 0 | 0 | 0 | 0 | 90.00 |
| 90. 01 09001 CLINIC - AMO | 1. 399323 | 0 | 0 | 0 | 0 | 90. 01 |
| 90. 02 09002 CLI NI C - AMH NEURO | 1. 264131 | 0 | 0 | 0 | 0 | 90. 02 |
| 90. 03 09003 GENERAL SURGERY OFFICE | 1. 926618 | 0 | 0 | 0 | 0 | 90. 03 |
| 90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH | 0. 000000 | 0 | 0 | 0 | 0 | 90. 04 |
| 91. 00 09100 EMERGENCY | 0. 537729 | | 1 | - | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1. 091102 | 0 | 0 | 0 | 0 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 95. 00 09500 AMBULANCE SERVICES | 1. 323664 | | 0 | | | 95.00 |
| 97.00 09700 DURABLE MEDICAL EQUIP-SOLD | 0. 000000 | 0 | 0 | 0 | 0 | |
| 200.00 Subtotal (see instructions) | | 0 | 0 | 0 | | 200. 00 |
| 201.00 Less PBP Clinic Lab. Services-Program | | | 0 | 0 | | 201. 00 |
| Only Charges | | | | | | |
| 202.00 Net Charges (line 200 - line 201) | | 0 | 0 | 0 | 0 | 202. 00 |
| | | | | | | |

Health Financial Systems

ADAMS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Component CCN: 15-1330

Component CCN: 15-2330

To 12/31/2022

Date/Time Prepared:

| | | Component | CCN: 15-Z330 | То | 12/31/2022 | Date/Time Pr 3/2/2024 10: | epared: 07 am |
|--|---------------|---------------|--------------|--------|------------|------------------------------|------------------|
| | | Title | XVIII | Swi ng | Beds - SNF | Cost | |
| | Cos | ts | | | | | |
| Cost Center Description | Cost | Cost | | | | | |
| | Rei mbursed | Rei mbursed | | | | | |
| | Servi ces | Services Not | | | | | |
| | Subject To | Subject To | | | | | |
| | Ded. & Coins. | Ded. & Coins. | | | | | |
| | (see inst.) | (see inst.) | | | | | |
| | 6. 00 | 7. 00 | | | | | |
| ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 50.00 05000 OPERATING ROOM | 0 | 0 | | | | | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | | | | | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | | | | | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | | | | 54.00 |
| 60. 00 06000 LABORATORY | 0 | 0 | | | | | 60.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 0 | 0 | | | | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | o | 0 | | | | | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | o | 0 | | | | | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0 | 0 | | | | | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | | | | 69.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 1 | | | | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | | 0 | | | | | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | | | | 73.00 |
| 76. 00 03020 OP PSYCH | 0 | 0 | 1 | | | | 76.00 |
| 76. 01 03030 WOUND CARE | 0 | 0 | | | | | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | <u> </u> | 0 | | | | | 70.01 |
| 88. 00 08800 MONROE FAMILY MEDICINE | | | | | | | 88. 00 |
| 88. 01 08801 WOODCREST | | | | | | | 88. 01 |
| 88. 02 08802 STAT CARE | | | | | | | 88. 02 |
| 88. 03 08803 BERNE FAMILY MEDICINE | | | | | | | 88. 03 |
| 88. 04 08804 HI GH STREET | | | | | | | 88. 04 |
| 90. 00 09000 CLI NI C | 0 | 0 | | | | | 90.00 |
| 90. 00 09000 CLINI C 90. 01 09001 CLINI C - AMO | 0 | 0 | | | | | 90.00 |
| | 0 | 0 | | | | | |
| 90. 02 09002 CLINIC - AMH NEURO | 0 | - | 1 | | | | 90. 02 |
| 90. 03 09003 GENERAL SURGERY OFFICE | 0 | 0 | 1 | | | | 90.03 |
| 90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH | 0 | 0 | 1 | | | | 90.04 |
| 91. 00 09100 EMERGENCY | 0 | 0 | • | | | | 91.00 |
| 92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | | | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 95. 00 09500 AMBULANCE SERVICES | 0 | | | | | | 95.00 |
| 97.00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | 1 | | | | 97.00 |
| 200.00 Subtotal (see instructions) | 0 | 0 | | | | | 200. 00 |
| 201.00 Less PBP Clinic Lab. Services-Program | 0 | | | | | | 201.00 |
| Only Charges | | | | | | | 1 |
| 202.00 Net Charges (line 200 - line 201) | 0 | 0 | | | | | 202.00 |
| | | | | | | | |

| Heal th | Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|--|--|---------------------------|-------------------------|------------------------|-----------------------|--|---------------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL | | L COSTS | | Provi der CCN: 15-1330 | | Worksheet D Part I Date/Time Prepared 3/2/2024 10:07 am | |
| | | | Ti tl | e XIX | Hospi tal | PPS | |
| | Cost Center Description | Capi tal Rel ated Cost | Swing Bed Adjustment | Reduced Capi tal | Total Patient Days | Per Diem (col. 3 / | |
| | | (from Wkst. | | Related Cost | | col. 4) | |
| | | B, Part II, | | (col. 1 - | | | |
| | | col. 26) | | col. 2) | | | |
| | | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | ADULTS & PEDIATRICS | 536, 713 | | | | 100. 53 | |
| 31.00 | INTENSIVE CARE UNIT | 97, 569 | | 97, 569 | | 110. 87 | |
| 40.00 | SUBPROVIDER - IPF | 0 | 0 | | 0 | 0. 00 | |
| 43.00 | NURSERY | 33, 884 | | 33, 884 | | 141. 77 | 1 |
| | SKILLED NURSING FACILITY | 0 | | | | 0. 00 | 1 |
| 200.00 | Total (lines 30 through 199) | 668, 166 | | 544, 635 | 5, 229 | | 200.00 |
| | Cost Center Description | Inpatient | Inpatient | | | | |
| | | Program days | Program | | | | |
| | | | Capital Cost | | | | |
| | | | (col. 5 x | | | | |
| | | | col. 6) | | | | |
| | INDATION DOUTING CEDVICE COCT CENTEDS | 6. 00 | 7. 00 | | | | |
| 20.00 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | | | ı | | | 1 20 00 |
| 30.00 | ADULTS & PEDIATRICS INTENSIVE CARE UNIT | 114 | 12 (20 | | | | 30. 00 31. 00 |
| 31.00 | | 114 | , | 1 | | | |
| 40.00 | SUBPROVIDER - I PF | 00 | 10.750 | | | | 40. 00 43. 00 |
| 43. 00 44. 00 | NURSERY SKILLED NURSING FACILITY | 90 | 12, 759 0 | 1 | | | 43.00 |
| | | 204 | 1 | | | | 200.00 |
| 200.00 | Total (lines 30 through 199) | 204 | 25, 398 | 1 | | | 200.00 |

| Health Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|---------------|---------------|---------------|---|--|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT. | AL COSTS | Provi der C | | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Pre 3/2/2024 10:0 | epared: |
| | | Ti tl | e XIX | Hospi tal | PPS | |
| Cost Center Description | Capi tal | | Ratio of Cost | Inpatient | Capital Costs | |
| | Related Cost | (from Wkst. | to Charges | Program | (column 3 x | |
| | (from Wkst. | C, Part I, | (col. 1 ÷ | Charges | column 4) | |
| | B, Part II, | col. 8) | col . 2) | | | |
| | col. 26) | | | | | |
| | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 286, 569 | | | | 0 | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 33, 021 | 184, 160 | | | 0 | |
| 53. 00 05300 ANESTHESI OLOGY | 0 | _ | 0.0000 | | 0 | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 196, 843 | | | | 0 | |
| 60. 00 06000 LABORATORY | 109, 646 | | | | 0 | |
| 65. 00 06500 RESPIRATORY THERAPY | 110, 388 | | | | 0 | |
| 66. 00 06600 PHYSI CAL THERAPY | 178, 770 | | | | 0 | |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 5, 383 | | | | 0 | 1 07.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 2, 490 | 1, 168, 844 | | | 0 | |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | 0.00000 | | 0 | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 0.00000 | | 0 | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 5, 598 | | | | 0 | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 60, 077 | 8, 892, 108 | | | 0 | |
| 76. 00 03020 OP PSYCH | 2, 962 | 96, 383 | | | 0 | 76.00 |
| 76. 01 03030 WOUND CARE | 1, 172 | 419, 726 | 0. 00279 | 2 0 | 0 | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | 1 |
| 88.00 08800 MONROE FAMILY MEDICINE | 7, 462 | | | | 0 | |
| 88. 01 08801 WOODCREST | 6, 677 | | | | 0 | |
| 88. 02 08802 STAT CARE | 55, 195 | | | | 0 | |
| 88.03 08803 BERNE FAMILY MEDICINE | 5, 971 | 1, 827, 639 | | | 0 | |
| 88. 04 08804 HI GH STREET | 6, 054 | | | | 0 | |
| 90. 00 09000 CLI NI C | 38, 164 | | | | 0 | |
| 90. 01 09001 CLINIC - AMO | 9, 452 | | | | 0 | |
| 90. 02 09002 CLINIC - AMH NEURO | 7, 011 | | | | 0 | |
| 90. 03 09003 GENERAL SURGERY OFFICE | 10, 325 | | | | 0 | |
| 90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH | 0 | | 0.0000 | | 0 | |
| 91. 00 09100 EMERGENCY | 137, 820 | | | | 0 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 192, 368 | 3, 756, 948 | 0. 05120 | 3 0 | 0 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | 1 | ı | | | | |
| 95. 00 09500 AMBULANCE SERVI CES | | | | _ | _ | 95.00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | | | | 0 | |
| 200.00 Total (lines 50 through 199) | 1, 469, 418 | 106, 568, 518 | | 0 | 0 | 200.00 |

| Health Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-: | 2552-10 |
|--|---------------|---------------|--------------|---|---|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P | | TS Provider C | | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part III Date/Time Pre 3/2/2024 10:0 | pared: |
| | | | e XIX | Hospi tal | PPS | |
| Cost Center Description | Nursi ng | Nursi ng | | Allied Health | All Other | |
| | Program | Program | Post-Stepdow | n Cost | Medi cal | |
| | Post-Stepdown | | Adjustments | | Educati on | |
| | Adjustments | | | | Cost | |
| | 1A | 1.00 | 2A | 2. 00 | 3. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 0 | 0 | | 0 0 | 0 | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 0 | 0 | | 0 | 0 | 31.00 |
| 40. 00 04000 SUBPROVI DER - 1 PF | 0 | 0 |) | 0 | 0 | 40.00 |
| 43. 00 04300 NURSERY | 0 | 0 | 1 | 0 0 | 0 | 43.00 |
| 44.00 04400 SKILLED NURSING FACILITY | 0 | 0 | 1 | 0 0 | | 44.00 |
| 200.00 Total (lines 30 through 199) | o | 0 | | 0 0 | 0 | 200.00 |
| Cost Center Description | Swi ng-Bed | Total Costs | Total Patien | t Per Diem | Inpatient | |
| | Adjustment | (sum of cols. | Days | (col. 5 ÷ | Program Days | |
| | Amount (see | 1 through 3, | | col. 6) | | |
| | | minus col. 4) | | | | |
| | 4. 00 | 5. 00 | 6.00 | 7. 00 | 8. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | • | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 0 | 0 | 4, 11 | 0.00 | 0 | 30.00 |
| 31. 00 03100 INTENSIVE CARE UNIT | | 0 | 88 | 0.00 | 114 | 31.00 |
| 40. 00 04000 SUBPROVI DER - 1 PF | o | 0 | | 0.00 | l o | 40.00 |
| 43. 00 04300 NURSERY | | 0 | 23 | 9 0.00 | 90 | 43.00 |
| 44.00 04400 SKILLED NURSING FACILITY | | 0 | | 0.00 | O | 44.00 |
| 200.00 Total (lines 30 through 199) | | 0 | 5, 22 | | | 200.00 |
| Cost Center Description | Inpatient | | <u> </u> | • | | |
| ' | 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 SUBPROVI DER - I PF | o | | | | | 40.00 |
| 43. 00 04300 NURSERY | o | | | | | 43.00 |
| 44.00 04400 SKILLED NURSING FACILITY | 0 | | | | | 44.00 |
| 200.00 Total (lines 30 through 199) | 0 | | | | | 200.00 |
| 1 | -1 | | | | | |

Health Financial Systems

ADAMS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Period: From 01/01/2022 Part IV

To 12/31/2022 Date/Time Prepared:

| 3/2 | 2/2024 10:07 am | ed: |
|--|-----------------|------|
| Title XIX Hospital | PPS | |
| Cost Center Description Non Physician Nursing Nursing Allied Health Alli | i ed Heal th | |
| Anesthetist Program Program Post-Stepdown | | |
| Cost Post-Stepdown Adjustments | | |
| Adjustments Adjustments | | |
| 1.00 2A 2.00 3A | 3. 00 | |
| ANCILLARY SERVICE COST CENTERS | | |
| 50. 00 05000 0PERATING ROOM 0 0 0 | 0 50. | |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 | | . 00 |
| 53. 00 05300 ANESTHESI OLOGY 0 0 0 | | . 00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 | | . 00 |
| 60. 00 06000 LABORATORY 0 0 0 0 | | . 00 |
| 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 | | . 00 |
| 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 | | . 00 |
| 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 | | . 00 |
| 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 | | . 00 |
| 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 | | . 00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 | | . 00 |
| 72.00 07200 1 MPL. DEV. CHARGED TO PATIENT 0 0 0 0 | | . 00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 | | . 00 |
| 76. 00 03020 0P PSYCH 0 0 0 0 | | . 00 |
| 76. 01 03030 WOUND_CARE 0 0 0 0 | 0 76. | . 01 |
| OUTPATIENT SERVICE COST CENTERS | | |
| 88. 00 08800 MONROE FAMILY MEDICINE 0 0 0 0 | 0 88. | |
| 88. 01 08801 WOODCREST 0 0 0 0 | | . 01 |
| 88. 02 08802 STAT CARE 0 0 0 0 0 | | . 02 |
| 88. 03 08803 BERNE FAMI LY MEDI CI NE 0 0 0 0 | | . 03 |
| 88. 04 08804 HI GH STREET 0 0 0 0 | | . 04 |
| 90. 00 09000 CLINIC 0 0 0 | | . 00 |
| 90. 01 09001 CLINIC - AMO 0 0 0 | | . 01 |
| 90. 02 09002 CLINIC - AMH NEURO 0 0 0 0 | | . 02 |
| 90. 03 09003 GENERAL SURGERY OFFICE 0 0 0 0 | 0 90. | . 03 |
| 90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH 0 0 0 0 0 | 0 90. | . 04 |
| 91. 00 09100 EMERGENCY 0 0 0 0 | 0 91. | . 00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 | 0 92. | . 00 |
| OTHER REIMBURSABLE COST CENTERS | | |
| 95. 00 09500 AMBULANCE SERVI CES | | . 00 |
| 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 | 0 97. | |
| 200.00 Total (lines 50 through 199) 0 0 0 | 0 200. | . 00 |

| THROUGH COSTS | | | | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | pared: 7 am |
|---|------------|---------------|--------------|-------------------|--------------------------------|----------------|
| | | Ti tl | e XIX | Hospi tal | PPS | |
| Cost Center Description | All Other | Total Cost | Total | Total Charges | Ratio of Cost | |
| | Medi cal | (sum of cols. | Outpati ent | (from Wkst. | to Charges | |
| | Educati on | 1, 2, 3, and | Cost (sum of | C, Part I, | (col. 5 ÷ | |
| | Cost | 4) | col s. 2, 3, | col. 8) | col. 7) | |
| | | | and 4) | | (see | |
| | | | | | instructions) | |
| | 4. 00 | 5. 00 | 6. 00 | 7. 00 | 8. 00 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 0 | 0 | (| 11, 924, 727 | 0. 000000 | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | (| 184, 160 | 0. 000000 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | (| 0 | 0.000000 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | (| 24, 277, 487 | 0.000000 | 54.00 |
| 60. 00 06000 LABORATORY | 0 | 0 | (| 17, 419, 118 | 0.000000 | 60.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 0 | 0 | (| 4, 128, 809 | 0.000000 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | (| 5, 184, 297 | 0.000000 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | (| 2, 130, 190 | 0.000000 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | (| 1, 168, 844 | 0.000000 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 | 0.000000 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | o | 0.000000 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | | 4, 095, 129 | 0.000000 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 8, 892, 108 | 0.000000 | 73.00 |
| 76. 00 03020 OP PSYCH | 0 | 0 | | 96, 383 | 0.000000 | 76.00 |
| 76. 01 03030 WOUND CARE | 0 | 0 | | 419, 726 | 0.000000 | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | 1 |
| 88.00 08800 MONROE FAMILY MEDICINE | 0 | 0 | (| 2, 259, 889 | 0.000000 | 88. 00 |
| 88. 01 08801 WOODCREST | 0 | 0 | (| 1, 951, 988 | 0.000000 | 88. 01 |
| 88. 02 08802 STAT CARE | 0 | 0 | (| 2, 221, 560 | 0.000000 | 88. 02 |
| 88.03 08803 BERNE FAMILY MEDICINE | 0 | 0 | (| 1, 827, 639 | 0.000000 | 88. 03 |
| 88. 04 08804 HI GH STREET | 0 | 0 | | 2, 203, 202 | 0.000000 | 88. 04 |
| 90. 00 09000 CLI NI C | 0 | 0 | | 2, 305, 617 | 0.000000 | 90.00 |
| 90. 01 09001 CLINIC - AMO | 0 | 0 | | 672,008 | 0.000000 | 90. 01 |
| 90. 02 09002 CLINIC - AMH NEURO | 0 | 0 | | 242, 497 | 0.000000 | 90. 02 |
| 90. 03 09003 GENERAL SURGERY OFFICE | 0 | 0 | | 406, 189 | 0.000000 | 90. 03 |
| 90.04 04950 INTENSIVE OP BEHAVIORAL HEALTH | 0 | 0 | | 0 | 0. 000000 | 90. 04 |
| 91. 00 09100 EMERGENCY | 0 | l o | | 8, 800, 003 | 0. 000000 | 91.00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | 3, 756, 948 | 0. 000000 | 1 |
| OTHER REIMBURSABLE COST CENTERS | | | | ., ., ., ., ., ., | | 1 |
| 95. 00 09500 AMBULANCE SERVICES | | | | | | 95.00 |
| 97.00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | | 0 | 0. 000000 | |
| 200.00 Total (lines 50 through 199) | 0 | o | (| 106, 568, 518 | | 200. 00 |

| Health Financial Systems | ADAMS MEMORIAL HOSPITAL | In Lieu of Form CMS-2552-10 |
|---|---|--|
| APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS | ANCI LLARY SERVI CE OTHER PASS Provi der CCN: 15-1330 | Peri od: Worksheet D From 01/01/2022 Part IV To 12/31/2022 Date/Time Prepared: |

| 11111000 | 66516 | | | To | 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
|----------|--|---------------|-----------|---------------|-------------|-----------------------------|--------|
| | | | Ti tl | e XIX | Hospi tal | PPS | 7 GIII |
| | Cost Center Description | Outpati ent | Inpatient | I npati ent | Outpati ent | Outpati ent | |
| | | Ratio of Cost | Program | Program | Program | Program | |
| | | to Charges | Charges | Pass-Through | Charges | Pass-Through | |
| | | (col. 6 ÷ | | Costs (col. 8 | | Costs (col. 9 | |
| | | col. 7) | | x col. 10) | | x col. 12) | |
| | | 9. 00 | 10. 00 | 11.00 | 12. 00 | 13.00 | |
| | ANCILLARY SERVICE COST CENTERS | T | | 1 | | | |
| | 05000 OPERATING ROOM | 0. 000000 | 0 | _ | 0 | 0 | |
| | 05200 DELIVERY ROOM & LABOR ROOM | 0. 000000 | 0 | _ | 0 | 0 | 52.00 |
| | 05300 ANESTHESI OLOGY | 0. 000000 | 0 | 0 | 0 | 0 | 53.00 |
| | 05400 RADI OLOGY-DI AGNOSTI C | 0. 000000 | 0 | 0 | 0 | 0 | 54.00 |
| | 06000 LABORATORY | 0. 000000 | 0 | _ | 0 | 0 | 60.00 |
| | 06500 RESPI RATORY THERAPY | 0. 000000 | 0 | _ | 0 | 0 | 65.00 |
| | 06600 PHYSI CAL THERAPY | 0. 000000 | 0 | _ | 0 | 0 | 66. 00 |
| | 06700 OCCUPATI ONAL THERAPY | 0. 000000 | 0 | _ | 0 | 0 | 67.00 |
| | 06800 SPEECH PATHOLOGY | 0. 000000 | 0 | _ | 0 | 0 | 68. 00 |
| | 06900 ELECTROCARDI OLOGY | 0. 000000 | 0 | _ | 0 | 0 | 69. 00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000 | 0 | _ | 0 | 0 | 71.00 |
| | 07200 IMPL. DEV. CHARGED TO PATIENT | 0. 000000 | 0 | 0 | 0 | 0 | 72.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0. 000000 | 0 | 0 | 0 | 0 | 73.00 |
| | 03020 OP PSYCH | 0. 000000 | 0 | · · | 0 | 0 | 76. 00 |
| 76. 01 | 03030 WOUND CARE | 0. 000000 | 0 | 0 | 0 | 0 | 76. 01 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| | 08800 MONROE FAMILY MEDICINE | 0. 000000 | 0 | | 0 | 0 | |
| | 08801 WOODCREST | 0. 000000 | 0 | 0 | 0 | 0 | 88. 01 |
| | 08802 STAT CARE | 0. 000000 | 0 | 0 | 0 | 0 | 88. 02 |
| | 08803 BERNE FAMILY MEDICINE | 0. 000000 | 0 | _ | 0 | 0 | 88. 03 |
| | 08804 HI GH STREET | 0. 000000 | 0 | _ | 0 | 0 | 88. 04 |
| | 09000 CLI NI C | 0. 000000 | 0 | _ | 0 | 0 | 90.00 |
| | 09001 CLINIC - AMO | 0. 000000 | 0 | _ | 0 | 0 | 90. 01 |
| | 09002 CLINIC - AMH NEURO | 0. 000000 | 0 | 0 | 0 | 0 | 90. 02 |
| | 09003 GENERAL SURGERY OFFICE | 0. 000000 | 0 | 0 | 0 | 0 | 90. 03 |
| | 04950 INTENSIVE OP BEHAVIORAL HEALTH | 0. 000000 | 0 | 0 | 0 | 0 | 90.04 |
| | 09100 EMERGENCY | 0. 000000 | 0 | 1 | 0 | 0 | 91.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000 | 0 | 0 | 0 | 0 | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| | 09500 AMBULANCE SERVI CES | | | | | | 95. 00 |
| | 09700 DURABLE MEDICAL EQUIP-SOLD | 0. 000000 | 0 | 1 | 0 | 0 | |
| 200.00 | Total (lines 50 through 199) | | 0 | 0 | 0 | 0 | 200.00 |

| Health Financial Systems | ADAMS MEMORIAL | HOSPI TAL | In Lie | u of Form CMS-2 | 2552-10 |
|---|----------------|-----------------------|-----------------------------|--------------------------------|----------------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider CCN: 15-1330 | Peri od: From 01/01/2022 | Worksheet D-1 | |
| | | | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | pared: 7 am |
| | | Title XVIII | Hospi tal | Cost | |
| Cost Center Description | | | | | |
| | | | | 1. 00 | |
| PART I - ALL PROVIDER COMPONENTS | | | | | |
| I NPATI ENT DAYS | | | | | |
| | | | | | |

| | Title XVIII Hospital | Cost | |
|------------------|--|------------------|------------------|
| | Cost Center Description | 1. 00 | |
| | PART I - ALL PROVIDER COMPONENTS | 1.00 | |
| | I NPATI ENT DAYS | | |
| 1.00 | Inpatient days (including private room days and swing-bed days, excluding newborn) | 5, 260 | 1.00 |
| 2. 00 | Inpatient days (including private room days, excluding swing-bed and newborn days) | 4, 110 | 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, 263 | 4.00 |
| 5. 00 | Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost | 1, 036 | 5. 00 |
| | reporting period | | |
| 6.00 | Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost | 0 | 6. 00 |
| 7. 00 | reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost | 114 | 7. 00 |
| 7.00 | reporting period | 114 | 7.00 |
| 8.00 | Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost | 0 | 8.00 |
| | reporting period (if calendar year, enter 0 on this line) | | |
| 9. 00 | Total inpatient days including private room days applicable to the Program (excluding swing-bed and | 827 | 9. 00 |
| 10.00 | newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) | 541 | 10.00 |
| | through December 31 of the cost reporting period (see instructions) | 3 | 10.00 |
| 11. 00 | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after | 0 | 11. 00 |
| 10.00 | December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | 10.00 |
| 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) | 0 | 13.00 |
| | after December 31 of the cost reporting period (if calendar year, enter 0 on this line) | | |
| 14.00 | Medically necessary private room days applicable to the Program (excluding swing-bed days) | 0 | 14.00 |
| 15. 00 16. 00 | Total nursery days (title V or XIX only) Nursery days (title V or XIX only) | 0 | 15. 00 16. 00 |
| 10.00 | SWING BED ADJUSTMENT | 0 | 10.00 |
| 17. 00 | Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost | | 17.00 |
| 40.00 | reporting period | | 40.00 |
| 18. 00 | Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period | | 18. 00 |
| 19. 00 | Medical dirate for swing-bed NF services applicable to services through December 31 of the cost | 140. 00 | 19.00 |
| | reporting period | | |
| 20. 00 | Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period | 140. 00 | 20.00 |
| 21. 00 | Total general inpatient routine service cost (see instructions) | 11, 436, 959 | 21. 00 |
| 22. 00 | Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line | | 22. 00 |
| 00.00 | 5 x line 17) | | 00.00 |
| 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 | 15, 960 | 24.00 |
| | 7 x line 19) | | |
| 25. 00 | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 | 0 | 25.00 |
| 26. 00 | x line 20) Total swing-bed cost (see instructions) | 2, 315, 248 | 26. 00 |
| 27. 00 | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) | 9, 121, 711 | |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | |
| 28. 00 | General inpatient routine service charges (excluding swing-bed and observation bed charges) | 0 | 28.00 |
| 29. 00 30. 00 | Pri vate room charges (excluding swing-bed charges) Semi-pri vate room charges (excluding swing-bed charges) | 0 | 29. 00 30. 00 |
| 31. 00 | General inpatient routine service cost/charge ratio (line 27 ÷ line 28) | 0. 000000 | 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 | • |
| 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) | 0.00 | 36.00 |
| 37. 00 | General inpatient routine service cost net of swing-bed cost and private room cost differential (line | | 37.00 |
| 57.00 | 27 minus line 36) | 7, 121, 711 | 07.00 |
| | 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) | 2, 219. 39 | 38. 00 |
| 39.00 | Program general inpatient routine service cost (line 9 x line 38) | 1, 835, 436 | 39.00 |
| 40. 00 41. 00 | Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40) | 0 1, 835, 436 | 40.00 |
| 11.00 | 1. Section 2. Section in the control of the section | 1, 555, 450 | 1 00 |

| ealth Financial Systems COMPUTATION OF INPATIENT OPERATING COST | ADAMS MEMORIA | Provider CCN: | | eri od: | u of Form CMS-2 Worksheet D-1 | |
|---|--|--|---|--------------------------------|-------------------------------------|--------------------------|
| | | | | rom 01/01/2022 o 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
| Cost Center Description | Total I npati ent Cost 1.00 | | VIII Average Per iem (col. 1 ÷ col. 2) 3.00 | Hospi tal Program Days 4.00 | Program Cost (col. 3 x col. 4) 5.00 | |
| 2.00 NURSERY (title V & XIX only) | 0 | | 0. 00 | | | 42. |
| Intensive Care Type Inpatient Ho 3.00 INTENSIVE CARE UNIT | spital Units 3,047,280 | 880 | 3, 462. 82 | 249 | 862, 242 | 43. |
| 4.00 CORONARY CARE UNIT 5.00 BURN INTENSIVE CARE UNIT 6.00 SURGICAL INTENSIVE CARE UNIT 7.00 OTHER SPECIAL CARE (SPECIFY) | 5,611,200 | | 57 1521 52 | | 332, 2 12 | 44. 45. 46. 47. |
| Cost Center Description | | | | | 1. 00 | |
| 8.00 Program inpatient ancillary serv | ice cost (Wkst. D-3, col. | 3, line 200) | | | 904, 407 | |
| 8.01 Program inpatient cellular thera 9.00 Total Program inpatient costs (s PASS THROUGH COST ADJUSTMENTS | py acquisition cost (Works um of lines 41 through 48. | heet D-6, Part II 01)(see instructi | I, line 10, ons) | column 1) | 3, 602, 085 | |
| 0.00 Pass through costs applicable to | Program inpatient routine | services (from \ | Vkst. D, sum | of Parts I and | 0 | 50. |
| | Program inpatient ancilla | ry services (from | n Wkst. D, su | um of Parts II | 0 | 51. |
| and IV) 2.00 Total Program excludable cost (s | um of lines 50 and 51) | | | | 0 | 52. |
| 3.00 Total Program inpatient operation medical education costs (line 49) | g cost excluding capital r minus line 52) | elated, non-physi | cian anesth | etist, and | 0 | |
| TARGET AMOUNT AND LIMIT COMPUTAT 4.00 Program discharges | UN | | | | 0 | 54. |
| 5.00 Target amount per discharge | | | | | 0. 00 | |
| 5.01 Permanent adjustment amount per | 3 | | | | 0. 00 0. 00 | |
| .02 Adjustment amount per discharge .00 Target amount (line 54 x sum of | |) | | | 0.00 | 1 |
| .00 Difference between adjusted inpa | | | ne 56 minus l | ine 53) | 0 | 57 |
| .00 Bonus payment (see instructions) | | | | | 0 | |
| 0.00 Trended costs (lesser of line 53 updated and compounded by the ma | | m the cost repor | ting period o | endi ng 1996, | 0. 00 | 59. |
| 0.00 Expected costs (lesser of line 5 | | om prior year cos | st report, u | odated by the | 0.00 | 60. |
| market basket) 1.00 Continuous improvement bonus pay 55.01, or line 59, or line 60, e 53) are less than expected costs enter zero. (see instructions) | nter the lesser of 50% of | the amount by whi | ch operating | g costs (line | 0 | 61. |
| 2.00 Relief payment (see instructions 3.00 Allowable Inpatient cost plus in | | ucti ons) | | | 0 | 62. 63. |
| PROGRAM INPATIENT ROUTINE SWING . 00 Medicare swing-bed SNF inpatient | | ember 31 of the d | cost reportio | na period (See | 1, 200, 690 | 64. |
| instructions)(title XVIII only) .00 Medicare swing-bed SNF inpatient | · · | | · | | | 65 |
| instructions)(title XVIII only) 5.00 Total Medicare swing-bed SNF inp | | | | | 1, 200, 690 | |
| CAH, see instructions | | | | • | | |
| 7.00 Title V or XIX swing-bed NF inpa (line 12 x line 19) | _ | | · | | 0 | 67 |
| <pre>1.00 Title V or XIX swing-bed NF inpa (line 13 x line 20)</pre> | | | • | rting period | 0 | 68 |
| PART III - SKILLED NURSING FACIL | | | | | 0 | 69. |
| .00 Skilled nursing facility/other n | ursing facility/ICF/IID ro | utine service cos | st (line 37) | | | 70 |
| .00 Adjusted general inpatient routi | | line 70 ÷ line 2) |) | | | 71 |
| .00 Program routine service cost (li.00 Medically necessary private room | | m (line 14 x line | e 35) | | | 72 73 |
| .00 Total Program general inpatient | routine service costs (lin | e 72 + line 73) | ŕ | | | 74 |
| .00 Capital-related cost allocated t 26, line 45) | o inpatient routine servic | e costs (from Woi | rksheet B, Pa | art II, column | | 75 |
| .00 Per diem capital-related costs (| | | | | | 76 |
| .00 Program capital -related costs (I | | | | | | 77 |
| .00 Inpatient routine service cost (.00 Aggregate charges to beneficiari | | provi den ineconds` |) | | | 78 79 |
| .00 Total Program routine service co | | | | us line 79) | | 80 |
| .00 Inpatient routine service cost p | | 4.) | | • | | 81 |
| .00 Inpatient routine service cost I | , | , | | | | 82 |
| .00 Reasonable inpatient routine ser.00 Program inpatient ancillary serv | | 115) | | | | 83 |
| 5.00 Utilization review - physician c | | ons) | | | | 85 |
| 5.00 Total Program inpatient operation | g costs (sum of lines 83 t | | | | | 86 |
| PART IV - COMPUTATION OF OBSERVA 7.00 Total observation bed days (see | | | | | 1 0/7 | 0.7 |
| | LIBERUCE OHS I | | | | 1, 847 | 10/ |

| Health Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|--|----------------|--------------|------------|----------------------------------|--------------------------------|----------------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provi der CO | | Peri od: | Worksheet D-1 | |
| | | | | From 01/01/2022 To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | pared: 7 am |
| | | Title | XVIII | Hospi tal | Cost | |
| Cost Center Description | | | | | | |
| | | | | | 1. 00 | |
| 89.00 Observation bed cost (line 87 x line 88) (se | e instructions |) | | | 4, 099, 213 | 89.00 |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observation | |
| | | (from line | column 2 | Observati on | Bed Pass | |
| | | 21) | | Bed Cost | Through Cost | |
| | | | | (from line | (col. 3 x | |
| | | | | 89) | col. 4) (see | |
| | | | | | instructions) | |
| | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | | | | | |
| 90.00 Capital -related cost | 536, 713 | 11, 436, 959 | 0. 04692 | 28 4, 099, 213 | 192, 368 | 90.00 |
| 91.00 Nursing Program cost | 0 | 11, 436, 959 | 0. 00000 | 00 4, 099, 213 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 11, 436, 959 | 0. 00000 | 00 4, 099, 213 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 11, 436, 959 | 0. 00000 | 00 4, 099, 213 | 0 | 93.00 |

| Health Financial Systems | ADAMS MEMORIAL HOSPITAL | In Lie | u of Form CMS- | 2552-10 |
|---|-------------------------|----------------------------|--------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 15-133 | Period: From 01/01/2022 | Worksheet D-1 | |
| | | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
| | Title XIX | Hospi tal | PPS | |
| Cost Center Description | | | | |
| | | | 1. 00 | |
| PART I - ALL PROVIDER COMPONENTS | | | | |
| INDATI ENT. DAVC | | | | |

| | | Title XIX | Hospi tal | PPS | | | |
|------------------|--|-----------------------------|-------------------|----------------------------|----------------|--|--|
| | Cost Center Description | | - | 1. 00 | | | |
| | PART I - ALL PROVIDER COMPONENTS | | | 1.00 | | | |
| | I NPATI ENT DAYS | | | | | | |
| 1.00 | Inpatient days (including private room days and swing-bed day | | | 5, 260 | • | | |
| 2. 00 3. 00 | Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da | | ivate room days | 4, 110 0 | 2. 00 3. 00 | | |
| 0.00 | do not complete this line. | | | | | | |
| 4. 00 | Semi-private room days (excluding swing-bed and observation b | | | 2, 263 | 4.00 | | |
| 5. 00 | Total swing-bed SNF type inpatient days (including private ro reporting period | om days) through Decembe | r 31 of the cost | 1, 225 | 5.00 | | |
| 6. 00 | Teporting period Total swing-bed SNF type inpatient days (including private ro | om davs) after December | 31 of the cost | 0 | 6.00 | | |
| | reporting period (if calendar year, enter 0 on this line) | | | _ | | | |
| 7. 00 | Total swing-bed NF type inpatient days (including private roo | m days) through December | 31 of the cost | 58 | 7.00 | | |
| 8. 00 | reporting period Total swing-bed NF type inpatient days (including private roo | m days) after December 3 | 1 of the cost | 0 | 8.00 | | |
| 0.00 | reporting period (if calendar year, enter 0 on this line) | iii days) arter beceiiber s | The cost | O | 0.00 | | |
| 9. 00 | Total inpatient days including private room days applicable t | o the Program (excluding | swing-bed and | 0 | 9.00 | | |
| 10.00 | newborn days) (see instructions) | nly (including private r | unam daya) | 0 | 10.00 | | |
| 10. 00 | Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc | | oolii days) | 0 | 10.00 | | |
| 11. 00 | Swing-bed SNF type inpatient days applicable to title XVIII o | | oom days) after | 0 | 11.00 | | |
| | December 31 of the cost reporting period (if calendar year, e | | | | | | |
| 12. 00 | Swing-bed NF type inpatient days applicable to titles V or XI | X only (including privat | e room days) | 0 | 12.00 | | |
| 13. 00 | through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI | X only (including privat | e room days) | 0 | 13.00 | | |
| | after December 31 of the cost reporting period (if calendar y | ear, enter O on this lin | e) | Ü | | | |
| 14.00 | Medically necessary private room days applicable to the Progr | am (excluding swing-bed | days) | 0 | 14.00 | | |
| 15.00 | Total nursery days (title V or XIX only) | | | 239 | | | |
| 16.00 | Nursery days (title V or XLX only) SWING BED ADJUSTMENT | | | 90 | 16.00 | | |
| 17. 00 | Medicare rate for swing-bed SNF services applicable to servic | es through December 31 c | f the cost | | 17.00 | | |
| | reporting period | Ü | | | | | |
| 18. 00 | Medicare rate for swing-bed SNF services applicable to servic | es after December 31 of | the cost | | 18.00 | | |
| 19. 00 | reporting period Medicaid rate for swing-bed NF services applicable to service | s through December 31 of | the cost | 140. 00 | 19 00 | | |
| 17.00 | reporting period | o tin dagii becember oi oi | the cost | 1 10. 00 | 17.00 | | |
| 20.00 | Medicaid rate for swing-bed NF services applicable to service | s after December 31 of t | he cost | 140. 00 | 20.00 | | |
| 21 00 | reporting period | | | 11, 436, 959 | 21.00 | | |
| 21. 00 22. 00 | Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb | | ing period (line | | 22.00 | | |
| 22.00 | 5 x line 17) | o. o. o. t.io ooot ropo. t | | Ü | 22.00 | | |
| 23. 00 | Swing-bed cost applicable to SNF type services after December | 31 of the cost reportin | g period (line o | 0 | 23.00 | | |
| 24. 00 | x line 18) Swing-bed cost applicable to NF type services through Decembe | r 21 of the cost reporti | ng poriod (line | 0 120 | 24.00 | | |
| 24.00 | 7 x line 19) | 1 31 01 the cost reporti | ing period (Title | 0, 120 | 24.00 | | |
| 25. 00 | | 31 of the cost reporting | period (line 8 | 0 | 25.00 | | |
| 0, 00 | x line 20) | | | 0 (00 0(4 | | | |
| 26. 00 27. 00 | Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost | (line 21 minus line 26) | | 2, 632, 364 8, 804, 595 | | | |
| 27.00 | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | (Trie 21 illinus Trie 20) | | 0, 004, 373 | 27.00 | | |
| 28. 00 | General inpatient routine service charges (excluding swing-be | d and observation bed ch | arges) | 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) | 1: 20) | | 0 | 30.00 | | |
| 31. 00 32. 00 | General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) | ÷ Tine 28) | | 0. 000000 0. 00 | ı | | |
| 33. 00 | Average semi-private room per diem charge (line 30 ÷ line 4) | | | 0.00 | | | |
| 34.00 | Average per diem private room charge differential (line 32 mi | nus line 33)(see instruc | tions) | 0.00 | | | |
| 35.00 | Average per diem private room cost differential (line 34 x li | ne 31) | | 0.00 | | | |
| 36.00 | Private room cost differential adjustment (line 3 x line 35) | and private seem cost di | fforontial (1:- | 0 904 505 | 36.00 | | |
| 37. 00 | General inpatient routine service cost net of swing-bed cost 27 minus line 36) | and private room cost di | rierential (IIne | 8, 804, 595 | 37.00 | | |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | | | |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ | | | | | | |
| 38.00 | Adjusted general inpatient routine service cost per diem (see | | | 2, 142. 24 | | | |
| 39. 00 40. 00 | Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr | | | 0 | 39.00 40.00 | | |
| | Total Program general inpatient routine service cost (line 39 | | | 0 | 41.00 | | |
| | | , | ' | _ | | | |

| MCRI F32 | - | 21. 3. 178. 2 |
|----------|---|---------------|

| | Financial Systems ATION OF INPATIENT OPERATING COST | ADAMS MEMORIA | Provi der C | | Peri od: | u of Form CMS-2 Worksheet D-1 | |
|--------------------------------------|---|--|-----------------|--------------------|----------------------------------|----------------------------------|------------------|
| | | | | | From 01/01/2022 To 12/31/2022 | Date/Time Pre | |
| | | | Ti tl | e XIX | Hospi tal | 3/2/2024 10: 0 | 17 alli |
| | Cost Center Description | Total | Total | Average Per | Program Days | Program Cost | |
| | | Inpatient | I npati ent | Diem (col. 1 | | (col. 3 x | |
| | | Cost | Days | ÷ col . 2) 3.00 | 4.00 | col . 4) 5. 00 | |
| 42. 00 | NURSERY (title V & XIX only) | 1. 00 122, 143 | 2.00 | | 4. 00 | | 42.00 |
| 12.00 | Intensive Care Type Inpatient Hospital Units | | 207 | 011.0 | 3 | 10, 770 | 12.00 |
| 43.00 | INTENSIVE CARE UNIT | 3, 047, 280 | 880 | 3, 462. 8 | 2 114 | 394, 761 | 43.00 |
| 44.00 | CORONARY CARE UNIT | | | | | | 44.00 |
| 45.00 | BURN INTENSIVE CARE UNIT | | | | | | 45.00 |
| 46.00 | SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) | | | | | | 46. 00 47. 00 |
| 47.00 | Cost Center Description | | | | | | 47.00 |
| | | | | | | 1. 00 | |
| 48. 00 | Program inpatient ancillary service cost (Wk | | | | | 0 | 48. 00 |
| 48. 01 | Program inpatient cellular therapy acquisiti | | | | column 1) | 0 | |
| 49. 00 | Total Program inpatient costs (sum of lines | 41 through 48.(| 01)(see instru | ctions) | | 440, 756 | 49.00 |
| 50.00 | PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp | atient routine | sarvicas (fro | m Wket D sun | of Parts I and | 25, 398 | 50.00 |
| 30.00 | | attent routine | services (Tro | ii wkst. D, suii | i or raits i and | 23, 370 | 30.00 |
| 51.00 | Pass through costs applicable to Program inp | atient ancillar | ry services (fi | rom Wkst. D, s | sum of Parts II | 0 | 51.00 |
| | and IV) | | | | | | |
| 52.00 | Total Program excludable cost (sum of lines | | alated assets | vol ol on sees !! | notict on- | 25, 398 | 1 |
| 53. 00 | Total Program inpatient operating cost exclumedical education costs (line 49 minus line | | erated, non-pn | ysician anestr | netist, and | 415, 358 | 53.00 |
| | TARGET AMOUNT AND LIMIT COMPUTATION | 32) | | | | | 1 |
| 54.00 | Program di scharges | | | | | 0 | 54.00 |
| 55.00 | Target amount per discharge | | | | | 0.00 | |
| 55. 01 | Permanent adjustment amount per discharge | | | | | 0.00 | 1 |
| 55. 02 56. 00 | Adjustment amount per discharge (contractor | J , | | | | 0.00 | 1 |
| 57.00 | Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat | | | line 56 minus | line 53) | | 1 |
| 58.00 | Bonus payment (see instructions) | ring cost and to | arget amount (| THE CO III HUS | 11110 00) | Ö | 58.00 |
| 59.00 | Trended costs (lesser of line 53 ÷ line 54, | | n the cost rep | orting period | endi ng 1996, | 0.00 | 59.00 |
| | updated and compounded by the market basket) | | | | | | |
| 60.00 | Expected costs (lesser of line 53 ÷ line 54, market basket) | or line 55 fro | om prior year | cost report, ι | ipdated by the | 0. 00 | 60.00 |
| 61. 00 | Continuous improvement bonus payment (if lin | e 53 ÷ line 54 | is less than | the Lowest of | lines 55 plus | 0 | 61.00 |
| 01.00 | 55.01, or line 59, or line 60, enter the les | | | | | | 000 |
| | 53) are less than expected costs (lines 54 x | 60), or 1 % of | the target a | mount (line 56 | o), otherwise | | |
| (2.00 | enter zero. (see instructions) | | | | | | (2.00 |
| 62. 00 63. 00 | Relief payment (see instructions) Allowable Inpatient cost plus incentive paym | ent (see instri | ictions) | | | 0 | |
| 00.00 | PROGRAM INPATIENT ROUTINE SWING BED COST | ient (see Thistic | 3011 0113) | | | | 00.00 |
| 64.00 | Medicare swing-bed SNF inpatient routine cos | ts through Dece | ember 31 of the | e cost reporti | ng period (See | 0 | 64.00 |
| <i>,</i> | instructions)(title XVIII only) | . 6. 6 | 04 6 11 | | | | / |
| 65.00 | Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only) | its after Decemb | per 31 of the o | cost reporting | period (See | 0 | 65.00 |
| 66. 00 | Total Medicare swing-bed SNF inpatient routi | ne costs (line | 64 plus line | 65)(title XVII | I only). for | 0 | 66.00 |
| | CAH, see instructions | | | , (| 37, | | |
| 67. 00 | Title V or XIX swing-bed NF inpatient routin | e costs through | n December 31 (| of the cost re | eporting period | 0 | 67.00 |
| 68. 00 | (line 12 x line 19) Title V or XIX swing-bed NF inpatient routin | o costs often [| Docombor 21 of | the cost rone | erting ported | | 40 00 |
| 00.00 | (line 13 x line 20) | le costs arter t | becember 31 or | the cost repo | n tring perrou | 0 | 68. 00 |
| 69.00 | Total title V or XIX swing-bed NF inpatient | routine costs (| (line 67 + line | e 68) | | 0 | 69.00 |
| | PART III - SKILLED NURSING FACILITY, OTHER N | | | | | |] |
| 70.00 | Skilled nursing facility/other nursing facil | | | | | | 70.00 |
| 71. 00 72. 00 | Adjusted general inpatient routine service of Program routine service cost (line 9 x line | | ine /U ÷ line | 2) | | | 71.00 |
| 73.00 | Medically necessary private room cost applic | | n (line 14 x li | ine 35) | | | 73.00 |
| 74. 00 | Total Program general inpatient routine serv | 9 | • | , | | | 74.00 |
| 75.00 | Capital-related cost allocated to inpatient | routine service | e costs (from | Worksheet B, F | Part II, column | | 75.00 |
| | 26, line 45) | | | | | | |
| 76.00 | Per diem capital related costs (line 75 ÷ li | | | | | | 76.00 77.00 |
| 77. 00 78. 00 | Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu | | | | | | 78.00 |
| 79. 00 | Aggregate charges to beneficiaries for exces | | provi der recor | ds) | | | 79.00 |
| 80.00 | Total Program routine service costs for comp | arison to the o | | | nus line 79) | | 80.00 |
| 81.00 | Inpatient routine service cost per diem limi | | | | | | 81.00 |
| 00 | Inpatient routine service cost limitation (I | | | | | | 82. 00 83. 00 |
| 82.00 | Reasonable inpatient routine service costs (| | 13) | | | | 84.00 |
| 83.00 | Program inpatient ancillary services (see in | STRUCTIONS | | | | | |
| | Program inpatient ancillary services (see in Utilization review - physician compensation | | ons) | | | | 85.00 |
| 83. 00 84. 00 | Utilization review - physician compensation Total Program inpatient operating costs (sum | (see instruction of lines 83 th | | | | | |
| 83. 00 84. 00 85. 00 86. 00 | Utilization review - physician compensation | (see instruction of lines 83 the STHROUGH COST | | | | | 85.00 |

| Health Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|--|----------------|--------------|-------------|----------------------------------|-----------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provi der CO | | Peri od: | Worksheet D-1 | |
| | | | | From 01/01/2022 To 12/31/2022 | | |
| | | Ti tl | e XIX | Hospi tal | PPS | |
| Cost Center Description | | | | | | |
| | | | | | 1. 00 | |
| 89.00 Observation bed cost (line 87 x line 88) (se | e instructions |) | | | 3, 956, 717 | 89. 00 |
| Cost Center Description | Cost | Routine Cost | col umn 1 ÷ | Total | Observation | |
| | | (from line | column 2 | Observati on | Bed Pass | |
| | | 21) | | Bed Cost | Through Cost | |
| | | ŕ | | (from line | (col. 3 x | |
| | | | | 89) | col. 4) (see | |
| | | | | | instructions) | |
| | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | | | | | |
| 90.00 Capital -related cost | 536, 713 | 11, 436, 959 | 0. 04692 | 8 3, 956, 717 | 185, 681 | 90.00 |
| 91.00 Nursing Program cost | 0 | 11, 436, 959 | 0. 00000 | 0 3, 956, 717 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 11, 436, 959 | 0. 00000 | 0 3, 956, 717 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 11, 436, 959 | 0. 00000 | 0 3, 956, 717 | 0 | 93.00 |

| | Financial Systems ADAMS MEMORIA ENT ANCILLARY SERVICE COST APPORTIONMENT | Provi der (| CCN: 15-1330 | Period: From 01/01/2022 | u of Form CMS-2 Worksheet D-3 | |
|------------------|---|-------------|----------------------------|-----------------------------------|---|--------|
| | | | | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | pared: |
| | | Ti tl | e XVIII | Hospi tal | Cost | |
| | Cost Center Description | | Ratio of Cos To Charges | t 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 & PEDI ATRI CS | | | 1, 486, 636 | | 30.00 |
| 31.00 | 03100 INTENSIVE CARE UNIT | | | 742, 578 | | 31.00 |
| 40.00 | 04000 SUBPROVI DER - I PF | | | 0 | | 40.00 |
| 43.00 | 04300 NURSERY | | | | | 43.00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | 1 |
| 50.00 | 05000 OPERATING ROOM | | 0. 51978 | | 128, 590 | |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | | 0. 70112 | | 0 | 52.00 |
| 53.00 | 05300 ANESTHESI OLOGY | | 0.00000 | | 0 | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | | 0. 16711 | · · | 71, 451 | 1 |
| 60.00 | 06000 LABORATORY 06500 RESPI RATORY THERAPY | | 0. 36065 | · · | 141, 120 | |
| 65. 00 66. 00 | 06600 PHYSI CAL THERAPY | | 0. 42449 0. 61449 | · · | 150, 057 52, 861 | |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | | 0. 42221 | | 39, 227 | |
| 68. 00 | 06800 SPEECH PATHOLOGY | | 0. 32949 | | 9, 277 | |
| | 06900 ELECTROCARDI OLOGY | | 0.00000 | · · | 0 | 1 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0. 00000 | | 0 | 71.00 |
| | 07200 IMPL. DEV. CHARGED TO PATIENT | | 0. 33795 | | 27, 760 | |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS | | 0. 33840 | | 258, 967 | |
| 76.00 | 03020 OP PSYCH | | 11. 33900 | | 0 | 76.00 |
| 76. 01 | 03030 WOUND CARE | | 0. 87152 | 26 651 | 567 | 76. 01 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | |
| 88.00 | 08800 MONROE FAMILY MEDICINE | | 0. 00000 | | 0 | 88.00 |
| | 08801 WOODCREST | | 0.00000 | | 0 | 88. 01 |
| 88. 02 | 08802 STAT CARE | | 0.00000 | | 0 | 88. 02 |
| 88. 03 | 08803 BERNE FAMILY MEDICINE | | 0.00000 | | 0 | 88. 03 |
| 88. 04 | 08804 HI GH STREET | | 0.00000 | | 0 | 88. 04 |
| 90.00 | 09000 CLI NI C | | 1. 37254 | | 126 | |
| | 09001 CLINIC - AMO | | 1. 39932 | | 0 | 90. 01 |
| | 09002 CLINIC - AMH NEURO | | 1. 26413 | | 0 | 90.02 |
| 90. 03 | 09003 GENERAL SURGERY OFFICE | | 1. 92661 | | 0 | 90.03 |
| 90. 04 91. 00 | O4950 I NTENSI VE OP BEHAVI ORAL HEALTH O9100 EMERGENCY | | 0. 00000 0. 53772 | | 0 9, 718 | 90.04 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 1. 09110 | · · | 9, 718 14, 686 | |
| 72. UU | OTHER REIMBURSABLE COST CENTERS | | 1.09110 | 13,400 | 14, 080 | 72.00 |
| 95 00 | 09500 AMBULANCE SERVICES | | | | | 95.00 |
| | 09700 DURABLE MEDI CAL EQUI P-SOLD | | 0.00000 | 00 | 0 | 1 |
| 200 00 | | | | 2 506 500 | 904 407 | |

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

2, 506, 509 2, 506, 509 904, 407 200. 00 201. 00 202. 00

200. 00 201. 00 202. 00

| I NPATI ENT | T ANCILLARY SERVICE COST APPORTIONMENT | | | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 Date/Time Pre 3/2/2024 10:0 | pared: |
|-------------|--|-------|--------------|---|---|-------------|
| | | Ti tl | e XVIII S | Swing Beds - SNF | | |
| | Cost Center Description | | Ratio of Cos | ' | I npati ent | |
| | | | To Charges | Program | Program Costs | |
| | | | | Charges | (col . 1 x | |
| | | | 1.00 | 0.00 | col . 2) | |
| I NI | DATIENT DOUTINE CEDVICE COCT CENTERS | | 1.00 | 2. 00 | 3. 00 | |
| | PATIENT ROUTINE SERVICE COST CENTERS OOO ADULTS & PEDIATRICS | | 1 | | | 30.00 |
| 1 | 100 INTENSIVE CARE UNIT | | | | | 30.00 |
| 4 | | | | | | |
| 4 | 000 SUBPROVI DER - I PF 300 NURSERY | | | | | 40.00 |
| | CILLARY SERVICE COST CENTERS | | | | | 43.00 |
| | 000 OPERATING ROOM | | 0. 51978 | 8 0 | 0 | 50.00 |
| | 200 DELIVERY ROOM & LABOR ROOM | | 0. 70112 | | 0 | |
| | 300 ANESTHESI OLOGY | | 0.00000 | | 0 | |
| | 400 RADI OLOGY-DI AGNOSTI C | | 0. 16711 | | 2, 662 | |
| | 000 LABORATORY | | 0. 36065 | | 13, 687 | |
| 4 | 500 RESPI RATORY THERAPY | | 0. 42449 | | 10, 917 | |
| | 600 PHYSI CAL THERAPY | | 0. 61449 | | 63, 074 | |
| 4 | 700 OCCUPATI ONAL THERAPY | | 0. 42221 | | 49, 415 | |
| 4 | 800 SPEECH PATHOLOGY | | 0. 32949 | | 12, 314 | |
| | 900 ELECTROCARDI OLOGY | | 0.00000 | | 0 | |
| 4 | 100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0.00000 | | 0 | |
| 72.00 07. | 200 IMPL. DEV. CHARGED TO PATIENT | | 0. 33795 | 1 0 | 0 | 72.00 |
| | 300 DRUGS CHARGED TO PATIENTS | | 0. 33840 | 3 192, 059 | 64, 993 | 73.00 |
| 76.00 03 | O20 OP PSYCH | | 11. 33900 | 2 0 | 0 | 76.00 |
| 76. 01 03 | 030 WOUND CARE | | 0. 87152 | 6 0 | 0 | 76. 01 |
| OU. | TPATIENT SERVICE COST CENTERS | | | | | |
| | 800 MONROE FAMILY MEDICINE | | 0.00000 | 0 | 0 | 88.00 |
| | 801 WOODCREST | | 0.00000 | | 0 | |
| | 802 STAT CARE | | 0.00000 | 0 | 0 | 88. 02 |
| | 803 BERNE FAMILY MEDICINE | | 0.00000 | | 0 | 88. 03 |
| | 804 HI GH STREET | | 0.00000 | | 0 | 88. 04 |
| | OOO CLI NI C | | 1. 37254 | 0 0 | 0 | 90.00 |
| | OO1 CLINIC - AMO | | 1. 39932 | | 0 | 90. 01 |
| | 002 CLINIC - AMH NEURO | | 1. 26413 | | 0 | 90.02 |
| | 003 GENERAL SURGERY OFFICE | | 1. 92661 | | 0 | 90.03 |
| | 950 INTENSIVE OP BEHAVIORAL HEALTH | | 0.00000 | | 0 | 1 , 0 . 0 . |
| | 100 EMERGENCY | | 0. 53772 | | 0 | 1 |
| | 200 OBSERVATION BEDS (NON-DISTINCT PART) | | 1. 09110 | 2 0 | 0 | 92.00 |
| | HER REIMBURSABLE COST CENTERS | | | | | |
| | SOO AMBULANCE SERVI CES | | 0.00000 | | ^ | 95.00 |
| 200 00 | 700 DURABLE MEDICAL EQUIP-SOLD Total (sum of lines 50 through 94 and 96 through 98) | | 0.00000 | 0 0 528 709 | 0 217 062 | |
| | | | | | | |

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

528, 709 528, 709 217, 062 200. 00 201. 00 202. 00

200. 00 201. 00 202. 00

| Health Financial Systems | ADAMS MEMORIAL HOSPITAL | | In Lie | u of Form CMS-: | 2552-10 |
|---|-------------------------|----------------------------|--|---|--------------------------------------|
| I NPATI ENT ANCI LLARY SERVI CE COST APPORTI ONMENT | Provi der C | | Peri od: From 01/01/2022 To 12/31/2022 | Worksheet D-3 Date/Time Pre 3/2/2024 10:0 | pared: |
| | Ti tl | e XIX | Hospi tal | PPS | |
| Cost Center Description | | Ratio of Cos To Charges | 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 & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY | | | 0 0 0 0 | | 30. 00 31. 00 40. 00 43. 00 |
| ANCILLARY SERVICE COST CENTERS | | | | | |
| 50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM | | 0. 51978 0. 70112 | | | 50. 00 52. 00 |
| 53. 00 05300 ANESTHESI OLOGY | | 0.00000 | | · | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | | 0. 16711 | | 1 | 54.00 |
| 60. 00 06000 LABORATORY | | 0. 36065 | | o o | 60.00 |
| 65. 00 06500 RESPIRATORY THERAPY | | 0. 42449 | | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | | 0. 61449 | | Ō | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | | 0. 42221 | | 0 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | | 0. 32949 | 91 0 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | | 0. 00000 | 00 | 0 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0. 00000 | 00 | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | | 0. 33795 | 51 0 | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | | 0. 33840 | 03 | 0 | 73.00 |
| 76. 00 03020 0P PSYCH | | 11. 33900 | | 0 | 76. 00 |
| 76. 01 03030 WOUND CARE OUTPATIENT SERVICE COST CENTERS | | 0. 87152 | 26 0 | 0 | 76. 01 |
| 88. 00 08800 MONROE FAMILY MEDICINE | | 1. 06277 | 78 0 | 0 | 88. 00 |
| 88. 01 08801 WOODCREST | | 1. 10718 | | ľ | 88. 01 |
| 88. 02 08802 STAT CARE | | 0. 98595 | | · - | 88. 02 |
| 88. 03 08803 BERNE FAMILY MEDICINE | | 1. 04976 | | o o | 88. 03 |
| 88. 04 08804 HI GH STREET | | 0. 85522 | | 0 | 88. 04 |
| 90. 00 09000 CLINI C | | 1. 37254 | | 0 | 90.00 |
| 90. 01 09001 CLI NI C - AMO | | 1. 39932 | | Ö | 90. 01 |
| 90. 02 09002 CLINIC - AMH NEURO | | 1. 26413 | | Ō | 90. 02 |
| 90. 03 09003 GENERAL SURGERY OFFICE | | 1. 92661 | | 0 | 90.03 |
| 90.04 04950 INTENSIVE OP BEHAVIORAL HEALTH | | 0. 00000 | 00 | 0 | 90.04 |
| 91 00 09100 EMERGENCY | | 0.53773 | 00 | 1 | 01 00 |

0 0

0

0 0 0

0. 537729

1. 091102

0.000000

91.00

95.00

0 97.00

0 200. 00 201. 00

202.00

0

0 92.00

91.00

92.00

200.00 201.00 202.00

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Net charges (line 200 minus line 201)

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

| | MS MEMORIAL HOSPITAL | | | u of Form CMS-2 | |
|---|----------------------|--------------|-----------------------------|-----------------------|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provi der CC | | Peri od: From 01/01/2022 | Worksheet D-3 | 3 |
| | Component C | | To 12/31/2022 | | epared: |
| | Ti +1. | e XIX | Swing Beds - SNF | 3/2/2024 10: 0 PPS | 07 am |
| Cost Center Description | | Ratio of Cos | | Inpati ent | |
| oost denter beschiptron | | To Charges | Program | Program Costs | |
| | | 3 | Charges | (col. 1 x | |
| | | | ŭ . | col . 2) | |
| | | 1. 00 | 2. 00 | 3. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | 4 |
| 30. 00 03000 ADULTS & PEDIATRICS | | | | | 30.00 |
| 31. 00 03100 I NTENSI VE CARE UNI T | | | | | 31.00 |
| 40. 00 04000 SUBPROVI DER - 1 PF | | | | | 40.00 |
| 43. 00 O4300 NURSERY ANCI LLARY SERVICE COST CENTERS | | | | | 43.00 |
| 50. 00 05000 OPERATING ROOM | | 0. 51978 | 38 0 | 0 | 50.00 |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM | | 0. 70112 | | 0 | 00.00 |
| 53. 00 05300 ANESTHESI OLOGY | | 0. 00000 | | 0 | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | | 0. 16711 | | , o | 1 |
| 60. 00 06000 LABORATORY | | 0. 36065 | | o o | |
| 65. 00 06500 RESPI RATORY THERAPY | | 0. 42449 | | Ō | 1 |
| 66. 00 06600 PHYSI CAL THERAPY | | 0. 61449 | 05 | 0 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | | 0. 42221 | 9 0 | 0 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | | 0. 32949 | 0 0 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | | 0.00000 | 00 | 0 | 69.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0.00000 | | 0 | 1 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | | 0. 33795 | | 0 | 1 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | | 0. 33840 | | 0 | |
| 76. 00 03020 OP PSYCH | | 11. 33900 | | 0 | |
| 76. 01 03030 WOUND CARE OUTPATIENT SERVICE COST CENTERS | | 0. 87152 | 26 0 | 0 | 76. 01 |
| 88. 00 08800 MONROE FAMILY MEDICINE | | 1. 06277 | 78 0 | 0 | 88. 00 |
| 88. 01 08801 WOODCREST | | 1. 10718 | | 0 | 00.00 |
| 88. 02 08802 STAT CARE | | 0. 98595 | | 0 | |
| 88. 03 08803 BERNE FAMILY MEDICINE | | 1. 04976 | | o o | 1 |
| 88. 04 08804 HI GH STREET | | 0. 85522 | | 0 | 1 |
| 90. 00 09000 CLINI C | | 1. 37254 | | Ö | 1 |
| 90. 01 09001 CLINIC - AMO | | 1. 39932 | | 0 | 1 |
| 90. 02 09002 CLINIC - AMH NEURO | | 1. 26413 | 0 0 | 0 | 90. 02 |
| 90. 03 09003 GENERAL SURGERY OFFICE | | 1. 92661 | 8 0 | 0 | 90.03 |
| 90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH | | 0.00000 | | 0 | 1 ,0.0. |
| 91. 00 09100 EMERGENCY | | 0. 53772 | | 0 | 1 |
| 02 OO OO2OO OPSEDVATION PEDS (NON DISTINCT DADT) | | 1 00110 |) O O | Ι Λ | 1 02 00 |

1. 091102

0.000000

95.00

0 97.00

0 200. 00 201. 00

202.00

0 92.00

0

0 0 0

92.00

200.00 201.00 202.00

95. 00 09500 AMBULANCE SERVICES

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Net charges (line 200 minus line 201)

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

| | Title XVIII | Hospi tal | 3/2/2024 10:0 Cost | / alli |
|------------------|--|-----------------|------------------------|------------------|
| | | | 1 00 | |
| | PART B - MEDICAL AND OTHER HEALTH SERVICES | | 1. 00 | |
| 1.00 | Medical and other services (see instructions) | | 9, 659, 101 | 1.00 |
| 2. 00 | Medical and other services reimbursed under OPPS (see instructions) | | 0 | 2.00 |
| 3.00 | OPPS or REH payments | | 0 | 3.00 |
| 4. 00 4. 01 | Outlier payment (see instructions) Outlier reconciliation amount (see instructions) | | 0 | 4. 00 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 from Wkst. D, Pt. IV, col. 13, line 200 | | 0 | 9.00 |
| 10. 00 11. 00 | | | 0 9, 659, 101 | 10. 00 11. 00 |
| 11.00 | COMPUTATION OF LESSER OF COST OR CHARGES | | 7,037,101 | 11.00 |
| | Reasonable charges | | | |
| 12.00 | | | 0 | 12.00 |
| 13.00 | | | 0 | 13.00 |
| 14. 00 | | | 0 | 14.00 |
| 15. 00 | Customary charges Aggregate amount actually collected from patients liable for payment for services or | a charge hasis | 0 | 15. 00 |
| 16. 00 | | | Ö | 16.00 |
| | had such payment been made in accordance with 42 CFR §413.13(e) | · · | | |
| 17. 00 | · · · · · · · · · · · · · · · · · · · | | 0.000000 | |
| 18.00 | , , , , | : 11) (| 0 | 18.00 |
| 19. 00 | Excess of customary charges over reasonable cost (complete only if line 18 exceeds linstructions) | rne II) (see | 0 | 19. 00 |
| 20. 00 | | ine 18) (see | 0 | 20.00 |
| | instructions) | , , | | |
| 21. 00 | | | 9, 755, 692 | 21.00 |
| 22. 00 | · · · · · · · · · · · · · · · · · · · | | 0 | 22.00 |
| 23. 00 24. 00 | | | 0 | 23. 00 24. 00 |
| 24.00 | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | 24.00 |
| 25. 00 | | | 115, 869 | 25. 00 |
| 26.00 | Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see inst | tructions) | 3, 215, 619 | 26.00 |
| 27. 00 | | 22 and 23] (see | 6, 424, 204 | 27. 00 |
| 28. 00 | instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) | | 0 | 28. 00 |
| 28. 50 | | | 0 | 28.50 |
| 29. 00 | | | 0 | 29. 00 |
| 30.00 | Subtotal (sum of lines 27, 28, 28.50 and 29) | | 6, 424, 204 | 30.00 |
| 31.00 | | | 8, 316 | |
| 32. 00 | , | | 6, 415, 888 | 32.00 |
| 33. 00 | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) | | 0 | 33.00 |
| 34. 00 | · · · · · · · · · · · · · · · · · · · | | 237, 157 | 34.00 |
| 35. 00 | | | 154, 152 | 35.00 |
| 36. 00 | | | 237, 157 | |
| 37. 00 | | | 6, 570, 040 | |
| 38. 00 39. 00 | | | 0 | 38. 00 39. 00 |
| 39. 50 | | | 0 | 39.50 |
| 39. 75 | | | 0 | 39. 75 |
| 39. 97 | Demonstration payment adjustment amount before sequestration | | 0 | 39. 97 |
| 39. 98 | · · | uctions) | 0 | 39. 98 |
| 39. 99 | | | 0 | 39. 99 |
| 40. 00 40. 01 | | | 6, 570, 040 82, 782 | 40. 00 40. 01 |
| 40. 01 | | | 02,762 | 40. 01 |
| 40. 03 | | | | 40. 03 |
| 41.00 | i i | | 6, 968, 205 | 41.00 |
| 41. 01 | | | | 41.01 |
| 42.00 | · · · · · · · · · · · · · · · · · · · | | 0 | 42.00 |
| 42. 01 43. 00 | Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions) | | -480, 947 | 42. 01 43. 00 |
| 43. 00 | Balance due provider/program-PARHM (see instructions) | | -460, 747 | 43. 00 |
| 44. 00 | | chapter 1, | 0 | 44.00 |
| | §115. 2 | <u> </u> | | |
| 00.05 | TO BE COMPLETED BY CONTRACTOR | | - | 00.00 |
| 90.00 | , , | | 0 | 90. 00 91. 00 |
| 91. 00 92. 00 | · · · · · · · · · · · · · · · · · · · | | 0.00 | |
| 93. 00 | | | 0.00 | 93.00 |
| 94.00 | | | 0 | 94.00 |
| | | | | |

| Health Financial Systems | ADAMS MEMORIAL | HOSPI TAL | In Lieu | of Form CMS- | 2552-10 |
|---|----------------|-------------|-----------------|---------------|---------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | | | | Worksheet E | |
| | | | From 01/01/2022 | Part B | |
| | | | To 12/31/2022 | Date/Time Pre | epared: |
| | | | | 3/2/2024 10:0 |)7 am |
| | | Title XVIII | Hospi tal | Cost | |
| | | | | | |
| | | | | 1. 00 | |
| MEDICARE PART B ANCILLARY COSTS | | | | | |
| 200.00 Part B Combined Billed Days | | | | 0 | 200.00 |

Health Financial Systems ADAI ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Provi der CCN: 15-1330

| | | | | 10 12/31/2022 | 3/2/2024 10: 0 | |
|----------------|--|------------|------------|---------------|----------------|----------------|
| | | Ti tl e | e XVIII | Hospi tal | Cost | |
| | | I npati er | nt Part A | Par | rt B | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| | | 1. 00 | 2. 00 | 3. 00 | 4.00 | |
| 1. 00 | Total interim payments paid to provider | 1.00 | 2, 896, 98 | | 6, 824, 305 | 1.00 |
| 2. 00 | Interim payments payable on individual bills, either | | 2,070,70 | 0 | 0, 024, 303 | 2. 00 |
| 2.00 | submitted or to be submitted to the contractor for | | | | | 2.00 |
| | services rendered in the cost reporting period. If none, | | | | | |
| | write "NONE" or enter a zero | | | | | |
| 3.00 | List separately each retroactive lump sum adjustment | | | | | 3.00 |
| | amount based on subsequent revision of the interim rate | | | | | |
| | for the cost reporting period. Also show date of each | | | | | |
| | payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | <u> </u> | | | |
| 3. 01 | ADJUSTMENTS TO PROVIDER | 10/14/2022 | 328, 60 | 00 10/14/2022 | 143, 900 | 3. 01 |
| 3. 01 | ADJUSTIMENTS TO PROVIDER | 10/14/2022 | | 0 | 143, 700 | 3. 02 |
| 3. 03 | | | l . | 0 | 0 | 3. 03 |
| 3. 04 | | | l | 0 | 0 | 3. 04 |
| 3. 05 | | | 1 | Ö | l ol | 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 3. 99 | Subtatal (sum of lines 2 01 2 40 minus sum of lines | | | 0 | 143,000 | 3. 54 3. 99 |
| 3. 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) | | 328, 60 | 00 | 143, 900 | 3. 99 |
| 4.00 | Total interim payments (sum of lines 1, 2, and 3.99) | | 3, 225, 58 | 32 | 6, 968, 205 | 4.00 |
| | (transfer to Wkst. E or Wkst. E-3, line and column as | | 0, ===, 0 | | 0, 100, 200 | |
| | appropri ate) | | | | | |
| | TO BE COMPLETED BY CONTRACTOR | | | | | |
| 5. 00 | List separately each tentative settlement payment after | | | | | 5.00 |
| | desk review. Also show date of each payment. If none, | | | | | |
| | write "NONE" or enter a zero. (1) Program to Provider | | | | | |
| 5. 01 | TENTATI VE TO PROVI DER | | | 0 | 0 | 5. 01 |
| 5. 02 | TENTATI VE TO TROVIDER | | l | 0 | | 5. 02 |
| 5. 03 | | | | Ö | l ol | 5. 03 |
| | Provider to Program | | | | | |
| 5.50 | TENTATI VE TO PROGRAM | | | 0 | 0 | 5.50 |
| 5. 51 | | | | 0 | 0 | 5. 51 |
| 5. 52 | | | | 0 | 0 | 5. 52 |
| 5. 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) | | | 0 | 0 | 5. 99 |
| 6. 00 | Determined net settlement amount (balance due) based on the cost report. (1) | | | | | 6. 00 |
| 6. 01 | SETTLEMENT TO PROVIDER | | 1 | 0 | 0 | 6. 01 |
| 6. 02 | SETTLEMENT TO PROGRAM | • | 2, 49 | 93 | 480, 947 | 6. 02 |
| 7. 00 | Total Medicare program liability (see instructions) | | 3, 223, 08 | 39 | 6, 487, 258 | 7.00 |
| | | | | Contractor | NPR Date | |
| | | | 0 | Number | (Mo/Day/Yr) | |
| 8. 00 | Name of Contractor | | 0 | 1. 00 | 2. 00 | 8. 00 |
| 0.00 | INAME OF COULT ACTOR | I | | | ı l | 0.00 |

Provider CCN: 15-1330

| | | Component | CCN. 15-2330 11 | 0 12/31/2022 | 3/2/2024 10: 0 | |
|----------------|---|------------|-------------------|-----------------|----------------|---------------|
| | | Title | XVIII Sv | ving Beds - SNF | Cost | |
| | | Inpatier | it Part A | Par | rt B | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| | | 1.00 | 2.00 | 3. 00 | 4. 00 | |
| 1. 00 | Total interim payments paid to provider | 1.00 | 1, 180, 136 | | 0 | 1.00 |
| 2. 00 | Interim payments payable on individual bills, either | | 0 | | o | 2. 0 |
| | submitted or to be submitted to the contractor for | | | | | |
| | services rendered in the cost reporting period. If none, | | | | | |
| | write "NONE" or enter a zero | | | | | |
| 3.00 | List separately each retroactive lump sum adjustment | | | | | 3.00 |
| | amount based on subsequent revision of the interim rate | | | | | |
| | for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | | | | | |
| | Program to Provider | | | | | |
| 3. 01 | ADJUSTMENTS TO PROVIDER | 10/14/2022 | 86, 500 | | 0 | 3. 0 |
| 3. 02 | 7.5555 TIMERTO TO TROTTEEN | | 0 | | 0 | 3. 02 |
| 3. 03 | | | 0 | | o | 3. 0 |
| 3.04 | | | 0 | | o | 3.04 |
| 3.05 | | | 0 | | 0 | 3. 0! |
| | Provider to Program | | | | | |
| 3.50 | ADJUSTMENTS TO PROGRAM | | 0 | | 0 | 3.50 |
| 3. 51 | | | 0 | | 0 | 3. 5 |
| 3. 52 | | | 0 | | 0 | 3. 5. |
| 3. 53 | | | 0 | | 0 0 | 3. 5 3. 5 |
| 3. 54 3. 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines | | 86, 500 | | 0 | 3. 9 |
| 3. 99 | 3. 50-3. 98) | | 80, 300 | | ا | 3. 9 |
| 4.00 | Total interim payments (sum of lines 1, 2, and 3.99) | | 1, 266, 636 | | 0 | 4.00 |
| | (transfer to Wkst. E or Wkst. E-3, line and column as | | 1, 200, 000 | | | |
| | appropri ate) | | | | | |
| | TO BE COMPLETED BY CONTRACTOR | | | | | |
| 5.00 | List separately each tentative settlement payment after | | | | | 5.00 |
| | desk review. Also show date of each payment. If none, | | | | | |
| | write "NONE" or enter a zero. (1) | | | | | |
| 5. 01 | Program to Provider TENTATIVE TO PROVIDER | | 0 | | 0 | 5. 0 |
| 5. 02 | TENTATIVE TO PROVIDER | | 0 | | 0 | 5. 0 |
| 5. 03 | | | 0 | | l ől | 5. 0 |
| | Provider to Program | | | | _ | |
| 5. 50 | TENTATI VE TO PROGRAM | | 0 | | 0 | 5. 50 |
| 5. 51 | | | 0 | | 0 | 5. 5 |
| 5. 52 | | | 0 | | 0 | 5. 5. |
| 5. 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) | | 0 | | 0 | 5. 9 |
| 6. 00 | Determined net settlement amount (balance due) based on | | | | | 6.0 |
| | the cost report. (1) | | | | | |
| 6. 01 | SETTLEMENT TO PROVIDER | | 121, 133 | | 0 | 6.0 |
| 6. 02 | SETTLEMENT TO PROGRAM Total Modicara program Liability (see instructions) | | 0 1, 387, 769 | | 0 | 6. 0. 7. 0 |
| 7. 00 | Total Medicare program liability (see instructions) | | 1, 387, 769 | Contractor | NPR Date | 7.0 |
| | | | | Number | (Mo/Day/Yr) | |
| | | |) | 1. 00 | 2. 00 | |
| 8. 00 | Name of Contractor | | | | | 8. 00 |

| Heal th | Financial Systems ADAMS MEMORIAL | HOSPI TAL | In Lie | u of Form CMS- | 2552-10 |
|---------|---|--------------------------|------------------|----------------|---------|
| CALCUL | CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1330 Period: From 01/01/2022 | | | | |
| | | | To 12/31/2022 | | |
| | | Title XVIII | Hospi tal | Cost | |
| | | | | | |
| | | | | 1. 00 | |
| | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS | | | | |
| | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO | | | | |
| 1. 00 | Total hospital discharges as defined in AARA §4102 from Wkst | . S-3, Pt. I col. 15 lin | e 14 | | 1.00 |
| 2.00 | Medicare days (see instructions) | | | | 2.00 |
| 3.00 | Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 | | | | 3.00 |
| 4.00 | Total inpatient days (see instructions) | | | | 4.00 |
| 5.00 | Total hospital charges from Wkst C, Pt. I, col. 8 line 200 | | | | 5.00 |
| 6.00 | Total hospital charity care charges from Wkst. S-10, col. 3 | line 20 | | | 6.00 |
| 7.00 | CAH only - The reasonable cost incurred for the purchase of | certified HIT technology | Wkst. S-2, Pt. I | | 7. 00 |
| | line 168 | | | | |
| 8.00 | Calculation of the HIT incentive payment (see instructions) | | | | 8. 00 |
| 9.00 | Sequestration adjustment amount (see instructions) | | | | 9. 00 |
| 10.00 | Calculation of the HIT incentive payment after sequestration | (see instructions) | | | 10.00 |
| | INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH | | | | |
| 30.00 | Initial/interim HIT payment adjustment (see instructions) | | | | 30.00 |
| | Other Adjustment (specify) | | | | 31.00 |
| | Balance due provider (line 8 (or line 10) minus line 30 and | line 31) (see instructio | ns) | | 32.00 |
| | | , . | . ' | | • |

| Health Financial Systems | ADAMS MEMORIAL | HOSPI TAL | In Lieu | u of Form CMS-2552-10 |
|---|----------------|------------------------|-----------------|-----------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT - | SWING BEDS | Provider CCN: 15-1330 | | Worksheet E-2 |
| | | | From 01/01/2022 | |
| | | Component CCN: 15-Z330 | To 12/31/2022 | |
| | | | | 3/2/2024 10:07 am |
| | | Ti +1 o V///// | Swing Rode SNE | Cost |

| | | Component CCN: 15-Z330 | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
|------------------|--|------------------------------|-----------------|--------------------------------|------------------|
| | | Title XVIII S | wing Beds - SNF | | |
| | | | Part A | Part B | |
| | COMPLETATION OF MET COOT OF COMPETE OFFI | | 1.00 | 2. 00 | |
| 1. 00 | COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions) | | 1, 212, 697 | 0 | 1.00 |
| 2.00 | Inpatient routine services - swing bed-NF (see instructions) | | 1, 212, 097 | U | 2.00 |
| 3. 00 | Ancillary services (from Wkst. D-3, col. 3, line 200, for Par | t A and sum of Wkst D | 219, 233 | 0 | |
| 0.00 | Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi | | 217, 200 | Ü | 0.00 |
| | instructions) | 3 h | | | |
| 3. 01 | Nursing and allied health payment-PARHM (see instructions) | | | | 3. 01 |
| 4.00 | Per diem cost for interns and residents not in approved teach | ing program (see | | 0.00 | 4.00 |
| | instructions) | | | _ | |
| 5.00 | Program days | | 541 | 0 | 1 |
| 6. 00 7. 00 | Interns and residents not in approved teaching program (see in Utilization review - physician compensation - SNF optional me | | | 0 | 6. 00 7. 00 |
| 8. 00 | Subtotal (sum of lines 1 through 3 plus lines 6 and 7) | thou only | 1, 431, 930 | 0 | |
| 9. 00 | Primary payer payments (see instructions) | | 1, 431, 730 | 0 | |
| 10.00 | Subtotal (line 8 minus line 9) | | 1, 431, 930 | 0 | |
| 11. 00 | Deductibles billed to program patients (exclude amounts applied | cable to physician | 0 | 0 | |
| | professional services) | | | | |
| 12.00 | Subtotal (line 10 minus line 11) | | 1, 431, 930 | 0 | 12.00 |
| 13.00 | Coinsurance billed to program patients (from provider records) |) (exclude coinsurance | 26, 452 | 0 | 13.00 |
| | for physician professional services) | | | | |
| 14.00 | 80% of Part B costs (line 12 x 80%) | | | 0 | |
| 15.00 | Subtotal (see instructions) | | 1, 405, 478 | 0 | 1 |
| 16.00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | -) | 0 | 0 | |
| 16. 50 16. 55 | Pioneer ACO demonstration payment adjustment (see instruction Rural community hospital demonstration project (§410A Demonst | | | | 16. 50 16. 55 |
| 10. 55 | adjustment (see instructions) | ration) payment | ٥ | | 10.55 |
| 16. 99 | Demonstration payment adjustment amount before sequestration | | 0 | 0 | 16. 99 |
| 17. 00 | Allowable bad debts (see instructions) | | o | 0 | |
| 17. 01 | Adjusted reimbursable bad debts (see instructions) | | 0 | 0 | |
| 18.00 | Allowable bad debts for dual eligible beneficiaries (see inst | ructions) | 0 | 0 | 18.00 |
| 19.00 | Total (see instructions) | | 1, 405, 478 | 0 | 19.00 |
| 19. 01 | Sequestration adjustment (see instructions) | | 17, 709 | 0 | |
| 19. 02 | Demonstration payment adjustment amount after sequestration) | | 0 | 0 | |
| 19. 03 | Sequestration adjustment-PARHM pass-throughs | | | | 19.03 |
| 19. 25 | Sequestration for non-claims based amounts (see instructions) | | 0 | 0 | |
| 20.00 | Interim payments | | 1, 266, 636 | 0 | |
| 20. 01 21. 00 | Interim payments-PARHM Tentative settlement (for contractor use only) | | 0 | 0 | 20.01 |
| 21.00 | Tentative settlement-PARHM (for contractor use only) | | | O | 21.00 |
| 22. 00 | Balance due provider/program (line 19 minus lines 19.01, 19.0. | 2. 19.25. 20. and 21) | 121, 133 | 0 | |
| 22. 01 | Balance due provider/program-PARHM (see instructions) | _,,,, | , | _ | 22. 01 |
| 23.00 | Protested amounts (nonallowable cost report items) in accorda | nce with CMS Pub. 15-2, | o | 0 | |
| | chapter 1, §115.2 | | | | |
| | Rural Community Hospital Demonstration Project (§410A Demonst | | | | |
| 200.00 | Is this the first year of the current 5-year demonstration pe | riod under the 21st | | | 200.00 |
| | Century Cures Act? Enter "Y" for yes or "N" for no. | | | | - |
| 201 00 | Cost Reimbursement Medicare swing-bed SNF inpatient routine service costs (from ' | Wkst. D-1, Pt. II, line | 1 | | 201. 00 |
| 201.00 | 66 (title XVIII hospital)) | wkst. D-1, it. ii, iiie | | | 201.00 |
| 202.00 | Medicare swing-bed SNF inpatient ancillary service costs (from | m Wkst. D-3. col. 3. line | | | 202.00 |
| | 200 (title XVIII swing-bed SNF)) | | | | |
| 203.00 | Total (sum of lines 201 and 202) | | | | 203.00 |
| 204.00 | Medicare swing-bed SNF discharges (see instructions) | | | | 204. 00 |
| | Computation of Demonstration Target Amount Limitation (N/A in | first year of the curren | t 5-year demons | trati on | |
| | peri od) | | 1 | | |
| | Medicare swing-bed SNF target amount | i 1 i 204) | | | 205.00 |
| 206.00 | Medicare swing-bed SNF inpatient routine cost cap (line 205 t | | | | 206. 00 |
| 207.00 | Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs Program reimbursement under the §410A Demonstration (see inst | | | | 207. 00 |
| | Medicare swing-bed SNF inpatient service costs (from Wkst. E- | * | | | 208.00 |
| 200.00 | and 3) | 2, 551. 1, 54III 01 111IES 1 | | | 200.00 |
| 209.00 | Adjustment to Medicare swing-bed SNF PPS payments (see instru | ctions) | | | 209. 00 |
| | Reserved for future use | , | | | 210.00 |
| | Comparision of PPS versus Cost Reimbursement | | | | |
| 215.00 | Total adjustment to Medicare swing-bed SNF PPS payment (line | 209 plus line 210) (see | | | 215. 00 |
| | instructions) | | | | |
| | | | | | |

| Title XIX Swing Bods - SNF Part A Part B | 10:07 am |
|---|---|
| COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-NF (see instructions) O Inpatient routine services - swing bed-NF (see instructions) O Ancillary services (from West, D-3, col. 3, line 200, for Part B, and sum of West, D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions) Nursing and all ied heal th payment-PARHM (see instructions) O Per diem cost for interns and residents not in approved teaching program (see O. 0.0) Program down residents not in approved teaching program (see O. 0.0) Program down - physician compensation - SNF optional method only O Utilization review - physician compensation - SNF optional method only O Utilization review - physician compensation - SNF optional method only O O Prinary payer payments (see instructions) O O Utilization review - physician compensation - SNF optional method only O O Prinary payer payments (see instructions) O O Utilization review - physician professional services) O D Prinary payer payments (see instructions) O O Utilization (in in i | PS |
| COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient routine services - swing bed-SNF (see instructions) 1.00 Inpatient routine services - swing bed-SNF (see instructions) 1.00 Ancillary services (from Wist. D3, col. 3, line 200, for Part A, and sum of Wkst. D. Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions) 1.01 Nursing and all ied health payment-PARRM (see instructions) 1.02 Nursing and all ied health payment-PARRM (see instructions) 1.03 Nursing and all ied health payment-PARRM (see instructions) 1.04 Per diem cost for interns and residents not in approved teaching program (see 0.00 1.02 Program days 1.03 Nursing and seidents not in approved teaching program (see instructions) 1.04 Utilization review - physician compensation - SNF optional method only 1.05 Utilization review - physician compensation - SNF optional method only 1.06 Obstantial (sum of lines 1 through 3 plus lines 6 and 7) 1.07 Obstantial (sum of lines 1 through 3 plus lines 6 and 7) 1.08 Obstantial (sum of lines 1 through 3 plus lines 6 and 7) 1.09 Obstantial (sum of lines 1 through 3 plus lines 6 and 7) 1.00 Obstantial (see instructions) 1.00 O | |
| Inpatient routine services - swing bed-SNF (see instructions) | |
| Impatient routine services - swing bed-NF (see Instructions) | 1.00 |
| Ancillary services (From Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D. Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions) 3.01 Nursing and allied health payment-PARHM (see instructions) 4.00 Per diem cost for interns and residents not in approved teaching program (see instructions) 5.00 Program days 0.00 Utilization review - physician compensation - SNF optional method only 0.01 Utilization review - physician compensation - SNF optional method only 0.02 Utilization review - physician compensation - SNF optional method only 0.03 Subtotal (sum of lines 1 through 3 plus ilnes 6 and 7) 0.04 Primary payer payments (see instructions) 0.05 Deductible Shilled to program patients (exclude amounts applicable to physician professional services) 12.00 Subtotal ((line 10 minus line 11) 13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 15.00 Subtotal (see instructions) 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.50 Promeer ACO demonstration payment adjustment (see instructions) 16.70 Ald Justed reimbursation payment adjustment (see instructions) 16.70 Ald Justed reimbursation payment adjustment amount before sequestration 17.00 Allowable bad debts (see instructions) 18.00 Allowable bad debts (see instructions) 18.00 Distention and ustment Advance of the payment adjustment on adjustment (see instructions) 18.00 Distention and ustment PARMM pass-throughs 18.00 Distention and payments Sympton and payments of the current S- | 2.00 |
| Part V, Cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see Instructions) 3.01 Nursing and allied health payment-PARHM (see Instructions) 5.00 Program days 5.00 Program days 6.00 Interns and residents not in approved teaching program (see Instructions) 7.00 Utilization review - physician compensation - SNF optional method only 8.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 9.00 Pringary payer payments (see instructions) 10.00 Subtotal (line 8 minus line 9) 10.00 Subtotal (line 8 minus line 9) 10.00 Deduction (line 1 minus line 9) 10.00 Deduction (line 1 minus line 9) 10.00 Control (line 8 minus line 11) 10.00 Control (line 1 minus line 11) 10.00 Control (| 3.00 |
| instructions) 1.01 Nursing and allied health payment-PARHM (see instructions) 2.02 Per diem cost for interns and residents not in approved teaching program (see instructions) 2.03 Program days 3.04 Oversian days 3.06 Uniterns and residents not in approved teaching program (see instructions) 3.07 Utilization review - physician compensation - SNF optional method only 3.08 Utilization review - physician compensation - SNF optional method only 3.09 Utilization review - physician compensation - SNF optional method only 3.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 3.00 Primary payer payments (see instructions) 3.00 Primary payer payments (see instructions) 3.00 Constituted (line 10 minus line 19) 3.00 Constructions in the subtotal (line 10 minus line 11) 3.00 Constructions in the subtotal (line 10 minus line 11) 3.00 Consurrance bill led to program patients (from provider records) (exclude coinsurance for physician professional services) 4.00 80% of Part B costs (line 12 x 80%) 5.00 Subtotal (see instructions) 6.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 6.55 Rural community hospital demonstration payment adjustment (see instructions) 6.56 For Iral community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions) 6.70 Aldivable bad debts (see instructions) 7.01 Aldivable bad debts (see instructions) 8.00 Allowable bad debts (see instructions) 9.01 Total (see instructions) 9.02 Allowable bad debts for dual eligible beneficiaries (see instructions) 9.03 Official (see instructions) 9.04 Official (see instructions) 9.05 Allowable bad debts for dual eligible beneficiaries (see instructions) 9.01 Total (see instructions) 9.02 Expects ration adjustment amount after sequestration) 9.03 Official (see instructions) 9.04 Official (see instructions) 9.05 Expects ration adjustment (see instructions) 9.06 Official (see instructions) 9.07 Official (see instructions) 9.08 Official (see instructions) 9.09 Official (see instructions) 9.00 Of | 3.0 |
| Nursing and allied health payment-PARHW (see instructions) 0.00 | |
| Instructions) 5. 00 Program days 6.00 Interns and residents not in approved teaching program (see instructions) 7. 00 Utilization review - physician compensation - SNF optional method only 8. 00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 8. 00 Primary payer payments (see instructions) 9. 00 Primary payer payments (see instructions) 9. 01. 00 Deductible billed to program patients (exclude amounts applicable to physician professional services) 9. 00 Primary payer payments (see instructions) 9. 00 Deductible billed to program patients (from provider records) (exclude coinsurance for physician professional services) 9. 00 Deductible of Part B costs (line 12 x 80%) 9. 00 Deductible ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 9. 00 Deductible ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 9. 00 Deductible ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 9. 01 Deductible ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 9. 02 Demonstration payment adjustment (see instructions) 16. 55 Rural community hospit lad demonstration project (\$410A Demonstration) payment adjustment (see instructions) 17. 00 Allowable bad debts (see instructions) 18. 00 Allowable bad debts (see instructions) 19. 01 Adjusted reimbursable bad debts (see instructions) 19. 01 Nortic (see instructions) 19. 01 Sequestration adjustment (see instructions) 19. 02 Demonstration payment adjustment amount after sequestration) 19. 02 Demonstration payment adjustment amount after sequestration 19. 03 Sequestration adjustment (see instructions) 19. 01 Sequestration for non-claims based amounts (see instructions) 19. 02 Demonstration payment adjustment amount after sequestration) 19. 01 Sequestration for non-claims based amounts (see instructions) 19. 01 Sequestration for non-claims based amounts (see instructions) 19. 01 Demonstration payments - PAREM Pass-throughs 19. 02 Demonstration payments - PAREM Pass-throughs 19. | 3.0 |
| Program days 0 | 4.00 |
| Interns and residents not in approved teaching program (see instructions) 0 | |
| Utilization review - physician compensation - SNF optional method only 0 0 0 0 0 0 0 0 0 | 5. 0 |
| 8.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 0 0 0 0 0 0 0 0 0 | 6. 0 |
| Primary payer payments (see instructions) 0 Primary payer payments (see instructions) 10.00 Subtotal (line 8 minus line 9) 11.00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 12.00 Subtotal (line 10 minus line 11) 13.00 Colinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 16.00 80% of Part B costs (line 12 x 80%) 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.50 Ploneer ACO demonstration payment adjustment (see instructions) 16.55 Ploneer ACO demonstration payment adjustment (see instructions) 16.56 Ploneer ACO demonstration payment adjustment (see instructions) 16.57 Ploneer ACO demonstration payment adjustment (see instructions) 16.59 Plomonstration payment adjustment amount before sequestration 16.90 Plomonstration payment adjustment amount before sequestration 17.01 Aljusted reimbursable bad debts (see instructions) 18.00 Aljusted reimbursable bad debts (see instructions) 19.01 Sequestration adjustment (see instructions) 19.02 Demonstration payment adjustment amount after sequestration) 19.03 Sequestration adjustment (see instructions) 19.04 Demonstration payment adjustment amount after sequestration) 19.05 Sequestration adjustment (see instructions) 19.06 Demonstration payment adjustment amount see instructions) 19.07 Tental (see instructions) 19.08 Demonstration payment adjustment amount after sequestration and payment adjustment payments (see instructions) 19.01 Tental (see instructions) 19.02 Demonstration payment adjustment amount after sequestration and payment adjustment payments (see instructions) 19.02 Demonstration adjustment-PARM (for contractor use only) 20.01 Interim payments. 20.02 Demonstration payments (see instructions) 20.03 Tental (see and payments (see instructions) 20.04 Demonstration payments (see instructions) 20.05 Tental (se | 7.00 |
| 10.00 Subtotal (ine 8 minus line 9) 11.00 Deductible so billed to program patients (exclude amounts applicable to physician professional services) 12.00 Subtotal (line 10 minus line 11) 13.00 Consurance billed to program patients (from provider records) (exclude coinsurance of for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 15.00 Subtotal (see instructions) 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 17.00 Pioneer ACO demonstration payment adjustment (see instructions) 18.00 Allowable bad debts (see instructions) 19.00 Allowable bad debts (see instructions) 19.00 Allowable bad debts (see instructions) 19.00 Total (see instructions) 19.01 Seguestration adjustment (see instructions) 19.02 Demonstration payment adjustment amount before sequestration 19.00 Total (see instructions) 19.01 Seguestration adjustment amount after sequestration) 19.02 Demonstration payment adjustment amount after sequestration) 19.03 Seguestration adjustment (see instructions) 19.03 Seguestration adjustment (see instructions) 19.04 Demonstration payment adjustment semount after sequestration) 19.03 Seguestration for non-claims based amounts (see instructions) 19.04 Demonstration payment adjustment see instructions) 19.05 Sequestration for non-claims based amounts (see instructions) 19.06 Interim payments 19.07 Demonstration payments 19.08 Sequestration adjustment (see instructions) 19.09 Demonstration payments 19.00 Interim payments 19.01 Tentative settlement (for contractor use only) 20.01 Interim payments 20.02 Demonstration project (\$410A Demonstration) Adjustment 20.03 Interim payments 20.04 Demonstration project (\$410A Demonstration) Adjustment 20.05 Experiment (\$40 Demonstration Project (\$410A Demonstration) Adjustment 20.06 Interim payment (\$40 Demonstration) Adjustment (\$40 Demo | 8. 00 |
| 11. 00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 12. 00 Subtotal ((ine 10 minus line 11) 0 0 0 0 0 0 0 0 0 | 9. 00 |
| professional services) 12. 00 Subtotal (line 10 minus line 11) 13. 00 For physician professional services (proposed particles) 14. 00 80 or Part B costs (line 12 x 80%) 15. 00 Subtotal (see instructions) 16. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16. 50 Pioneer ACO demonstration payment adjustment (see instructions) 16. 55 Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions) 17. 00 Allowable bad debts (see instructions) 18. 00 Allowable bad debts (see instructions) 19. 00 Allowable bad debts (see instructions) 19. 01 Sequestration adjustment (see instructions) 19. 01 Sequestration adjustment (see instructions) 19. 01 Sequestration adjustment (see instructions) 19. 02 Demonstration payment adjustment amount after sequestration) 19. 03 Sequestration adjustment (see instructions) 19. 01 Sequestration adjustment (see instructions) 19. 02 Demonstration payment adjustment amount after sequestration) 19. 03 Sequestration for non-claims based amounts (see instructions) 19. 01 Sequestration adjustment (see instructions) 19. 02 Demonstration payments 19. 03 Sequestration for non-claims based amounts (see instructions) 20. 01 Interim payments 20. 02 Interim payments 20. 03 Interim payments 20. 04 Interim payments 20. 05 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 0 chapter 1, \$115.2 20. 07 Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment 20. 08 Interim payment of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. 20. Cost Reimbursement 20. 01 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-3, col. 3, line 20 (title XVIII ho | 11. 0 |
| 12.00 Subtotal (line 10 minus line 11) 0 13.00 Consurance billed to program patients (from provider records) (exclude coinsurance of for physician professional services) 0 0 0 0 0 0 0 0 0 | 11.0 |
| 13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 0 0 0 0 0 0 0 0 0 | 12. 0 |
| for physician professional services) 80% of Part B costs (line 12 x 80%) 15.00 Subtotal (see instructions) 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.50 Ploneer ACO demonstration payment adjustment (see instructions) 16.55 Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions) 16.99 Demonstration payment adjustment amount before sequestration 17.00 Allowable bad debts (see instructions) 18.00 Allowable bad debts (see instructions) 19.01 Allowable bad debts for dual eligible beneficiaries (see instructions) 19.02 Allowable bad debts for dual eligible beneficiaries (see instructions) 19.03 Sequestration adjustment (see instructions) 19.04 Demonstration payment adjustment amount after sequestration) 19.05 Demonstration payment adjustment amount after sequestration) 19.06 Demonstration on adjustment (see instructions) 19.07 Demonstration payment adjustment amount after sequestration) 19.08 Sequestration for non-claims based amounts (see instructions) 19.09 Demonstration payments 19.25 Sequestration for non-claims based amounts (see instructions) 20.00 Interim payments 20.01 Interim payments-PARHM pass-throughs 20.02 Tratative settlement (for contractor use only) 21.01 Tentative settlement-PARHM (see instructions) 22.00 Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 28.01 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 201.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF) 203.00 Total (sum of lines 201 and 202) 204.00 Medicare swing-bed SNF inspatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (with care swing-bed SNF) inspatient ancillary service costs (from Wkst. D-3, col. | 13. 0 |
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| chapter 1, §115.2 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. Cost Rei mbursement 201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 203.00 Total (sum of lines 201 and 202) 204.00 Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration | 22. 0 |
| 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. Cost Reimbursement 201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 203.00 Total (sum of lines 201 and 202) 204.00 Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration | 23. 0 |
| 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. Cost Reimbursement 201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 203.00 Total (sum of lines 201 and 202) 204.00 Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration | |
| Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 203.00 Total (sum of lines 201 and 202) 204.00 Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration | 200. 0 |
| Cost Reimbursement 201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 203.00 Total (sum of lines 201 and 202) 204.00 Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration | 200.0 |
| 201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 203.00 Total (sum of lines 201 and 202) 204.00 Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration | |
| 66 (title XVIII hospital)) 202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 203.00 Total (sum of lines 201 and 202) 204.00 Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration | 201. 0 |
| 202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 203.00 Total (sum of lines 201 and 202) 204.00 Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration | 20 |
| 203.00 Total (sum of lines 201 and 202) 204.00 Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration | 202. 0 |
| 204.00 Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration | |
| Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration | 203. 0 |
| | 204. 0 |
| | |
| peri od) | |
| 205.00 Medicare swing-bed SNF target amount | 205. 0 |
| 206.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) | 206. 0 |
| Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement | 207.0 |
| 207.00 Program reimbursement under the §410A Demonstration (see instructions) | 207. 0 |
| 208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3) | 208. 0 |
| 209. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) | 209. 0 |
| 210. 00 Reserved for future use | 210. 0 |
| Comparision of PPS versus Cost Reimbursement | ======================================= |
| 215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see | 215. 0 |
| instructions) | |

| Health Financial Systems | ADAMS MEMORIAL HOSPITAL | In Lie | u of Form CMS-2552-10 |
|---|-------------------------|-----------------|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-1330 | From 01/01/2022 | Worksheet E-3 Part V Date/Time Prepared: 3/2/2024 10:07 am |
| | Title XVIII | Hospi tal | Cost |

| | | | | 3/2/2024 10:0 | 7 am |
|----------------------|--|----------------------------|-------------------|---------------|--------|
| | | Title XVIII | Hospi tal | Cost | |
| | | | · · | | |
| | | | | 1. 00 | |
| | PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE | E DADT A SERVICES _ COST | DELMBLIDSEMENT | 1.00 | |
| 1. 00 | Inpatient services | TAKT A SERVICES COST | KETWIDOKSEWENT | 3, 602, 085 | 1.00 |
| 2. 00 | Nursing and Allied Health Managed Care payment (see instructi | one) | | 3, 002, 083 | 2.00 |
| | | UIS) | | 0 | |
| 3.00 | Organ acquisition | | | - 1 | 3.00 |
| 3. 01 | Cellular therapy acquisition cost (see instructions) | | | 0 | 3. 01 |
| 4. 00 | Subtotal (sum of lines 1 through 3.01) | | | 3, 602, 085 | 4. 00 |
| 5. 00 | Primary payer payments | | | 0 | 5.00 |
| 6.00 | Total cost (line 4 less line 5). For CAH (see instructions) | | | 3, 638, 106 | 6.00 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | | |
| | Reasonable charges | | | | |
| 7.00 | Routine service charges | | | 0 | 7. 00 |
| 8.00 | Ancillary service charges | | | 0 | 8. 00 |
| 9.00 | Organ acquisition charges, net of revenue | | | 0 | 9. 00 |
| 10.00 | Total reasonable charges | | | 0 | 10.00 |
| | Customary charges | | | _ | |
| 11. 00 | Aggregate amount actually collected from patients liable for | navment for services on | a charge basis | 0 | 11.00 |
| 12. 00 | Amounts that would have been realized from patients liable for | 1 3 | 9 | . 0 | 12.00 |
| 12.00 | had such payment been made in accordance with 42 CFR 413.13(e | . 3 | in a charge basis | . 0 | 12.00 |
| 13. 00 | Ratio of line 11 to line 12 (not to exceed 1.000000) | =) | | 0. 000000 | 13. 00 |
| 14. 00 | , | | | 0.000000 | 14.00 |
| | Total customary charges (see instructions) | alv if line 14 avecede li | no () (coo | - | |
| 15. 00 | Excess of customary charges over reasonable cost (complete or | if y if fine 14 exceeds if | ne o) (see | 0 | 15. 00 |
| 1/ 00 | instructions) | | - 14) (| 0 | 1/ 00 |
| 16. 00 | Excess of reasonable cost over customary charges (complete or | nry it time 6 exceeds fir | ie 14) (See | 0 | 16. 00 |
| 47.00 | instructions) | | | | 47.00 |
| 17. 00 | Cost of physicians' services in a teaching hospital (see inst | tructions) | | 0 | 17. 00 |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | | |
| 18. 00 | Direct graduate medical education payments (from Worksheet E- | -4, line 49) | | 0 | |
| 19. 00 | Cost of covered services (sum of lines 6, 17 and 18) | | | 3, 638, 106 | |
| 20.00 | Deductibles (exclude professional component) | | | 379, 016 | 20.00 |
| 21.00 | Excess reasonable cost (from line 16) | | | 0 | 21.00 |
| 22.00 | Subtotal (line 19 minus line 20 and 21) | | | 3, 259, 090 | 22.00 |
| 23.00 | Coinsurance | | | 0 | |
| 24.00 | Subtotal (line 22 minus line 23) | | | 3, 259, 090 | 24.00 |
| 25.00 | Allowable bad debts (exclude bad debts for professional servi | ces) (see instructions) | | 7, 891 | |
| 26. 00 | Adjusted reimbursable bad debts (see instructions) | , (, | | 5, 129 | |
| 27. 00 | Allowable bad debts for dual eligible beneficiaries (see inst | tructions) | | 7, 891 | 27.00 |
| 28. 00 | Subtotal (sum of lines 24 and 25, or line 26) | 11 40 11 0113) | | 3, 264, 219 | |
| 29. 00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0, 204, 217 | |
| 29. 50 | Pioneer ACO demonstration payment adjustment (see instruction | 20) | | 0 | 29.50 |
| | | 15) | | - | |
| 29. 98 | Recovery of accelerated depreciation. | | | 0 | |
| 29. 99 | Demonstration payment adjustment amount before sequestration | | | 0 | 29. 99 |
| 30.00 | Subtotal (see instructions) | | | 3, 264, 219 | |
| 30. 01 | Sequestration adjustment (see instructions) | | | 41, 130 | |
| 30. 02 | Demonstration payment adjustment amount after sequestration | | | 0 | 30. 02 |
| 30. 03 | Sequestration adjustment-PARHM | | | | 30. 03 |
| 31.00 | Interim payments | | | 3, 225, 582 | 31.00 |
| 31. 01 | Interim payments-PARHM | | | | 31.01 |
| 32.00 | Tentative settlement (for contractor use only) | | | 0 | 32.00 |
| 32. 01 | Tentative settlement-PARHM (for contractor use only) | | | | 32. 01 |
| 33.00 | Balance due provider/program (line 30 minus lines 30.01, 30.0 | 02, 31, and 32) | | -2, 493 | 33.00 |
| 33. 01 | Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m | | and 32.01) | | 33. 01 |
| 34. 00 | Protested amounts (nonallowable cost report items) in accorda | | | 0 | |
| - · · · - | §115. 2 | | , , , | - | |
| | 10 - | | | | |

Health Financial Systems

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

Provider CCN: 15-1330

Peri od: Worksheet G From 01/01/2022 To 12/31/2022 Date/Time Prepared: 3/2/2024 10:07 am

| | | General Fund | Specific Purpose Fund | Endowment Fund | Plant Fund | . dill |
|------------------|---|-------------------------|--------------------------|-------------------|------------|------------------|
| | | 1.00 | 2.00 | 3. 00 | 4. 00 | |
| | CURRENT ASSETS | | | | | |
| 1.00 | Cash on hand in banks | 2, 249, 694 | | 0 | 0 | |
| 2. 00 3. 00 | Temporary investments Notes receivable | 0 | 0 | 0 | 0 | 2. 00 3. 00 |
| 4. 00 | Accounts receivable | 34, 251, 886 | | 0 | 0 | |
| 5. 00 | Other recei vabl e | 0 1,7 20 1,7 000 | Ö | 0 | Ö | 5.00 |
| 6.00 | Allowances for uncollectible notes and accounts receivable | -20, 936, 442 | О | 0 | 0 | |
| 7. 00 | Inventory | 1, 133, 983 | 0 | 0 | 0 | 7. 00 |
| 8. 00 | Prepai d expenses | 1, 069, 412 | 1 | 0 | 0 | 8.00 |
| 9.00 | Other current assets | 22, 875 | | 0 | 0 | 9.00 |
| 10.00 | Due from other funds Total current assets (sum of lines 1-10) | 17, 791, 408 | 0 | 0 | 0 | |
| 11.00 | FIXED ASSETS | 17,771,400 | <u>ا</u> | <u> </u> | | 11.00 |
| 12.00 | Land | 473, 119 | 0 | 0 | 0 | 12.00 |
| 13.00 | Land improvements | 2, 267, 188 | | 0 | 0 | |
| 14.00 | Accumulated depreciation | -1, 723, 870 | | 0 | | |
| 15.00 | Buildings | 42, 774, 185 | | 0 | 0 | 15.00 |
| 16. 00 17. 00 | · | -25, 965, 558 | 0 | 0 | 0 | 16. 00 17. 00 |
| | Accumulated depreciation | 0 | | 0 | 0 | 1 |
| | Fi xed equipment | 9, 719, 737 | | 0 | Ö | |
| 20.00 | Accumulated depreciation | -5, 623, 432 | О | 0 | 0 | 20.00 |
| 21. 00 | | 0 | 0 | 0 | 0 | 21.00 |
| 22. 00 | | 0 | 0 | 0 | 0 | 22.00 |
| 23.00 | 1 . | 20, 765, 689 | | 0 | 0 | 23.00 |
| 24. 00 | Accumulated depreciation Minor equipment depreciable | -17, 214, 622 | 0 | 0 | 0 | 24.00 |
| 26. 00 | Accumulated depreciation | 0 | 0 | 0 | 0 | 25. 00 26. 00 |
| | HIT designated Assets | 0 | 0 | 0 | 0 | 1 |
| 28. 00 | | Ö | Ö | 0 | _ | 1 |
| 29.00 | Mi nor equi pment-nondepreci abl e | 365, 701 | 0 | 0 | 0 | 29. 00 |
| 30.00 | , | 25, 838, 137 | 0 | 0 | 0 | 30.00 |
| 04.00 | OTHER ASSETS | | | 0 | | 04.00 |
| 31. 00 32. 00 | Investments Deposits on Leases | 6, 658, 334 | 0 | 0 | 0 | 31.00 |
| 33. 00 | 1 . | 0 | | 0 | 0 | |
| 34. 00 | Other assets | 9, 333, 021 | | 0 | Ö | 1 |
| 35.00 | Total other assets (sum of lines 31-34) | 15, 991, 355 | О | 0 | 0 | |
| 36.00 | Total assets (sum of lines 11, 30, and 35) | 59, 620, 900 | 0 | 0 | 0 | 36.00 |
| | CURRENT LIABILITIES | | | | | |
| 37.00 | | 114, 655 | | 0 | 0 | |
| 38.00 | Salaries, wages, and fees payable Payroll taxes payable | 4, 752, 986 228, 958 | | 0 | 0 | |
| 40. 00 | Notes and Loans payable (short term) | 220, 730 | | 0 | 0 | |
| | Deferred income | Ö | Ö | 0 | Ö | |
| 42.00 | Accel erated payments | 0 | | | | 42.00 |
| 43.00 | | 0 | 0 | 0 | 0 | |
| | Other current liabilities | 3, 963, 658 | | 0 | | |
| 45.00 | Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES | 9, 060, 257 | 0 | 0 | 0 | 45.00 |
| 46. 00 | Mortgage payable | 22, 960, 000 | O | 0 | 0 | 46.00 |
| 47. 00 | Notes payable | 22, 700, 000 | | 0 | 0 | 1 |
| 48. 00 | Unsecured Loans | Ö | Ö | 0 | Ö | 1 |
| 49.00 | Other long term liabilities | 0 | О | 0 | 0 | 1 |
| 50.00 | , | 22, 960, 000 | | 0 | | |
| 51. 00 | Total liabilities (sum of lines 45 and 50) | 32, 020, 257 | 0 | 0 | 0 | 51.00 |
| E2 00 | CAPITAL ACCOUNTS General fund balance | 27 (00 (42 | | | | F2 00 |
| 52. 00 53. 00 | Specific purpose fund | 27, 600, 643 | 0 | | | 52. 00 53. 00 |
| 54. 00 | Donor created - endowment fund balance - restricted | | | 0 | | 54.00 |
| 55.00 | | | | 0 | | 55.00 |
| 56.00 | Governing body created - endowment fund balance | | | 0 | | 56.00 |
| 57.00 | Plant fund balance - invested in plant | | | | 0 | |
| 58. 00 | | | | | 0 | 58.00 |
| 59. 00 | replacement, and expansion Total fund balances (sum of lines 52 thru 58) | 27, 600, 643 | | 0 | 0 | 59.00 |
| 60.00 | Total liabilities and fund balances (sum of lines 51 and | 59, 620, 900 | | 0 | 0 | |
| 55. 55 | [59] | 27,020,700 | | J | | 55.55 |
| | | | ' | , | | |

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES ADAMS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Peri od: Worksheet G-1 From 01/01/2022 Provi der CCN: 15-1330

| | | | | | To 1 | 2/31/2022 | Date/Time Pr 3/2/2024 10: | |
|------------------|---|-----------|--------------|----------|---------|-----------|------------------------------|------------------|
| | | General | Fund | Speci al | Purpose | Fund | Endowment Fund | |
| | | 1. 00 | 2.00 | 3.00 | | 4. 00 | 5. 00 | |
| 1. 00 | Fund balances at beginning of period | 1.00 | 28, 190, 357 | | | 4.00 | | 1.00 |
| 2. 00 | Net income (loss) (from Wkst. G-3, line 29) | | -589, 714 | | | | | 2.00 |
| 3.00 | Total (sum of line 1 and line 2) | | 27, 600, 643 | | | 0 | | 3.00 |
| 4.00 | Additions (credit adjustments) (specify) | 0 | | | 0 | | l | 4.00 |
| 5. 00 | | 0 | | | 0 | | l . | 5.00 |
| 6.00 | | 0 | | | 0 | | l . | 6.00 |
| 7. 00 8. 00 | | 0 | | | 0 | | 1 | 7. 00 8. 00 |
| 9. 00 | | 0 | | | 0 | | l | 9.00 |
| 10.00 | Total additions (sum of line 4-9) | ١ | 0 | | O . | 0 | l | 10.00 |
| 11. 00 | Subtotal (line 3 plus line 10) | | 27, 600, 643 | | | 0 | | 11.00 |
| 12. 00 | Deductions (debit adjustments) (specify) | o | | | 0 | | | 12.00 |
| 13.00 | | o | | | 0 | | | 13.00 |
| 14.00 | | 0 | | | 0 | | | 14.00 |
| 15.00 | | 0 | | | 0 | | l | 15.00 |
| 16.00 | | 0 | | | 0 | | l | 16.00 |
| 17. 00 18. 00 | Total deductions (sum of lines 12-17) | U | 0 | | 0 | 0 | ' | 0 17.00 18.00 |
| 19.00 | | | 27, 600, 643 | | | 0 | | 19.00 |
| 17.00 | sheet (line 11 minus line 18) | | 27,000,043 | | | U | | 17.00 |
| | | Endowment | PI ant | Fund | | | | |
| | | Fund | | I | | | | |
| | | 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 5. 00 | Additions (credit adjustments) (specify) | | 0 | | | | | 4. 00 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 15. 00 | | | 0 | | | | | 14. 00 15. 00 |
| 16. 00 | | | 0 | | | | | 16.00 |
| 17. 00 | | | 0 | | | | | 17.00 |
| 18. 00 | Total deductions (sum of lines 12-17) | o | J | | 0 | | | 18. 00 |
| | Fund halance at and of pariod par halance | ا | | I | _ | | | 1 10 00 |
| 19. 00 | Fund balance at end of period per balance sheet (line 11 minus line 18) | ᅵ | | | 0 | | | 19. 00 |

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Period: Worksheet G-2 From 01/01/2022 Parts I & II To 12/31/2022 Date/Time Prepared: Provi der CCN: 15-1330

| | | 1 | o 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
|------------------|--|--------------------|-----------------|-----------------------------|------------------|
| | Cost Center Description | Inpatient | Outpati ent | Total | / aiii |
| | 3331 331131 23331 pt 31 | 1.00 | 2. 00 | 3. 00 | |
| | PART I - PATIENT REVENUES | | | | |
| | General Inpatient Routine Services | | | | |
| 1.00 | Hospi tal | 6, 681, 044 | | 6, 681, 044 | 1.00 |
| 2.00 | SUBPROVI DER - I PF | | | 0 | 2.00 |
| 3.00 | SUBPROVI DER - I RF | | | | 3.00 |
| 4.00 | SUBPROVI DER | | | | 4. 00 |
| 5. 00 | Swing bed - SNF | | 1 | 0 | 5. 00 |
| 6. 00 | Swing bed - NF | 950, 292 | 2 | 950, 292 | 6.00 |
| 7.00 | SKILLED NURSING FACILITY | |) | 0 | 7.00 |
| 8. 00 | NURSI NG FACI LITY | | | | 8.00 |
| 9.00 | OTHER LONG TERM CARE | 7 (21 22) | | 7 (21 22) | 9.00 |
| 10. 00 | Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services | 7, 631, 336 |) | 7, 631, 336 | 10. 00 |
| 11. 00 | INTENSIVE CARE UNIT | 2, 936, 838 | | 2, 936, 838 | 11. 00 |
| 12. 00 | CORONARY CARE UNIT | 2, 430, 636 | | 2, 730, 030 | 12.00 |
| 13. 00 | BURN INTENSIVE CARE UNIT | | | | 13. 00 |
| 14. 00 | SURGI CAL INTENSI VE CARE UNI T | | | | 14. 00 |
| 15. 00 | OTHER SPECIAL CARE (SPECIFY) | | | | 15. 00 |
| 16. 00 | Total intensive care type inpatient hospital services (sum of lir | nes 2, 936, 838 | 3 | 2, 936, 838 | 16. 00 |
| | 11-15) | | | , , | |
| 17.00 | Total inpatient routine care services (sum of lines 10 and 16) | 10, 568, 174 | | 10, 568, 174 | 17.00 |
| 18.00 | Ancillary services | 11, 121, 108 | 68, 799, 870 | 79, 920, 978 | 18.00 |
| 19.00 | Outpatient services | 275, 202 | 15, 908, 060 | 16, 183, 262 | 19.00 |
| 20.00 | MONROE FAMILY MEDICINE | | 2, 259, 889 | 2, 259, 889 | 20.00 |
| 20. 01 | WOODCREST | | 1, 951, 988 | 1, 951, 988 | 20. 01 |
| 20. 02 | STAT CARE | | , , , , , , , , | 2, 221, 560 | 20. 02 |
| 20. 03 | BERNE FAMILY MEDICINE | | | 1, 827, 639 | 20. 03 |
| 20. 04 | HI GH STREET | | _, _, _, _, | 2, 203, 202 | 20. 04 |
| 21. 00 | FEDERALLY QUALIFIED HEALTH CENTER | | 0 | 0 | 21. 00 |
| 22. 00 | HOME HEALTH AGENCY | | 0 | 0 | 22. 00 |
| 23. 00 | AMBULANCE SERVICES | (| 2, 095, 667 | 2, 095, 667 | 23.00 |
| 24. 00 | CMHC | | | | 24.00 |
| 25. 00 | AMBULATORY SURGICAL CENTER (D. P.) | | | 0 | 25.00 |
| 26. 00 27. 00 | HOSPI CE PROFESSI ONAL FEES | | | 0 23, 400, 180 | 26. 00 27. 00 |
| 27. 00 | OTHER CLINICS | | | 101, 549 | 27.00 |
| 28. 00 | Total patient revenues (sum of lines 17-27)(transfer column 3 to | ' | | 142, 734, 088 | 28. 00 |
| 20.00 | G-3, line 1) | WKST. 21, 704, 482 | 120, 709, 004 | 142, 734, 000 | 20.00 |
| | PART II - OPERATING EXPENSES | | | | |
| 29. 00 | Operating expenses (per Wkst. A, column 3, line 200) | | 76, 398, 461 | | 29. 00 |
| 30.00 | ADD (SPECIFY) | | | | 30.00 |
| 31.00 | | | | | 31.00 |
| 32.00 | | |) | | 32.00 |
| 33.00 | | |) | | 33.00 |
| 34.00 | | |) | | 34.00 |
| 35.00 | | | | | 35.00 |
| 36.00 | Total additions (sum of lines 30-35) | | 0 | | 36.00 |
| 37.00 | DEDUCT (SPECIFY) | | | | 37.00 |
| 38. 00 | | | | | 38.00 |
| 39. 00 | | (| | | 39. 00 |
| 40.00 | | (| | | 40.00 |
| 41.00 | T-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1 | |] _ | | 41.00 |
| 42.00 | Total deductions (sum of lines 37-41) | | 7/ 200 4/4 | | 42.00 |
| 43. 00 | Total operating expenses (sum of lines 29 and 36 minus line 42)(t | ransrer | 76, 398, 461 | | 43. 00 |
| | to Wkst. G-3, line 4) | I. | 1 | | l |

| | Financial Systems ADAMS MEN ENT OF REVENUES AND EXPENSES | MORIAL HOSPITAL Provider CCN: 15-1330 | Peri od: | u of Form CMS-2 Worksheet G-3 | |
|------------------|--|--|-----------------|----------------------------------|-------|
| SIAIEW | ENT OF REVENUES AND EXPENSES | Provider CCN. 15-1330 | From 01/01/2022 | WOLKSHEET G-3 | |
| | | | To 12/31/2022 | | |
| | | | | 3/2/2024 10: 0 | / am |
| | | | | 1. 00 | |
| 1. 00 | Total patient revenues (from Wkst. G-2, Part I, column | 3, line 28) | | 142, 734, 088 | 1.00 |
| 2. 00 | Less contractual allowances and discounts on patients' | | | 66, 247, 044 | |
| 3. 00 | Net patient revenues (line 1 minus line 2) | | | 76, 487, 044 | 3.00 |
| 4. 00 | Less total operating expenses (from Wkst. G-2, Part II, | , line 43) | | 76, 398, 461 | |
| 5. 00 | Net income from service to patients (line 3 minus line | | | 88, 583 | 5.00 |
| | OTHER I NCOME | | | | ĺ |
| 6. 00 | Contributions, donations, bequests, etc | | | 437, 584 | 6.00 |
| 7. 00 | Income from investments | | | 200, 789 | 7.00 |
| 8. 00 | Revenues from telephone and other miscellaneous communi | ication services | | 0 | 8.00 |
| 9. 00 | Revenue from television and radio service | | | 0 | 9.00 |
| 10.00 | Purchase di scounts | | | 0 | |
| | Rebates and refunds of expenses | | | 0 | 11.00 |
| | Parking lot receipts | | | 0 | |
| | Revenue from Laundry and Linen service | | | 0 | |
| | Revenue from meals sold to employees and guests | | | 338, 849 | |
| | Revenue from rental of living quarters | | | 0 | |
| | Revenue from sale of medical and surgical supplies to | other than patients | | 0 | |
| | Revenue from sale of drugs to other than patients | | | 476, 027 | |
| | Revenue from sale of medical records and abstracts | | | 25, 911 | |
| | Tuition (fees, sale of textbooks, uniforms, etc.) | | | 0 | |
| | Revenue from gifts, flowers, coffee shops, and canteen | | | 0 | |
| | Rental of vending machines | | | 0 | |
| | Rental of hospital space | | | 187, 365 | |
| 23. 00 24. 00 | Governmental appropriations | | | 1 120 170 | |
| | CEDIT INCOME | | | 1, 130, 179 | |
| | FITNESS REVENUE | | | 1, 649, 287 81, 608 | |
| | TRANSPORTATION REVENUE | | | 9, 481 | |
| | COVID-19 PHE Funding | | | 491, 527 | |
| | Total other income (sum of lines 6-24) | | | 5, 028, 607 | |
| | Total (line 5 plus line 25) | | | 5, 117, 190 | |
| | BAD DEBTS | | | 5, 706, 904 | |
| | Total other expenses (sum of line 27 and subscripts) | | | 5, 706, 904 | |
| | Net income (or loss) for the period (line 26 minus line | 00) | | -589, 714 | |

| Heal th | Financial Systems | ADAMS MEMORIA | L HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|----------------|--|--------------------|-------------------|---------------------|----------------------------------|--------------------------------|---------|
| ANALYS | SIS OF HOSPITAL-BASED RHC/FQHC COSTS | | Provi der C | CN: 15-1330 | Peri od: | Worksheet M-1 | |
| | | | Component | CCN: 15-8526 | From 01/01/2022 To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
| | | | | | RHC I | Cost | |
| | | Compensation | Other Costs | Total (col. | 1 Reclassi fi cat | Recl assi fi ed | |
| | | | | + col . 2) | i ons | Trial Balance | |
| | | | | | | (col. 3 + | |
| | | 1 00 | 2.00 | 2.00 | 4.00 | col . 4) | |
| | FACILITY HEALTH CARE STAFF COSTS | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| 1 00 | | 395, 704 | OF 417 | 401 1 | 21 0 | 401 121 | 1.00 |
| 1.00 | Physician Assistant | 395, 704 7, 509 | 95, 417 1, 811 | | | 491, 121 9, 320 | 2.00 |
| 2. 00 3. 00 | Physician Assistant Nurse Practitioner | 605, 706 | 1,811 | | | 751, 762 | 3.00 |
| 4. 00 | Visiting Nurse | 003, 700 | 140, 030 | /51, /0 | 0 0 | 751, 762 | 4.00 |
| 5.00 | Other Nurse | 301, 082 | 72, 601 | 373, 68 | 9 | 373, 683 | 5.00 |
| 6. 00 | Clinical Psychologist | 301, 002 | 72,001 | 3/3,00 | 0 0 | 373,003 | 6.00 |
| 7. 00 | Clinical Social Worker | 0 | 0 | | 0 0 | 0 | |
| 8. 00 | Laboratory Techni ci an | 0 | 0 | | 0 0 | 0 | 8.00 |
| 9. 00 | Other Facility Health Care Staff Costs | 0 | 0 | | 0 0 | 0 | 9.00 |
| 10.00 | Subtotal (sum of lines 1 through 9) | 1, 310, 001 | 315, 885 | 1, 625, 8 | ٥ | 1, 625, 886 | |
| 11. 00 | Physician Services Under Agreement | 0 | 010,000 | 1,020,0 | 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 | 14.00 |
| 15.00 | Medical Supplies | O | 115, 475 | 115, 4 ⁻ | 75 0 | 115, 475 | 15.00 |
| 16.00 | Transportation (Health Care Staff) | O | 0 | | 0 0 | 0 | 16.00 |
| 17.00 | Depreciation-Medical Equipment | o | 0 | | 0 0 | 0 | 17.00 |
| 18.00 | Professional Liability Insurance | o | 0 | | 0 0 | 0 | 18.00 |
| 19.00 | Other Health Care Costs | 0 | 0 | 1 | 0 0 | 0 | 19.00 |
| 20.00 | Allowable GME Costs | | | | | | 20.00 |
| 21.00 | Subtotal (sum of lines 15 through 20) | 0 | 115, 475 | 115, 4 | 75 0 | 115, 475 | 21.00 |
| 22.00 | Total Cost of Health Care Services (sum of | 1, 310, 001 | 431, 360 | 1, 741, 3 | 61 0 | 1, 741, 361 | 22.00 |
| | lines 10, 14, and 21) | | | | | | |
| | COSTS OTHER THAN RHC/FQHC SERVICES | | | 1 | | | |
| 23. 00 | Pharmacy | 0 | 0 | | 0 0 | 0 | 23.00 |
| 24.00 | Dental | 0 | 0 | 1 | 0 0 | 0 | 24.00 |
| 25. 00 | Optometry | 0 | 0 | | 0 0 | 0 | |
| 25. 01 | Tel eheal th | 21, 231 | 5, 120 | 26, 3! | | 26, 351 | 25. 01 |
| 25. 02 | Chronic Care Management | 0 | 0 | | 0 0 | 0 | 25. 02 |
| 26. 00 | All other nonreimbursable costs | O | 0 | | 0 0 | 0 | 26.00 |
| 27. 00 | Nonallowable GME costs | 24 224 | F 400 |] | -1 | 2/ 254 | 27.00 |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | 21, 231 | 5, 120 | 26, 3! | 51 0 | 26, 351 | 28. 00 |
| | through 27) FACILITY OVERHEAD | | | | | | 1 |
| 29. 00 | Facility Overhead Facility Costs | ol | 61, 608 | 61, 60 | 0 80 | 61, 608 | 29.00 |
| 30.00 | Administrative Costs | 26, 852 | 37, 681 | | | 64, 533 | |
| 31. 00 | Total Facility Overhead (sum of lines 29 and | 26, 852 | 99, 289 | | | 126, 141 | 31.00 |
| 51.00 | 30) | 20, 002 | 77, 207 | 120, 1 | ' | 120, 141 |] 31.00 |
| 22 00 | Total facility costs (sum of lines 22, 28 | 1, 358, 084 | 535, 769 | 1, 893, 8! | 53 0 | 1, 893, 853 | 22 00 |

535, 769

1, 358, 084

1, 893, 853

1, 893, 853

| Health Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|---------------|-------------|--------------|-----------------------------|--------------------------------|---------|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | | Provi der C | CN: 15-1330 | Peri od: From 01/01/2022 | Worksheet M-1 | |
| | | Component | CCN: 15-8526 | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
| | | | | RHC I | Cost | |
| | Adiustmonts | Not Exposes | | | | |

| | | | | | 3/2/2024 10:07 am |
|--------|--|-------------|--------------|-------|-------------------|
| | | | | RHC I | Cost |
| | | Adjustments | Net Expenses | | |
| | | | for | | |
| | | | Allocation | | |
| | | | (col. 5 + | | |
| | | | col. 6) | | |
| | | 6. 00 | 7.00 | | |
| | FACILITY HEALTH CARE STAFF COSTS | | 1 11 22 | | |
| 1.00 | Physi ci an | 0 | 491, 121 | | 1.00 |
| 2. 00 | Physician Assistant | 0 | 9, 320 | | 2.00 |
| 3. 00 | Nurse Practitioner | 0 | 751, 762 | | 3.00 |
| 4. 00 | Visiting Nurse | 0 | 751, 762 | | 4.00 |
| 5. 00 | | 0 | 373, 683 | | 5. 00 |
| | Other Nurse | 0 | | | |
| 6. 00 | Clinical Psychologist | 0 | 0 | | 6.00 |
| 7. 00 | Clinical Social Worker | 0 | 0 | | 7. 00 |
| 8. 00 | Laboratory Techni ci an | 0 | 0 | | 8.00 |
| 9. 00 | Other Facility Health Care Staff Costs | 0 | 0 | | 9. 00 |
| 10.00 | Subtotal (sum of lines 1 through 9) | 0 | 1, 625, 886 | | 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 | ol | | 13.00 |
| 14.00 | Subtotal (sum of lines 11 through 13) | 0 | l ol | | 14.00 |
| 15. 00 | Medical Supplies | 0 | 115, 475 | | 15. 00 |
| 16. 00 | | 0 | 0 | | 16.00 |
| 17. 00 | , , , | 0 | ٥ | | 17.00 |
| | Professional Liability Insurance | 0 | | | 18. 00 |
| 19. 00 | | 0 | | | 19.00 |
| 20. 00 | | 0 | ٩ | | 20.00 |
| | | 0 | 115 475 | | |
| 21.00 | Subtotal (sum of lines 15 through 20) | 0 | 115, 475 | | 21.00 |
| 22. 00 | Total Cost of Health Care Services (sum of | 0 | 1, 741, 361 | | 22. 00 |
| | lines 10, 14, and 21) | | | | |
| | COSTS OTHER THAN RHC/FQHC SERVICES | | | | |
| 23. 00 | | 0 | | | 23.00 |
| 24. 00 | Dental | 0 | 0 | | 24.00 |
| 25. 00 | 1' | 0 | 0 | | 25. 00 |
| 25. 01 | Tel eheal th | 0 | 26, 351 | | 25. 01 |
| 25. 02 | Chronic Care Management | 0 | 0 | | 25. 02 |
| 26.00 | All other nonreimbursable costs | 0 | 0 | | 26.00 |
| 27.00 | Nonallowable GME costs | | | | 27.00 |
| 28.00 | Total Nonreimbursable Costs (sum of lines 23 | 0 | 26, 351 | | 28.00 |
| | through 27) | | | | |
| | FACILITY OVERHEAD | | | | |
| 29. 00 | | 0 | 61, 608 | | 29. 00 |
| 30. 00 | 1 | 0 | 64, 533 | | 30.00 |
| 31. 00 | Total Facility Overhead (sum of lines 29 and | 0 | 126, 141 | | 31.00 |
| 51.00 | 30) | 0 | [120, 141] | | 31.00 |
| 32. 00 | Total facility costs (sum of lines 22, 28 | ^ | 1, 893, 853 | | 32.00 |
| 32.00 | and 31) | 0 | 1, 073, 033 | | 32.00 |
| | Julia 31) | | I I | | į. |

| ∐oal ±h | Financial Systems | ADAMS MEMORIA | N HOSDITAI | | In Lio | u of Form CMS-: | 2552 10 |
|---------|--|---------------|--------------|-------------|----------------------------------|-----------------|------------------|
| | IS OF HOSPITAL-BASED RHC/FOHC COSTS | ADAMS WEMORTA | Provider Co | CN: 15-1330 | Peri od: | Worksheet M-1 | |
| | | | | | From 01/01/2022 To 12/31/2022 | | pared: |
| | | | | | RHC II | Cost | 77 dili |
| | | Compensation | Other Costs | Total (col. | 1 Reclassificat | Recl assi fi ed | |
| | | | | + col . 2) | i ons | Trial Balance | |
| | | | | | | (col. 3 + | |
| | | 1.00 | | | 1.00 | col . 4) | |
| | FACILITY HEALTH CARE CTAFE COCTO | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| 1. 00 | FACILITY HEALTH CARE STAFF COSTS Physi ci an | 613, 028 | 73, 961 | 686, 98 | 9 0 | 686, 989 | 1.00 |
| 2. 00 | Physician Assistant | 013,028 | 73, 961 | 080, 98 | 0 0 | 086, 989 | |
| 3. 00 | Nurse Practitioner | 266, 458 | 41, 934 | 308, 39 | 9 | 308, 392 | |
| 4. 00 | Vi si ti ng Nurse | 200, 430 | 41, 754 O | 300, 37 | 0 0 | 0 | 4.00 |
| 5. 00 | Other Nurse | 320, 916 | 63, 694 | 384, 61 | 0 0 | 384, 610 | |
| 6. 00 | Clinical Psychologist | 0 | 0 | 00.,0. | 0 0 | 0 | 1 |
| 7. 00 | Clinical Social Worker | o | 0 | | 0 0 | 0 | 1 |
| 8. 00 | Laboratory Techni ci an | O | 0 | | 0 0 | 0 | 1 |
| 9.00 | Other Facility Health Care Staff Costs | o | 0 | | 0 0 | 0 | 9.00 |
| 10.00 | Subtotal (sum of lines 1 through 9) | 1, 200, 402 | 179, 589 | 1, 379, 99 | 0 1 | 1, 379, 991 | 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 | |
| 13.00 | Other Costs Under Agreement | 0 | 0 | | 0 | 0 | |
| 14. 00 | Subtotal (sum of lines 11 through 13) | 0 | 0 | | 0 0 | 0 | |
| 15. 00 | Medical Supplies | 0 | 200, 810 | 200, 81 | 0 | 200, 810 | |
| 16.00 | Transportation (Health Care Staff) | 0 | 0 | | 0 | 0 | |
| 17.00 | Depreciation-Medical Equipment | 0 | 0 | | 0 0 | 0 | |
| 18.00 | Professional Liability Insurance Other Health Care Costs | 0 | 0 | | 0 0 | | 18. 00 19. 00 |
| 20.00 | Allowable GME Costs | U | U | | 0 | U | 20.00 |
| 21. 00 | Subtotal (sum of lines 15 through 20) | 0 | 200, 810 | 200, 81 | 0 | 200, 810 | |
| 22. 00 | Total Cost of Health Care Services (sum of | 1, 200, 402 | 380, 399 | | | 1, 580, 801 | 22.00 |
| 22.00 | lines 10, 14, and 21) | 1,200,102 | 000,077 | 1, 555, 55 | | 1,000,001 | 22.00 |
| | COSTS OTHER THAN RHC/FQHC SERVICES | | | | | • | 1 |
| 23.00 | Pharmacy | 0 | 0 | | 0 0 | 0 | 23. 00 |
| 24.00 | Dental | 0 | 0 | | 0 0 | 0 | |
| 25.00 | Optometry | 0 | 0 | | 0 | 0 | 25.00 |
| 25. 01 | Tel eheal th | 618 | 123 | 74 | 1 | 741 | 25. 01 |
| 25. 02 | Chronic Care Management | 0 | 0 | | 0 | 0 | 25. 02 |
| 26.00 | All other nonreimbursable costs | 0 | 0 | | 0 | 0 | |
| 27. 00 | Nonallowable GME costs | | 100 | | | | 27.00 |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | 618 | 123 | 74 | 1 0 | 741 | 28. 00 |
| | through 27) FACILITY OVERHEAD | | | | | | 1 |
| 29. 00 | Facility Overhead Facility Costs | ol | 73, 140 | 73, 14 | 0 0 | 73, 140 | 29. 00 |
| 30.00 | Administrative Costs | 20. 285 | 29, 705 | 49, 99 | | 49, 990 | 1 |
| 31. 00 | Total Facility Overhead (sum of lines 29 and | | 102, 845 | 123, 13 | | 123, 130 | |
| 550 | 30) | 25, 200 | .52,010 | .23, 10 | | 1.25, 100 | 355 |

1, 221, 305

483, 367

1, 704, 672

32.00

1, 704, 672

| Health Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|---------------|--------------|--------------|-----------------------------|--------------------------------|---------|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | | Provi der 0 | CCN: 15-1330 | Peri od: From 01/01/2022 | Worksheet M-1 | |
| | | Component | CCN: 15-8536 | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
| | | | | RHC II | Cost | |
| | Adjustments | Net Expenses | | | | |

| | | | | | | 3/2/2024 10:0 | 7 am |
|--------|--|-------------|--------------|----------|--------|---------------|--------|
| | | | | | RHC II | Cost | |
| | | Adjustments | Net Expenses | | | | |
| | | | for | | | | |
| | | | Allocation | | | | |
| | | | (col. 5 + | | | | |
| | | | col. 6) | | | | |
| | | 6. 00 | 7.00 | | | | |
| | FACILITY HEALTH CARE STAFF COSTS | | | | | | |
| 1.00 | Physi ci an | 0 | 686, 989 | 9 | | | 1.00 |
| 2.00 | Physician Assistant | 0 | | 0 | | | 2. 00 |
| 3.00 | Nurse Practitioner | 0 | 308, 392 | 2 | | | 3. 00 |
| 4.00 | Visiting Nurse | 0 | (| 0 | | | 4. 00 |
| 5. 00 | Other Nurse | 0 | 384, 610 | 0 | | | 5. 00 |
| 6.00 | Clinical Psychologist | 0 | (| 0 | | | 6. 00 |
| 7. 00 | Clinical Social Worker | 0 | (| 0 | | | 7. 00 |
| 8.00 | Laboratory Techni ci an | 0 | (| 0 | | | 8. 00 |
| 9. 00 | Other Facility Health Care Staff Costs | 0 | |) | | | 9. 00 |
| 10.00 | Subtotal (sum of lines 1 through 9) | 0 | 1, 379, 99 | 1 | | | 10.00 |
| 11. 00 | Physician Services Under Agreement | 0 | (|) | | | 11. 00 |
| 12. 00 | Physician Supervision Under Agreement | 0 | (|) | | | 12.00 |
| 13. 00 | 1 | 0 | , |) | | | 13. 00 |
| 14.00 | Subtotal (sum of lines 11 through 13) | 0 | | 0 | | | 14.00 |
| 15.00 | Medical Supplies | 0 | 200, 810 | 0 | | | 15.00 |
| 16.00 | ' ' ' | 0 | | 0 | | | 16. 00 |
| 17. 00 | | 0 | (| 0 | | | 17.00 |
| | Professional Liability Insurance | 0 | | 0 | | | 18. 00 |
| 19. 00 | Other Health Care Costs | 0 | (| 0 | | | 19. 00 |
| 20.00 | Allowable GME Costs | | | | | | 20.00 |
| 21. 00 | | 0 | 200, 810 | 1 | | | 21.00 |
| 22. 00 | Total Cost of Health Care Services (sum of | 0 | 1, 580, 80 | 1 | | | 22. 00 |
| | lines 10, 14, and 21) | | | | | | |
| | COSTS OTHER THAN RHC/FQHC SERVICES | | | , | | | |
| | Pharmacy | 0 | | O | | | 23. 00 |
| 24. 00 | 1 | 0 | | O | | | 24. 00 |
| 25. 00 | 1' | 0 | | O | | | 25. 00 |
| 25. 01 | Tel eheal th | 0 | 74 | 1 | | | 25. 01 |
| 25. 02 | 1 | 0 | (| | | | 25. 02 |
| 26. 00 | All other nonreimbursable costs | 0 | (| P | | | 26. 00 |
| 27. 00 | Nonallowable GME costs | | | | | | 27. 00 |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | 0 | 74 | 1 | | | 28. 00 |
| | through 27) | | | | | | |
| | FACILITY OVERHEAD | _1 | 70 | N. | | | |
| | Facility Costs | 0 | 73, 140 | | | | 29.00 |
| 30.00 | Administrative Costs | 0 | 49, 990 | | | | 30.00 |
| 31. 00 | Total Facility Overhead (sum of lines 29 and | 이 | 123, 130 | וי | | | 31.00 |
| 22.00 | 30) | | 1 704 (7) | | | | 22.00 |
| 32. 00 | Total facility costs (sum of lines 22, 28 | O | 1, 704, 672 | <u>-</u> | | | 32.00 |
| | and 31) | ı | | 1 | | | 1 |

| | Financial Systems | ADAMS MEMORIA | | | | u of Form CMS-2 | |
|----------------|--|---------------|--------------|--------------|-----------------------------|--------------------------------|----------------|
| ANALYS | SIS OF HOSPITAL-BASED RHC/FQHC COSTS | | Provi der Co | CN: 15-1330 | Peri od: From 01/01/2022 | Worksheet M-1 | |
| | | | Component | CCN: 15-8537 | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | pared: 7 am |
| | | | | | RHC III | Cost | |
| | | Compensati on | Other Costs | | 1 Reclassi fi cat | Recl assi fi ed | |
| | | | | + col . 2) | i ons | Trial Balance | |
| | | | | | | (col. 3 + | |
| | | | | | | col . 4) | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| 4 00 | FACILITY HEALTH CARE STAFF COSTS | 450.047 | 04 (53 | · · · | | | |
| 1.00 | Physi ci an | 458, 967 | 81, 657 | 540, 62 | | 540, 624 | 1.00 |
| 2.00 | Physician Assistant | 56, 901 | 10, 124 | | | 67, 025 | |
| 3.00 | Nurse Practitioner | 109, 216 | 19, 431 | 128, 64 | | 128, 647 | 3.00 |
| 4.00 | Visiting Nurse | 271 (41 | 40.220 | 210.0 | 0 0 | 0 | |
| 5. 00 6. 00 | Other Nurse Clinical Psychologist | 271, 641 | 48, 329 | 319, 97 | 0 | 319, 970 0 | |
| 7. 00 | Clinical Social Worker | 0 | 0 | | 0 0 | 0 | |
| 8. 00 | Laboratory Technician | 0 | 0 | | 0 0 | 0 | |
| 9. 00 | Other Facility Health Care Staff Costs | 67, 483 | 12, 006 | 79, 48 | 0 | 79, 489 | |
| 10.00 | Subtotal (sum of lines 1 through 9) | 964, 208 | | 1, 135, 75 | | 1, 135, 755 | 1 |
| 11. 00 | Physician Services Under Agreement | 704, 200 0 | 1/1, 34/ | 1, 135, 75 | 0 | 1, 135, 755 | 1 |
| 12.00 | Physician Supervision Under Agreement | 0 | 0 | | | 0 | |
| 13. 00 | Other Costs Under Agreement | 0 | 0 | | | 0 | 1 |
| 14. 00 | Subtotal (sum of lines 11 through 13) | 0 | 0 | | | 0 | 1 |
| 15. 00 | Medical Supplies | 0 | 70, 891 | 70, 89 | 0 | 70, 891 | |
| 16. 00 | Transportation (Health Care Staff) | 0 | 70,071 | 70,07 | | 0 | 1 |
| 17. 00 | Depreciation-Medical Equipment | 0 | n | | 0 0 | Ö | 1 |
| 18. 00 | Professional Liability Insurance | 0 | 0 | | 0 0 | o o | 18.00 |
| | Other Health Care Costs | 0 | 0 | | 0 0 | 0 | |
| 20.00 | Allowable GME Costs | | _ | | | _ | 20.00 |
| 21. 00 | Subtotal (sum of lines 15 through 20) | 0 | 70, 891 | 70. 89 | 0 | 70, 891 | |
| 22. 00 | Total Cost of Health Care Services (sum of | 964, 208 | 242, 438 | 1, 206, 64 | 6 0 | 1, 206, 646 | |
| | lines 10, 14, and 21) | | | | | | |
| | COSTS OTHER THAN RHC/FQHC SERVICES | | | | | | 1 |
| 23.00 | Pharmacy | 0 | 0 | | 0 0 | 0 | 23. 00 |
| 24.00 | Dental | 0 | 0 | | 0 0 | 0 | 24.00 |
| 25.00 | Optometry | 0 | 0 | | 0 | 0 | 25. 00 |
| 25. 01 | Tel eheal th | 0 | 0 | | 0 | 0 | 25. 01 |
| 25.02 | Chronic Care Management | 0 | 0 | | 0 | 0 | 25. 02 |
| 26.00 | All other nonreimbursable costs | 0 | 0 | | 0 | 0 | 26.00 |
| 27.00 | Nonallowable GME costs | | | | | | 27. 00 |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | 0 | 0 | | 0 | 0 | 28. 00 |
| | through 27) | | | | | | |
| | FACILITY OVERHEAD | | | | | | ļ |
| | Facility Costs | 0 | | | | | 29.00 |
| 30 00 | Administrative Costs | 175 576 | 206 527 | 382.10 | 0.3 | 382 103 | 1 30, 00 |

175, 576

1, 139, 784

25, 358 206, 527 231, 885

474, 323

25, 358 382, 103

407, 461

1, 614, 107

25, 358 382, 103 407, 461

1, 614, 107

0

0

30.00

31.00

32.00

30.00 Administrative Costs

31.00

32.00

Total Facility Overhead (sum of lines 29 and

| Health Financial Systems | ADAMS MEMORIAL HOSPITAL | In Lieu | ı of Form CMS-2552-10 |
|---|-------------------------|-----------------------------|---------------------------------------|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provi der CCN: 15-1330 | Peri od: From 01/01/2022 | Worksheet M-1 |
| | Component CCN: 15-8537 | To 12/31/2022 | Date/Time Prepared: 3/2/2024 10:07 am |
| | | RHC III | Cost |

| | | | Component Con. 15-83 | 337 | 12/31/2022 | 3/2/2024 10:0 | |
|--------|--|-------------|----------------------|-----|------------|---------------|---------|
| | | | | | RHC III | Cost | |
| | | Adjustments | Net Expenses | | | | |
| | | | for | | | | |
| | | | Allocation | | | | |
| | | | (col. 5 + | | | | |
| | | | col. 6) | | | | |
| | | 6. 00 | 7. 00 | | | | |
| | FACILITY HEALTH CARE STAFF COSTS | | | | | | |
| 1.00 | Physi ci an | 0 | 540, 624 | | | | 1.00 |
| 2.00 | Physician Assistant | ol | 67, 025 | | | | 2.00 |
| 3.00 | Nurse Practitioner | o | 128, 647 | | | | 3.00 |
| 4.00 | Visiting Nurse | ol | o | | | | 4.00 |
| 5.00 | Other Nurse | ol | 319, 970 | | | | 5.00 |
| 6.00 | Clinical Psychologist | ol | 0 | | | | 6.00 |
| 7.00 | Clinical Social Worker | ol | ol | | | | 7.00 |
| 8.00 | Laboratory Techni ci an | ol | ol | | | | 8.00 |
| 9. 00 | Other Facility Health Care Staff Costs | ol | 79, 489 | | | | 9.00 |
| 10.00 | Subtotal (sum of lines 1 through 9) | ol | 1, 135, 755 | | | | 10.00 |
| 11. 00 | Physician Services Under Agreement | o | 0 | | | | 11.00 |
| 12. 00 | 9 | ol | 0 | | | | 12.00 |
| 13. 00 | | ol | 0 | | | | 13.00 |
| 14. 00 | ŭ | ol | 0 | | | | 14.00 |
| 15. 00 | , , , | Ö | 70, 891 | | | | 15.00 |
| 16. 00 | 1 '' | Ö | 0 | | | | 16.00 |
| 17. 00 | , , , | Ö | ol | | | | 17.00 |
| | Professional Liability Insurance | o o | o | | | | 18.00 |
| | Other Health Care Costs | 0 | Ö | | | | 19.00 |
| 20.00 | | ď | 9 | | | | 20.00 |
| 21. 00 | | ٥ | 70. 891 | | | | 21.00 |
| 22. 00 | | 0 | 1, 206, 646 | | | | 22.00 |
| 22.00 | lines 10, 14, and 21) | ď | 1, 200, 040 | | | | 22.00 |
| | COSTS OTHER THAN RHC/FQHC SERVICES | | | | | | |
| 23 00 | Pharmacy | O | 0 | | | | 23.00 |
| 24. 00 | 1 | ol | ol | | | | 24.00 |
| 25. 00 | l l | ol O | o | | | | 25.00 |
| 25. 01 | Tel eheal th | ol O | o | | | | 25. 01 |
| 25. 01 | l l | 0 | Ö | | | | 25. 02 |
| 26. 00 | All other nonreimbursable costs | 0 | Ö | | | | 26.00 |
| 27. 00 | Nonallowable GME costs | ď | 9 | | | | 27.00 |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | 0 | 0 | | | | 28.00 |
| 20.00 | through 27) | ď | 9 | | | | 20.00 |
| | FACILITY OVERHEAD | | | | | | 1 |
| 29 ∩∩ | Facility Costs | O | 25, 358 | | | | 29.00 |
| 30.00 | | ol | 382, 103 | | | | 30.00 |
| 31. 00 | Total Facility Overhead (sum of lines 29 and | 0 | 407, 461 | | | | 31.00 |
| 31.00 | 30) | ٩ | 707, 701 | | | |] 31.00 |
| 32. 00 | Total facility costs (sum of lines 22, 28 | ٥ | 1, 614, 107 | | | | 32.00 |
| 32. 00 | and 31) | ٩ | ., 511, 157 | | | |] 32.00 |
| | [and 01) | ı | 1 | | | | 1 |

| Heal th | Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|------------------|---|---------------|-------------|--------------|----------------------------------|--------------------------------|------------------|
| ANALYS | SIS OF HOSPITAL-BASED RHC/FQHC COSTS | | Provi der C | CN: 15-1330 | Peri od: | Worksheet M-1 | |
| | | | Component | CCN: 15-8559 | From 01/01/2022 To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
| | | | | | RHC IV | Cost | |
| | | Compensation | Other Costs | | 1 Recl assi fi cat | Recl assi fi ed | |
| | | | | + col . 2) | i ons | Trial Balance | |
| | | | | | | (col. 3 + | |
| | | 1. 00 | 2. 00 | 3.00 | 4. 00 | col . 4) 5.00 | |
| | FACILITY HEALTH CARE STAFF COSTS | 1.00 | 2.00 | 3.00 | 4.00 | 3.00 | |
| 1. 00 | Physi ci an | 365, 942 | 84, 241 | 450, 18 | 3 0 | 450, 183 | 1.00 |
| 2. 00 | Physician Assistant | 0 | 0.,2 | 1 | o o | 0 | 2.00 |
| 3.00 | Nurse Practitioner | 261, 656 | 60, 234 | 321, 89 | 0 0 | 321, 890 | 1 |
| 4.00 | Visiting Nurse | 0 | 0 | | 0 0 | 0 | 4.00 |
| 5.00 | Other Nurse | 294, 201 | 67, 726 | 361, 92 | 7 0 | 361, 927 | 5.00 |
| 6.00 | Clinical Psychologist | 0 | 0 |) | 0 | 0 | |
| 7. 00 | Clinical Social Worker | 0 | 0 | | 0 | 0 | |
| 8. 00 | Laboratory Techni ci an | 0 | 0 | | 0 | 0 | |
| 9. 00 | Other Facility Health Care Staff Costs | 0 | 0 | | 0 | 0 | 9.00 |
| 10.00 | Subtotal (sum of lines 1 through 9) | 921, 799 | 212, 201 | 1, 134, 00 | | 1, 134, 000 | |
| 11.00 | Physician Services Under Agreement | 0 | 0 | | 0 | 0 | 11.00 |
| 12. 00 13. 00 | Physician Supervision Under Agreement Other Costs Under Agreement | 0 | 0 | | 0 0 | 0 | 12. 00 13. 00 |
| 14. 00 | Subtotal (sum of lines 11 through 13) | 0 | 0 | | 0 0 | 0 | |
| 15. 00 | Medical Supplies | 0 | 188, 267 | 188, 26 | - | 188, 267 | |
| 16. 00 | Transportation (Health Care Staff) | 0 | 100, 207 | 100, 20 | 0 | 0 | |
| 17. 00 | Depreciation-Medical Equipment | 0 | | | 0 0 | ő | |
| 18. 00 | Professional Liability Insurance | 0 | 0 | , | 0 0 | Ō | |
| 19.00 | Other Health Care Costs | 0 | O | | 0 0 | 0 | 19.00 |
| 20.00 | Allowable GME Costs | | | | | | 20.00 |
| 21.00 | Subtotal (sum of lines 15 through 20) | 0 | 188, 267 | 188, 26 | 7 0 | 188, 267 | 21.00 |
| 22. 00 | Total Cost of Health Care Services (sum of | 921, 799 | 400, 468 | 1, 322, 26 | 7 0 | 1, 322, 267 | 22. 00 |
| | lines 10, 14, and 21) | | | | | | |
| 00.00 | COSTS OTHER THAN RHC/FQHC SERVICES | ٥ | | ı | | | 00.00 |
| 23.00 | Pharmacy | 0 | 0 | 1 | 0 | 0 | |
| 24. 00 25. 00 | Dental Optometry | 0 | 0 | | 0 0 | 0 | 24. 00 25. 00 |
| 25. 00 | Tel eheal th | 0 | | | 0 0 | 0 | |
| 25. 01 | Chronic Care Management | 0 | 0 | | 0 0 | 0 | • |
| 26. 00 | All other nonreimbursable costs | 0 | | | 0 0 | o o | 26.00 |
| 27. 00 | Nonallowable GME costs | Ö | | | | | 27.00 |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | 0 | 0 | i | 0 0 | 0 | |
| | through 27) | | | | | | |
| | FACILITY OVERHEAD | | | | | | |
| 29. 00 | Facility Costs | 0 | | | | 113, 377 | 29. 00 |
| 30.00 | Administrative Costs | 56, 482 | 75, 308 | | | 131, 790 | 1 |
| 31. 00 | Total Facility Overhead (sum of lines 29 and | 56, 482 | 188, 685 | 245, 16 | 7 0 | 245, 167 | 31.00 |

978, 281

589, 153

1, 567, 434

1, 567, 434

0

32.00

| Health Financial Systems | ADAMS MEMORI. | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|---------------|--------------|--------------|-----------------------------|-----------------|---------|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | | Provi der C | CCN: 15-1330 | Peri od: From 01/01/2022 | Worksheet M-1 | |
| | | Component | CCN: 15-8559 | To 12/31/2022 | | |
| | | | | RHC IV | Cost | |
| | Adjustments | Net Expenses | | | | |

| | | | Component | JON. 15-6557 | 10 | 12/31/2022 | 3/2/2024 10:0 | |
|------------------|--|-------------|----------------|--------------|----|------------|---------------|------------------|
| | | | | | | RHC IV | Cost | |
| | | Adjustments | Net Expenses | | | | | |
| | | · | for | | | | | |
| | | | Allocation | | | | | |
| | | | (col. 5 + | | | | | |
| | | | col. 6) | | | | | |
| | | 6. 00 | 7. 00 | | | | | |
| | FACILITY HEALTH CARE STAFF COSTS | | | | | | | |
| 1.00 | Physi ci an | -53, 859 | 396, 324 | | | | | 1.00 |
| 2.00 | Physician Assistant | 0 | 0 | | | | | 2.00 |
| 3.00 | Nurse Practitioner | 0 | 321, 890 | | | | | 3. 00 |
| 4.00 | Visiting Nurse | 0 | 0 | | | | | 4. 00 |
| 5.00 | Other Nurse | 0 | 361, 927 | | | | | 5. 00 |
| 6.00 | Clinical Psychologist | 0 | 0 | | | | | 6. 00 |
| 7. 00 | Clinical Social Worker | 0 | 0 | | | | | 7. 00 |
| 8.00 | Laboratory Techni ci an | 0 | 0 | | | | | 8. 00 |
| 9.00 | Other Facility Health Care Staff Costs | 0 | 0 | | | | | 9. 00 |
| 10. 00 | Subtotal (sum of lines 1 through 9) | -53, 859 | 1, 080, 141 | | | | | 10.00 |
| 11. 00 | Physician Services Under Agreement | 0 | 0 | | | | | 11.00 |
| 12.00 | Physician Supervision Under Agreement | 0 | 0 | | | | | 12.00 |
| | Other Costs Under Agreement | 0 | 0 | | | | | 13. 00 |
| 14. 00 | Subtotal (sum of lines 11 through 13) | 0 | 0 | | | | | 14.00 |
| 15. 00 | Medical Supplies | 0 | 188, 267 | | | | | 15. 00 |
| 16. 00 | Transportation (Health Care Staff) | 0 | 0 | | | | | 16. 00 |
| 17. 00 | , · · · · · · · · · · · · · · · · · · · | 0 | 0 | | | | | 17. 00 |
| 18. 00 | 1 | 0 | 0 | | | | | 18. 00 |
| | Other Health Care Costs | 0 | 0 | | | | | 19.00 |
| 20.00 | Allowable GME Costs | _ | | | | | | 20.00 |
| 21. 00 | Subtotal (sum of lines 15 through 20) | 0 | 188, 267 | | | | | 21.00 |
| 22. 00 | Total Cost of Health Care Services (sum of | -53, 859 | 1, 268, 408 | | | | | 22. 00 |
| | lines 10, 14, and 21) | | | | | | | |
| 22 00 | COSTS OTHER THAN RHC/FQHC SERVICES | ام | 0 | | | | | 22.00 |
| 23. 00 | 1 - | 0 | 0 | | | | | 23. 00 24. 00 |
| 24. 00 | Dental | 0 | 0 | | | | | 25. 00 |
| 25. 00 25. 01 | Optometry Telehealth | 0 | 0 | | | | | 25. 00 |
| 25. 01 | Chronic Care Management | 0 | 0 | | | | | 25. 01 |
| 26. 00 | All other nonreimbursable costs | 0 | 0 | | | | | 26. 00 |
| 27.00 | Nonallowable GME costs | U | U | | | | | 27. 00 |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | 0 | 0 | | | | | 28.00 |
| 20.00 | through 27) | U | o _l | | | | | 20.00 |
| | FACILITY OVERHEAD | | | | | | | |
| 29 00 | Facility Costs | 0 | 113, 377 | | | | | 29. 00 |
| 30.00 | Administrative Costs | o n | 131, 790 | | | | | 30.00 |
| 31. 00 | Total Facility Overhead (sum of lines 29 and | 0 | 245, 167 | | | | | 31.00 |
| 51.00 | 30) | Ĭ | 210, 107 | | | | | 31.00 |
| 32.00 | 1 / | -53, 859 | 1, 513, 575 | | | | | 32.00 |
| | and 31) | , | | | | | | |
| | • | ' | ' | | | | | • |

| | Financial Systems | ADAMS MEMORIA | | | | u of Form CMS-2 | |
|------------------|--|---------------|-------------|--------------|-----------------------------|--------------------------------|------------------|
| ANALYS | SIS OF HOSPITAL-BASED RHC/FQHC COSTS | | Provi der C | CN: 15-1330 | Peri od: From 01/01/2022 | Worksheet M-1 | |
| | | | Component | CCN: 15-8555 | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
| | | | | | RHC V | Cost | |
| | | Compensation | Other Costs | | 1 Reclassi fi cat | Reclassi fied | |
| | | | | + col . 2) | i ons | Tri al Bal ance | |
| | | | | | | (col. 3 + | |
| | | 1. 00 | 2. 00 | 3.00 | 4. 00 | col . 4) 5. 00 | |
| | FACILITY HEALTH CARE STAFF COSTS | 1.00 | 2.00 | 3.00 | 4.00 | 3.00 | |
| 1.00 | Physi ci an | 337, 627 | 63, 584 | 401, 21 | 1 0 | 401, 211 | 1.00 |
| 2.00 | Physician Assistant | 0 | 0 | | 0 0 | 0 | |
| 3.00 | Nurse Practitioner | 319, 063 | 51, 708 | 370, 77 | 1 0 | 370, 771 | 3.00 |
| 4.00 | Visiting Nurse | 0 | 0 | | 0 | 0 | |
| 5.00 | Other Nurse | 339, 827 | 55, 073 | 394, 90 | 0 | 394, 900 | |
| 6.00 | Clinical Psychologist | 0 | 0 | | 0 | 0 | |
| 7. 00 | Clinical Social Worker | 0 | 0 | 1 | 0 | 0 | |
| 8.00 | Laboratory Techni ci an | 0 | 0 | | 0 | 0 | |
| 9.00 | Other Facility Health Care Staff Costs | 007 517 | 170.275 | 1 | 0 | 1 1// 003 | |
| 10.00 | Subtotal (sum of lines 1 through 9) | 996, 517 | 170, 365 | 1, 166, 88 | 2 0 | 1, 166, 882 | |
| 11. 00 12. 00 | Physician Services Under Agreement Physician Supervision Under Agreement | 0 | 0 | | 0 | 0 | 11. 00 12. 00 |
| 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 | 192, 443 | 192, 44 | - | 192, 443 | |
| 16. 00 | Transportation (Health Care Staff) | 0 | 0 | .,_, | o o | 0 | |
| 17. 00 | Depreciation-Medical Equipment | 0 | 0 | | 0 0 | 0 | 1 |
| 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 | | | | | | 20.00 |
| 21. 00 | Subtotal (sum of lines 15 through 20) | 0 | 192, 443 | | | 192, 443 | |
| 22. 00 | Total Cost of Health Care Services (sum of | 996, 517 | 362, 808 | 1, 359, 32 | 5 0 | 1, 359, 325 | 22. 00 |
| | lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES | | | | | | |
| 23. 00 | Pharmacy | 0 | 0 | ı | 0 0 | 0 | 23.00 |
| 24. 00 | Dental | 0 | | 1 | 0 0 | 0 | |
| 25. 00 | Optometry | 0 | 0 | 1 | 0 0 | 0 | |
| 25. 01 | Tel eheal th | 59 | 10 | 1 | 9 0 | 69 | |
| 25. 02 | Chronic Care Management | 0 | 0 | 1 | 0 0 | 0 | 1 |
| 26.00 | All other nonreimbursable costs | 0 | О | | 0 0 | 0 | 26.00 |
| 27.00 | Nonallowable GME costs | | | | | | 27. 00 |
| 28.00 | Total Nonreimbursable Costs (sum of lines 23 | 59 | 10 | 6 | 9 0 | 69 | 28. 00 |
| | through 27) | | | | | | |
| | FACILITY OVERHEAD | | | 1 | .1 | | |
| 29. 00 | Facility Costs | 0 | | | | 29, 346 | |
| 30.00 | Administrative Costs | 55, 553 | · · | | | 101, 467 | 30.00 |
| 31. 00 | Total Facility Overhead (sum of lines 29 and | 55, 553 | 75, 260 | 130, 81 | 3 | 130, 813 | 31.00 |

1, 052, 129

1, 490, 207

438, 078

1, 490, 207

0

32.00

| Health Financial Systems | ADAMS MEMORIA | AL HOSPITAL | In Lie | u of Form CMS-2552-10 |
|---|---------------|-----------------------|-----------------------------|-----------------------|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | | Provider CCN: 15-1330 | Peri od: From 01/01/2022 | Worksheet M-1 |
| | | Component CCN: 15-855 | | |
| | | | RHC V | Cost |
| | Adjustments | Net Expenses | | |

| | | | | | 3/2/2024 10:0 | 07 am |
|--------|--|-------------|--------------|-------|---------------|---------|
| | | | | RHC V | Cost | |
| | | Adjustments | Net Expenses | | | |
| | | | for | | | |
| | | | Allocation | | | |
| | | | (col. 5 + | | | |
| | | | col. 6) | | | |
| | | 6. 00 | 7. 00 | | | |
| | FACILITY HEALTH CARE STAFF COSTS | | | | | |
| 1.00 | Physi ci an | 0 | 401, 211 | | | 1.00 |
| 2.00 | Physician Assistant | 0 | o | | | 2.00 |
| 3. 00 | Nurse Practitioner | 0 | 370, 771 | | | 3.00 |
| 4. 00 | Visiting Nurse | 0 | 0 | | | 4.00 |
| 5. 00 | Other Nurse | 0 | 394, 900 | | | 5.00 |
| 6. 00 | Clinical Psychologist | 0 | 374, 700 | | | 6.00 |
| 7. 00 | Clinical Social Worker | 0 | | | | 7.00 |
| | | 0 | | | | 1 |
| 8. 00 | Laboratory Techni ci an | 0 | 0 | | | 8.00 |
| 9. 00 | Other Facility Health Care Staff Costs | 0 | 0 | | | 9. 00 |
| 10. 00 | Subtotal (sum of lines 1 through 9) | 0 | 1, 166, 882 | | | 10.00 |
| 11. 00 | Physician Services Under Agreement | 0 | 0 | | | 11.00 |
| 12.00 | | 0 | 0 | | | 12.00 |
| 13.00 | Other Costs Under Agreement | 0 | 0 | | | 13.00 |
| 14.00 | Subtotal (sum of lines 11 through 13) | 0 | o | | | 14.00 |
| 15.00 | | 0 | 192, 443 | | | 15.00 |
| 16. 00 | • • | 0 | o | | | 16.00 |
| | Depreciation-Medical Equipment | 0 | 0 | | | 17. 00 |
| | Professional Liability Insurance | 0 | o o | | | 18.00 |
| | Other Health Care Costs | 0 | l o | | | 19.00 |
| 20. 00 | | 0 | ١ | | | 20.00 |
| 21. 00 | | 0 | 192, 443 | | | 21.00 |
| | | 0 | | | | |
| 22. 00 | Total Cost of Health Care Services (sum of | U | 1, 359, 325 | | | 22. 00 |
| | lines 10, 14, and 21) | | | | | - |
| 22 00 | COSTS OTHER THAN RHC/FQHC SERVICES | 0 | | | | 1 22 00 |
| | Pharmacy | 0 | ١ | | | 23.00 |
| 24.00 | Dental | 0 | 0 | | | 24.00 |
| 25. 00 | , , | 0 | 0 | | | 25. 00 |
| 25. 01 | Tel eheal th | 0 | 69 | | | 25. 01 |
| 25. 02 | 9 | 0 | 0 | | | 25. 02 |
| 26.00 | All other nonreimbursable costs | 0 | 0 | | | 26.00 |
| 27.00 | Nonallowable GME costs | | | | | 27. 00 |
| 28.00 | Total Nonreimbursable Costs (sum of lines 23 | 0 | 69 | | | 28. 00 |
| | through 27) | | | | | |
| | FACILITY OVERHEAD | | | | | |
| 29.00 | Facility Costs | -6, 912 | 22, 434 | | | 29. 00 |
| 30.00 | | 0 | 101, 467 | | | 30.00 |
| 31. 00 | | -6, 912 | | | | 31.00 |
| 2 20 | 30) | -, , | , | | | |
| 32.00 | | -6, 912 | 1, 483, 295 | | | 32.00 |
| | and 31) | -, , | ', ', | | | 1 |
| | 1 | l . | 1 | | | 1 |

| | Financial Systems | ADAMS MEMORIA | | OU 45 4000 | | u of Form CMS-2 | |
|--------|---|----------------|----------------|--------------|-----------------------------|--------------------------------|-------|
| ALLOCA | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S | SERVICES | Provi der C | CN: 15-1330 | Peri od: From 01/01/2022 | Worksheet M-2 | |
| | | | Component | CCN: 15-8526 | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
| | | | | | RHC I | Cost | |
| | | Number of FTE | Total Visits | | | Greater of | |
| | | Personnel | | Standard (1) | Visits (col. | col. 2 or | |
| | | | | | 1 x col. 3) | col. 4 | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | VISITS AND PRODUCTIVITY | | | | | | |
| | Posi ti ons | | | | | | |
| 1.00 | Physi ci an | 1. 10 | , | | 1 1 | | 1.00 |
| 2.00 | Physician Assistant | 0. 03 | | | 1 0 | | 2.00 |
| 3.00 | Nurse Practitioner | 3. 48 | | | 1 3 | | 3.00 |
| 4.00 | Subtotal (sum of lines 1 through 3) | 4. 61 | • | | 4 | 9, 915 | 4.00 |
| 5.00 | Visiting Nurse | 0.00 | | | | 0 | 5.00 |
| 6.00 | Clinical Psychologist | 0.00 | | | | 0 | 6.00 |
| 7.00 | Clinical Social Worker | 0.00 | | | | 0 | 7.00 |
| 7. 01 | Medical Nutrition Therapist (FQHC only) | 0.00 | l . | | | 0 | 7. 01 |
| 7. 02 | Diabetes Self Management Training (FQHC | 0.00 | 0 | | | 0 | 7. 02 |
| | onl y) | | | | | | |
| 8.00 | Total FTEs and Visits (sum of lines 4 | 4. 61 | 9, 915 | | | 9, 915 | 8. 00 |
| | through 7) | | | | | | |
| 9. 00 | Physician Services Under Agreements | | 0 | | | 0 | 9. 00 |
| | | | | | | | |
| | I | | | | | 1. 00 | |
| | DETERMINATION OF ALLOWABLE COST APPLICABLE T | | | RVI CES | | | |
| 10.00 | Total costs of health care services (from Wk | | | | | 1, 741, 361 | ı |
| 11. 00 | Total nonreimbursable costs (from Wkst. M-1, | | | | | 26, 351 | ı |
| 12.00 | Cost of all services (excluding overhead) (s | | | | | 1, 767, 712 | |
| 13.00 | Ratio of hospital-based RHC/FQHC services (I | | | | | 0. 985093 | |
| 14.00 | Total hospital-based RHC/FQHC overhead - (fr | | | ine 31) | | 126, 141 | |
| 15.00 | Parent provider overhead allocated to facili | ty (see instru | ctions) | | | 507, 907 | |
| 16.00 | Total overhead (sum of lines 14 and 15) | | | | | 634, 048 | |
| 17. 00 | Allowable GME overhead (see instructions) | | | | | 0 | |
| | Enter the amount from line 16 | | | | | 634, 048 | |
| | Overhead applicable to hospital-based RHC/FC | | | | | 624, 596 | |
| 20. 00 | Total allowable cost of hospital-based RHC/F | QHC services (| sum of lines 1 | 0 and 19) | | 2, 365, 957 | 20.00 |

| | Financial Systems | ADAMS MEMORIA | | ou 45 4000 | | u of Form CMS-2 | |
|--------|---|----------------|----------------|----------------|-----------------------------|--------------------------------|-------|
| ALLOCA | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S | SERVICES | Provi der C | CN: 15-1330 | Peri od: From 01/01/2022 | Worksheet M-2 | |
| | | | Component | CCN: 15-8536 | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
| | | | | | RHC II | Cost | |
| | · | Number of FTE | Total Visits | Producti vi ty | y Minimum | Greater of | |
| | | Personnel | | Standard (1) | Visits (col. | col. 2 or | |
| | | | | | 1 x col. 3) | col. 4 | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | VISITS AND PRODUCTIVITY | | | | | | |
| | Posi ti ons | | | | | | |
| 1.00 | Physi ci an | 1. 52 | | | 1 2 | | 1.00 |
| 2.00 | Physician Assistant | 0.00 | | 1 | 1 0 | | 2.00 |
| 3.00 | Nurse Practitioner | 1. 14 | | | 1 1 | | 3.00 |
| 4.00 | Subtotal (sum of lines 1 through 3) | 2. 66 | 7, 815 | | 3 | 7, 815 | 4.00 |
| 5.00 | Visiting Nurse | 0.00 | | | | 0 | 5.00 |
| 6.00 | Clinical Psychologist | 0.00 | | | | 0 | 6.00 |
| 7.00 | Clinical Social Worker | 0.00 | | | | 0 | 7. 00 |
| 7. 01 | Medical Nutrition Therapist (FQHC only) | 0.00 | 0 | | | 0 | 7. 01 |
| 7. 02 | Diabetes Self Management Training (FQHC | 0.00 | 0 | | | 0 | 7. 02 |
| | onl y) | | | | | | |
| 8.00 | Total FTEs and Visits (sum of lines 4 | 2. 66 | 7, 815 | | | 7, 815 | 8. 00 |
| | through 7) | | | | | | |
| 9. 00 | Physician Services Under Agreements | | 0 | | | 0 | 9. 00 |
| | | | | | | | |
| | | | | | | 1. 00 | |
| | DETERMINATION OF ALLOWABLE COST APPLICABLE T | | | RVI CES | | | |
| 10.00 | Total costs of health care services (from Wk | | | | | 1, 580, 801 | |
| 11. 00 | Total nonreimbursable costs (from Wkst. M-1, | | | | | 741 | |
| 12.00 | Cost of all services (excluding overhead) (s | | | | | 1, 581, 542 | |
| 13.00 | Ratio of hospital-based RHC/FQHC services (I | | | | | 0. 999531 | |
| 14.00 | Total hospital-based RHC/FQHC overhead - (fr | | | ine 31) | | 123, 130 | |
| 15. 00 | Parent provider overhead allocated to facili | ty (see instru | ctions) | | | 456, 545 | |
| 16.00 | Total overhead (sum of lines 14 and 15) | | | | | 579, 675 | |
| 17.00 | Allowable GME overhead (see instructions) | | | | | 0 | |
| | Enter the amount from line 16 | | | | | 579, 675 | |
| | Overhead applicable to hospital-based RHC/FC | | | | | 579, 403 | |
| 20. 00 | Total allowable cost of hospital-based RHC/F | QHC services (| sum of lines 1 | 0 and 19) | | 2, 160, 204 | 20.00 |

| | Financial Systems | ADAMS MEMORIA | | | | u of Form CMS-2 | |
|--------|---|-------------------|-----------------|--------------|-----------------------------|--------------------------------|--------|
| ALLOCA | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S | SERVI CES | Provi der C | | Peri od: From 01/01/2022 | Worksheet M-2 | |
| | | | Component | | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
| | | | | | RHC III | Cost | |
| | | Number of FTE | Total Visits | | | Greater of | |
| | | Personnel | | Standard (1) | , | col. 2 or | |
| | | | | | 1 x col. 3) | col. 4 | |
| | | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| | VISITS AND PRODUCTIVITY | | | | | | |
| | Posi ti ons | | T | T | | | |
| 1. 00 | Physi ci an | 0. 82 | | | | | 1.00 |
| 2.00 | Physician Assistant | 0. 41 | | | | | 2.00 |
| 3. 00 | Nurse Practitioner | 0. 79 | | | · · | | 3.00 |
| 4.00 | Subtotal (sum of lines 1 through 3) | 2. 02 | | i | 5, 964 | 11, 748 | |
| 5. 00 | Visiting Nurse | 0.00 | | 1 | | 0 | 5.00 |
| 6.00 | Clinical Psychologist | 0.00 | | 1 | | 0 | 6.00 |
| 7. 00 | Clinical Social Worker | 0.00 | | 1 | | 0 | 7.00 |
| 7. 01 | Medical Nutrition Therapist (FQHC only) | 0.00 | | 1 | | 0 | 7. 01 |
| 7. 02 | Diabetes Self Management Training (FQHC | 0.00 | 0 | 1 | | 0 | 7. 02 |
| 0.00 | only) | 0.00 | 44 740 | | | 44 740 | 0.00 |
| 8. 00 | Total FTEs and Visits (sum of lines 4 | 2. 02 | 11, 748 | İ | | 11, 748 | 8. 00 |
| 0.00 | through 7) | | | | | 0 | 0.00 |
| 9. 00 | Physician Services Under Agreements | | 0 | | | 0 | 9. 00 |
| | | | | | | 1. 00 | |
| | DETERMINATION OF ALLOWABLE COST APPLICABLE T | O HUCDITAL BACI | ED DUC/EDUC SE | DVI CES | | 1.00 | |
| | Total costs of health care services (from Wk | | | KVICLS | | 1, 206, 646 | 10 00 |
| | Total nonreimbursable costs (from Wkst. M-1, | | | | | 1, 200, 040 | 11.00 |
| 12. 00 | Cost of all services (excluding overhead) (s | | | | | 1, 206, 646 | |
| 13. 00 | Ratio of hospital-based RHC/FQHC services (I | | | | | 1, 000000 | |
| 14. 00 | Total hospital-based RHC/FQHC overhead - (fr | | | ine 31) | | 407, 461 | |
| 15. 00 | Parent provider overhead allocated to facili | | | 1116 31) | | 576, 243 | |
| 16. 00 | Total overhead (sum of lines 14 and 15) | ty (See Histian | cti olis) | | | 983, 704 | |
| 17. 00 | Allowable GME overhead (see instructions) | | | | | 903, 704 | 17. 00 |
| | , , , | | | | | 983, 704 | |
| | Overhead applicable to hospital-based RHC/FQ | HC services (Li | ine 13 x line | 18) | | 983, 704 | |
| | Total allowable cost of hospital-based RHC/F | | | | | 2, 190, 350 | |
| 20.00 | 1 otal allowable cost of hospital based Mic/I | and activities (. | Jun OI IIIIG3 I | 0 and 17) | ļ | 2, 170, 330 | 20.00 |

| Heal th | Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---------|--|------------------|-----------------|--------------|----------------------------------|--------------------------------|---------|
| ALLOCA | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S | SERVI CES | Provi der C | | Peri od: | Worksheet M-2 | |
| | | | Component | CCN: 15-8559 | From 01/01/2022 To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
| | | | | | RHC IV | Cost | |
| | | Number of FTE | Total Visits | | | Greater of | |
| | | Personnel | | Standard (1) | | col. 2 or | |
| | | | | | 1 x col. 3) | col. 4 | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | VISITS AND PRODUCTIVITY | | | | | | |
| | Positions | 1 | 1 | 1 | _1 | | |
| 1. 00 | Physi ci an | 0. 91 | | | | | 1.00 |
| 2.00 | Physician Assistant | 0.00 | | _, | | | 2.00 |
| 3.00 | Nurse Practitioner | 1. 40 | | | | 7 0/0 | 3.00 |
| 4.00 | Subtotal (sum of lines 1 through 3) | 2. 31 | , | 1 | 6, 762 | 7, 960 | |
| 5.00 | Visiting Nurse | 0.00 | | • | | 0 | 5.00 |
| 6.00 | Clinical Psychologist | 0.00 | | | | 0 | 6.00 |
| 7.00 | Clinical Social Worker | 0.00 | | | | 0 | 7.00 |
| 7. 01 | Medical Nutrition Therapist (FQHC only) | 0.00 | | | | 0 | 7. 01 |
| 7. 02 | Diabetes Self Management Training (FQHC | 0.00 | 0 | | | 0 | 7. 02 |
| 8. 00 | only) Total FTEs and Visits (sum of lines 4 | 2. 31 | 7, 960 | | | 7, 960 | 8. 00 |
| 8.00 | through 7) | 2. 31 | 7, 900 | | | 7, 900 | 0.00 |
| 9. 00 | Physician Services Under Agreements | | 0 | | | 0 | 9. 00 |
| 7.00 | Triysi crair Servi ces onder Agreements | | | | | 0 | 7.00 |
| | | | | | | 1. 00 | |
| | DETERMINATION OF ALLOWABLE COST APPLICABLE T | O HOSPI TAL-BASI | ED RHC/FOHC SEI | RVICES | | 11.00 | |
| 10.00 | Total costs of health care services (from Wk | | | | | 1, 268, 408 | 10.00 |
| 11. 00 | | | | | | 0 | |
| 12.00 | Cost of all services (excluding overhead) (s | | | | | 1, 268, 408 | 12.00 |
| 13.00 | Ratio of hospital-based RHC/FQHC services (I | | | | | 1.000000 | |
| 14.00 | Total hospital-based RHC/FQHC overhead - (fr | om Worksheet. | M-1, col. 7, l | ine 31) | | 245, 167 | 14.00 |
| 15.00 | Parent provider overhead allocated to facili | | | • | | 405, 008 | 15.00 |
| 16.00 | Total overhead (sum of lines 14 and 15) | • | , | | | 650, 175 | 16.00 |
| 17.00 | Allowable GME overhead (see instructions) | | | | | 0 | 17.00 |
| 18.00 | Enter the amount from line 16 | | | | | 650, 175 | 18.00 |
| 19.00 | Overhead applicable to hospital-based RHC/FO | HC services (I | ine 13 x line | 18) | | 650, 175 | 19.00 |
| 20.00 | Total allowable cost of hospital-based RHC/F | QHC services (| sum of lines 1 | 0 and 19) | | 1, 918, 583 | 20.00 |
| | | | | | | | |

| Heal th | Financial Systems | ADAMS MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---------|--|------------------|-----------------|--------------|----------------------------------|--------------------------------|---------|
| ALLOCA | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S | SERVI CES | Provi der C | | Peri od: | Worksheet M-2 | |
| | | | Component | | From 01/01/2022 To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
| | | | | | RHC V | Cost | |
| | | Number of FTE | Total Visits | | | Greater of | |
| | | Personnel | | Standard (1) | | col. 2 or | |
| | | | | | 1 x col. 3) | col. 4 | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | VISITS AND PRODUCTIVITY | | | | | | |
| | Positions | 1 | 1 | 1 | | | |
| 1. 00 | Physi ci an | 0. 71 | | | | | 1.00 |
| 2.00 | Physician Assistant | 0.00 | | | | | 2.00 |
| 3.00 | Nurse Practitioner | 0. 70 | | | | | 3.00 |
| 4.00 | Subtotal (sum of lines 1 through 3) | 1. 41 | , | 1 | 4, 452 | , | 1 |
| 5.00 | Visiting Nurse | 0.00 | | • | | 0 | 1 |
| 6.00 | Clinical Psychologist | 0.00 | | | | 0 | |
| 7.00 | Clinical Social Worker | 0.00 | | | | 0 | |
| 7. 01 | Medical Nutrition Therapist (FQHC only) | 0.00 | | | | 0 | 7.01 |
| 7. 02 | Diabetes Self Management Training (FQHC | 0.00 | 0 | | | 0 | 7. 02 |
| 8. 00 | only) Total FTEs and Visits (sum of lines 4 | 1. 41 | 7, 510 | | | 7, 510 | 8. 00 |
| 8.00 | through 7) | 1.41 | 7,510 | | | 7,310 | 0.00 |
| 9. 00 | Physician Services Under Agreements | | 0 | | | 0 | 9. 00 |
| 7.00 | Triysi ci air sei vi ces under Agreements | | | | | U | 7.00 |
| | | | | | | 1. 00 | |
| | DETERMINATION OF ALLOWABLE COST APPLICABLE TO | O HOSPI TAL-BASI | ED RHC/FOHC SEI | RVICES | | | |
| | Total costs of health care services (from Wk | | | | | 1, 359, 325 | 10.00 |
| | Total nonreimbursable costs (from Wkst. M-1, | | | | | 69 | • |
| 12.00 | Cost of all services (excluding overhead) (s | | | | | 1, 359, 394 | 12.00 |
| 13.00 | Ratio of hospital-based RHC/FQHC services (I | | | | | 0. 999949 | |
| 14.00 | Total hospital-based RHC/FQHC overhead - (fr | om Worksheet. | M-1, col. 7, l | ine 31) | | 123, 901 | 14.00 |
| 15.00 | Parent provider overhead allocated to facili | ty (see instru | ctions) | ŕ | | 400, 928 | 15.00 |
| 16.00 | Total overhead (sum of lines 14 and 15) | • | | | | 524, 829 | 16.00 |
| 17.00 | Allowable GME overhead (see instructions) | | | | | 0 | 17. 00 |
| 18.00 | Enter the amount from line 16 | | | | | 524, 829 | 18.00 |
| 19.00 | Overhead applicable to hospital-based RHC/FQ | HC services (I | ine 13 x line | 18) | | 524, 802 | 19.00 |
| 20.00 | Total allowable cost of hospital-based RHC/F | QHC services (| sum of lines 1 | 0 and 19) | | 1, 884, 127 | 20.00 |
| | | | | | | | |

| Health Financial Systems ADAMS MEMOR | I AL HOSPI TAL | In Lie | u of Form CMS-2 | 2552-10 |
|--|----------------------------|----------------------------------|---------------------|---------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/ | FQHC Provider CCN: 15-1330 | Peri od: | Worksheet M-3 | 1 |
| SERVI CES | Component CCN: 15-8526 | From 01/01/2022 To 12/31/2022 | Date/Time Pre | nared. |
| | compensate cont. 10 doze | 10 12/01/2022 | 3/2/2024 10: 0 | |
| | Title XVIII | RHC I | Cost | |
| | | | 1 00 | |
| DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICE | S | | 1. 00 | |
| 1.00 Total Allowable Cost of hospital-based RHC/FQHC Services | | | 2, 365, 957 | 1.00 |
| 2.00 Cost of injections/infusions and their administration (fr | • | | 62, 824 | 1 |
| 3.00 Total allowable cost excluding injections/infusions (line | 2, 303, 133 | 1 | | |
| 4.00 Total Visits (from Wkst. M-2, column 5, line 8) | | | 9, 915 | 4.00 |
| 5.00 Physicians visits under agreement (from Wkst. M-2, column | n 5, line 9) | | 0 | 5.00 |
| 6.00 Total adjusted visits (line 4 plus line 5) | | | 9, 915 | |
| 7.00 Adjusted cost per visit (line 3 divided by line 6) | | | 232. 29 | 7.00 |
| | | Cal cul ati on | of Limit (1) | |
| | | Rate Period | Rate Period 1 | |
| | | N/A | (01/01/2022 | |
| | | | through | |
| | | | 12/31/2022) | |
| | | 1.00 | 2. 00 | 0.00 |
| 8.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, | §20.6 or your contractor) | 0. 00 0. 00 | 296. 67 | 1 |
| 9.00 Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT | | 0.00 | 232. 29 | 9.00 |
| 10.00 Program covered visits excluding mental health services | from contractor records) | 0 | 3, 705 | 10.00 |
| 11.00 Program cost excluding costs for mental health services (| | 0 | 860, 634 | |
| 12.00 Program covered visits for mental health services (from o | , | 0 | 0 | 1 |
| 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 instruct | i ons) | 0 | 0 | 14.00 |
| 15.00 Graduate Medical Education Pass Through Cost (see instruc | ctions) | | | 15.00 |
| 16.00 Total Program cost (sum of lines 11, 14, and 15, columns | • | 0 | 860, 634 | 1 |
| 16.01 Total program charges (see instructions) (from contractor' | • | | 652, 364 | 1 |
| 16.02 Total program preventive charges (see instructions) (from | | | 15, 223 | |
| 16.03 Total program preventive costs ((line 16.02/line 16.01) 16.04 Total Program non-preventive costs ((line 16 minus lines | | | 20, 083 640, 488 | |
| 16.04 Total Program non-preventive costs ((line 16 minus lines (Titles V and XIX see instructions.) | 10.03 and 10) trilles .00) | | 040, 466 | 10.04 |
| 16.05 Total program cost (see instructions) | | 0 | 660, 571 | 16. 05 |
| 17. 00 Primary payer amounts | | | 0 | 1 |
| 18.00 Less: Beneficiary deductible for RHC only (see instructi | ons) (from contractor | | 39, 941 | 18.00 |
| records) | | | | |
| 19.00 Beneficiary coinsurance for RHC/FQHC services (see instru | uctions) (from contractor | | 119, 440 | 19.00 |
| records) 20.00 Net Medicare cost excluding vaccines (see instructions) | | | 660 E71 | 20.00 |
| 21.00 Program cost of vaccines and their administration (from V | Ukst M-4 line 16) | | 660, 571 11, 630 | |
| 22.00 Total reimbursable Program cost (line 20 plus line 21) | M31. W 4, 11116 10) | | 672, 201 | |
| 23.00 Allowable bad debts (see instructions) | | | 0 | 1 |
| 23.01 Adjusted reimbursable bad debts (see instructions) | | | 0 | 1 |
| 24.00 Allowable bad debts for dual eligible beneficiaries (see | instructions) | | 0 | 24.00 |
| 25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0 | |
| 25.50 Pioneer ACO demonstration payment adjustment (see instruc | | | 0 | 1 |
| 25. 99 Demonstration payment adjustment amount before sequestration | i on | | 0 | |
| 26.00 Net reimbursable amount (see instructions) | | | 672, 201 | 1 |
| 26.01 Sequestration adjustment (see instructions) | on | | | 26.01 |
| 26.02 Demonstration payment adjustment amount after sequestrati 27.00 Interim payments | UII | | 0 450, 014 | |
| 28.00 Tentative settlement (for contractor use only) | | | 450, 014 | 1 |
| 29. 00 Balance due component/program (line 26 minus lines 26.01, | 26. 02. 27. and 28) | | 213, 717 | 1 |
| 30.00 Protested amounts (nonallowable cost report items) in accounts | | , | 0 | 1 |
| | | 1 | | 1 |

| | Financial Systems ADAMS MEMORIAL | | In Lie | u of Form CMS-2 | 2552-10 |
|------------------|--|-------------------------|----------------------------------|----------------------|------------------|
| | ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC | Provider CCN: 15-1330 | Peri od: | Worksheet M-3 | |
| SERVI C | ES | Component CCN: 15-8536 | From 01/01/2022 To 12/31/2022 | Date/Time Pre | pared: |
| | | | | 3/2/2024 10:0 | |
| | <u> </u> | Title XVIII | RHC II | Cost | |
| | | | | 1. 00 | |
| | DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES | | | 1.00 | |
| 1.00 | Total Allowable Cost of hospital-based RHC/FQHC Services (fro | m Wkst. M-2, line 20) | | 2, 160, 204 | 1.00 |
| 2.00 | Cost of injections/infusions and their administration (from W | /kst. M-4, line 15) | | 97, 501 | 2.00 |
| 3.00 | Total allowable cost excluding injections/infusions (line 1 m | inus line 2) | | 2, 062, 703 | |
| 4.00 | Total Visits (from Wkst. M-2, column 5, line 8) | | | 7, 815 | 4.00 |
| 5.00 | Physicians visits under agreement (from Wkst. M-2, column 5, | line 9) | | 7 015 | 5.00 |
| 6. 00 7. 00 | Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6) | | | 7, 815 263. 94 | ı |
| 7.00 | Adjusted Cost per visit (Time 3 divided by Time 6) | | Cal cul ati on | | 7.00 |
| | | | Carcuration | OI LIMIT (I) | |
| | | | Rate Period | Rate Period 1 | |
| | | | N/A | (01/01/2022 | |
| | | | | through | |
| | | | 1.00 | 12/31/2022) 2. 00 | |
| 8. 00 | Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 | (6 or your contractor) | 0.00 | 358. 57 | 8.00 |
| 9. 00 | Rate for Program covered visits (see instructions) | | 0.00 | 263. 94 | 1 |
| | CALCULATION OF SETTLEMENT | | | | |
| 10.00 | Program covered visits excluding mental health services (from | | 0 | 1, 366 | |
| 11.00 | Program cost excluding costs for mental health services (line | • | 0 | 360, 542 | |
| 12.00 | Program covered visits for mental health services (from contr | , | 0 | 0 | |
| 13. 00 14. 00 | Program covered cost from mental health services (line 9 x li Limit adjustment for mental health services (see instructions | , | 0 | 0 | 13. 00 14. 00 |
| 15. 00 | Graduate Medical Education Pass Through Cost (see instruction | | | O | 15.00 |
| 16. 00 | Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 | • | 0 | 360, 542 | |
| 16. 01 | Total program charges (see instructions)(from contractor's re | * | | 294, 100 | • |
| 16. 02 | Total program preventive charges (see instructions)(from prov | • | | 2, 227 | 1 |
| 16. 03 | Total program preventive costs ((line 16.02/line 16.01) times | | | 2, 730 | 1 |
| 16. 04 | Total Program non-preventive costs ((line 16 minus lines 16.0 | 3 and 18) times .80) | | 255, 446 | 16. 04 |
| 16. 05 | (Titles V and XIX see instructions.) Total program cost (see instructions) | | 0 | 258, 176 | 16 05 |
| 17. 00 | Primary payer amounts | | | 0 | l |
| 18.00 | Less: Beneficiary deductible for RHC only (see instructions) | (from contractor | | 38, 504 | 18.00 |
| | records) | | | | |
| 19. 00 | Beneficiary coinsurance for RHC/FQHC services (see instruction | ns) (from contractor | | 51, 119 | 19.00 |
| 20. 00 | records) Net Medicare cost excluding vaccines (see instructions) | | | 258, 176 | 20.00 |
| 21. 00 | Program cost of vaccines and their administration (from Wkst. | M-4 line 16) | | 13, 821 | |
| 22. 00 | Total reimbursable Program cost (line 20 plus line 21) | , | | 271, 997 | |
| 23. 00 | Allowable bad debts (see instructions) | | | 0 | 1 |
| 23. 01 | Adjusted reimbursable bad debts (see instructions) | | | 0 | 23. 01 |
| 24.00 | Allowable bad debts for dual eligible beneficiaries (see inst | ructions) | | 0 | |
| 25.00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0 | 25.00 |
| 25. 50 | Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration | 15) | | 0 | 1 |
| 26. 00 | Net reimbursable amount (see instructions) | | | 271, 997 | 1 |
| 26. 01 | Sequestration adjustment (see instructions) | | | | 26. 01 |
| 26. 02 | Demonstration payment adjustment amount after sequestration | | | 0 | 1 |
| 27. 00 | Interim payments | | | 154, 657 | • |
| 28. 00 | Tentative settlement (for contractor use only) | 00 07 1 | | 0 | • |
| 29.00 | Balance due component/program (line 26 minus lines 26.01, 26. Protested amounts (nonallowable cost report items) in accorda | | | 113, 913 0 | 1 |
| 30.00 | | | | | |

| | Financial Systems ADAMS MEMORIAL | | | u of Form CMS-2 | |
|------------------|--|---------------------------------------|-----------------------------|----------------------------|------------------|
| | ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC | Provider CCN: 15-1330 | Peri od: From 01/01/2022 | Worksheet M-3 | |
| SERVI C | ES | Component CCN: 15-8537 | To 12/31/2022 | Date/Time Pre | pared: |
| | | · | | 3/2/2024 10: 0 | |
| | | Title XVIII | RHC III | Cost | |
| | | | | 1. 00 | |
| | DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES | | | | |
| 1.00 | Total Allowable Cost of hospital-based RHC/FQHC Services (fro | · · · · · · · · · · · · · · · · · · · | | 2, 190, 350 | 1.00 |
| 2. 00 | Cost of injections/infusions and their administration (from W | | | 0 | 2.00 |
| 3. 00 | Total allowable cost excluding injections/infusions (line 1 m | inus line 2) | | 2, 190, 350 | 3.00 |
| 4. 00 5. 00 | Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5, | line (1) | | 11, 748 0 | 4.00 5.00 |
| 5. 00 | Total adjusted visits (line 4 plus line 5) | Title 9) | | 11, 748 | 6.00 |
| 7. 00 | Adjusted cost per visit (line 3 divided by line 6) | | | 186. 44 | 7.00 |
| | | | Cal cul ati on | | |
| | | | Data Barbart | Data Barbarta | |
| | | | Rate Period N/A | Rate Peri od 1 (01/01/2022 | |
| | | | IV/A | through | |
| | | | | 12/31/2022) | |
| | | | 1.00 | 2. 00 | |
| 8. 00 | Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 | .6 or your contractor) | 0.00 | 176. 92 | 8.00 |
| 9. 00 | Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT | | 0.00 | 176. 92 | 9.00 |
| 10. 00 | Program covered visits excluding mental health services (from | contractor records) | 0 | 789 | 10.00 |
| 11. 00 | Program cost excluding costs for mental health services (line | | 0 | 139, 590 | |
| 12. 00 | Program covered visits for mental health services (from contr | actor records) | 0 | 0 | 12.00 |
| 13. 00 | Program covered cost from mental health services (line 9 x li | , | 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 instruction | • | 0 | 120 F00 | 15.00 |
| 16. 00 16. 01 | Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's re | * | U U | 139, 590 124, 091 | 16. 00 16. 01 |
| 16. 02 | Total program preventive charges (see instructions) (from prov | | | 11, 225 | |
| 16. 03 | Total program preventive costs ((line 16.02/line 16.01) times | • | | 12, 627 | 16. 03 |
| 16. 04 | Total Program non-preventive costs ((line 16 minus lines 16.0 | 3 and 18) times .80) | | 86, 518 | 16. 04 |
| | (Titles V and XIX see instructions.) | | | | |
| 16. 05 | Total program cost (see instructions) | | 0 | 99, 145 | |
| 17. 00 18. 00 | Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions) | (from contractor | | 0 18, 816 | 17. 00 18. 00 |
| 10.00 | records) | (11 om contractor | | 10, 010 | 10.00 |
| 19. 00 | Beneficiary coinsurance for RHC/FQHC services (see instruction | ns) (from contractor | | 18, 810 | 19.00 |
| | records) | | | | |
| 20.00 | Net Medicare cost excluding vaccines (see instructions) | M 4 1: 1/) | | 99, 145 | |
| 21. 00 22. 00 | Program cost of vaccines and their administration (from Wkst. Total reimbursable Program cost (line 20 plus line 21) | M-4, TINE 16) | | 0 99, 145 | 21. 00 22. 00 |
| 23. 00 | Allowable bad debts (see instructions) | | | 99, 143 | 23.00 |
| 23. 01 | Adjusted reimbursable bad debts (see instructions) | | | Ö | 23.01 |
| 24. 00 | Allowable bad debts for dual eligible beneficiaries (see inst | ructions) | | 0 | 24.00 |
| 25. 00 | | | | 0 | 25.00 |
| | Pioneer ACO demonstration payment adjustment (see instruction | is) | | 0 | |
| 25. 99 26. 00 | Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions) | | | 0 99, 145 | 25. 99 26. 00 |
| 26. 00 26. 01 | Sequestration adjustment (see instructions) | | | 1, 249 | 1 |
| 26. 02 | , , | | | 1, 249 | 26. 02 |
| 27. 00 | Interim payments | | | 75, 375 | |
| 28. 00 | Tentative settlement (for contractor use only) | | | 0 | 28.00 |
| 29. 00 | Balance due component/program (line 26 minus lines 26.01, 26. | • | | 22, 521 | 29. 00 |
| 30.00 | Protested amounts (nonallowable cost report items) in accorda | nce with CMS Pub. 15-II | , | 0 | 30.00 |

| ealth Financial Systems ADAMS MEMORIAL | | | u of Form CMS-2 | |
|--|---------------------------------------|-----------------------------|------------------------|----------------|
| ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC | Provider CCN: 15-1330 | Peri od: From 01/01/2022 | Worksheet M-3 | |
| ERVI CES | Component CCN: 15-8559 | To 12/31/2022 | Date/Time Pre | pared: |
| | | | 3/2/2024 10:0 | ל am |
| | Title XVIII | RHC I V | Cost | |
| | | | 1. 00 | |
| DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES | | I | | |
| .00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro | om Wkst. M-2, line 20) | | 1, 918, 583 | 1.0 |
| .00 Cost of injections/infusions and their administration (from W | | | 73, 465 | |
| Total allowable cost excluding injections/infusions (line 1 m | ninus line 2) | | 1, 845, 118 | 1 |
| Total Visits (from Wkst. M-2, column 5, line 8) | line () | | 7, 960 | |
| .00 Physicians visits under agreement (from Wkst. M-2, column 5, .00 Total adjusted visits (line 4 plus line 5) | Title 9) | | 0 7, 960 | 5. 0 6. 0 |
| .00 Adjusted cost per visit (line 3 divided by line 6) | | | 231. 80 | 7.0 |
| najusted east per visit (Time a divided by Time a) | | Cal cul ati on | | 7.0 |
| | | | . , | |
| | | | Rate Period 1 | |
| | | N/A | (01/01/2022 | |
| | | | through 12/31/2022) | |
| | | 1. 00 | 2. 00 | |
| .00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 | 0.6 or your contractor) | 0.00 | 323. 86 | 8.0 |
| 00 Rate for Program covered visits (see instructions) | | 0. 00 | 231. 80 | 9.0 |
| CALCULATION OF SETTLEMENT | | | | |
| 0.00 Program covered visits excluding mental health services (from | | 0 | 1, 296 | |
| 1.00 Program cost excluding costs for mental health services (line 2.00 Program covered visits for mental health services (from contr | * | 0 | 300, 413 0 | 11. C |
| 3.00 Program covered cost from mental health services (line 9 x li | | 0 | 0 | 13.0 |
| 4.00 Limit adjustment for mental health services (see instructions | • | o | 0 | 14.0 |
| 5.00 Graduate Medical Education Pass Through Cost (see instruction | * | | | 15.0 |
| 6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 | 2 and 3) * | 0 | 300, 413 | 16.0 |
| 6.01 Total program charges (see instructions)(from contractor's re | | | 246, 915 | |
| 6.02 Total program preventive charges (see instructions)(from prov | | | 14, 908 | |
| 6.03 Total program preventive costs ((line 16.02/line 16.01) times 6.04 Total Program non-preventive costs ((line 16 minus lines 16.0 | | | 18, 138 196, 121 | 16. 0 16. 0 |
| (Titles V and XIX see instructions.) | os and roy trines . ooy | | 170, 121 | 10.0 |
| 6.05 Total program cost (see instructions) | | 0 | 214, 259 | 16.0 |
| 7.00 Primary payer amounts | | | 0 | 17.0 |
| B.00 Less: Beneficiary deductible for RHC only (see instructions) | (from contractor | | 37, 124 | 18.0 |
| records) | ons) (from contractor | | 20 077 | 19.0 |
| 9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction records) | ons) (110m contractor | | 38, 977 | 19.0 |
| 0.00 Net Medicare cost excluding vaccines (see instructions) | | | 214, 259 | 20.0 |
| 1.00 Program cost of vaccines and their administration (from Wkst. | M-4, line 16) | | 10, 617 | • |
| 2.00 Total reimbursable Program cost (line 20 plus line 21) | | | 224, 876 | |
| 3.00 Allowable bad debts (see instructions) | | | 0 | 23.0 |
| 3.01 Adjusted reimbursable bad debts (see instructions) 4.00 Allowable bad debts for dual eligible beneficiaries (see inst | rueti enc) | | 0 | 23.0 |
| 4.00 Allowable bad debts for dual eligible beneficiaries (see inst 5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | Tuctions) | | 0 | 25.0 |
| 5.50 Pioneer ACO demonstration payment adjustment (see instruction | ns) | | 0 | |
| 5.99 Demonstration payment adjustment amount before sequestration | , | | 0 | |
| 6.00 Net reimbursable amount (see instructions) | | | 224, 876 | |
| 6.01 Sequestration adjustment (see instructions) | | | 2, 833 | |
| 6.02 Demonstration payment adjustment amount after sequestration | | | 0 | |
| 7.00 Interim payments | | | 82, 135 | • |
| 8.00 Tentative settlement (for contractor use only) 9.00 Balance due component/program (line 26 minus lines 26.01, 26. | 02 27 and 28) | | 0 139, 908 | 28. 0 29. 0 |
| 0.00 Protested amounts (nonallowable cost report items) in accorda | · · · · · · · · · · · · · · · · · · · | . | 139, 908 | 30.0 |
| chapter I, §115.2 | | · | ŭ | |

| CALCUL SERVI C | ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC | | | | |
|-------------------|--|---------------------------------------|----------------------------------|------------------|--------|
| ERVI C | | Provider CCN: 15-1330 | Peri od: | Worksheet M-3 | |
| | ES | Component CCN: 15-8555 | From 01/01/2022 To 12/31/2022 | Date/Time Pre | pared: |
| | | | | 3/2/2024 10:0 | |
| | | Title XVIII | RHC V | Cost | |
| | | | | 1 00 | |
| | DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES | | | 1. 00 | |
| . 00 | Total Allowable Cost of hospital-based RHC/FQHC Services (fro | m Wkst M-2 line 20) | | 1, 884, 127 | 1.0 |
| 2. 00 | Cost of injections/infusions and their administration (from W | | | 72, 720 | 1 |
| . 00 | Total allowable cost excluding injections/infusions (line 1 m | | | 1, 811, 407 | |
| . 00 | Total Visits (from Wkst. M-2, column 5, line 8) | | | 7, 510 | 4.0 |
| 5. 00 | Physicians visits under agreement (from Wkst. M-2, column 5, | line 9) | | 0 | 5.0 |
| . 00 | Total adjusted visits (line 4 plus line 5) | | | 7, 510 | 1 |
| 7. 00 | Adjusted cost per visit (line 3 divided by line 6) | | Cal and attack | 241. 20 | 7.0 |
| | | | Cal cul ati on | OT LIMIT (I) | |
| | | | Rate Period | Rate Period 1 | |
| | | | N/A | (01/01/2022 | |
| | | | | through | |
| | | | 1.00 | 12/31/2022) | |
| 3. 00 | Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 | 6 or your contractor) | 1. 00 | 2. 00 191. 96 | 8.0 |
| 9. 00 | Rate for Program covered visits (see instructions) | . o or your contractor) | 0.00 | 191. 96 | |
| | CALCULATION OF SETTLEMENT | | 0.00 | 171170 | 1 |
| 0.00 | Program covered visits excluding mental health services (from | contractor records) | 0 | 1, 849 | 10. C |
| 1. 00 | Program cost excluding costs for mental health services (line | • | 0 | 354, 934 | |
| 2.00 | Program covered visits for mental health services (from contr | - | 0 | 0 | 12.0 |
| 3.00 | Program covered cost from mental health services (line 9 x li | • | 0 | 0 | 13.0 |
| 4.00 | Limit adjustment for mental health services (see instructions Graduate Medical Education Pass Through Cost (see instruction | • | 0 | 0 | 14. C |
| 6. 00 | Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 | • | 0 | 354, 934 | 1 |
| 6. 01 | Total program charges (see instructions) (from contractor's re | • | | 305, 405 | |
| 6. 02 | Total program preventive charges (see instructions) (from prov | | | 7, 476 | |
| 6. 03 | Total program preventive costs ((line 16.02/line 16.01) times | line 16) | | 8, 688 | 16.0 |
| 16. 04 | Total Program non-preventive costs ((line 16 minus lines 16.0 | 3 and 18) times .80) | | 234, 369 | 16.0 |
| | (Titles V and XIX see instructions.) | | | 0.40 057 | |
| 6. 05 | Total program cost (see instructions) | | 0 | 243, 057 | 1 |
| 17. 00 18. 00 | Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions) | (from contractor | | 0 53, 285 | 17. C |
| 0.00 | records) | (11 oil contractor | | 33, 203 | 10.0 |
| 19. 00 | Beneficiary coinsurance for RHC/FQHC services (see instruction | ns) (from contractor | | 48, 929 | 19.0 |
| | records) | | | | |
| 0.00 | Net Medicare cost excluding vaccines (see instructions) | | | 243, 057 | |
| 1.00 | Program cost of vaccines and their administration (from Wkst. | M-4, line 16) | | 20, 528 | |
| 2. 00 3. 00 | Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions) | | | 263, 585 0 | 1 |
| 3. 00 | Adjusted reimbursable bad debts (see instructions) | | | 0 | 23.0 |
| 4. 00 | Allowable bad debts for dual eligible beneficiaries (see inst | ructions) | | 0 | 1 |
| 5. 00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | , | | 0 | 25.0 |
| 5. 50 | Pioneer ACO demonstration payment adjustment (see instruction | s) | | 0 | 25. 5 |
| 5. 99 | Demonstration payment adjustment amount before sequestration | | | 0 | 1 |
| 6.00 | Net reimbursable amount (see instructions) | | | 263, 585 | 1 |
| 26. 01 | Sequestration adjustment (see instructions) | | | 3, 321 | |
| 26. 02 27. 00 | Demonstration payment adjustment amount after sequestration Interim payments | | | 0 237, 787 | 1 |
| 28. 00 | Tentative settlement (for contractor use only) | | | 237, 767 | 28.0 |
| 29. 00 | Balance due component/program (line 26 minus lines 26.01, 26. | 02, 27, and 28) | | 22, 477 | |
| | Protested amounts (nonallowable cost report items) in accorda | · · · · · · · · · · · · · · · · · · · | | 0 | 30.0 |

| COMPUT | ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST | Provi der CC | CN: 15-1330 | Peri od: From 01/01/2022 | Worksheet M-4 | |
|------------------|---|---------------------------|-----------------------------|-----------------------------|--|------------------|
| | | Component C | CCN: 15-8526 | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
| | | Title | XVIII | RHC I | Cost | |
| | | PNEUMOCOCCAL VACCI NES | I NFLUENZA VACCI NES | COVI D-19 VACCI NES | MONOCLONAL ANTI BODY PRODUCTS | |
| | | 1.00 | 2. 00 | 2. 01 | 2. 02 | |
| 1. 00 2. 00 | Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health | 1, 625, 886 0. 001491 | 1, 625, 88 0. 00425 | | 1, 625, 886 0. 000000 | |
| 3. 00 | care staff time Injection/infusion health care staff cost (line 1 x line 2) | 2, 424 | 6, 9 | 0 | 0 | 3.00 |
| 1. 00 | Injections/infusions and related medical supplies costs (from your records) | 28, 895 | 8, 00 | 0 | 0 | 4.00 |
| 5. 00 6. 00 | Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) | 31, 319 1, 741, 361 | 14, 92 1, 741, 36 | | 0 1, 741, 361 | 5. 00 6. 00 |
| 7. 00 3. 00 | Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6) | 624, 596 0. 017985 | 624, 59 0. 0085 <i>6</i> | | 624, 596 0. 000000 | |
| 9. 00 10. 00 | Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9) | 11, 233 42, 552 | 5, 35 20, 27 | | 0 | |
| 11. 00 12. 00 | Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) | 205 207. 57 | 58 34. <i>6</i> | | 0 0. 00 | 11. 00 12. 00 |
| 13. 00 | Number of injection/infusion administered to Program beneficiaries | 38 | 10 | 0 8 | 0 | 13.00 |
| 3. 01 | Number of COVID-19 vaccine injections/infusions administered to MA enrollees | | | 0 | 0 | 13.0 |
| 14. 00 | Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) | 7, 888 | 3, 74 | 12 0 | 0 | 14.00 |
| | | | | | COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N | |
| | | | | 1. 00 | 2. 00 | |
| 15. 00 | Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. | • | columns 1, | | 62, 824 | 15. 00 |
| 16 00 | Total Program cost of injections/infusions and their admin | | (cum of | | 11, 630 | 16 0 |

| COMPUT | ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST | Provider CC | | Peri od: From 01/01/2022 | Worksheet M-4 | |
|--------------|--|---------------------------|-------------------------|-----------------------------|-------------------------------------|----------------|
| | | Component C | UN: 15-8536 | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
| | | Title | | RHC II | Cost | |
| | | PNEUMOCOCCAL VACCI NES | I NFLUENZA VACCI NES | COVI D-19 VACCI NES | MONOCLONAL ANTI BODY PRODUCTS | |
| | | 1.00 | 2.00 | 2. 01 | 2. 02 | |
| 1.00 2.00 | Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health | 1, 379, 991 0. 003360 | 1, 379, 99 0. 0066 | · · · | 1, 379, 991 0. 000000 | 1. 00 2. 00 |
| | care staff time | | | | | |
| 3. 00 | <pre>Injection/infusion health care staff cost (line 1 x line 2)</pre> | 4, 637 | 9, 12 | 29 0 | 0 | 3.00 |
| 1. 00 | Injections/infusions and related medical supplies costs (from your records) | 49, 882 | 7, 70 | 0 | 0 | 4.00 |
| 5. 00 | Direct cost of injections/infusions (line 3 plus line 4) | 54, 519 | 16, 83 | 31 0 | 0 | 5.0 |
| 5. 00 | Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) | 1, 580, 801 | 1, 580, 80 | 1, 580, 801 | 1, 580, 801 | 6.0 |
| 7. 00 | Total overhead (from Wkst. M-2, line 19) | 579, 403 | 579, 40 | 579, 403 | 579, 403 | 7.0 |
| 3. 00 | Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6) | 0. 034488 | 0. 01064 | 0. 000000 | 0. 000000 | 8.0 |
| 9. 00 | Overhead cost - injection/infusion (line 7 x line 8) | 19, 982 | 6, 10 | | 0 | 9.0 |
| 0.00 | Total injection/infusion costs and their administration costs (sum of lines 5 and 9) | 74, 501 | 23, 00 | 00 | 0 | 10.0 |
| 11.00 | Total number of injections/infusions (from your records) | 286 | | 63 0 | 0 | |
| 12.00 | Cost per injection/infusion (line 10/line 11) | 260. 49 | 40.8 | 0.00 | 0.00 | 12.0 |
| 13. 00 | Number of injection/infusion administered to Program beneficiaries | 38 | (| 96 0 | 0 | 13.0 |
| 3. 01 | Number of COVID-19 vaccine injections/infusions administered to MA enrollees | | | 0 | 0 | 13.0 |
| 14. 00 | Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) | 9, 899 | 3, 92 | 22 0 | 0 | 14.00 |
| | | | | | COST OF | |
| | | | | | I NJECTI ONS / | |
| | | | | | I NFUSIONS AND | |
| | | | | | ADMINISTRATIO N | |
| | | | | 1. 00 | 2. 00 | |
| 5. 00 | Total cost of injections/infusions and their administratio | | col umns 1, | 1.00 | 97, 501 | 15. C |
| 16 00 | 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. | | com of | | 13, 821 | 14 0 |
| o. 00 | Total Program cost of injections/infusions and their admin columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou | | | | 13, 821 | 10.0 |

| COMPUT | ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST | Provider CC | CN: 15-1330 | Peri od: From 01/01/2022 | Worksheet M-4 | |
|--|--|---------------------------|-------------------------|-----------------------------|--|--------------|
| | | Component (| CCN: 15-8537 | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
| | | Title | XVIII | RHC III | Cost | |
| | | PNEUMOCOCCAL VACCI NES | I NFLUENZA VACCI NES | COVI D-19 VACCI NES | MONOCLONAL ANTI BODY PRODUCTS | |
| | | 1.00 | 2.00 | 2. 01 | 2. 02 | |
| 1. 00 2. 00 | Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time | 1, 135, 755 0. 000000 | 1, 135, 79 0. 00000 | · · · · · | 1, 135, 755 0. 000000 | |
| 3. 00 | Injection/infusion health care staff cost (line 1 x line 2) | 0 | | 0 0 | 0 | 3. 0 |
| 1. 00 | Injections/infusions and related medical supplies costs (from your records) | 0 | | 0 | 0 | 4.0 |
| 5. 00 5. 00 | Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) | 0 1, 206, 646 | 1, 206, 64 | 0 1, 206, 646 | 0 1, 206, 646 | 1 0.0 |
| 7. 00 3. 00 | Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6) | 983, 704 0. 000000 | 983, 70 0. 00000 | | 983, 704 0. 000000 | 7. 0 8. 0 |
| 9. 00 10. 00 | Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9) | 0 | | 0 0 | 0 | |
| 11.00 | Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) | 0.00 | 0. 0 | 0 0 0.00 | | 12.0 |
| 3. 00 3. 01 | Number of injection/infusion administered to Program beneficiaries Number of COVID-19 vaccine injections/infusions | | | 0 | 0 | 13.0 |
| 4. 00 | administered to MA enrollees Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) | O | | 0 0 | 0 | 14.0 |
| | iana 10.0., ao appiritatro, | | | | COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N | |
| | | | | 1. 00 | 2. 00 | |
| | Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. | M-3, line 2) | | | 0 | |
| 6.00 | Total Program cost of injections/infusions and their admin | istration costs | s (sum of | | 0 | 16.0 |

| OMPUT | ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST | Provi der CC | CN: 15-1330 | Peri od: From 01/01/2022 | Worksheet M-4 | |
|--------------|--|---------------------------|-------------------------|-----------------------------|-------------------------------------|--------------|
| | | Component (| | To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
| | | | XVIII | RHC I V | Cost | |
| | | PNEUMOCOCCAL VACCI NES | I NFLUENZA VACCI NES | COVI D-19 VACCI NES | MONOCLONAL ANTI BODY PRODUCTS | |
| | | 1.00 | 2. 00 | 2. 01 | 2. 02 | |
| . 00 . 00 | Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time | 1, 080, 141 0. 002361 | 1, 080, 1 0. 0075 | | 1, 080, 141 0. 000000 | 1. (2. (|
| . 00 | lnjection/infusion health care staff cost (line 1 x line 2) | 2, 550 | 8, 1 | 75 0 | 0 | 3. (|
| . 00 | Injections/infusions and related medical supplies costs (from your records) | 30, 170 | 7, 6 | 74 0 | 0 | 4.0 |
| . 00 | Direct cost of injections/infusions (line 3 plus line 4) | 32, 720 | 15, 8 | | 0 | ١ ٠. |
| . 00 | Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) | 1, 268, 408 | 1, 268, 40 | | | |
| . 00 | Total overhead (from Wkst. M-2, line 19) | 650, 175 | 650, 1 | | | |
| . 00 | Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6) | 0. 025796 | 0. 0124 | | | |
| . 00 | Overhead cost - injection/infusion (line 7 x line 8) | 16, 772 | 8, 1: | | 0 | |
| 0.00 | Total injection/infusion costs and their administration costs (sum of lines 5 and 9) | 49, 492 | 23, 9 | | 0 | |
| 1.00 | Total number of injections/infusions (from your records) | 175 | | 61 0 | | 11. |
| 2. 00 | Cost per injection/infusion (line 10/line 11) | 282. 81 | 42. | | | |
| 3. 00 | Number of injection/infusion administered to Program beneficiaries | 25 | • | 83 0 | 0 | |
| 3. 01 | Number of COVID-19 vaccine injections/infusions administered to MA enrollees | 7 070 | 0.5 | 0 | 0 | |
| 4. 00 | Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) | 7, 070 | 3, 54 | 47 | 0 | 14. |
| | | | | | COST OF | |
| | | | | | INJECTIONS / | |
| | | | | | INFUSIONS AND | |
| | | | | | ADMI NI STRATI O | |
| | | | | 1.00 | N 2.00 | |
| . 00 | Total cost of injections/infusions and their administratio | n costs (sum of | F columns 1 | 1. 00 | 2. 00 73, 465 | 15. |
|). UU | 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. | | COLUMNIS I, | | /3, 465 | 15. |
| 5. 00 | Total Program cost of injections/infusions and their admin | | s (sum of | | 10, 617 | 16 |
| | columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou | nt to Wkst. M-3 | 3. line 21) | | | |

| OMPUT | ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST | Provi der CC | | Peri od: | Worksheet M-4 | |
|---------------|--|---------------------------|-------------------------|----------------------------------|-------------------------------------|------|
| | | Component C | | From 01/01/2022 To 12/31/2022 | Date/Time Pre 3/2/2024 10:0 | |
| | | Title | XVIII | RHC V | Cost | |
| | | PNEUMOCOCCAL VACCI NES | I NFLUENZA VACCI NES | COVI D-19 VACCI NES | MONOCLONAL ANTI BODY PRODUCTS | |
| | | 1.00 | 2. 00 | 2. 01 | 2. 02 | |
| . 00 ?. 00 | Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time | 1, 166, 882 0. 002421 | 1, 166, 88 0. 01813 | | 1, 166, 882 0. 000000 | |
| 3. 00 | Injection/infusion health care staff cost (line 1 x line 2) | 2, 825 | 21, 16 | 0 | 0 | 3.0 |
| . 00 | Injections/infusions and related medical supplies costs (from your records) | 17, 202 | 11, 27 | 72 0 | 0 | 4.00 |
| . 00 | Direct cost of injections/infusions (line 3 plus line 4) | 20, 027 | 32, 43 | 38 0 | 0 | 5.0 |
| . 00 | Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) | 1, 359, 325 | 1, 359, 32 | | | |
| . 00 | Total overhead (from Wkst. M-2, line 19) | 524, 802 | 524, 80 | | 524, 802 | |
| 3. 00 | Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6) | 0. 014733 | 0. 02386 | | 0. 000000 | |
| . 00 | Overhead cost - injection/infusion (line 7 x line 8) | 7, 732 | 12, 52 | | 0 | |
| 0. 00 | Total injection/infusion costs and their administration costs (sum of lines 5 and 9) | 27, 759 | 44, 96 | | 0 | |
| 1.00 | Total number of injections/infusions (from your records) | 110 | 82 | | 0 | |
| 2.00 | Cost per injection/infusion (line 10/line 11) | 252. 35 | 54. 5 | | | 12.0 |
| 3.00 | Number of injection/infusion administered to Program beneficiaries | 26 | 25 | 0 | 0 | |
| | Number of COVID-19 vaccine injections/infusions administered to MA enrollees | | | 0 | 0 | |
| 4. 00 | Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) | 6, 561 | 13, 96 | 0 | | 14.0 |
| | | | | | COST OF | |
| | | | | | INJECTIONS / | |
| | | | | | INFUSIONS AND | |
| | | | | | ADMI NI STRATI O | |
| | | | | | N | |
| | | | | 1. 00 | 2. 00 | |
| | Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. | M-3, line 2) | | | 72, 720 | |
| 6 00 | Total Program cost of injections/infusions and their admin | istration costs | (SUM OF | | 20, 528 | 16 (|

| Health Financial Systems | ADAMS MEMORIAL | HOSPI TAL | | In Lieu | of Form CMS-2552-10 |
|--|----------------|--|----|--------------------------------|---|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHI SERVICES RENDERED TO PROGRAM BENEFICIARIES | | Provider CCN: 15-13 Component CCN: 15-8 | Fi | rom 01/01/2022 o 12/31/2022 | Worksheet M-5 Date/Time Prepared: 3/2/2024 10:07 am |
| • | | | | DIIO I | |

| | | | | 3/2/2024 10:0 | 7 am |
|----|--|-----------------------------|------------|---------------|------|
| | | | RHC I | Cost | |
| | | | Par | rt B | |
| | | | mm/dd/yyyy | Amount | |
| | | | 1.00 | 2.00 | |
| 00 | Total interim payments paid to hospital-based RHC/FQHC | | | 450, 014 | 1. |
| 00 | Interim payments payable on individual bills, either submit | ted or to be submitted to | | 0 | 2. |
| | the contractor for services rendered in the cost reporting | period. If none, write | | | |
| | "NONE" or enter a zero | | | | |
| 00 | List separately each retroactive lump sum adjustment amount | based on subsequent | | | 3. |
| | revision of the interim rate for the cost reporting period. | Also show date of each | | | |
| | payment. If none, write "NONE" or enter a zero. (1) | | | | |
| | Program to Provider | | | | |
| 21 | | | | 0 | 3. |
| 02 | | | | 0 | 3. |
| 03 | | | | 0 | 3 |
|)4 | | | | 0 | 3 |
|)5 | | | | 0 | 3 |
| | Provider to Program | | | | |
| 0 | | | | 0 | 3 |
| 51 | | | | 0 | 3 |
| 52 | | | | 0 | 3 |
| 53 | | | | 0 | 3 |
| 54 | | | | 0 | 3 |
| 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3. | 98) | | 0 | 3 |
| 00 | Total interim payments (sum of lines 1, 2, and 3.99) (trans | fer to Worksheet M-3, line | | 450, 014 | 4 |
| | 27) | | | | |
| | TO BE COMPLETED BY CONTRACTOR | | | | |
| 00 | List separately each tentative settlement payment after des | sk review. Also show date o | f | | 5 |
| | each payment. If none, write "NONE" or enter a zero. (1) | | | | |
| | Program to Provider | | | | |
|)1 | | | | 0 | 5 |
|)2 | | | | 0 | 5 |
|)3 | | | | 0 | 5 |
| | Provider to Program | | | | |
| 50 | | | | 0 | 5 |
| 1 | | | | 0 | 5 |
| 52 | | | | 0 | 5 |
| 9 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) | | | 0 | 5 |
| 00 | Determined net settlement amount (balance due) based on the cost report. (1) | | | | 6 |
| 1 | SETTLEMENT TO PROVI DER | | | 213, 717 | 6 |
|)2 | SETTLEMENT TO PROGRAM | | | 0 | 6 |
| 00 | Total Medicare program liability (see instructions) | | | 663, 731 | 7 |
| | | | Contractor | NPR Date | |
| | | | Number | (Mo/Day/Yr) | |
| | | 0 | 1. 00 | 2. 00 | |
| 00 | Name of Contractor | | | | 8 |

| Health Financial Systems | ADAMS MEMORIAL | HOSPI TAL | In Lie | u of Form CMS-2552-10 |
|--|----------------|--|--|-----------------------|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL | | Provi der CCN: 15-1330 Component CCN: 15-8536 | Peri od: From 01/01/2022 To 12/31/2022 | |
| ' | | | | _ |

| | | | | 3/2/2024 10:0 | 7 am |
|-------|--|------------------------------|------------|---------------|------|
| | | | RHC II | Cost | |
| | | | | rt B | |
| | | | mm/dd/yyyy | Amount | |
| | | | 1. 00 | 2.00 | |
| 1.00 | Total interim payments paid to hospital-based RHC/FQHC | | | 154, 657 | 1. (|
| 2. 00 | Interim payments payable on individual bills, either submit | ted or to be submitted to | | 0 | 2. (|
| | the contractor for services rendered in the cost reporting | period. If none, write | | | |
| | "NONE" or enter a zero | | | | |
| . 00 | List separately each retroactive lump sum adjustment amount | based on subsequent | | | 3. |
| | revision of the interim rate for the cost reporting period. | Also show date of each | | | |
| | payment. If none, write "NONE" or enter a zero. (1) | | | | |
| | Program to Provider | | | | |
| . 01 | | | | 0 | 3. |
| . 02 | | | | 0 | 3. |
| . 03 | | | | 0 | 3. |
| . 04 | | | | 0 | 3. |
| . 05 | | | | 0 | 3. |
| | Provider to Program | | | | |
| 50 | | | | 0 | 3. |
| 51 | | | | 0 | 3. |
| 52 | | | | 0 | 3. |
| 53 | | | | 0 | 3. |
| 54 | | | | 0 | 3. |
| . 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3. | 98) | | 0 | 3. |
| . 00 | Total interim payments (sum of lines 1, 2, and 3.99) (trans | sfer to Worksheet M-3, line | | 154, 657 | 4. |
| | 27) | | | | |
| | TO BE COMPLETED BY CONTRACTOR | | | | |
| . 00 | List separately each tentative settlement payment after des | sk review. Also show date of | 7 | | 5. |
| | each payment. If none, write "NONE" or enter a zero. (1) | | | | |
| | Program to Provider | | | | |
| 01 | | | | 0 | 5. |
| 02 | | | | 0 | 5. |
| 03 | | | | 0 | 5. |
| | Provider to Program | | | | |
| 50 | | | | 0 | 5. |
| 51 | | | | 0 | 5. |
| 52 | | | | 0 | 5. |
| 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) | | | 0 | 5. |
| 00 | Determined net settlement amount (balance due) based on the cost report. (1) | | | | 6. |
| 01 | | | | 113, 913 | 6. |
| 02 | SETTLEMENT TO PROGRAM | | | 0 | 6. |
| .00 | Total Medicare program liability (see instructions) | | | 268, 570 | 7. |
| | | | Contractor | NPR Date | |
| | | | Number | (Mo/Day/Yr) | |
| | | 0 | 1. 00 | 2. 00 | |
| . 00 | Name of Contractor | | | 1 | 8. |

| Health Financial Systems | ADAMS MEMORIAL | HOSPI TAL | In Lieu | u of Form CMS-2552-10 |
|---|----------------|---|-----------------|-----------------------|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA | | Provider CCN: 15-1330 Component CCN: 15-8537 | From 01/01/2022 | |
| | | | | |

| | | Component CCN. 13-0337 | 10 12/31/2022 | 3/2/2024 10: 0 | |
|----|--|-----------------------------|---------------|----------------|-----|
| | | | RHC III | Cost | |
| | | | Par | t B | |
| | | | mm/dd/yyyy | Amount | |
| | | | 1, 00 | 2, 00 | |
| 00 | Total interim payments paid to hospital-based RHC/FQHC | | | 75, 375 | 1. |
| 00 | Interim payments payable on individual bills, either submit | ted or to be submitted to | | o | 2. |
| | the contractor for services rendered in the cost reporting | | | | |
| | "NONE" or enter a zero | | | | |
| 00 | List separately each retroactive lump sum adjustment amount | based on subsequent | | | 3 |
| | revision of the interim rate for the cost reporting period. | Also show date of each | | | |
| | payment. If none, write "NONE" or enter a zero. (1) | | | | |
| | Program to Provider | | | | |
| 01 | | | | 0 | 3 |
|)2 | | | | 0 | 3 |
| 23 | | | | 0 | 3 |
| 04 | | | | 0 | 3 |
| 05 | | | | 0 |] 3 |
| | Provider to Program | | | | |
| 50 | | | | 0 | 3 |
| 51 | | | | 0 | 3 |
| 52 | | | | 0 | 3 |
| 53 | | | | 0 | 3 |
| 54 | | | | 0 | 3 |
| 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3. | | | 0 | 3 |
| 00 | Total interim payments (sum of lines 1, 2, and 3.99) (trans | fer to Worksheet M-3, line | 9 | 75, 375 | 4 |
| | 27) | | | | |
| | TO BE COMPLETED BY CONTRACTOR | | | | |
| 00 | List separately each tentative settlement payment after des | sk review. Also show date o | DT | | 5 |
| | each payment. If none, write "NONE" or enter a zero. (1) | | | | |
| 01 | Program to Provider | | | 0 | 5 |
|)2 | | | | | 5 |
|)3 | | | | 0 | 5 |
| | Provider to Program | | | 0 | |
| 50 | Tovider to Trogram | | | 0 | 5 |
| 51 | | | | l ől | 5 |
| 52 | | | | Ö | 5 |
| 9 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. | 98) | | 0 | 5 |
| 00 | Determined net settlement amount (balance due) based on the cost report. (1) | | | | e |
| 1 | SETTLEMENT TO PROVIDER | 1111 . 000 (1) | | 22, 521 | 1 |
|)2 | SETTLEMENT TO PROGRAM | | | 22, 321 | 6 |
| 00 | Total Medicare program liability (see instructions) | | | 97, 896 | |
| | Total mod. od. o program readility (300 restractions) | | Contractor | NPR Date | |
| | | | Number | (Mo/Day/Yr) | |
| | | 0 | 1, 00 | 2.00 | |
| | Name of Contractor | | | | 8 |

| Health Financial Systems | ADAMS MEMORIAL | HOSPI TAL | In Lieu | u of Form CMS-2552-10 |
|--|----------------|------------------------|-----------------------------|---------------------------------------|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RESERVICES RENDERED TO PROGRAM BENEFICIARIE | | Provider CCN: 15-1330 | Peri od: From 01/01/2022 | |
| | | Component CCN: 15-8559 | | Date/Time Prepared: 3/2/2024 10:07 am |
| | | | | |

| | | Component CCN. 13-8337 | 10 12/31/2022 | 3/2/2024 10: 0 | |
|-------|---|-----------------------------|---------------|---------------------|------|
| | | | RHC IV | Cost | |
| | | | | t B | |
| | | | mm/dd/yyyy | Amount | |
| | | | 1. 00 | 2.00 | |
| 1.00 | Total interim payments paid to hospital-based RHC/FQHC | | | 82, 135 | 1. (|
| 2. 00 | Interim payments payable on individual bills, either submit | | | 0 | 2. (|
| | the contractor for services rendered in the cost reporting | period. If none, write | | | |
| | "NONE" or enter a zero | | | | |
| 3. 00 | List separately each retroactive lump sum adjustment amount | | | | 3. (|
| | revision of the interim rate for the cost reporting period. | Also show date of each | | | |
| | payment. If none, write "NONE" or enter a zero. (1) | | | | |
| | Program to Provider | | | | |
| 3. 01 | | | | 0 | 3. |
| 3. 02 | | | | 0 | 3. |
| 3. 03 | | | | l ol | 3. |
| 3. 04 | | | | l ol | 3. |
| 3. 05 | | | | l ol | 3. |
| | Provider to Program | | <u>'</u> | | |
| . 50 | | | | 0 | 3. |
| . 51 | | | | l ol | 3. |
| . 52 | | | | l ol | 3. |
| . 53 | | | | l ol | 3. |
| 3. 54 | | | | l ol | 3. |
| 3. 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3. | 98) | | l ol | 3. |
| 1. 00 | Total interim payments (sum of lines 1, 2, and 3.99) (trans | | , | 82, 135 | 4. |
| | 27) | | | | |
| | TO BE COMPLETED BY CONTRACTOR | | - | | |
| 5. 00 | List separately each tentative settlement payment after des | sk review. Also show date o | f | | 5. |
| | each payment. If none, write "NONE" or enter a zero. (1) | | | | |
| | Program to Provider | | | | |
| 5. 01 | | | | 0 | 5. |
| . 02 | | | | 0 | 5. |
| . 03 | | | | 0 | 5. |
| | Provider to Program | | | | |
| . 50 | | | | 0 | 5. |
| . 51 | | | | 0 | 5. |
| . 52 | | | | l ol | 5. |
| . 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. | 98) | | o | 5. |
| . 00 | Determined net settlement amount (balance due) based on the | e cost report. (1) | | | 6. |
| . 01 | SETTLEMENT TO PROVIDER | , | | 139, 908 | 6. |
| . 02 | SETTLEMENT TO PROGRAM | | | 0 | 6. |
| | Total Medicare program liability (see instructions) | | | 222, 043 | 7. |
| | | | Contractor | NPR Date | |
| | | | | | |
| 7. 00 | | | Number | (Mo/Day/Yr) | |
| | | 0 | | (Mo/Day/Yr) 2.00 | |

| Health Financial Systems | ADAMS MEMORIAL | HOSPI TAL | In Lieu | u of Form CMS-2552-10 |
|---|----------------|---|-----------------|-----------------------|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA | | Provider CCN: 15-1330 Component CCN: 15-8555 | From 01/01/2022 | |
| | | | | |

| | | component con. 13-6333 | 10 12/31/2022 | 3/2/2024 10: 07 | |
|----|--|-----------------------------|---------------|-----------------|----|
| | | | RHC V | Cost | |
| | | | Par | t B | |
| | | | mm/dd/yyyy | Amount | |
| | | | 1, 00 | 2, 00 | |
| 00 | Total interim payments paid to hospital-based RHC/FQHC | | | 237, 787 | 1. |
| 00 | Interim payments payable on individual bills, either submit | ted or to be submitted to | | 0 | 2. |
| | the contractor for services rendered in the cost reporting | | | | |
| | "NONE" or enter a zero | | | | |
| 00 | List separately each retroactive lump sum adjustment amount | based on subsequent | | | 3 |
| | revision of the interim rate for the cost reporting period. | Also show date of each | | | |
| | payment. If none, write "NONE" or enter a zero. (1) | | | | |
| | Program to Provider | | | | |
| 01 | | | | 0 | 3 |
|)2 | | | | 0 | 3 |
| 03 | | | | 0 | 3 |
| 04 | | | | 0 | 3 |
| 05 | | | | 0 | 3 |
| | Provider to Program | | | | |
| 50 | | | | 0 | 3 |
| 51 | | | | 0 | 3 |
| 52 | | | | 0 | 3 |
| 53 | | | | 0 | 3 |
| 54 | | | | 0 | 3 |
| 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3. | | | 0 | 3 |
| 00 | Total interim payments (sum of lines 1, 2, and 3.99) (trans | fer to Worksheet M-3, line | | 237, 787 | 4 |
| | 27) | | | | |
| | TO BE COMPLETED BY CONTRACTOR | | | | |
| 00 | List separately each tentative settlement payment after des | sk review. Also show date o | OT | | 5 |
| | each payment. If none, write "NONE" or enter a zero. (1) | | | | |
| 01 | Program to Provider | | | 0 | 5 |
|)2 | | | | 0 | 5 |
|)3 | | | | 0 | 5 |
| | Provider to Program | | | 0 | |
| 50 | 1 Tovi dei 10 1 Togi alli | | | 0 | 5 |
| 51 | | | | 0 | 5 |
| 52 | | | | l ől | 5 |
| 9 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. | 98) | | ا | 5 |
| 00 | Determined net settlement amount (balance due) based on the cost report. (1) | | | | 6 |
|)1 | SETTLEMENT TO PROVIDER | 1111 . 000. 1. (1) | | 22, 477 | 1 |
|)2 | SETTLEMENT TO PROGRAM | | | 22, 477 | 6 |
| 00 | Total Medicare program liability (see instructions) | | | 260, 264 | 7 |
| - | incar car o program readinity (see restricted) | | Contractor | NPR Date | |
| | | | Number | (Mo/Day/Yr) | |
| | | 0 | 1, 00 | 2.00 | |
| | Name of Contractor | | | | 8 |