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 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/29/2024 8: 49 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/29/2024 8: 49 am] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ADAMS MEMORIAL HOSPITAL (15-1330) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	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	(Dated when report is electronica			4

			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	448, 783	-662, 732	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	208, 282	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		250, 977		0	10.00
10. 01	WOODCREST II	0		72, 751		0	10.01
10. 02	STAT CARE III	o		17, 358		0	10.02
10. 03	BERNE FAMILY MEDICINE IV	o		147, 531		0	10.03
10. 04	HIGH STREET V	0		14, 822		0	10.04
200.00	TOTAL	0	657, 065	-159, 293	0	0	200.00

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

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

Health Financial Systems

ADAMS MEMORIAL HOSPITAL

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX LDENTIFICATION DATA

Provider CCN: 15-1330 Period: Worksheet S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1330 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 8: 49 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1100 MERCER AVENEUE 1.00 PO Box: 1.00 State: IN 2.00 City: DECATUR Zi p Code: 46733 County: ADAMS 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal ADAMS MEMORIAL HOSPITAL 151330 99915 11/01/2005 Ν 0 3.00 Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5 00 Subprovi der - (Other) 6.00 6.00 7 00 Swing Beds - SNF ADAMS MEMORIAL HOSPITAL 157330 99915 11/01/2005 N 0 P 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital -Based SNF 9.00 10.00 Hospital -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 Hospi tal -Based HHA 12.00 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 15.00 Hospital -Based Health Clinic - RHC MONROF FAMILY MEDICINE 99915 10/25/2017 158526 0 N 15 00 Ν 15.01 Hospital-Based Health Clinic - RHC DECATUR FAMILY 158536 99915 12/26/2018 Ν 0 Ν 15.01 MEDICINE-WOODCREST 15.02 Hospital-Based Health Clinic - RHC STAT CARE & PRIMARY 158537 99915 12/18/2018 0 15.02 CARE CLINIC 1111 Hospital-Based Health Clinic - RHC BERNE FAMILY MEDICINE 15.03 158559 99915 07/01/2020 N 0 N 15.03 ١V Hospital-Based Health Clinic - RHC VHIGH STREET FAMILY 158555 99915 01/24/2020 15.04 15.04 0 Ν MEDI CI NE 16.00 Hospital-Based Health Clinic - FQHC 16,00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 20.00 21.00 Type of Control (see instructions) 21.00 1. 00 2.00 3. 00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for 22.00 Ν disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for 22.01 Ν Ν 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 | Is this a newly merged hospital that requires a final UCP to be 22 02 N N determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν 22 03 N Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" yes or "N" for no.

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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 8: 49 am 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 1. 00 2.00 5. 00 3.00 4.00 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.

.001 1 1	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Provi de	er CCN: 15-1330	Peri od:	Worksheet S-2	2
					From 01/01/2023 To 12/31/2023	Part I Date/Time Pre 5/29/2024 8:4	pared 9 am
						1.00	-
	ACA Provisions Affecting the Hea					1.00	
. 00	Enter the number of FTE resident your hospital received HRSA PCRE			cost reporting p	eriod for which		62.
. 01	Enter the number of FTE resident during in this cost reporting pe Teaching Hospitals that Claim Re	riod of HRSA THC pro	gram. (see instru		to your hospital	0.00	62.
. 00	Has your facility trained reside "Y" for yes or "N" for no in col	nts in nonprovider s	ettings during th			N	63.
	, ,	<u> </u>		Unweighted FTEs		Ratio (col. 1/ (col. 1 +	
				Nonprovi de Si te		col . 2))	
				1.00	2. 00	3.00	
	Section 5504 of the ACA Base Year period that begins on or after J			ngsThis base ye	ar is your cost	reporti ng	
. 00	Enter in column 1, if line 63 is			nts 0.	0.00	0. 000000	64.
	in the base year period, the num						
	resident FTEs attributable to resettings. Enter in column 2 the			e			
	resident FTEs that trained in yo			tio			
	of (column 1 divided by (column	1 + column 2)). (see Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
		3		FTEs	FTEs in	3/ (col. 3 +	
				Nonprovi de Si te	- Hospi tal	col. 4))	
		1. 00	2. 00	3. 00	4. 00	5. 00	1
	is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted	FTEs in	Ratio (col. 1/ (col. 1 +	
				Nonprovi de Si te 1.00		col. 2))	
	Section 5504 of the ACA Current		n Nonprovi der Set				
. 00	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	unweighted non-prima occurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.	0.00	0. 000000	66.
	(column 1 divided by (column 1 +			Unwei ahtaa	Upwoi abtod	Patio (col	
		Program Name	Program Code	Unwei ghted FTEs Nonprovi de	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
				Si te	nospi tai	COI. 4))	

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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 8:49 am Ratio (col. Program Name Program Code Unwei ghted Unwei ghted 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 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 70.00 Ν 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 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 Ν amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line

89. (see instructions)

Column 2: Enter the number of approved permanent adjustments.

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	Fr		Part I Date/Time Pre 5/29/2024 8:4	
			Wkst. A Line No.	Effecti ve Date	Approved Permanent Adjustment Amount Per Discharge	
20. 00	Calumna 1. 16 lina 00 calumna 1 in V contact the Wardishart A li		1.00	2. 00	3. 00	2 00 00
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A lin on which the per discharge permanent adjustment approval was I Column 2: Enter the effective date (i.e., the cost reporting peginning date) for the permanent adjustment to the TEFRA targer discharge. Column 3: Enter the amount of the approved permanent adjustment TEFRA target amount per discharge.	oased. oeriod get amount	0.00			0 89.00
			-	1. 00	2. 00	-
	Title V and XIX Services			1.00	2.00	
	Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.			N	Y	90.00
	Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applicate title XIX NF patients occupying title XVIII SNF beds (dual	cable column		N	N N	91.00
	instructions) Enter "Y" for yes or "N" for no in the applicable Does this facility operate an ICF/IID facility for purposes or	e column.		N	N	93. 00
94. 00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, an applicable column.	nd "N" for n	o in the	N	N	94.00
	If line 94 is "Y", enter the reduction percentage in the appli Does title V or XIX reduce operating cost? Enter "Y" for yes o		O. 00 N	0. 00 N	95. 00 96. 00	
7 00	applicable column. If line 96 is "Y", enter the reduction percentage in the appli	cable colum	n	0. 00	0.00	97.00
	Does title V or XIX follow Medicare (title XVIII) for the into stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for	Υ Υ	Y Y	98.00		
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the report C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.	Υ	Y	98.0		
8. 02	Does title V or XIX follow Medicare (title XVIII) for the calc bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.	Υ	Y	98. 02		
8. 03	Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.			N	N	98. 03
98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH ro outpatient services cost? Enter "Y" for yes or "N" for no in o			N	N	98. 04
8. 05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add bacl Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in col column 2 for title XIX.			Υ	Y	98. 05
98. 06	Does title V or XIX follow Medicare (title XVIII) when cost ropes. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98.00
05 00	Rural Providers Does this hospital qualify as a CAH?			Υ		105.00
	lf this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-infor outpatient services? (see instructions)	nclusive met	hod of payment	Y		106.00
07. 00	Column 1: If line 105 is Y, is this facility eligible for costraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do yo approved medical education program in the CAH's excluded IPF	1. (see ins ou train I&R and/or IRF	tructions) s in an	N		107.00
07. 01	Enter "Y" for yes or "N" for no in column 2. (see instruction of this facility is a REH (line 3, column 4, is "12"), is it or reimbursement for I&R training programs? Enter "Y" for yes or instructions)	elígible for				107.0
08. 00	Instructions) Is this a rural hospital qualifying for an exception to the CI CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	RNA fee sche	dul e? See 42	N		108.00
		Physi cal	Occupati onal	Speech	Respiratory	-
		1. 00	2. 00	3. 00	4. 00	

Health Financial Systems ADAMS MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC		riod: com 01/01/2023	u of Form CMS Worksheet S- Part I Date/Time Pi 5/29/2024 8:	-2 repared:
			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. It	f yes,	N N	110.00
		1. 00	2. 00	
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Comparison 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 Is this facility classified as a referral center? Enter "Y" for yes or	N			116. 00
"N" for no. 117.00 s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117. 00
118.00 is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118. 00
	Premiums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:	1. 00 540, 150	2.00	3. 00	0118.01
118.01 List amounts of malpractice premiums and paid losses:		0		0118.01
118.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing co	540, 150 than the		3. 00	
118.02 Are mal practice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing count 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 profits and applicable amendments? (see instructions) Enter in column 1, "Y" "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)	540,150 than the ost centers vision in ACA " for yes or he Outpatient	1.00		118. 02
 118.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing county 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 programments and applicable amendments? (see instructions) Enter in column 1, "Y" "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) Enter in column 2, "Y" for yes or "N" for no. 	than the ost centers vision in ACA " for yes or he Outpatient ructions)	1. 00 N		118. 02 119. 00 120. 00
118.02 Are mal practice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing coand 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 prosports \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "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) Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devices 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	than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to (w)(3) of the	0 1.00 N		118. 02 119. 00 120. 00
 118.02 Are mal practice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing of 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 prof §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "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) Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devices 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? located in a CBSA outside of the main hospital CBSA? In column 2, enter " 	than the ost centers vision in ACA "for yes or he Outpatient ructions) s charged to (w)(3) of the rin column 2 ional and/or 1, enter "Y" 50% of total anizations	0 1.00 N N	2. 00 N	118. 02 119. 00 120. 00 121. 00 122. 00
118.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing or 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 prosports and applicable amendments? (see instructions) Enter in column 1, "Y "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) Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devices 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, enter "N" for no. Certified Transplant Center Information	than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to (w)(3) of the r in column 2 i onal and/or 1, enter "Y" 50% of total ani zations Y" for yes or	0 1.00 N N Y Y	2. 00 N 5. 00	118. 02 119. 00 120. 00 121. 00 122. 00 123. 00
 118.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing of 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 programmers (see instructions) Enter in column 1, "Y" "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) Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devices 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 organizated in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. Certified Transplant Center Information 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. 	than the ost centers vision in ACA for yes or he Outpatient ructions) s charged to (w)(3) of the rin column 2 ional and/or 1, enter "Y" 50% of total anizations y" for yes or	0 1.00 N N Y	2. 00 N 5. 00	118. 02 119. 00 120. 00 121. 00 122. 00 123. 00
118.02 Are mal practice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing coand amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless proves 33121 and applicable amendments? (see instructions) Enter in column 1, "Y" "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) Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devices 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 organizated in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. Certified Transplant Center Information 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 column 1 and termination date, if applicable, in column 2.	than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to (w)(3) of the r in column 2 ional and/or 1, enter "Y" 50% of total anizations Y" for yes or "Y" for yes ification date	0 1.00 N N Y Y	2. 00 N 5. 00	118. 02 119. 00 120. 00 121. 00 122. 00 123. 00 125. 00 126. 00
and amounts contained therein. 119. 00 DNOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prowed since the second of the s	than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to (w)(3) of the r in column 2 ional and/or 1, enter "Y" 50% of total anizations Y" for yes or "Y" for yes i fication date fication date	0 1.00 N N Y Y	2. 00 N 5. 00	118. 02 119. 00 120. 00 121. 00 122. 00 123. 00 125. 00 126. 00 127. 00
118.02 Are mal practice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing coand 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 promounts space in the space of the submitted in the space of th	than the ost centers vision in ACA "for yes or he Outpatient ructions) s charged to (w)(3) of the rin column 2 ional and/or 1, enter "Y" 50% of total anizations Y" for yes or "Y" for yes or "Y" for yes i fication date fication date	0 1.00 N N Y Y	2. 00 N 5. 00	118. 01 118. 02 119. 00 120. 00 121. 00 122. 00 123. 00 126. 00 127. 00 128. 00 129. 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	Provider CC	N: 15-1330		1/01/2023 2/31/2023		epared:
		·			1. 00	2.00	
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.	If yes, and home	office cos	ts	Y	15H060	140. 00
1.00 If this facility is part of a cha		2.00	ugh 142 +bc	nomo on	3. 00	of the home	
office and enter the home office			ugn 143 the	паше ап	iu auuress	or the nome	
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' co	sts included in Workshe	et A?				1.00 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						N	147. 00
148.00 Was there a change in the order of 149.00 Was there a change to the simplif				or no.		N N	148. 00 149. 00
		Part A 1.00	Part B 2.00		itle V 3.00	Title XIX 4.00	_
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
160.00HOME HEALTH AGENCY		N N	N N		N N	N N	159. 00 160. 00
161. 00 CMHC			N		N	N	161.00
Multicampus						1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has	one or more camp	uses in dif	ferent C	BSAs?	N	165. 00
Enter 1 for yes or N for No.	Name O	County 1.00	State Z	ip Code 3.00	CBSA 4.00	FTE/Campus 5.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					30		0166.00
						1. 00	
Health Information Technology (HI				ent Act		Υ	167. 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 (lin		"), ente	r the	Y	168. 00
168.01 If this provider is a CAH and is	not a meaningful user,	does this provide			dshi p	1	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	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	ENTIFICATION DATA		Peri od:	Worksheet S-2	!
			From 01/01/2023		
			To 12/31/2023		pared:
			5/29/2024 8: 4	9 am	
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR begin period respectively (mm/dd/yyyy)			170. 00		
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provider	have any days for indi	viduals enrolled in	N	0	171. 00
section 1876 Medicare cost plans repor					
"Y" for yes and "N" for no in column 1	. If column 1 is yes, e	enter the number of section	on		
1876 Medicare days in column 2. (see i					
	,		· ·	l	

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 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/29/2024 8:49 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 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? Ν 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 04/17/2024 17.00 Υ 04/17/2024 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 I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der (CCN: 15-1330	Peri od: From 01/01/2023 To 12/31/2023		repared:
			iption	Y/N	Y/N	
20.00	LE Line 1/ on 17 in the property and to DCOD		0	1.00	3.00	20.00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
	Troport data for other beson to other dajustments.	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)			
	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 dui	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	red into durino	this cost re	eporting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during	? If yes, see	N	25. 00		
24 00	instructions.	the cost sees	ing ported?	f voc soo	NI.	24 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during tinstructions.	ı yes, see	N	26. 00		
27. 00	Has the provider's capitalization policy changed during th copy.	ne cost reporti	ng period? I	f yes, submit	N	27. 00
28. 00	<pre>Interest Expense Were new Loans, mortgage agreements or letters of credit e</pre>	t reporting	N	28. 00		
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	Reserve Fund)	Υ	29. 00		
30. 00	treated as a funded depreciation account? If yes, see inst 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>	s, see	N	31.00		
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se		ned through co	ontractual	N	32.00
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		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?	Υ	34.00
05 00	If yes, see instructions.				.,	05.00
35. 00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		ents with the	provi der-based	Y	35. 00
	phrysicians during the cost reporting period: if yes, see i	iisti ucti olis.		Y/N	Date	
				1. 00	2.00	
	Home Office Costs					
	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	prepared by the	e nome office	? Y		37. 00
38. 00				F N		38. 00
39. 00	If line 36 is yes, did the provider render services to oth see instructions.			s, Y		39. 00
40. 00		e home office?	If yes, see	N		40. 00
		1	. 00	2	00	
	Cost Report Preparer Contact Information			Σ.		
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	ANDREW		MCCABE		41.00
42. 00	respectively. Enter the employer/company name of the cost report	WI PFLI				42.00
43 NO	preparer. Enter the telephone number and email address of the cost	715-858-6660		AMCCABE@WI PFLI	COM	43.00
+5.00	report preparer in columns 1 and 2, respectively.	, 13 030-0000		MINIOUNDLEWITTE	. JOIN	43.00

Heal th	Financial Systems	ADAMS MEMORIA	AL HOSPITA	_		In Lieu	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi d	er CCN:	Peri od	d: 01/01/2023	Worksheet S-	2
							Date/Time Pr	epared:
							5/29/2024 8:	49 am
				3.00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the t	itle/position	CPA					41.00
	held by the cost report preparer in colum	ns 1, 2, and 3,						
	respectively.							
42.00	Enter the employer/company name of the co	st report						42.00
	preparer.	·						
43.00	Enter the telephone number and email addre	ess of the cost						43.00
	report preparer in columns 1 and 2, respe	cti vel y.						

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

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

				أ	Го 12/31/2023	Date/Time Pre 5/29/2024 8:4	
						I/P Days /	7 dill
						0/P Visits /	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Trips Title V	
	Component	Li ne No.	No. or beas	Avai LabLe	CAN/ KEN HOULS	iiiie v	
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	2	7, 665	41, 904. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4. 00 5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF					0	4. 00 5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF					0	
7. 00	Total Adults and Peds. (exclude observation		2	7, 665	41, 904. 00	0	
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00		1, 460	10, 056. 00	0	8.00
9. 00 10. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						9. 00 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)		2	9, 125	51, 960. 00	0	
15. 00 15. 10	CAH visits REH hours and visits				0.00	0 0	15. 00 15. 10
16. 00	SUBPROVI DER - I PF	40.00		0 2, 730		ő	
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER					_	18.00
19. 00 20. 00	SKILLED NURSING FACILITY NURSING FACILITY	44. 00		0		0	19.00 20.00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	101.00				0	
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	116. 00		0	O		24.00
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30. 00					24. 10 25. 00
26. 00	MONROE FAMILY MEDICINE	88. 00				0	
26. 01	WOODCREST	88. 01				Ö	
26. 02	STAT CARE	88. 02				0	
26. 03	BERNE FAMILY MEDICINE	88. 03				0	
26. 04 26. 25	HIGH STREET FEDERALLY QUALIFIED HEALTH CENTER	88. 04 89. 00				0	26. 04 26. 25
27. 00	Total (sum of lines 14-26)	69.00		25		Ü	27.00
28. 00	Observation Bed Days		-			0	
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00 32. 00	Employee discount days - IRF Labor & delivery days (see instructions)			0			31.00 32.00
32. 00	Total ancillary labor & delivery room			Ĭ '			32.00
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges	20.00				0	33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	1	0 0	0	0	34.00

Health Financial SystemsADAMS MHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-1330

				'	0 12/31/2023	5/29/2024 8: 4	
		I/P Davs	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	·			Pati ents	& Residents	Payrol I	
		6. 00	7.00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA					•	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	840	0	1, 746			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)	577	133				2.00
3.00	HMO IPF Subprovider	o	0				3.00
4.00	HMO IRF Subprovider	o	o				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	458	o	885			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		o	141			6.00
7.00	Total Adults and Peds. (exclude observation	1, 298	o	2, 772			7.00
	beds) (see instructions)			·			
8.00	INTENSIVE CARE UNIT	175	131	779			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		107	293			13.00
14.00	Total (see instructions)	1, 473	238	3, 844	0.00	562. 41	14.00
15.00	CAH vi si ts	o	0	0			15.00
15. 10	REH hours and visits	0	0	0			15. 10
16.00	SUBPROVIDER - IPF	O	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY	o	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	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	0	0	0	0.00	0.00	24.00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25.00	CMHC - CMHC						25.00
26.00	MONROE FAMILY MEDICINE	4, 706	0	13, 852	0.00	18. 85	26.00
26. 01	WOODCREST	1, 327	0	9, 095	0. 00	13. 61	26. 01
26.02	STAT CARE	692	0	11, 111	0.00	15. 27	26. 02
26.03	BERNE FAMILY MEDICINE	1, 191	0	8, 539	0.00	13. 97	26. 03
26.04	HI GH STREET	1, 900	0	7, 764	0.00	8. 88	26. 04
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	632. 99	27.00
28.00	Observation Bed Days		0	1, 882			28. 00
29.00	Ambul ance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room			93			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	0	0	0			34.00

Provi der CCN: 15-1330

				10) 12/31/2023	5/29/2024 8: 4	
		Full Time Equivalents	<u>'</u>	Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	·	Workers				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		0	316	0	931	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)			198	191		2.00
3. 00	HMO IPF Subprovi der			170	0		3.00
4. 00	HMO IRF Subprovider				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF				J		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	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY					201	13.00
14.00	Total (see instructions)	0. 00	0	316	0	931	14.00
15.00	CAH visits						15.00
15. 10 16. 00	REH hours and visits SUBPROVIDER - IPF	0.00	0	0	o	0	15. 10 16. 00
17. 00	SUBPROVIDER - I PF	0.00	U		U	U	17.00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0.00					19.00
20. 00	NURSING FACILITY	0.00					20.00
21. 00	OTHER LONG TERM CARE						21. 00
22.00	HOME HEALTH AGENCY	0.00					22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE	0.00					24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26. 00	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 0. 00					26. 03 26. 04
26. 04 26. 25	HIGH STREET	0.00					26. 04 26. 25
26. 25	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	0.00					26. 25
28. 00	Observation Bed Days	0.00					28.00
29. 00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see Thisti detroit)						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						34.00

Health Financial Systems HOSPITAL-BASED RHC/FQHC STATISTICAL	DATA	ADAMS MEMORI.		CN: 15-1330	In Lie	eu of Form CM Worksheet S		552-1
HOSPITAL-BASED RHC/FUHC STATISTICAL	DATA		Provider C	CN: 15-1330	From 01/01/2023		0-8	
			Component	CCN: 15-8526	To 12/31/2023			
					RHC I	5/29/2024 8 Cost		alli
						, 000		
					1	. 00	4	
Clinic Address and Identifica 1.00 Street	ation				205 TOWER DRIV	VF	-	1.0
1. 00 011 001			Ci	ty	State	ZIP Code		1.0
				00	2. 00	3. 00		
2.00 City, State, ZIP Code, County	У		MONROE			N 46772	_	2. 0
						1. 00		
3.00 HOSPITAL-BASED FQHCs ONLY: De	esignation - Ent	er "R" for rur	al or "U" for	urban			0	3. 0
				Gra	nt Award	Date		
Course of Foderal Funda					1. 00	2. 00		
Source of Federal Funds 4.00 Community Health Center (Sec	tion 330(d) PHS	Act)				Τ		4. 0
5.00 Migrant Health Center (Section								5. 0
6.00 Health Services for the Homel	•	O(d), PHS Act)						6.0
7.00 Appalachian Regional Commissi 8.00 Look-Alikes	on							7. 00 8. 00
9. 00 OTHER (SPECIFY)								9. 0
				1				
10.00 D			DUO - FOURD F		1.00	2. 00		10.0
10.00 Does this facility operate as yes or "N" for no in column ?							1	10. 0
2. (Enter in subscripts of lin								
hours.)			-				_	
		Sur from	iday to	from	londay to	Tuesday from	-	
				3.00			\rightarrow	
		1. 00	1 2.00	3.00	4.00	1 5.00		
Facility hours of operations	(1)	1. 00	2.00		4. 00	5. 00		
	(1)	1. 00	2.00	08: 00	20: 00	08: 00		11. 0
Facility hours of operations 11.00 CLINIC	(1)	1.00	2.00		20: 00	08: 00		11. 00
11. 00 CLINIC				08: 00				
11. 00 CLINIC 12. 00 Have you received an approval 13. 00 Is this a consolidated cost i	for an exception	on to the prod d in CMS Pub.	uctivity stand	08:00 ard? r 9, section	20: 00 1. 00 N	08: 00	0	12. 0
11.00 CLINIC 12.00 Have you received an approval 13.00 Is this a consolidated cost is 30.8? Enter "Y" for yes or "I"	for an exception for an exception for as defined with the formal	on to the prod d in CMS Pub. umn 1. If yes,	uctivity stanc 100-04, chapte enter in colu	o8:00 ard? r 9, section mn 2 the	20: 00 1. 00 N	08: 00	0	12. 0
11.00 CLINIC 12.00 Have you received an approval 13.00 Is this a consolidated cost and approval 30.8? Enter "Y" for yes or "Inumber of providers included	for an exception for an exception for as defined with the formal	on to the prod d in CMS Pub. umn 1. If yes,	uctivity stanc 100-04, chapte enter in colu	o8:00 ard? r 9, section mn 2 the	20: 00 1. 00 N	08: 00	0	12.0
12.00 Have you received an approval 13.00 Is this a consolidated cost is 30.8? Enter "Y" for yes or "Inumber of providers included numbers below.	for an exception report as define " for no in coll in this report.	on to the prod d in CMS Pub. umn 1. If yes, List the name	uctivity stand 100-04, chapte enter in colu s of all provi	one of the ders and	20: 00 1. 00 N N	08: 00		12. 00 13. 00
12.00 Have you received an approval 13.00 Is this a consolidated cost in 30.8? Enter "Y" for yes or "I' number of providers included numbers below. 13.01 If line 13, column 1, is "Y", in CMS Pub. 100-02, chapter "	for an exception for an exception for as defined the form of the f	on to the prod d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y"	uctivity stand 100-04, chapte enter in colu s of all provi onsolidated RH for yes or "N"	ard? r 9, section mn 2 the ders and Cs (as defin- for no. If	20: 00 1. 00 N N	08: 00		12. 00 13. 00
11.00 CLINIC 12.00 Have you received an approval 13.00 Is this a consolidated cost in 30.8? Enter "Y" for yes or "I' number of providers included numbers below. 13.01 If line 13, column 1, is "Y", in CMS Pub. 100-02, chapter yes, enter in column 2 the number of the state of t	for an exception report as defined by for no in coluin this report. are you report are you report section 80.2 umber of consolice.	on to the prod d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC grou	uctivity stand 100-04, chapte enter in colu s of all provi onsolidated RH for yes or "N" pings and comp	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a	20: 00 1. 00 N N	08: 00		12. 00 13. 00
12.00 Have you received an approval 13.00 Is this a consolidated cost is 30.8? Enter "Y" for yes or "Inumber of providers included numbers below. 13.01 If line 13, column 1, is "Y", in CMS Pub. 100-02, chapter yes, enter in column 2 the number separate Worksheet S-8 for each separate was se	for an exception for an exception for a defined the following forms of the forms of	on to the prod d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC group	uctivity stand 100-04, chapte enter in colu s of all provi onsolidated RH for yes or "N" pings and comp Consolidated	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin	20: 00 1. 00 N N	08: 00		12. 00 13. 00
11.00 CLINIC 12.00 Have you received an approval 13.00 Is this a consolidated cost in 30.8? Enter "Y" for yes or "I' number of providers included numbers below. 13.01 If line 13, column 1, is "Y", in CMS Pub. 100-02, chapter yes, enter in column 2 the number in column 3 the number in column 4 th	for an exception report as defined with form the following terms of	on to the prod d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC group RHC grouping. onsolidated RH	uctivity stance 100-04, chapte enter in colus s of all provi onsolidated RH for yes or "N" pings and comp Consolidatec Cs in the grou	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or	20: 00 1. 00 N N ed N	08: 00		12. 00 13. 00
12.00 Have you received an approval 13.00 Is this a consolidated cost in 30.8? Enter "Y" for yes or "Inumber of providers included numbers below. 13.01 If line 13, column 1, is "Y", in CMS Pub. 100-02, chapter yes, enter in column 2 the numbers are comprised exclusively of	for an exception report as defined with form the following terms of	on to the prod d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC group RHC grouping. onsolidated RH	uctivity stance 100-04, chapte enter in colus s of all provi onsolidated RH for yes or "N" pings and comp Consolidatec Cs in the grou	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or	20:00 1.00 N N ed N	08: 00 2. 00		12. 00 13. 00
12.00 Have you received an approval 13.00 Is this a consolidated cost is 30.8? Enter "Y" for yes or "Inumber of providers included numbers below. 13.01 If line 13, column 1, is "Y", in CMS Pub. 100-02, chapter yes, enter in column 2 the numbers below. 13.01 Separate Worksheet S-8 for ear are comprised exclusively of new	for an exception report as defined with form the following terms of	on to the prod d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC group RHC grouping. onsolidated RH	uctivity stance 100-04, chapte enter in colus s of all provi onsolidated RH for yes or "N" pings and comp Consolidatec Cs in the grou	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or	20: 00 1. 00 N N ed N	08: 00		12. 00 13. 00
12.00 Have you received an approval 13.00 Is this a consolidated cost is 30.8? Enter "Y" for yes or "I number of providers included numbers below. 13.01 If line 13, column 1, is "Y", in CMS Pub. 100-02, chapter yes, enter in column 2 the numbers de worksheet S-8 for eater comprised exclusively of new	for an exception report as defined with form the following terms of	on to the prod d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC group RHC grouping. onsolidated RH	uctivity stance 100-04, chapte enter in colus s of all provi onsolidated RH for yes or "N" pings and comp Consolidatec Cs in the grou	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or	20:00 1.00 N N ed N	08: 00 2. 00	0	12. 0 13. 0
12.00 Have you received an approval 13.00 Is this a consolidated cost in 30.8? Enter "Y" for yes or "Inumber of providers included numbers below. 13.01 If line 13, column 1, is "Y", in CMS Pub. 100-02, chapter yes, enter in column 2 the numbers described by the separate Worksheet S-8 for exare comprised exclusively of comprised exclusively of new.	for an exception report as defined with form the following terms of	on to the prod d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC grou RHC grouping. onsolidated RH Cs in the grou	uctivity stand 100-04, chapte enter in colu s of all provi onsolidated RH for yes or "N" pings and comp Consolidated Cs in the grouping.	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or	20:00 1.00 N N ed N gs ider name 1.00	08: 00 2. 00 CCN 2. 00	0	12. 0 13. 0 13. 0
12.00 Have you received an approval 13.00 Is this a consolidated cost is 30.8? Enter "Y" for yes or "Inumber of providers included numbers below. 13.01 If line 13, column 1, is "Y", in CMS Pub. 100-02, chapter yes, enter in column 2 the numbers are comprised exclusively of comprised exclusively of new. 14.00 RHC/FQHC name, CCN	for an exception report as defined N" for no in coluin this report. are you report 13, section 80.2 2 cumber of consolidated grandfathered consolidated RH exception 13 consolidated RH exception 14 consolidated RH exception 15 consolidated RH excep	on to the prod d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC group RHC grouping. onsolidated RH Cs in the grou Y/N 1.00	uctivity stand 100-04, chapte enter in colus of all provi onsolidated RH for yes or "N" pings and comp Consolidated Cs in the grouping.	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or Prov	20: 00 1. 00 N N ed N gs ider name 1. 00	08: 00 2. 00 CCN 2. 00 Total Visit	0	12. 0 13. 0 13. 0
12.00 Have you received an approval 13.00 Is this a consolidated cost in 30.8? Enter "Y" for yes or "Inumber of providers included numbers below. 13.01 If line 13, column 1, is "Y", in CMS Pub. 100-02, chapter yes, enter in column 2 the number of yes, enter in column 3 the yes, enter in column 2 the number of yes, enter in column 3 the yes, enter in column 3 the yes, enter in column 4 the yes, enter in column 4 the yes, enter in column 4 the yes, enter in column 5 the yes, enter in column 4 the yes, enter in column 5 the yes, enter in column 5 the yes, enter in column 6 the yes, enter in column 1 the yes, enter in column 2 the number of yes, enter in column 2 the number of yes, enter in column 2 the number of yes, enter in column 3 the yes, enter in column 4 the yes, enter in column 5 the yes, enter in yes,	for an exception report as defined N" for no in coluin this report. are you report 13, section 80.2 2 cumber of consolidated grandfathered consolidated RH consolidated RH report 15 consolidated RH re	on to the prod d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC group RHC grouping. onsolidated RH Cs in the grou Y/N 1.00	uctivity stand 100-04, chapte enter in colus of all provi onsolidated RH for yes or "N" pings and comp Consolidated Cs in the grouping.	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or Prov	20: 00 1. 00 N N ed N gs ider name 1. 00	08: 00 2. 00 CCN 2. 00 Total Visit	0	12. 0 13. 0 13. 0
12.00 Have you received an approval 13.00 Is this a consolidated cost in some solidated cost in solida	for an exception report as defined with form of the following the following the form of the following the form of the following the form of the form o	on to the prod d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC group RHC grouping. onsolidated RH Cs in the grou Y/N 1.00	uctivity stand 100-04, chapte enter in colus of all provi onsolidated RH for yes or "N" pings and comp Consolidated Cs in the grouping.	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or Prov	20: 00 1. 00 N N ed N gs ider name 1. 00	08: 00 2. 00 CCN 2. 00 Total Visit	0	12. 0 13. 0 13. 0
12.00 Have you received an approval 13.00 Is this a consolidated cost in 30.8? Enter "Y" for yes or "Inumber of providers included numbers below. 13.01 If line 13, column 1, is "Y", in CMS Pub. 100-02, chapter yes, enter in column 2 the number separate Worksheet S-8 for exare comprised exclusively of comprised exclusively of new 14.00 RHC/FQHC name, CCN 15.00 Have you provided all or subsequence of the separate worksheet S-8 for exare comprised exclusively of new 14.00 RHC/FQHC name, CCN	I for an exception report as defined with this report. I are you report. I are you report as section 80.22 umber of consolidated grandfathered consolidated RHG and the con	on to the prod d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC group RHC grouping. onsolidated RH Cs in the grou Y/N 1.00	uctivity stand 100-04, chapte enter in colus of all provi onsolidated RH for yes or "N" pings and comp Consolidated Cs in the grouping.	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or Prov	20: 00 1. 00 N N ed N gs ider name 1. 00	08: 00 2. 00 CCN 2. 00 Total Visit	0	12. 00 13. 00
12.00 Have you received an approval 13.00 Is this a consolidated cost in some solidated cost in solidate and solidated cost in solidate and solidate	I for an exception report as defined with this report. I are you report as action 80.22 umber of consolidated grandfathered consolidated RH for "N" for no in lumns 2, 3 and the stantially and the performed by s V, XVIII, and column 5 the	on to the prod d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC group RHC grouping. onsolidated RH Cs in the grou Y/N 1.00	uctivity stand 100-04, chapte enter in colus of all provi onsolidated RH for yes or "N" pings and comp Consolidated Cs in the grouping.	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or Prov	20: 00 1. 00 N N ed N gs ider name 1. 00	08: 00 2. 00 CCN 2. 00 Total Visit	0	12. 0 13. 0 13. 0

Health Financial Systems	ADAMS MEMORIAL HOSPITAL			In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1330	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8526	From 01/01/2023 To 12/31/2023		narod:
		Component	CCN. 15-6520	10 12/31/2023	5/29/2024 8: 4	
				RHC I	Cost	
		County				
		4.	00			
2.00 City, State, ZIP Code, County		ADAMS				2.00
	Tuesday	Wedne	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11.00

Heal th	Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Li∈	eu of Form CMS	-2552-10
HOSPI 1	FAL-BASED RHC/FQHC STATISTICAL DATA		Provider Component	CN: 15-1330 CCN: 15-8536	Peri od: From 01/01/2023 To 12/31/2023		epared:
					RHC II	Cost	
					1	00	_
	Clinic Address and Identification					00	
1.00	Street		0:		1300 MERCER AV		1.00
				ty 00	State 2.00	ZIP Code 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 i	urban		1. 00	0 3.00
0.00	THE BREEF LANCE CHETT DOOR GREEF CHET				nt Award	Date	0.00
	C C. F. L F L.				1. 00	2. 00	
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A Health Services for the Homeless (Section 34 Appalachian Regional Commission Look-Alikes OTHER (SPECIFY)	ct)					4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
					1.00	2.00	
10, 00	Does this facility operate as other than a h	ospi tal -based I	RHC or FOHC? Fi	nter "Y" for	1. 00 N	2. 00	0 10.00
	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of o	other operation	ns in column			
		Sun	day		londay	Tuesday	
		from 1.00	to 2. 00	from 3.00	4. 00	from 5.00	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	3.00	
11.00	CLINIC			08: 00	17: 00	08: 00	11. 00
					1. 00	2. 00	
12. 00 13. 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		12.00 0 13.00
13. 01	If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH)? Enter "Y" ; dated RHC group RHC grouping. onsolidated RHC	for yes or "N" bings and comp Consolidated Cs in the group	for no. If lete a RHC grouping			0 13.01
	Teemprised exercisivery of new consortuated kin	os in the group	or rig.	Prov	ider name	CCN	
14.00	DUC/FOUC TOTAL 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 XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

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	3
		Component	CCN: 15-8536	From 01/01/2023 To 12/31/2023		
				RHC II	Cost	
	County					
		4.	00			
2.00 City, State, ZIP Code, County		ADAMS				2.00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7.00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00	11. 00
	Fri	day	Sa ⁻	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)	•			<u> </u>		
11. 00 CLINIC	08: 00	17: 00				11.00

Heal th	n Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS	-2552-10
HOSPI	TAL-BASED RHC/FQHC STATISTICAL DATA		Provider Component	CN: 15-1330 CCN: 15-8537	Period: From 01/01/2023 To 12/31/2023		epared:
					RHC III	Cost	47 dili
					1	. 00	
	Clinic Address and Identification					. 00	
1.00	Street		0'		1100 MERCER AV		1.00
				ty 00	State 2.00	ZIP Code 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	urban			0 3.00
					nt Award	Date	
	Source of Endoral Funds				1. 00	2. 00	
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A Health Services for the Homeless (Section 34 Appalachian Regional Commission Look-Alikes OTHER (SPECIFY)	ct)					4. 00 5. 00 6. 00 7. 00 8. 00 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	1. 00 N	2. 00	0 10.00
	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type of hours.)	ate number of	other operation	ns in column			
			day		Monday	Tuesday	
		from 1.00	2. 00	from 3.00	4. 00	5.00	
	Facility hours of operations (1)						
11. 00	CLINIC	09: 00	17: 00	07: 30	20: 30	07: 30	11.00
					1. 00	2. 00	
12. 00 13. 00	1 1	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N		12. 00 0 13. 00
13. 01)? Enter "Y" dated RHC grou RHC grouping. onsolidated RH	for yes or "N" pings and comp Consolidated Cs in the grou	for no. If lete a RHC groupin			0 13.01
	Teemprised exercises very of new consort dated kil	os in the grou	pring.	Prov	ider name	CCN	
14.00	DUC/FOUC name 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 XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

Health Financial Systems	ADAMS MEMORIAL HOSPITAL			In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1330	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8537	From 01/01/2023 To 12/31/2023		narod:
		Component	CCN. 13-6337	10 12/31/2023	5/29/2024 8: 4	
				RHC III	Cost	
	County					
		4.	00			
2.00 City, State, ZIP Code, County		ADAMS				2.00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7.00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLI NI C	20: 30	07: 30	20: 30	07: 30	20: 30	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 30	20: 30	09: 00	17: 00		11.00

		15-1330			
			From 01/01/2023	3	
Compo	onent CCN	: 15-8559	10 12/31/202		
			RHC IV	Cost	
			1	00	
				. 00	
			1521 WEST MAI	N STREET	1
	Ci ty		State	ZIP Code	
BERNE	1.00				2
DEITHE				10711	
				1. 00	
for rural or "U	for urb		at Award	Dato	0 3
					4
4S Act)					5
10 7101)					7
					8
					9
			1. 00	2.00	
-based RHC or FO	OHC? Ente	r "Y" for	N		0 10
operation(s) ar	nd the op	erating			
Sunday		M	onday	Tuesday	
Juliudy		191	Oriua y	Tuesday	
om to		from	to	from	
om to	0	from 3.00	to 4.00	from 5.00	11
om to	0	from	to	from	11
om to 00 2.0	07:	from 3.00	to 4.00	from 5.00	
om to 00 2.0	07:	from 3.00 30	to 4.00	from 5.00	12
om to 00 2.0	07: standard	from 3.00 30 ?	to 4.00	from 5.00	
om to 00 2.0 ne productivity 6 Pub. 100-04, (07: standard chapter 9	from 3.00 30 ? , section 2 the	to 4.00	from 5.00	12
om to 00 2.0 ne productivity S Pub. 100-04, of f yes, enter in ne names of all	oo	from 3.00 30 ? , section 2 the s and	17: 00 1. 00 N	from 5.00	0 13
ne productivity S Pub. 100-04, of yes, enter in the names of all tiple consolidations.	oo 07: standard chapter 9 n column provider	from 3.00 30 ? , section 2 the s and (as define	17: 00 1. 00 N	from 5.00	12
ne productivity S Pub. 100-04, of yes, enter in the names of all tiple consolidater "Y" for yes of the groupings and	standard chapter 9 n column provi der ted RHCs or "N" fo	? , section 2 the s and (as define r no. If e a	17: 00 1. 00 N	from 5.00	0 13
me productivity S Pub. 100-04, of yes, enter in the names of all tiple consolidater "Y" for yes of the groupings and puping. Consoli	standard chapter 9 n column provi der ted RHCs or "N" fo	from 3.00 30 ? , section 2 the s and (as definer no. If e a C grouping	17: 00 1. 00 N	from 5.00	0 13
ne productivity S Pub. 100-04, of yes, enter in the names of all tiple consolidater "Y" for yes of the groupings and puping. Consoliated RHCs in the	standard chapter 9 n column provi der ted RHCs or "N" fo	from 3.00 30 ? , section 2 the s and (as definer no. If e a C grouping	17: 00 1. 00 N	from 5.00	0 13
me productivity S Pub. 100-04, of yes, enter in the names of all tiple consolidater "Y" for yes of the groupings and puping. Consoli	standard chapter 9 n column provi der ted RHCs or "N" fo	from 3.00 30 ? , section 2 the s and (as define r no. If e a C grouping g or Provi	to 4.00	From 5.00 07:30	0 13
ne productivity S Pub. 100-04, of yes, enter in the names of all tiple consolidater "Y" for yes of the groupings and puping. Consoliated RHCs in the	standard chapter 9 n column provi der ted RHCs or "N" fo	from 3.00 30 ? , section 2 the s and (as define r no. If e a C grouping g or Provi	17: 00 17: 00 N N add N	from 5.00 07:30	0 13
ne productivity S Pub. 100-04, of yes, enter in the names of all tiple consolidater "Y" for yes of the groupings and puping. Consolited RHCs in the grouping.	standard chapter 9 n column provi der ted RHCs or "N" fo	from 3.00 30 ? , section 2 the s and (as define r no. If e a C grouping g or Provi	to 4.00 17:00 1.00 N ed N gs der name 1.00	From 5.00 07:30	0 13
ne productivity S Pub. 100-04, of yes, enter in the names of all tiple consolidater "Y" for yes of the groupings and puping. Consoliated RHCs in the	standard chapter 9 n column provi der ted RHCs or "N" fod d complet dated RH e groupi n	from 3.00 30 ? , section 2 the s and (as define r no. If e a C grouping g or Provi	to 4.00	From 5.00 07:30	0 13
ne productivity S Pub. 100-04, of yes, enter in the names of all tiple consolidater "Y" for yes of the groupings and puping. Consoliated RHCs in the grouping.	standard chapter 9 n column provi der ted RHCs or "N" fod d complet dated RH e groupi n	? , section 2 the s and (as define r no. If e a C grouping or Provi	to 4.00 17:00 1.00 N ed N der name 1.00	From 5.00 07:30	0 13
ne productivity S Pub. 100-04, of yes, enter in the names of all tiple consolidater "Y" for yes of the groupings and puping. Consoliated RHCs in the grouping.	standard chapter 9 n column provi der ted RHCs or "N" fod d complet dated RH e groupi n	? , section 2 the s and (as define r no. If e a C grouping or Provi	to 4.00 17:00 1.00 N ed N der name 1.00	From 5.00 07:30	0 13 0 13
ne productivity S Pub. 100-04, of yes, enter in the names of all tiple consolidater "Y" for yes of the groupings and puping. Consoliated RHCs in the grouping.	standard chapter 9 n column provi der ted RHCs or "N" fod d complet dated RH e groupi n	? , section 2 the s and (as define r no. If e a C grouping or Provi	to 4.00 17:00 1.00 N ed N der name 1.00	From 5.00 07:30	0 13 0 13
ne productivity S Pub. 100-04, of yes, enter in the names of all tiple consolidater "Y" for yes of the groupings and puping. Consoliated RHCs in the grouping.	standard chapter 9 n column provi der ted RHCs or "N" fod d complet dated RH e groupi n	? , section 2 the s and (as define r no. If e a C grouping or Provi	to 4.00 17:00 1.00 N ed N der name 1.00	From 5.00 07:30	0 13 0 13
ne productivity S Pub. 100-04, of yes, enter in the names of all tiple consolidater "Y" for yes of the groupings and puping. Consoliated RHCs in the grouping.	standard chapter 9 n column provi der ted RHCs or "N" fod d complet dated RH e groupi n	? , section 2 the s and (as define r no. If e a C grouping or Provi	to 4.00 17:00 1.00 N ed N der name 1.00	From 5.00 07:30	0 13 0 13
ne productivity S Pub. 100-04, of yes, enter in the names of all tiple consolidater "Y" for yes of the groupings and puping. Consoliated RHCs in the grouping.	standard chapter 9 n column provi der ted RHCs or "N" fod d complet dated RH e groupi n	? , section 2 the s and (as define r no. If e a C grouping or Provi	to 4.00 17:00 1.00 N ed N der name 1.00	From 5.00 07:30	0 13 0 13
	BERNE For rural or "U" HS Act) -based RHC or For oper of other oper operation(s) are	City 1.00 BERNE For rural or "U" for urb HS Act)	City 1.00 BERNE City 1.00 BERNE For rural or "U" for urban Gran Gran Gran HS Act)	Provider CCN: 15-1330	Provider CCN: 15-1330

Health Financial Systems	ADAMS MEMORIA	AL HOSPITAL	In Lieu of Form CMS-2552			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1330	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8559	From 01/01/2023 To 12/31/2023		
				RHC I V	Cost	
		County				
		4.	00			
2.00 City, State, ZIP Code, County		ADAMS				2.00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	17: 00	07: 00	17: 00	07: 30	17: 00	11. 00
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)	•			·		
11. 00 CLINIC	07: 00	17: 00				11. 00

Heal th	Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Li∈	eu of Form CMS	S-25!	52-10
HOSPI 7	FAL-BASED RHC/FQHC STATISTICAL DATA		Provider Component	CN: 15-1330 CCN: 15-8555	Period: From 01/01/2023 To 12/31/2023		repa	
					RHC V	5/29/2024 8 Cost		<u>alli</u>
					1	00		
	Clinic Address and Identification				1.	00		
1.00	Street				955 HI GH STREE			1.00
				ty	State	ZIP Code	_	
2. 00	City, State, ZIP Code, County		DECATUR	00	2.00	3. 00 46733		2.00
	<u> </u>							
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "P" for rur	al or "II" for i	urhan		1.00	0	3.00
3.00	THOSE THE BASED TURES ONET. DESIGNATION - LITE	er k for fura			nt Award	Date		3.00
	To the second se				1. 00	2.00		
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A Health Services for the Homeless (Section 34 Appalachian Regional Commission Look-Alikes OTHER (SPECIFY)	ct)						4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
					1.00	2.00	_	
10. 00	Does this facility operate as other than a h	ospi tal -based f	RHC or FQHC? E	nter "Y" for	1. 00 N	2.00	0 1	10. 00
	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of o	other operation	ns in column				
		Sun			londay	Tuesday		
		1.00	to 2.00	from 3.00	4. 00	from 5.00	+	
	Facility hours of operations (1)							
11. 00	CLINIC			08: 00	17: 00	08: 00	1	11. 00
					1. 00	2. 00	-	
12. 00 13. 00	Have you received an approval for an excepting this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. In numbers below.	d in CMS Pub. ´ umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the		2.00		12. 00 13. 00
13. 01	If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC	for yes or "N" pings and comp Consolidated Cs in the group	for no. If lete a RHC groupin			0 1	13. 01
	Teemprised exercisivery of new consortuated kill	os in the group	Ji rig.	Prov	ider name	CCN		
14 00	DUC/FOUC name CCN				1. 00	2. 00	1	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 XIX, as applicable. Enter in column 5 the						1	15. 00

Health Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od:	Worksheet S-8	3
		Component	CCN: 15-8555	From 01/01/2023 To 12/31/2023		epared: 19 am
				RHC V	Cost	
		Cou	ınty			
		4.	00			
2.00 City, State, ZIP Code, County		ADAMS				2.00
	Tuesday	Wedn	esday	Thursday		
	to	from	to	from	to	
	6. 00	7.00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
	Fri	day	Sat	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLI NI C	08: 00	17: 00				11.00

40SPLT		AL HOSPITAL			u of Form CMS-2	
	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co	CN: 15-1330	Peri od: From 01/01/2023 To 12/31/2023		pared:
					1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1.00	
	Uncompensated and Indigent Care Cost-to-Charge Ratio					1
1. 00	Cost to charge ratio (see instructions)				0. 542581	1.00
	Medicaid (see instructions for each line)					
2. 00	Net revenue from Medicaid	_			6, 893, 149	
3.00	Did you receive DSH or supplemental payments from Medicaic			-: -!	Y	3.00
4. 00 5. 00	If line 3 is yes, does line 2 include all DSH and/or suppl If line 4 is no, then enter DSH and/or supplemental paymer			car d?	Y	4. 00 5. 00
6. 00	Medicaid charges	its ironi wedicai	u		24, 564, 084	
7. 00						
8. 00	Difference between net revenue and costs for Medicaid prod	ram (see instr	uctions)		13, 328, 005 6, 434, 856	
	Children's Health Insurance Program (CHIP) (see instruction					1
9. 00	Net revenue from stand-alone CHIP				0	9.00
10. 00	Stand-alone CHIP charges				0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	
12. 00	Difference between net revenue and costs for stand-alone C			`	0	12.00
13. 00	Other state or local government indigent care program (see Net revenue from state or local indigent care program (Not				0	13.00
14. 00	Charges for patients covered under state or local indigent					
14.00	10)	care program	(Not Therauce	1 111 111103 0 01	Ĭ	14.0
15. 00	State or local indigent care program cost (line 1 times li	ne 14)			0	15.00
16. 00	Difference between net revenue and costs for state or local	I indigent care	e program (se	e instructions)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid	, CHIP and stat	te/Local indi	gent care progra	ams (see	
	instructions for each line)					
	Drivate grants denotions or endowment income restricted	to funding char	si tu cara			17 0
	3				0	
18. 00	Government grants, appropriations or transfers for support	of hospital o	perati ons	ns (sum of lines	0	18.00
18. 00		of hospital o	perati ons	ns (sum of lines		18.00
18. 00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid , CHIP and state and	of hospital o	perations care program Uninsured	Insured	0 6, 434, 856 Total (col. 1	18.00
18. 00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid , CHIP and state and	of hospital o	care progran Uni nsured pati ents	Insured patients	0 6, 434, 856 Total (col. 1 + col. 2)	
18. 00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16)	of hospital o	perations care program Uninsured	Insured	0 6, 434, 856 Total (col. 1	18.00
18. 00 19. 00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16) Uncompensated care cost (see instructions for each line)	of hospital op local indigent	perations care program Uninsured patients 1.00	Insured patients 2.00	0 6,434,856 Total (col. 1 + col. 2) 3.00	18. 0 19. 0
18. 00 19. 00 20. 00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16)	of hospital of local indigent	care progran Uni nsured pati ents	Insured patients 2.00	0 6, 434, 856 Total (col. 1 + col. 2) 3. 00	18. 00 19. 00
18. 00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruct	of hospital of local indigent	Derations care program Uninsured patients 1.00	Insured patients 2.00	0 6, 434, 856 Total (col. 1 + col. 2) 3. 00	18. 00 19. 00
18. 00 19. 00 20. 00 21. 00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruct Cost of patients approved for charity care and uninsured of	of hospital oplocal indigent ions) iscounts (see	Derations care program Uninsured patients 1.00	Insured patients 2.00	0 6, 434, 856 Total (col. 1 + col. 2) 3.00 52, 345 38, 001	18. 00 19. 00 20. 00 21. 00
18. 00 19. 00 20. 00 21. 00 22. 00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruct Cost of patients approved for charity care and uninsured cinstructions) Payments received from patients for amounts previously wricharity care	of hospital oplocal indigent ions) iscounts (see	Uninsured patients 1.00 31,3 17,0	Insured patients 2.00 20,986 15 20,986 0	0 6, 434, 856 Total (col. 1 + col. 2) 3.00 52, 345 38, 001	20. 00 21. 00
18. 00 19. 00 20. 00 21. 00 22. 00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruct Cost of patients approved for charity care and uninsured cinstructions) Payments received from patients for amounts previously wricharity care	of hospital oplocal indigent ions) iscounts (see	Derations care program Uninsured patients 1.00	Insured patients 2.00 20,986 15 20,986 0	0 6, 434, 856 Total (col. 1 + col. 2) 3.00 52, 345 38, 001	20. 00 21. 00
18. 00 19. 00 20. 00 21. 00 22. 00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruct Cost of patients approved for charity care and uninsured cinstructions) Payments received from patients for amounts previously wricharity care	of hospital oplocal indigent ions) iscounts (see	Uninsured patients 1.00 31,3 17,0	Insured patients 2.00 20,986 15 20,986 0	0 6, 434, 856 Total (col. 1 + col. 2) 3. 00 52, 345 38, 001 0 38, 001	20. 00 21. 00
18. 00 19. 00 20. 00 21. 00 22. 00 23. 00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruct Cost of patients approved for charity care and uninsured cinstructions) Payments received from patients for amounts previously wricharity care	ions) iscounts (see	Uni nsured pati ents 1.00 31,3 17,0	Insured patients 2.00 59 20,986 15 20,986 0 0	0 6, 434, 856 Total (col. 1 + col. 2) 3.00 52, 345 38, 001	20. 00 21. 00 23. 00
18. 00 19. 00 20. 00 21. 00 22. 00 23. 00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruct Cost of patients approved for charity care and uninsured cinstructions) Payments received from patients for amounts previously wricharity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patimposed on patients covered by Medicaid or other indigent	ions) i scounts (see tten off as ient days beyon	Uninsured patients 1.00 31,3 17,0	Insured patients 2.00 59 20,986 15 20,986 0 0 15 20,986 of stay limit	0 6, 434, 856 Total (col. 1 + col. 2) 3.00 52, 345 38, 001 0 38, 001	20. 00 21. 00 22. 00 23. 00
18. 00 19. 00 20. 00 21. 00 22. 00 23. 00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruct Cost of patients approved for charity care and uninsured cinstructions) Payments received from patients for amounts previously wricharity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patimposed on patients covered by Medicaid or other indigent If line 24 is yes, enter the charges for patient days beyon	ions) i scounts (see tten off as ient days beyon	Uninsured patients 1.00 31,3 17,0	Insured patients 2.00 59 20,986 15 20,986 0 0 15 20,986 of stay limit	0 6, 434, 856 Total (col. 1 + col. 2) 3. 00 52, 345 38, 001 0 38, 001	20. 00 21. 00 22. 00 23. 00
18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruct Cost of patients approved for charity care and uninsured cinstructions) Payments received from patients for amounts previously wricharity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patimposed on patients covered by Medicaid or other indigent lif line 24 is yes, enter the charges for patient days beyoney	ient days beyon care program?	Uninsured patients 1.00 31,3 17,0	Insured patients 2.00 59 20,986 15 20,986 0 0 15 20,986 of stay limit	0 6, 434, 856 Total (col. 1 + col. 2) 3. 00 52, 345 38, 001 0 38, 001 1. 00 N	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00
18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruct Cost of patients approved for charity care and uninsured cinstructions) Payments received from patients for amounts previously wricharity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patimposed on patients covered by Medicaid or other indigent If line 24 is yes, enter the charges for patient days beyonstay limit Charges for insured patients' liability (see instructions)	ient days beyon care program?	Uninsured patients 1.00 31,3 17,0	Insured patients 2.00 59 20,986 15 20,986 0 0 15 20,986 of stay limit	0 6, 434, 856 Total (col. 1 + col. 2) 3. 00 52, 345 38, 001 0 38, 001 1. 00 N	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00
18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 25. 01 26. 00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruct Cost of patients approved for charity care and uninsured cinstructions) Payments received from patients for amounts previously wricharity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patimposed on patients covered by Medicaid or other indigent If line 24 is yes, enter the charges for patient days beyonstay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions)	ient days beyon care program?	Uninsured patients 1.00 31,3 17,0	Insured patients 2.00 59 20,986 15 20,986 0 0 15 20,986 of stay limit	0 6, 434, 856 Total (col. 1 + col. 2) 3. 00 52, 345 38, 001 0 38, 001 1. 00 N 0 9, 718, 753	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00
18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 01 26. 00 27. 00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruct Cost of patients approved for charity care and uninsured cinstructions) Payments received from patients for amounts previously wricharity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patimposed on patients covered by Medicaid or other indigent If line 24 is yes, enter the charges for patient days beyons tay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions)	ient days beyon care program?	Uninsured patients 1.00 31,3 17,0	Insured patients 2.00 59 20,986 15 20,986 0 0 15 20,986 of stay limit	0 6, 434, 856 Total (col. 1 + col. 2) 3. 00 52, 345 38, 001 0 38, 001 1. 00 N 0 9, 718, 753 123, 983	20. 00 21. 00 22. 00 23. 00 25. 00 26. 00 27. 00
18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 01 26. 00 27. 00 27. 01	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruct Cost of patients approved for charity care and uninsured cinstructions) Payments received from patients for amounts previously wricharity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patimposed on patients covered by Medicaid or other indigent If line 24 is yes, enter the charges for patient days beyons tay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions)	ient days beyon care program?	Uninsured patients 1.00 31,3 17,0	Insured patients 2.00 59 20,986 15 20,986 0 0 15 20,986 of stay limit	0 6, 434, 856 Total (col. 1 + col. 2) 3.00 52, 345 38, 001 0 38, 001 1.00 N 0 9, 718, 753 123, 983 190, 744	20. 00 21. 00 22. 00 23. 00 25. 00 25. 00 27. 00 27. 00
18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 01 26. 00 27. 01 28. 00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruct Cost of patients approved for charity care and uninsured cinstructions) Payments received from patients for amounts previously wricharity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patimposed on patients covered by Medicaid or other indigent If line 24 is yes, enter the charges for patient days beyonstay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions) Non-Medicare bad debt amount (see instructions)	ions) iscounts (see tten off as ient days beyon care program? nd the indigen	Uninsured patients 1.00 31,3 17,0 17,0 and a Length of the care progra	Insured patients 2.00 59 20,986 15 20,986 0 0 15 20,986 of stay limit	0 6, 434, 856 Total (col. 1 + col. 2) 3.00 52, 345 38, 001 0 38, 001 1.00 N 0 9, 718, 753 123, 983 190, 744 9, 528, 009	20. 00 21. 00 22. 00 23. 00 25. 00 25. 00 27. 00 28. 00
17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 01 26. 00 27. 01 28. 00 27. 01 28. 00 29. 00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instruct Cost of patients approved for charity care and uninsured cinstructions) Payments received from patients for amounts previously wricharity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patimposed on patients covered by Medicaid or other indigent If line 24 is yes, enter the charges for patient days beyons the summer of the composition of	ions) iscounts (see tten off as ient days beyon care program? nd the indigen:	Uninsured patients 1.00 31,3 17,0 17,0 and a Length of the care progra	Insured patients 2.00 59 20,986 15 20,986 0 0 15 20,986 of stay limit	0 6, 434, 856 Total (col. 1 + col. 2) 3.00 52, 345 38, 001 0 38, 001 1.00 N 0 9, 718, 753 123, 983 190, 744	20. 00 21. 00 22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 29. 00

HOSPI 1	TAL UNCOMPENSATED AND INDIGENT CARE DATA Provi	der CCN: 15-1330	Peri od: From 01/01/2023 To 12/31/2023		epared:
				1. 00	
	PART II - HOSPITAL DATA				
	Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)				1.00
	Medicaid (see instructions for each line)				
2. 00	Net revenue from Medicaid				2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		. 10		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental p		cai d'?		4.00
5. 00 6. 00	If line 4 is no, then enter DSH and/or supplemental payments from M Medicaid charges	leui cai u			5.00
7. 00	Medicaid cost (line 1 times line 6)				7.00
8. 00	Difference between net revenue and costs for Medicaid program (see	instructions)		•	8.00
0.00	Children's Health Insurance Program (CHIP) (see instructions for ea				1 0.00
9.00	Net revenue from stand-alone CHIP	<u> </u>			9.00
10.00	Stand-alone CHIP charges				10.00
11. 00	Stand-alone CHIP cost (line 1 times line 10)				11.00
12. 00	Difference between net revenue and costs for stand-alone CHIP (see				12.00
40.00	Other state or local government indigent care program (see instruct				40.00
13. 00 14. 00	Net revenue from state or local indigent care program (Not included Charges for patients covered under state or local indigent care pro				13.00
14.00	10)	igi alli (NOT THET due	a ili ililes o oi		14.00
15. 00	State or local indigent care program cost (line 1 times line 14)				15.00
16.00	Difference between net revenue and costs for state or local indigen	t care program (s	ee instructions)		16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP an	d state/local inc	igent care progra	ams (see	
	instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding				17.00
18. 00 19. 00	Government grants, appropriations or transfers for support of hospi		ma (aum af linas		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)	ingent care progra	IIIS (Suill OI TITIES		19.00
	jo, 12 did 10)	Uni nsured	Insured	Total (col. 1	
		patients	pati ents	+ col . 2)	
		1.00	2. 00	3. 00	
	Uncompensated care cost (see instructions for each line)				
20. 00	Charity care charges and uninsured discounts (see instructions)				20.00
21. 00	Cost of patients approved for charity care and uninsured discounts	(see			21.00
22. 00	instructions) Payments received from patients for amounts previously written off	26			22.00
22.00	charity care	as			22.00
23. 00	1				23.00
				1. 00	0, -
24. 00	Does the amount on line 20 col. 2, include charges for patient days		of stay limit		24.00
25. 00	imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the in		am's Longth of		25. 00
23.00	stay limit	urgent care progr	am 3 rengtii 01		25.00
25 01	Chargos for insured nationts' liability (see instructions)				25 01

26. 00 27. 00

27.01

28. 00 29. 00

30.00

31.00

25.01 Charges for insured patients' liability (see instructions)

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

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

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

26.00 Bad debt amount (see instructions)
27.00 Medicare reimbursable bad debts (see instructions)

27.01 Medicare allowable bad debts (see instructions)

Heal th	Financial Systems	ADAMS MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider Co		Period: From 01/01/2023 Fo 12/31/2023	Worksheet A Date/Time Pre 5/29/2024 8:4	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Recl assi fi cat i ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT		2, 057, 404	2, 057, 404	83, 962		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0	(0	0	2.00
3. 00	00300 OTHER CAP REL COSTS		0	(0	0	3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	133, 939	139, 591	273, 530		273, 530	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	3, 660, 492	9, 776, 980			13, 337, 978	5. 00
7. 00	00700 OPERATION OF PLANT	0	2, 328, 778				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	90, 205	195, 523			285, 728	8.00
9.00	00900 HOUSEKEEPI NG	688, 332	288, 522			980, 805	
10.00	01000 DI ETARY	673, 838	799, 082	1, 472, 920	0	1, 472, 920	
11.00	01100 CAFETERI A	007 070	0	1 1/2 47	0	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	937, 273	225, 202	1, 162, 47		1, 162, 475	
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	014 554	470 200	1, 595, 863		1 505 043	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	916, 554 362, 765	679, 309 213, 051	575, 810		1, 595, 863 575, 816	
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	302, 703	213,031	575, 610	J ₁ 0	373, 610	10.00
30. 00	03000 ADULTS & PEDI ATRI CS	3, 828, 053	3, 026, 824	6, 854, 87	7 -24, 611	6, 830, 266	30.00
31.00	03100 NTENSI VE CARE UNI T	792, 995	846, 019			1, 639, 014	1
40.00	04000 SUBPROVI DER - I PF	7,72,7,75	040, 017	1,037,014	0	0	40.00
43. 00	04300 NURSERY	Ö	0	1	7, 533	7, 533	
44. 00	04400 SKILLED NURSING FACILITY	o	0		0	0	44. 00
	ANCILLARY SERVICE COST CENTERS	-1				-	
50.00	05000 OPERATI NG ROOM	2, 554, 704	3, 473, 215	6, 027, 919	9 0	6, 027, 919	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(17, 078	17, 078	52.00
53.00	05300 ANESTHESI OLOGY	0	0	(0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 509, 142	1, 898, 528	3, 407, 670	0	3, 407, 670	54.00
60.00	06000 LABORATORY	1, 625, 859	3, 156, 636	4, 782, 495	7, 070	4, 789, 565	60.00
65.00	06500 RESPI RATORY THERAPY	582, 666	190, 470	773, 136	0	773, 136	65.00
66.00	06600 PHYSI CAL THERAPY	2, 072, 819	642, 745	2, 715, 56	1 0	2, 715, 564	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	571, 506	129, 131			700, 637	1
68. 00	06800 SPEECH PATHOLOGY	290, 919	48, 463			339, 382	1
69. 00	06900 ELECTROCARDI OLOGY	0	0	(0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1 22/ 12/	1 20/ 10/	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	1, 226, 126			1, 226, 126	
73.00	07300 DRUGS CHARGED TO PATIENTS	1 007 007	1, 558, 763			1, 558, 763	
76. 00 76. 01	03020 OP PSYCH 03030 WOUND CARE	1, 007, 007 365, 010	250, 159 111, 739			1, 257, 166 476, 749	
70.01	OUTPATIENT SERVICE COST CENTERS	303,010	111, 737	470,74	7	470, 747	70.01
88. 00	08800 MONROE FAMILY MEDICINE	1, 903, 251	725, 213	2, 628, 464	1 0	2, 628, 464	88. 00
88. 01	08801 WOODCREST	1, 239, 123	569, 079			1, 808, 202	
88. 02	08802 STAT CARE	1, 147, 285	471, 603			1, 618, 888	
88. 03	08803 BERNE FAMILY MEDICINE	1, 247, 672	748, 534			1, 996, 206	
88. 04	1 1	949, 239	471, 684				
90.00	09000 CLI NI C	3, 169, 456	1, 598, 888	4, 768, 344	-58, 934	4, 709, 410	90.00
90. 01	09001 CLINIC - AMO	2, 232, 528	430, 597	2, 663, 125	21, 110	2, 684, 235	90. 01
90. 02	09002 CLINIC - AMH NEURO	869, 971	133, 346	1, 003, 31	24, 324	1, 027, 641	90.02
90. 03	09003 GENERAL SURGERY OFFICE	1, 478, 983	741, 769	2, 220, 752	25, 625	2, 246, 377	90. 03
90.04	04950 I NTENSI VE OP BEHAVI ORAL HEALTH	0	0	(0	0	
91.00	09100 EMERGENCY	3, 010, 376	1, 168, 552	4, 178, 928	0	4, 178, 928	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES	1, 476, 252	885, 286			2, 361, 538	
	09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	9		0	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0	U	101.00
116 00	11600 HOSPI CE	0					116. 00
118.00		41, 388, 214	41, 206, 811	82, 595, 025	8, 792		
110.00	NONREI MBURSABLE COST CENTERS	41, 300, 214	41, 200, 011	02, 373, 02	0, 172	02,003,017	110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190. 00
194.00	07950 TITLE XX	ol O	0				194. 00
	07951 OTHER NRCC	740, 270	461, 410	1, 201, 680	-24, 324	1, 177, 356	
	07952 OTHER MOBS	0	0	., _5., 560	15, 532	15, 532	
	07953 I DLE SPACE	ől	0	Ì	0		194. 03
	07954 OTHER NONREIMBURSABLE COST CENTERS	o	322, 219		e o	322, 219	
200.00		42, 128, 484	41, 990, 440	84, 118, 92			

Provi der CCN: 15-1330

				10 12/31/2023 Date/lime Pro 5/29/2024 8:	
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
		4.00	Allocation		
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT	-108, 306	2, 033, 060		1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	00300 OTHER CAP REL COSTS	0	0		3.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	273, 530		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 254, 652	14, 592, 630		5.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	698, 106 0	3, 028, 062		7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	0	285, 728 980, 805		9.00
10. 00	01000 DI ETARY	-410, 314	1, 062, 606		10.00
11. 00	01100 CAFETERI A	0	0		11.00
13.00	01300 NURSING ADMINISTRATION	0	1, 162, 475		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		14.00
15. 00	01500 PHARMACY	-127, 208	1, 468, 655	l .	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	-23, 862	551, 954		16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	-576, 070	6, 254, 196		30.00
31. 00	03100 NTENSIVE CARE UNIT	-576, 070 -6, 863	1, 632, 151		31.00
40. 00	04000 SUBPROVI DER - I PF	0, 000	0		40.00
43.00	04300 NURSERY	0	7, 533		43.00
44.00	04400 SKILLED NURSING FACILITY	0	0		44. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-1, 309, 729	4, 718, 190	·	50.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	17, 078 0		52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	3, 407, 670		54.00
60.00	06000 LABORATORY	-110, 950	4, 678, 615	·	60.00
65. 00	06500 RESPI RATORY THERAPY	-97, 318	675, 818		65.00
66.00	06600 PHYSI CAL THERAPY	0	2, 715, 564		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	700, 637		67. 00
68.00	06800 SPEECH PATHOLOGY	0	339, 382		68.00
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		69. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATTENTS	0	1, 226, 126		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	-249, 510	1, 309, 253		73.00
76.00	03020 OP PSYCH	-352, 403	904, 763		76.00
76. 01	03030 WOUND CARE	-95, 435	381, 314		76. 01
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 MONROE FAMILY MEDICINE	0	2, 628, 464		88.00
88. 01 88. 02	08801 WOODCREST 08802 STAT CARE	0	1, 808, 202		88. 01 88. 02
88. 03	08803 BERNE FAMILY MEDICINE	-53, 859	1, 618, 888 1, 942, 347		88. 03
88. 04	08804 HI GH STREET	-39, 643	1, 381, 280		88. 04
90.00	09000 CLI NI C	-2, 202, 627	2, 506, 783		90.00
90. 01	09001 CLINIC - AMO	-2, 012, 744	671, 491		90. 01
	09002 CLINIC - AMH NEURO	-757, 002	270, 639		90. 02
	09003 GENERAL SURGERY OFFICE	-1, 656, 653	589, 724		90.03
90.04	04950 INTENSIVE OP BEHAVIORAL HEALTH 09100 EMERGENCY	0 -1, 023, 503	0 3, 155, 425	l .	90. 04 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-1,023,303	3, 133, 423		92.00
72.00	OTHER REIMBURSABLE COST CENTERS				72.00
95.00	09500 AMBULANCE SERVI CES	-41, 166	2, 320, 372		95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
101.00	10100 HOME HEALTH AGENCY	0	0		101.00
44/ 00	SPECIAL PURPOSE COST CENTERS		ما		111 00
116.00	11600 HOSPI CE	0 -9, 302, 407	72 201 410		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	-9, 302, 407	73, 301, 410		118. 00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0		190.00
	07950 TITLE XX	ő	Ö		194.00
	07951 OTHER NRCC	0	1, 177, 356		194. 01
	2 07952 OTHER MOBS	0	15, 532	l .	194. 02
	3 07953 I DLE SPACE	0	0	l .	194. 03
194. 04 200. 00	O7954 OTHER NONREIMBURSABLE COST CENTERS TOTAL (SUM OF LINES 118 through 199)	0 202 407	322, 219 74, 816, 517		194. 04 200. 00
200. UC	PI TOTAL (SUM OF LINES FIG THEOUGH 199)	-9, 302, 407	74,010,017	I	₁ 200.00

Heal th Financial Systems

ADAMS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

RECLASSIFICATIONS

Provider CCN: 15-1330
Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared:

					5/29/2024 8:	
		Increases		·		
	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		2, 296		1.00
2.00	DELIVERY ROOM & LABOR ROOM _	5200	1 <u>1, 8</u> 74	<u>5, 2</u> 04		2. 00
	0		17, 111	7, 500		
	B - INSURANCE					
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	0	83, 962		1.00
	FIXT					
2. 00	OTHER MOBS	1 <u>94.</u> 02	0	1 <u>5, 5</u> 32		2. 00
	0	ITEMA OF	0	99, 494		_
	K - RECLASS MOC BUILDING MAIN					
1. 00	OPERATION OF PLANT	7. 00	0	1, 178		1.00
2.00	HOUSEKEEPI NG	9. 00	0	3, 951		2.00
3.00	LABORATORY	60.00	0	7, 070		3.00
4.00	CLINIC	90. 00	0	72, 587		4.00
5.00	CLINIC - AMO	90. 01	0	21, 110		5. 00
6.00	GENERAL SURGERY OFFICE	90. 03	0	25, 625		6. 00
	TOTALS		0	131, 521		
	L - RECLASS NEURO CLINIC BUIL	DING COSTS				
1.00	CLINIC - AMH NEURO	90. 02	0	2 <u>4, 3</u> 24		1.00
	TOTALS		0	24, 324		
500.00	Grand Total: Increases		17, 111	262, 839		500.00

Health Financial Systems

ADAMS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-1330
Period:
From 01/01/2023
To 12/31/2023 Date/Time Prepared:

					То	12/31/2023 Date/Time Pi 5/29/2024 8:	repared: 49 am
		Decreases		'		6, 2, 7, 2, 62, 1	1
	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	17, 111	7, 500	0		1.00
2.00			0	0	0		2.00
	0		17, 111	7, 500			
	B - INSURANCE						
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	99, 494	12		1.00
2.00		0.00	0	0	0		2.00
	0		0	99, 494			
	K - RECLASS MOC BUILDING MAIN						
1. 00	CLINIC	90. 00	0	131, 521	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	0		6. 00
	TOTALS		0	131, 521			_
	L - RECLASS NEURO CLINIC BUIL						
1. 00	OTHER NRCC	1 <u>94.</u> 01	0	2 <u>4, 3</u> 24			1.00
	TOTALS		0	24, 324			
500.00	Grand Total: Decreases		17, 111	262, 839			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS ADAMS MEMORIAL HOSPITAL

Provi der CCN: 15-1330

					To 12/31/2023	B Date/Time Pre 5/29/2024 8:4	pared: 9 am
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s 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	473, 119	0		0	0	1.00
2.00	Land Improvements	2, 267, 188	0		0	0	2.00
3.00	Buildings and Fixtures	42, 774, 185	0		0	0	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	9, 719, 737	0		0 0	0	5. 00
6.00	Movable Equipment	20, 765, 689	0		0 0	0	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	75, 999, 918	0		0 0	0	8.00
9.00	Reconciling Items	0	0		0	0	9.00
10.00	Total (line 8 minus line 9)	75, 999, 918	0		0 0	0	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
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	Fixed Equipment	9, 719, 737	0				5.00
6.00	Movable Equipment	20, 765, 689	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	75, 999, 918	0				8.00
9.00	Reconciling Items	0	0				9.00
10. 00	Total (line 8 minus line 9)	75, 999, 918	o				10.00

Heal th	Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7	
					From 01/01/2023 To 12/31/2023		narodi
					10 12/31/2023	5/29/2024 8: 4	
			SL	JMMARY OF CAPI	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, COLUN	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	1, 602, 725	0	454, 67	9 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2.00
3.00	Total (sum of lines 1-2)	1, 602, 725		454, 67	9 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at					
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2, 057, 404				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
0 00	T-1-1 (C 11 4 0)		0 057 404	1			1 2 22

0 0

2, 057, 404

3.00

3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2023 To 12/31/2023	Date/Time Prep 5/29/2024 8: 49	pared:
		COMF	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
		1, 00	2.00	col. 2) 3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	5.00	
1.00	NEW CAP REL COSTS-BLDG & FLXT	54, 761, 110	0	54, 761, 11	0. 725055	0	1.00
2. 00	NEW CAP REL COSTS-MVBLE EQUIP	20, 765, 689	l .	20, 765, 68			2. 00
3.00	Total (sum of lines 1-2)	75, 526, 799	0	75, 526, 79	9 1. 000000	o	3.00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)			
	DART III DECONCILIATION OF CARLTAL COCTO	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C NEW CAP REL COSTS-BLDG & FIXT	ENTERS 0		1	0 1, 630, 154	0	1. 00
2. 00	NEW CAP REL COSTS-BLDG & FIXT	0	ľ		0 1, 030, 134 0 0		2. 00
3. 00	Total (sum of lines 1-2)	0			0 1, 630, 154		3. 00
0.00	Total (Sam of Titles 1 2)	Ü	SI	JMMARY OF CAPI		Ü	0.00
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)	Capi tal -Rel at		
			instructions)			9 through 14)	
		11.00	12.00	12.00	instructions)	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12. 00	13.00	14. 00	15. 00	
1. 00	NEW CAP REL COSTS-BLDG & FIXT	318, 944	83, 962	,	0 0	2, 033, 060	1. 00
2. 00	NEW CAP REL COSTS-DEDG & TTAT	0		1	0 0		2.00
3. 00	Total (sum of lines 1-2)	318, 944	1	1	o o	l .	3. 00
				1			

Health Financial Systems
ADJUSTMENTS TO EXPENSES ADAMS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 | Peri od: | Worksheet A-8 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-1330

				To	12/31/2023	Date/Time Pre 5/29/2024 8: 4	
				Expense Classification on		0,2,,2021 0.1) diii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)	2.00	2.00	4.00	Ref.	
1. 00	Investment income - NEW CAP	1. 00 B	2. 00 -141 688	3.00 NEW CAP REL COSTS-BLDG &	4. 00	5. 00 11	1.00
1.00	REL COSTS-BLDG & FIXT (chapter	b	111,000	FIXT	1.00		1.00
	2)						
2. 00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		0	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
	2)			2011			
3. 00	Investment income - other		0		0. 00	0	3.00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
4.00	discounts (chapter 8)		O		0.00		4.00
5. 00	Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
0.00	suppliers (chapter 8)		O		0.00		0.00
7. 00	Tel ephone servi ces (pay		0		0. 00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service	Α	-7, 445	ADMINISTRATIVE & GENERAL	5. 00	0	8. 00
	(chapter 21)						
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-9, 841, 749		0. 00	0	9. 00 10. 00
10.00	adjustment	A-8-2	-9,841,749			U	10.00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
10.00	(chapter 23)	4.0.1	2 07/ 210				10.00
12. 00	Related organization transactions (chapter 10)	A-8-1	3, 076, 310			0	12.00
13.00	Laundry and linen service		0		0. 00	0	13.00
14.00	Cafeteria-employees and guests	В	-410, 314	DI ETARY	10.00	0	
15. 00	Rental of quarters to employee and others		U		0. 00	0	15. 00
16.00	Sale of medical and surgical		0		0. 00	0	16.00
	supplies to other than						
17. 00	patients Sale of drugs to other than	В	-249 510	DRUGS CHARGED TO PATIENTS	73. 00	0	17. 00
17.00	pati ents	5	217,010	DIGGS SIMINGED TO TATTENTS	70.00	Ĭ	17.00
18. 00	Sale of medical records and	В	-23, 862	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19. 00
17.00	education (tuition, fees,		Ö		0.00	Ĭ	17.00
	books, etc.)						
20.00	Vending machines Income from imposition of		0		0. 00 0. 00	0	•
21.00	interest, finance or penalty		O		0.00	Ĭ	21.00
	charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24.00
	therapy costs in excess of						
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
25.00	physicians' compensation		Ö	cost center bereted	114.00		25.00
	(chapter 21)		_			_	
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FLXT		0	NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
27. 00	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE	2. 00	0	27. 00
20. 22	COSTS-MVBLE EQUIP		=	EQUIP	10.5		20.00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	67. 00		30.00
	therapy costs in excess of						
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
50. 77	instructions)		0	LIBOLIO & LEDIATRICO	30.00		30. 77
	·				'		·

-513, 332 ADMINISTRATIVE & GENERAL

-386, 809 ADMINISTRATIVE & GENERAL

-102, 895 ADMI NI STRATI VE & GENERAL

-49, 775 ADMINISTRATI VE & GENERAL

5, 953 NEW CAP REL COSTS-BLDG &

-53, 859 BERNE FAMILY MEDICINE

-110, 950 LABORATORY

-39, 643 HI GH STREET

FI XT

-10, 280 OP PSYCH

-43,000 OP PSYCH

-98,000 OP PSYCH

-9, 302, 407

OOP PSYCH

5.00

5.00

5.00

60.00

76.00

5.00

88.03

88.04

0.00

1.00

76.00

76.00

76.00

33.07

33.09

33.10

33.11

33.12

34.00

34 01

34.02

34.03

34.04

34.05

34.07

50.00

11

0 34.06

Α

Α

Α

В

В

В

В

В

Α

В

В

B

(2) Basis for adjustment (see instructions)

HOSPITAL PROVIDER TAX

PHYSICIAN RECRUITING

MISC PSYCH INCOME

RENTAL INCOME

RENTAL INCOME

RENTAL INCOME

(3)

VALUE ASSIGNMENT/MISC TESTING

OTHER ADJUSTMENTS (SPECIFY)

LAPSE LOSS ON REFINANCING

NA SCHOOL SERVICES - OP BH

(Transfer to Worksheet A,

COMMUNITY CORRECTIONS SERVICES

TOTAL (sum of lines 1 thru 49)

EAP SERVICES - OP BH

SHORTFALL

MARKETI NG

33.07

33.09

33.10

33. 11

33. 12

34.00

34.01

34.02

34.03

34.04

34.05

34.06

34.07

50.00

B. Amount Received - if cost cannot be determined.

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

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

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

					<u> 5/29/2024 8: 4</u>	<u> 19 am</u>	
	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	90, 331	62, 902	1.00	
2.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE AND IT COSTS	6, 057, 311	3, 706, 536	2.00	
3.00	7. 00	OPERATION OF PLANT	MAINTENANCE AND GROUNDS	1, 336, 163	638, 057	3.00	
3. 01	0.00			0	0	3. 01	
3. 02	0.00			0	0	3. 02	
3. 03	0.00			0	0	3.03	
3.04	0.00			0	0	3.04	
3.05	0.00			0	0	3.05	
3.06	0.00			0	0	3.06	
4.00	0.00			0	0	4.00	
5. 00	0		0	7, 483, 805	4, 407, 495	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	ł		
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 Syste	ems		ADAMS N	MEMORI AL	HOSPI TAL		In Lieu	of Form CMS-	2552-10
STATEME OFFICE		SERVI C	ES FROM	I RELATED ORGANIZATIONS A	ND HOME	Provi der	CCN: 15-1330	Peri od: From 01/01/2023	Worksheet A-	8-1
								To 12/31/2023	Date/Time Pro 5/29/2024 8:4	
	Net	Wkst. A	-7 Ref.							
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6. 00	7.	00							
	A. COSTS INCUR	RED AND	ADJUST	MENTS REQUIRED AS A RESU	LT OF TR	ANSACTI ONS	WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:									
1.00	27, 429		9	9						1.00
2.00	2, 350, 775		0							2.00
3.00	698, 106		0							3.00
3. 01	0		0							3. 01
3. 02	0		0							3. 02
3. 03	0		0							3. 03
3. 04	0		0							3. 04
3. 05	0		0							3.05
3. 06	0		0	ol						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.

Termbur Schieft under trette 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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-1330

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

5/29/2024 8: 49 am Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er der Component Remuneration Component Component Hours 1.00 2.00 3. 00 4.00 5.00 6 00 7 00 30.00 ADULTS & PEDIATRICS 1.00 576,070 576,070 1.00 6, 863 2.00 31.00 INTENSIVE CARE UNIT 6,863 0 0 0 2.00 50. 00 OPERATING ROOM 1, 309, 729 3.00 1, 309, 729 0 0 0 0 0 3.00 76. 00 OP PSYCH 0 201, 123 201, 123 4 00 4 00 0 90. 00 CLI NI C 5.00 2, 287, 023 2, 202, 627 84, 396 0 5.00 6.00 90. 01 CLINIC - AMO 2, 012, 744 2,012,744 6.00 90. 02 CLINIC - AMH NEURO 90. 03 GENERAL SURGERY OFFICE 0 7.00 757, 002 757.002 0 7.00 44, 510 8.00 1, 701, 163 1,656,653 0 8.00 0 9.00 91. 00 EMERGENCY 2, 180, 449 1,023,503 1, 156, 946 9.00 10.00 76. 01 WOUND CARE 95, 435 95, 435 0 10.00 11, 127, 601 9, 841, 749 1, 285, 852 200.00 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of I denti fi er Li mi t Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col Insurance Education 12.00 1.00 2.00 8. 00 9.00 13.00 14. 00 30.00 ADULTS & PEDIATRICS 1.00 0 0 1.00 2.00 31.00 INTENSIVE CARE UNIT 0 0 0 0 2.00 3.00 50. 00 OPERATING ROOM 0 0 0 0 3.00 0 76. 00 OP PSYCH 90. 00 CLI NI C 0 0 0 4 00 0 4 00 5.00 0 0 0 0 5.00 0 90. 01 CLINIC - AMO 6.00 0 0 0 0 0 6.00 90. 02 CLINIC - AMH NEURO 90. 03 GENERAL SURGERY OFFICE 0 7 00 7.00 0 0 0 0 8.00 0 8.00 9.00 91. 00 EMERGENCY 0 0 9.00 76. 01 WOUND CARE 0 10.00 0 0 0 0 10.00 o 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment I denti fi er Component Limit Di sal I owance Share of col. 14 2.00 1.00 15.00 16.00 17.00 18.00 1.00 30. 00 ADULTS & PEDIATRICS 0 0 576,070 1.00 31.00 INTENSIVE CARE UNIT 0 0 0 2.00 6,863 2.00 0 3.00 50. OOOPERATING ROOM 0 0 1, 309, 729 3.00 76.00 OP PSYCH 0 4.00 201, 123 4.00 5.00 90. 00 CLI NI C 0 0 0 2, 202, 627 5.00 6.00 90. 01 CLINIC - AMO 0 0 2, 012, 744 6.00 90. 02 CLINIC - AMH NEURO 90. 03 GENERAL SURGERY OFFICE 7.00 0 0 0 757,002 7 00 0 0 8.00 0 1,656,653 8.00 9.00 91. 00 EMERGENCY o 0 1, 023, 503 9.00 76. 01 WOUND CARE 0 0 10.00 0 95, 435 10.00 9, 841, 749 200.00 200.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1330

					Ť	o 12/31/2023	Date/Time Pre 5/29/2024 8:4	
				CAPI TAL REI	LATED COSTS		3/27/2024 0.4	7 dili
		Cost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal	
		cost center bescription	for Cost	FLXT	EQUI P	BENEFI TS	Subtotal	
			Allocation			DEPARTMENT		
			(from Wkst A col. 7)					
			0	1. 00	2.00	4. 00	4A	
		AL SERVICE COST CENTERS						
1. 00 2. 00		NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP	2, 033, 060	2, 033, 060	0			1. 00 2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	273, 530	0				4.00
5. 00	00500	ADMINISTRATIVE & GENERAL	14, 592, 630	184, 521	0		14, 800, 992	5. 00
7.00		OPERATION OF PLANT	3, 028, 062	278, 325	•		3, 306, 387	7.00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	285, 728 980, 805	32, 340 53, 514			318, 656 1, 038, 802	8. 00 9. 00
10.00	01000	DI ETARY	1, 062, 606	127, 622	0	4, 389	1, 194, 617	10.00
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	1 142 475	0 F 011		_	1 174 400	11.00
14. 00		CENTRAL SERVICES & SUPPLY	1, 162, 475 0	5, 911 0			1, 174, 490 0	13. 00 14. 00
15.00	01500	PHARMACY	1, 468, 655	41, 749		· ·	1, 516, 374	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	551, 954	47, 491	0	2, 363	601, 808	16. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	6, 254, 196	299, 310	0	24, 840	6, 578, 346	30. 00
31.00	03100	INTENSIVE CARE UNIT	1, 632, 151	53, 757			1, 691, 073	
		SUBPROVI DER - I PF	0	0	1		0	40.00
43. 00 44. 00		NURSERY SKILLED NURSING FACILITY	7, 533	28, 001 0	1		35, 568 0	43. 00 44. 00
44.00	ANCI L	LARY SERVICE COST CENTERS	<u> </u>	<u> </u>		U	O	44.00
50.00		OPERATING ROOM	4, 718, 190	205, 096		·	4, 939, 925	50.00
52. 00 53. 00	1	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	17, 078	28, 001 0			45, 156 0	52. 00 53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	3, 407, 670	165, 629	1		3, 583, 128	
60.00		LABORATORY	4, 678, 615	73, 434			4, 762, 638	
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	675, 818 2, 715, 564	76, 483 170, 736			756, 096 2, 899, 800	65. 00 66. 00
67. 00		OCCUPATIONAL THERAPY	700, 637	1, 870			706, 229	67. 00
68. 00		SPEECH PATHOLOGY	339, 382	935			342, 212	68. 00
69. 00 71. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	69. 00 71. 00
71.00		IMPL. DEV. CHARGED TO PATIENT	1, 226, 126	0		0	1, 226, 126	
73. 00		DRUGS CHARGED TO PATIENTS	1, 309, 253	0			1, 309, 253	
		OP PSYCH WOUND CARE	904, 763 381, 314	0		· ·	911, 322 383, 691	76. 00 76. 01
70.01	OUTPA	TIENT SERVICE COST CENTERS	301, 314	0	0	2,311	303, 071	70.01
88. 00	08800	MONROE FAMILY MEDICINE	2, 628, 464	0		· ·	2, 640, 860	
88. 01		WOODCREST STAT CARE	1, 808, 202	42 104	1	·	1, 816, 272	88. 01 88. 02
88. 02 88. 03	1	BERNE FAMILY MEDICINE	1, 618, 888 1, 942, 347	42, 104 0		.,	1, 668, 464 1, 950, 473	
88. 04	08804	HI GH STREET	1, 381, 280	0		6, 182	1, 387, 462	88. 04
	1	CLINIC AMO	2, 506, 783	0	0	20, 643	2, 527, 426	
90. 01 90. 02		CLINIC - AMO CLINIC - AMH NEURO	671, 491 270, 639	0		14, 540 5, 666	686, 031 276, 305	90. 01 90. 02
90. 03		GENERAL SURGERY OFFICE	589, 724	0	0	9, 633	599, 357	90. 03
		INTENSIVE OP BEHAVIORAL HEALTH	0	103.000	0		0	90.04
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	3, 155, 425	103, 998	0	19, 607	3, 279, 030 0	91. 00 92. 00
72.00		REI MBURSABLE COST CENTERS						72.00
95.00		AMBULANCE SERVICES	2, 320, 372	0	•	·	2, 329, 987	95.00
		DURABLE MEDICAL EQUIP-SOLD HOME HEALTH AGENCY	0	0			0	97. 00 101. 00
	SPECI.	AL PURPOSE COST CENTERS	9			3		
	1	HOSPICE	0	0	•			116.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	73, 301, 410	2, 020, 827	0	268, 709	73, 284, 356	118.00
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	12, 233	0	0	12, 233	
		TITLE XX	0	0				194.00
		OTHER NRCC OTHER MOBS	1, 177, 356 15, 532	0		4, 821 0	1, 182, 177 15, 532	
194. 03	07953	IDLE SPACE	0	0	0	o o	0	194. 03
		OTHER NONREIMBURSABLE COST CENTERS	322, 219	0	0	0	322, 219	
200. 00 201. 00	1	Cross Foot Adjustments Negative Cost Centers		0	0	0		200. 00 201. 00
202.00	1	TOTAL (sum lines 118 through 201)	74, 816, 517	2, 033, 060				
		-	·			·		

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared: 5/29/2024 8:40 am

				''	0 12/31/2023	5/29/2024 8: 4	
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	PLANT	LINEN SERVICE			
	Ta	5. 00	7. 00	8.00	9. 00	10. 00	
1 00	GENERAL SERVICE COST CENTERS			1			1 00
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	14 000 000					4.00
5.00	00500 ADMINISTRATIVE & GENERAL	14, 800, 992	4 101 005				5.00
7.00	00700 OPERATION OF PLANT	815, 418	4, 121, 805	1			7.00
8. 00	00800 LAUNDRY & LI NEN SERVI CE	78, 587	65, 969		l		8.00
9.00	00900 HOUSEKEEPI NG	256, 188	109, 160	1	.,,	1 042 770	9.00
10.00	01000 DI ETARY 01100 CAFETERI A	294, 615 0	260, 329	1	93, 209	1, 842, 770 0	
11. 00 13. 00	01300 NURSI NG ADMI NI STRATI ON		12.057	_	4 217	0	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	289, 652	12, 057		4, 317	0	14.00
15. 00	01500 PHARMACY	373, 967	85, 161		30, 491	0	15.00
16. 00		1		1		0	16.00
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	148, 417	96, 875	1 0	34, 685	U	16.00
30. 00	03000 ADULTS & PEDIATRICS	1, 622, 371	610, 550	370, 474	218, 604	1, 578, 548	30.00
31. 00	03100 INTENSIVE CARE UNIT	417, 051	109, 656	1	39, 262	264, 222	
40.00	04000 SUBPROVI DER – I PF	417,031	109, 656	02,011	39, 202	204, 222	40.00
43. 00	04300 NURSERY	8, 772	57, 117	_	<u>۱</u>	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	0, 772	37, 117	1	20, 431	0	44.00
44.00	ANCI LLARY SERVICE COST CENTERS	U	0	<u> </u>	<u> </u>	0	44.00
50.00	05000 OPERATI NG ROOM	1, 218, 279	756, 227	0	270, 762	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	11, 136	57, 117	1		0	52.00
53.00	05300 ANESTHESI OLOGY	11, 130	37, 117	1	20, 431	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	883, 667	149, 795	· · · · · ·	53, 633	0	54.00
60.00	06000 LABORATORY	1, 174, 557	156, 014	1	55, 860	0	
65.00	06500 RESPIRATORY THERAPY	186, 468	348, 275	1	124, 698	0	65.00
66. 00	06600 PHYSI CAL THERAPY	715, 146	3, 815	1	1, 366	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	174, 169	1, 908	1		0	67.00
68. 00	06800 SPEECH PATHOLOGY	84, 396	1, 700		003	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	04, 370	0		0	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0			0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	302, 386	0			0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	322, 887	0			0	73.00
76. 00	03020 OP PSYCH	224, 749	0			0	76.00
76. 00	03030 WOUND CARE	94, 625	0	0		0	76.00
70.01	OUTPATIENT SERVICE COST CENTERS	74, 023		1 0	<u> </u>		70.01
88. 00	08800 MONROE FAMILY MEDICINE	651, 286	0	0	ام	0	88. 00
88. 01	08801 WOODCREST	447, 927	0	0	ام	0	88. 01
88. 02	08802 STAT CARE	411, 475	85, 886	_	30, 751	Ö	88. 02
88. 03	08803 BERNE FAMILY MEDICINE	481, 024	00,000	i	00,701	0	88. 03
88. 04	08804 HI GH STREET	342, 174	0	0	ام	0	88. 04
90.00	09000 CLINIC	623, 311	351, 480	0	125, 846	0	90.00
90. 01	09001 CLINIC - AMO	169, 188	81, 346	1	29, 125	0	90. 01
90. 02	09002 CLINIC - AMH NEURO	68, 142	74, 592	1		0	90.02
90. 03	09003 GENERAL SURGERY OFFICE	147, 813	98, 744	1	35, 355	0	90.03
90. 04	04950 INTENSIVE OP BEHAVIORAL HEALTH	0	,,,,,,	l ő	0	0	90.04
91.00	09100 EMERGENCY	808, 671	212, 140	l o	75, 955	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	000,011	2.27.10		70,700	,	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00		574, 619	0	0	0	0	95.00
	09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	1		0	
	10100 HOME HEALTH AGENCY	l ol	0				101.00
	SPECIAL PURPOSE COST CENTERS	-1	-	_	-1		
116. 00	11600 HOSPI CE	0	0	0	0	0	116. 00
118. 00		14, 423, 133	3, 784, 213		- 1	1, 842, 770	
	NONREI MBURSABLE COST CENTERS	, .==,,	27 . 2 . 7 = . 2		.,, _,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 017	24, 953	0	ol	0	190.00
	07950 TITLE XX	0	0	ő	l ol		194.00
	07951 OTHER NRCC	291, 547	175, 168	· ·	62, 718		194. 01
	07952 OTHER MOBS	3, 830	137, 471		49, 221		194. 02
	07953 I DLE SPACE	ol	0	Ō	ol		194. 03
	107954 OTHER NONREIMBURSABLE COST CENTERS	79, 465	n	o o			194. 04
200.00			_				200.00
201. 00			0	0	ol		201.00
202.00		14, 800, 992	4, 121, 805	463, 212	1, 404, 150		
	, , , , , , , , , , , , , , , , , , , ,			•	,		•

			10	12/31/2023	Date/lime Pre 5/29/2024 8:4	
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	Zalli
		N N	SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS				ı		1 4 00
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT 5.00 O0500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	0					11.00
13.00 01300 NURSING ADMINISTRATION	0	1, 480, 516				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15. 00 01500 PHARMACY	0	0	0	2, 005, 993		15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	881, 785	16.00
INPATIENT ROUTINE SERVICE COST CENTERS		505.00/		ما	21.211	
30. 00 03000 ADULTS & PEDI ATRI CS	0	525, 086	0	0	84, 264	30.00
31. 00 03100 INTENSIVE CARE UNIT	0	108, 774	0	0	22, 088	31. 00 40. 00
40. 00 04000 SUBPROVI DER - PF 43. 00 04300 NURSERY	0	1 023	0	0	1 200	43.00
44.00 04400 SKILLED NURSING FACILITY	0	1, 033 0	0	0	1, 388 0	44.00
ANCILLARY SERVICE COST CENTERS	0	<u> </u>	<u> </u>	<u> </u>	0	44.00
50. 00 05000 OPERATING ROOM	0	350, 426	0	O	89, 686	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	2, 343	Ö	o	1, 385	•
53. 00 05300 ANESTHESI OLOGY	0	0	0	O	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	o	0	О	182, 625	54.00
60. 00 06000 LABORATORY	0	o	0	o	131, 009	60.00
65. 00 06500 RESPIRATORY THERAPY	0	79, 924	0	0	31, 053	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	0	38, 991	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	16, 021	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	8, 791	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 30, 799	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	2, 005, 993	66, 878	73.00
76. 00 03020 0P PSYCH	0	0	0	2,003,773	725	76.00
76. 01 03030 WOUND CARE	0	Ö	Ö	Ö	3, 157	76. 01
OUTPATIENT SERVICE COST CENTERS				-,		
88.00 08800 MONROE FAMILY MEDICINE	0	0	0	0	16, 997	88. 00
88. 01 08801 WOODCREST	0	0	0	0	14, 681	88. 01
88. 02 08802 STAT CARE	0	0	0	0	16, 708	88. 02
88. 03 08803 BERNE FAMILY MEDICINE	0	0	0	0	13, 746	1
88. 04 08804 HI GH STREET	0	0	0	0	16, 570	88. 04
90. 00 09000 CLI NI C	0	0	0	0	17, 341	•
90. 01 09001 CLINIC - AMO 90. 02 09002 CLINIC - AMH NEURO	0	0	0	0	5, 054	•
90.02 09002 CLINIC - AMH NEURO 90.03 09003 GENERAL SURGERY OFFICE	0	0	0	0	1, 824 3, 055	•
90. 04 04950 INTENSIVE OP BEHAVI ORAL HEALTH	0	0	0	0	3, 033	
91. 00 09100 EMERGENCY	0	412, 930	0	0	66, 185	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	· ·	1.2, 700	J	J	337 133	92.00
OTHER REIMBURSABLE COST CENTERS			!			
95. 00 09500 AMBULANCE SERVICES	0	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						
116. 00 11600 HOSPI CE	0		0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 480, 516	0	2, 005, 993	881, 021	118. 00
NONREI MBURSABLE COST CENTERS				- I		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
194.00 07950 TITLE XX 194.01 07951 0THER NRCC	0	0	0	0		194.00
194. 01 07951 0THER_NRCC 194. 02 07952 0THER_MOBS	0			o o		194. 01 194. 02
194. 03 07953 I DLE SPACE	0	ا		0		194. 02
194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS	0			0		194. 04
200.00 Cross Foot Adjustments				٩	O	200.00
201.00 Negative Cost Centers	0	l ol	0	o	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0		Ö	2, 005, 993		
			'			

Health Financial Systems

ADAMS MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1330 | Period: | Worksheet B

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1330 Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 8: 49 am Cost Center Description Subtotal Intern & Total Resi dents Cost & Post Stepdown Adj ustments 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 1.00 1.00 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11 00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 11, 588, 243 11, 588, 243 30.00 03100 INTENSIVE CARE UNIT 31 00 2, 714, 137 C 2, 714, 137 31 00 40.00 04000 SUBPROVI DER - I PF 0 0 40.00 04300 NURSERY 43.00 147, 653 0 147, 653 43.00 04400 SKILLED NURSING FACILITY 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 7, 625, 305 0 7, 625, 305 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 144, 991 144, 991 52.00 53.00 05300 ANESTHESI OLOGY 0 53 00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 4, 852, 848 0 4, 852, 848 54.00 60.00 06000 LABORATORY 6, 280, 078 6, 280, 078 60.00 06500 RESPIRATORY THERAPY 65.00 1, 526, 514 1, 526, 514 65.00 06600 PHYSI CAL THERAPY 3, 659, 118 66 00 3, 659, 118 66 00 06700 OCCUPATIONAL THERAPY 67.00 899, 010 899, 010 67.00 06800 SPEECH PATHOLOGY 435, 399 435, 399 68.00 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 1, 559, 311 0 1, 559, 311 72.00 3, 705, 011 3, 705, 011 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 76.00 03020 OP PSYCH 1, 136, 796 0 1, 136, 796 76.00 03030 WOUND CARE 481, 473 76.01 481.473 0 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 MONROE FAMILY MEDICINE 3, 309, 143 3, 309, 143 88.00 08801 WOODCREST 2, 278, 880 88.01 2, 278, 880 88.01 0 88.02 08802 STAT CARE 2, 213, 284 Ω 2, 213, 284 88 02 88.03 08803 BERNE FAMILY MEDICINE 2, 445, 243 2, 445, 243 88.03 08804 HI GH STREET 1, 746, 206 1, 746, 206 88.04 88.04 90.00 09000 CLI NI C 3, 645, 404 0 3, 645, 404 90 00 90.01 09001 CLINIC - AMO 970, 744 0 970, 744 90.01 90 02 09002 CLINIC - AMH NEURO 447, 570 447, 570 90.02 09003 GENERAL SURGERY OFFICE 0 90.03 90.03 884, 324 884, 324 04950 INTENSIVE OP BEHAVIORAL HEALTH 90.04 C 90.04 09100 EMERGENCY 4, 854, 911 4, 854, 911 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 2, 904, 606 0 2, 904, 606 95.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 0 0 SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE 0 116.00 | SUBTOTALS (SUM OF LINES 1 through 117) | NONREIMBURSABLE COST CENTERS 118.00 72, 456, 202 0 72, 456, 202 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 40, 203 40, 203 194.00 07950 TITLE XX 194.00 194. 01 07951 OTHER NRCC 1, 712, 374 0 1, 712, 374 194.01 194. 02 07952 OTHER MOBS 206,054 0 194. 02 206, 054 194. 03 194. 03 07953 I DLE SPACE 0 \cap 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 401, 684 0 401, 684 194.04 200.00 Cross Foot Adjustments 0 0 0 200.00 201 00 201 00 Negative Cost Centers 0 0 202.00 TOTAL (sum lines 118 through 201) 74, 816, 517 74, 816, 517 202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 01/2024 | Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1330

			10	12/31/2023	Date/IIme Pre 5/29/2024 8:4	
		CAPITAL REL	ATED COSTS		7 0, 2, 1, 202 1 0. 1	
		NEW BLBG &	NEW 18/81 E		ENDL OVEE	
Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
	Assigned New Capital	FLXT	EQUI P		BENEFITS DEPARTMENT	
	Related Costs				DEFARTMENT	
	0	1. 00	2.00	2A	4. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP	_		_	_	_	2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00 00500 ADMINI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT	0	184, 521	0	184, 521 278, 325	0	5.00
8. 00 00800 LAUNDRY & LINEN SERVICE		278, 325 32, 340	0	32, 340	0	7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG	0	53, 514	0	53, 514	0	9.00
10. 00 01000 DI ETARY	o	127, 622	0	127, 622	0	10.00
11. 00 01100 CAFETERI A	0	0	0	O	0	11.00
13.00 01300 NURSING ADMINISTRATION	0	5, 911	0	5, 911	0	13.00
14.00 01400 CENTRAL SERVI CES & SUPPLY	0	0	0	0	0	14.00
15. 00 01500 PHARMACY	0	41, 749	0	41, 749	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	47, 491	0	47, 491	0	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS	l ol	299, 310	0	299, 310	0	30.00
31. 00 03100 NTENSI VE CARE UNI T		53, 757	0	53, 757	0	31.00
40. 00 04000 SUBPROVI DER - PF	o	0	0	0	0	40.00
43. 00 04300 NURSERY	0	28, 001	0	28, 001	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	205, 096	0	205, 096	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	28, 001	0	28, 001	0	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	165, 629	0	165, 629	0	53. 00 54. 00
60. 00 06000 LABORATORY	0	73, 434	0	73, 434	0	60.00
65. 00 06500 RESPI RATORY THERAPY	o	76, 483	0	76, 483	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	170, 736	0	170, 736	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 870	0	1, 870	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	935	0	935	0	68. 00
69. 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 73.00 07300 DRUGS CHARGED TO PATIENTS		0	0	0	0	72. 00 73. 00
76. 00 03020 OP PSYCH		0	0	0	0	76.00
76. 01 03030 WOUND CARE	o	ő	0	ő	0	76.01
OUTPATIENT SERVICE COST CENTERS		-	- 1	-		
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	42, 104	0	42, 104	0	88. 02
88. 03 08803 BERNE FAMILY MEDICINE 88. 04 08804 HIGH STREET	0	0	0	0	0	88. 03 88. 04
90. 00 09000 CLI NI C		0	0	0	0	90.00
90. 01 09001 CLI NI C - AMO	0	Ö	0	Ö	0	90.01
90. 02 09002 CLINIC - AMH NEURO	o	Ö	0	Ö	0	90. 02
90. 03 09003 GENERAL SURGERY OFFICE	0	0	0	o	0	90. 03
90.04 04950 INTENSIVE OP BEHAVIORAL HEALTH	0	0	0	0	0	90. 04
91. 00 09100 EMERGENCY	0	103, 998	0	103, 998	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES		ما	0	ام	0	95.00
95. 00 09500 AMBULANCE SERVICES 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	95.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	<u> </u>			11011.00
116. 00 11600 HOSPI CE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 020, 827	0	2, 020, 827	0	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12, 233	0	12, 233		190. 00
194. 00 07950 TITLE XX	0	0	0	0		194.00
194. 01 07951 OTHER NRCC 194. 02 07952 OTHER MOBS	0	0	0	0		194. 01 194. 02
194. 02 07952 0THER MOBS 194. 03 07953 I DLE SPACE		O O	0	0		194. 02
194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS		ol Ol	0	ol Ol		194. 03
200.00 Cross Foot Adjustments		Ĭ		ől	O	200.00
201.00 Negative Cost Centers		o	0	o		201.00
202.00 TOTAL (sum lines 118 through 201)	0	2, 033, 060	0	2, 033, 060	0	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 01/2024 | Prepared: |

				1	0 12/31/2023	Date/IIme Pre 5/29/2024 8:4	
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	, <u>u</u>
		E & GENERAL	PLANT	LINEN SERVICE			
OENE	DAL CERVI OF COCT OFFITERS	5. 00	7. 00	8. 00	9. 00	10. 00	
	RAL SERVICE COST CENTERS O NEW CAP REL COSTS-BLDG & FIXT						1.00
	NEW CAP REL COSTS-BLDG & FIXT						2.00
	O EMPLOYEE BENEFITS DEPARTMENT						4.00
1	O ADMINISTRATIVE & GENERAL	184, 521					5. 00
1	O OPERATION OF PLANT	10, 167	288, 492				7.00
8. 00 0080	O LAUNDRY & LINEN SERVICE	980	4, 617	37, 937			8. 00
9. 00 0090	O HOUSEKEEPI NG	3, 194	7, 640	0	64, 348		9. 00
	O DI ETARY	3, 673	18, 221	0	4, 272	153, 788	10.00
	O CAFETERI A	0	0	1	0	0	11.00
	O NURSI NG ADMI NI STRATI ON	3, 612	844	0	198	0	13.00
1	O CENTRAL SERVICES & SUPPLY	0	- O	0	1 207	0	14.00
	IO PHARMACY IO MEDICAL RECORDS & LIBRARY	4, 663 1, 851	5, 961 6, 780	1	1, 397 1, 590	0	15. 00 16. 00
	TIENT ROUTINE SERVICE COST CENTERS	1, 631	0, 760	<u> </u>	1, 390	U	10.00
	O ADULTS & PEDIATRICS	20, 200	42, 733	30, 342	10, 018	131, 737	30.00
	O INTENSIVE CARE UNIT	5, 200	7, 675		· · ·	22, 051	31.00
	O SUBPROVI DER - I PF	0	0	0	0	0	40.00
	NURSERY	109	3, 998	1, 910	937	0	43.00
44.00 0440	O SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	LLARY SERVICE COST CENTERS			_			
	O OPERATING ROOM	15, 190	52, 929			0	50.00
	O DELIVERY ROOM & LABOR ROOM	139	3, 998	1	·	0	52.00
	O ANESTHESI OLOGY	0	10 404	1	· ·	0	53.00
	IO RADI OLOGY-DI AGNOSTI C IO LABORATORY	11, 018	10, 484 10, 920		_,	0	54.00
	O RESPI RATORY THERAPY	14, 645 2, 325	24, 376		,	0	60. 00 65. 00
	O PHYSI CAL THERAPY	8, 917	24, 370		63	0	66.00
	O OCCUPATI ONAL THERAPY	2, 172	134		31	0	67.00
	O SPEECH PATHOLOGY	1, 052	0	1	o	0	68.00
	O ELECTROCARDI OLOGY	0	0	o o	O	0	69.00
71. 00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS	O	0	0	0	0	71.00
	O IMPL. DEV. CHARGED TO PATIENT	3, 770	0	0	0	0	72. 00
	DRUGS CHARGED TO PATIENTS	4, 026	0	0	0	0	73.00
	O OP PSYCH	2, 802	0	0	· ·	0	76.00
	O WOUND CARE	1, 180	0	0	0	0	76. 01
	ATIENT SERVICE COST CENTERS O MONROE FAMILY MEDICINE	8, 121	0	0	Ol	0	88. 00
I	1 WOODCREST	5, 585	0	1		0	88. 01
	2 STAT CARE	5, 131	6, 011	1	1, 409	0	88. 02
1	3 BERNE FAMILY MEDICINE	5, 998	0	1	0	0	88. 03
88. 04 0880	4 HI GH STREET	4, 266	0	0	o	0	88. 04
90.00 0900	O CLI NI C	7, 772	24, 601	0	5, 767	0	90.00
1	1 CLINIC - AMO	2, 110	5, 694		1, 335	0	90. 01
l	2 CLINIC - AMH NEURO	850	5, 221		1, 224	0	90. 02
	3 GENERAL SURGERY OFFICE	1, 843	6, 911	1	1, 620	0	90.03
	O INTENSIVE OP BEHAVIORAL HEALTH O EMERGENCY	10, 083	14, 848	0	3, 481	0	90. 04 91. 00
	O OBSERVATION BEDS (NON-DISTINCT PART)	10, 083	14, 848	0	3, 481	U	91.00
	R REIMBURSABLE COST CENTERS						72.00
	O AMBULANCE SERVICES	7, 165	0	0	ol	0	95. 00
	O DURABLE MEDICAL EQUIP-SOLD	0	0		· ·	0	
	O HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPEC	I AL PURPOSE COST CENTERS						
116. 00 1160		0	0	0	0	0	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	179, 809	264, 863	37, 937	59, 218	153, 788	118. 00
	EIMBURSABLE COST CENTERS						
	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	38	1, 747	1	- I		190.00
194. 00 0795		0	12.240	0	ı		194.00
	1 OTHER NRCC 2 OTHER MOBS	3, 635	12, 260 9, 622		2, 874 2, 256		194. 01 194. 02
	3 IDLE SPACE	48	9, 022		2, 236		194. 02
	4 OTHER NONREIMBURSABLE COST CENTERS	991	0				194. 03
200. 00	Cross Foot Adjustments	//	O			O	200.00
201.00	Negative Cost Centers	0	0	0	o		201.00
202. 00	TOTAL (sum lines 118 through 201)	184, 521	288, 492	37, 937	64, 348	153, 788	
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| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | Part |

			To	12/31/2023	Date/Time Pre 5/29/2024 8:4	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O N	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11. 00	13. 00	14.00	15.00	16. 00	
GENERAL SERVICE COST CENTERS	Г					
1.00 OO100 NEW CAP REL COSTS-BLDG & FIXT 2.00 OO200 NEW CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	_					10. 00 11. 00
13. 00 01300 NURSI NG ADMINI STRATI ON		10, 565				13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	ď	0	0			14. 00
15. 00 01500 PHARMACY	C	o	0	53, 770		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	C	0	0	0	57, 712	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS			-	ما		
30. 00 03000 ADULTS & PEDI ATRI CS	C		0	0	5, 512	30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF		1	0	0	1, 445 0	31. 00 40. 00
43. 00 04300 NURSERY		1	0	0	91	43.00
44.00 04400 SKILLED NURSING FACILITY	C	1	0	ō	0	44.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	C	,	0	0	5, 867	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	C	1 '''	0	0	91	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C			0	O O	11 075	53. 00 54. 00
60. 00 06000 LABORATORY			0	0	11, 975 8, 570	60.00
65. 00 06500 RESPIRATORY THERAPY	ď	570	0	o	2, 031	65.00
66. 00 06600 PHYSI CAL THERAPY	C	o	0	o	2, 551	66.00
67.00 06700 OCCUPATIONAL THERAPY	C	0	0	0	1, 048	67. 00
68. 00 06800 SPEECH PATHOLOGY	C	0	0	0	575	68.00
69.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS			0	0	0	69. 00 71. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT			0	0	2, 015	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS			0	53, 770	4, 375	73.00
76. 00 03020 OP PSYCH	C	o	0	0	47	76.00
76. 01 03030 WOUND CARE	C	0	0	0	207	76. 01
OUTPATIENT SERVICE COST CENTERS			-1			
88. 00 08800 MONROE FAMILY MEDICINE 88. 01 08801 WOODCREST	C	1	0	0	1, 112	88.00
88. 01 08801 WOODCREST 88. 02 08802 STAT CARE			0	0	960 1, 093	88. 01 88. 02
88. 03 08803 BERNE FAMILY MEDICINE			0	0	899	88. 03
88. 04 08804 HI GH STREET	C	o	0	Ö	1, 084	88. 04
90. 00 09000 CLI NI C	C	o	0	o	1, 134	90.00
90. 01 09001 CLI NI C - AMO	C	0	0	0	331	90. 01
90. 02 09002 CLI NI C - AMH NEURO	C	0	0	0	119	90.02
90. 03 09003 GENERAL SURGERY OFFI CE 90. 04 04950 INTENSI VE OP BEHAVI ORAL HEALTH			0	0	200 0	90. 03 90. 04
91. 00 09100 EMERGENCY		2, 947	0	0	4, 330	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	_	_,		- ا	.,	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	C		0	0	0	95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	C	1	0	0	0	97.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	C)[0	U	0	101. 00
116. 00 11600 HOSPI CE	С		0	O	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	C			53, 770	57, 662	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	1	0	0		190. 00
194. 00 07950 TITLE XX	C	0	0	0		194.00
194. 01 07951 OTHER NRCC 194. 02 07952 OTHER MOBS			0	0		194. 01 194. 02
194. 03 07953 I DLE SPACE			0	ol Ol		194. 02
194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS		ol ől	Ö	ő		194. 04
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	C	o o	0	o		201. 00
202.00 TOTAL (sum lines 118 through 201)	[C	10, 565	0	53, 770	57, 712	202.00

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

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1330 Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/29/2024 8: 49 am Cost Center Description Subtotal Intern & Total Resi dents Cost & Post Stepdown Adj ustments 24. 00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 1.00 1.00 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11 00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 543, 599 543, 599 30.00 03100 INTENSIVE CARE UNIT 31 00 31 00 97, 782 C 97, 782 40.00 04000 SUBPROVI DER - I PF 0 0 40.00 04300 NURSERY 43.00 35, 053 0 35, 053 43.00 04400 SKILLED NURSING FACILITY 0 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 293, 990 0 293, 990 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 33, 789 0 33, 789 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 201, 564 0 201, 564 54.00 60.00 06000 LABORATORY 110, 129 0 110, 129 60.00 06500 RESPIRATORY THERAPY 65.00 111,500 0 111,500 65.00 06600 PHYSI CAL THERAPY 66 00 182, 534 0 182 534 66 00 06700 OCCUPATIONAL THERAPY 67.00 5, 255 0 5, 255 67.00 06800 SPEECH PATHOLOGY 2, 562 0 2, 562 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 5, 785 0 5, 785 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 62, 171 62, 171 73.00 76.00 03020 OP PSYCH 2.849 0 2.849 76.00 03030 WOUND CARE 76.01 1.387 0 1.387 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 MONROE FAMILY MEDICINE 9, 233 9, 233 88.00 08801 WOODCREST 6, 545 6, 545 88.01 88.01 0 08802 STAT CARE 0 88.02 55, 748 55.748 88 02 88.03 08803 BERNE FAMILY MEDICINE 6, 897 0 6,897 88.03 08804 HIGH STREET 5, 350 5, 350 88.04 0 88.04 90.00 39, 274 09000 CLI NI C 39, 274 0 90 00 90.01 09001 CLINIC - AMO 9, 470 0 9, 470 90.01 90 02 09002 CLINIC - AMH NEURO 7, 414 7, 414 90.02 09003 GENERAL SURGERY OFFICE 10, 574 0 90.03 90.03 10, 574 04950 INTENSIVE OP BEHAVIORAL HEALTH 90.04 C 90.04 09100 EMERGENCY 139, 687 139, 687 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 7, 165 Ω 7, 165 95.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 0 0 SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 118.00 1, 987, 306 0 1, 987, 306 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 14, 018 14,018 194.00 07950 TITLE XX 194.00 194. 01 07951 OTHER NRCC 18, 819 0 18,819 194.01 194. 02 07952 OTHER MOBS 11, 926 0 11, 926 194. 02 194. 03 194. 03 07953 I DLE SPACE 0 0 C 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 991 0 991 194.04 200.00 Cross Foot Adjustments 0 0 0 200.00

0

0

2, 033, 060

0

2, 033, 060

201 00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

201 00

202.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS ADAMS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-1330

Cost Center Description CAPITAL RELATED COSTS RELEGIUP COURAGE FEET) COURAGE FEET COU						o 12/31/2023	Date/lime Pre 5/29/2024 8:4	
SAMPRIST SOURCE PET SOURC			CAPI TAL RE	LATED COSTS			0,2,,2021 0.1	
SAMPRIST SOURCE PET SOURC		Coot Conton Decemintion	NEW DLDC 9	NEW MYDLE	EMDLOVEE	December	ADMINI CTDATIV	
COMPART SERVICE COST CENTERS		Cost Center Description						
CROSS SALARIES S						"		
SALARIES SALA			(SQO/INE TEET)	(SQOTINE TEET)			(7.000 0001)	
CEMERAL SERVICE COST CENTERS								
1.00 00100 New Cap ReL COSTS-BUBLE 6417 108,693			1. 00	2. 00	4. 00	5A	5. 00	
2.00 000000 MEN CAP REL COSTS-MYBLE EQUIP 0	1 00		100 403	,	ı		Γ	1.00
0.000 DIPLOYEE BRIFETTS DEPARTIENT 0			100, 043	l				2.00
7. 00 0.0000 DPERATION OF PLANT 14,880 0 0 0 3,306,387 9. 00 0.0000 LUMIDRY & LINES SERVICE 1,729 0 0,025 318,687 9. 00 0.0000 DRUSEREEPING 2,861 0 688,332 0 1,938,802 11. 00 0.1000 DISEREEPING 3,861 0 9,37,233 0 1,174,490 11. 00 0.1000 DISEREEPING 316 0 937,273 0 1,174,490 15. 00 0.1000 PHARMACY 2,232 0 916,554 0 1,516,374 15. 00 0.1000 PHARMACY 2,232 0 916,554 0 1,516,374 16. 00 1.000 DISCAL PROSIDES & LIBRARY 2,234 0 352,768 601,191 30. 00 3.000 AUSTALLER PROUT MERCH CORS & LIBRARY 2,234 0 792,795 0 1,691,073 44. 00 3.000 BRASSILLED RATE OF CORS & LIBRARY 2,234 0 792,995 0 1,691,073 44. 00 3.000 BRASSILLED RATE OF CORS & LIBRARY 1		l	C		1	j		4.00
8.00 00800 JAUNDRY & LI NEN SERVI CE 1,720 0 90, 205 0 318, 862 1,038 802 1,038 1,034 1,039	5.00	00500 ADMINISTRATIVE & GENERAL	9, 865	0	3, 660, 492	-14, 800, 992	60, 015, 525	5.00
9.00 0.090p 0.095ecce PN 0.095ecc					1	_		
10.00 01000 DETARY 6,823 0 67,3,838 0 1,194,617 0 13.00 0 0 0 0 0 0 0 0 0				l .				
11.00 01100 CAFETERIA 0 0 0 0 0 0 1.74, 490		1						
13.00 01300 MURSI NO. ADMINISTRATION 316 0 037, 273 0 1,174, 400 10400 CENTRAL SERVICE S& SUPPLY 2 0 0 0 0 0 0 0 0 0		1	1					1
15.00 01500 PHARMACY			316	0	937, 273	0	1, 174, 490	
16.00 01600 MEDICAL RECORDS & LIBRARY 2,539 0 362,765 0 601,808 PIPATE TROUTIN BESENICE COST CENTERS 30.00 30300 ADULTS & PEDIATRICS 16.002 0 3,810,942 0 6,578,346 41.00 03000 ADULTS & PEDIATRICS 16.002 0 779,995 0 1,691,073 41.00 03000 ADULTS & PEDIATRICS 16.002 0 0 0 0 0 0 0 0 0			C	0				14.00
IMPATI ENT BOUTINE SERVICE COST CENTERS			· ·	l control of the cont				
03.00 03000 ADULTS & PEDIATRICS 16,002 0 3,810,942 0 6,578,346 1,691,073 1,000 1,000 1,000 1,000 1,000 1,000 0	16.00		2, 539	<u>'</u>	362, 765	0	601,808	16.00
13.10 03100 INTENSIVE CARE UNIT	30. 00		16, 002) 0	3, 810, 942	0	6, 578, 346	30.00
43.00 04500 NURSERY 1.497 0 5.237 0 35.568								
44.00 0.4400 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0	40.00	04000 SUBPROVI DER - I PF	C	0	C	0	0	40.00
## AMCILLARY SERVICE COST CENTERS 50. 00 5000 OPERATIN RO ROOM 10,965 0 2,554,704 0 4,939,925 50. 00 5000 OPERATIN RO ROOM 1,497 0 11,874 0 45,156 50. 00 5000 DELIVERY ROOM & LABOR ROOM 1,497 0 11,874 0 45,156 50. 00 5000 DELIVERY ROOM & LABOR ROOM 1,497 0 0 1,874 0 45,156 50. 00 5000 DELIVERY ROOM & LABOR ROOM 1,497 0 0 0 0 54. 00 05400 DRESTHEST OLOGY 0 0 0 0 0 0 54. 00 05400 DRESTHEST OLOGY 3,926 0 1,525,859 0 4,762,638 65. 00 06500 DRESTREADRY THERRAPY 4,089 0 582,666 0 756,096 66. 00 06500 PHYSI CAL THERRAPY 9,128 0 2,272,819 0 2,899,800 67. 00 06700 DRESTREADRY THERRAPY 100 0 571,506 0 706,229 68. 00 06800 SPECCH PATHOLOGY 50 0 0 0 0 0 69. 00 06800 SPECCH PATHOLOGY 50 0 0 0 0 0 72. 00 06900 ELECTROCARDI OLOGY 50 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 03020 DRUSS CHARGED TO PATIENTS 0 0 0 0 0 72. 00 03020 DRUSS CHARGED TO PATIENTS 0 0 0 0 0 72. 00 03020 DRUSS CHARGED TO PATIENTS 0 0 0 0 0 72. 00 03020 DRUSS CHARGED TO PATIENTS 0 0 0 0 0 72. 00 03020 DRUSS CHARGED TO PATIENTS 0 0 0 0 0 72. 00 03020 DRUSS CHARGED TO PATIENTS 0 0 0 0 72. 00 03020 DRUSS CHARGED TO PATIENTS 0 0 0 0 72. 00 03020 DRUSS CHARGED TO PATIENTS 0 0 0 0 72. 00 03020 DRUSS CHARGED TO PATIENTS 0 0 0 0 72. 00 03020 DRUSS CHARGED TO PATIENTS 0 0 0 0 72. 00 03020 DRUSS CHARGED TO PATIENTS 0 0 0 0 72. 00 03020 DRUSS CHARGED TO PATIENTS 0 0 0 0 0 72. 00 03020 DRUSS CHARGED TO PATIENTS 0 0 0 0 0 72. 00 03020 DRUSS CHARGED TO PATI								1
50.00	44. 00		C) 0) 0	0	44.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	50 00		10 965		2 554 704	0	4 939 925	50.00
53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0			1	I				
60.00 0.0000 LABORATORY 1.000	53.00	05300 ANESTHESI OLOGY		1				1
65.00 06500 RESPIRATORY THERAPY			· ·	l control of the cont			-,,	
66.00 06600 PHYSI CAL THERAPY 9,128 0 2,072,819 0 2,899,800 0 7.00 0 6700 0 6		l						
67. 00 06700 06700 0620PATI ONAL THERAPY 100 0 571, 506 0 706, 229 88. 00 06800 SPECEH PATHOLOGY 50 0 0 0 0 0 87. 00 07300 07300 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 87. 00 07300 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 87. 00 07300 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 88. 00 0800 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 89. 00 07300 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 89. 00 07300 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 89. 00 07300 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 89. 00 07300 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 89. 00 07300 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 89. 00 07300 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 89. 00 07300 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 89. 00 07300 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 89. 00 07300 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 89. 00 07300 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 89. 00 07300 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 89. 00 07300 07300 07300 0 0 0 0 0 89. 00 07300 07300 07300 07300 0 0 0 89. 00 07300 07300 07300 07300 0 0 0 89. 00 07300 07300 07300 07300 07300 0 0 89. 00 07300 0				I .				
68. 00 08.000 SPEECH PATHOLOGY 50 0 290,919 0 342,212		l		I .				
17.1 00		l		l control of the cont	•			
1.2 1.2			C	0				
173.00 07300 DRICS CHARGED TO PATIENTS 0 0 0 1, 309, 253			C	0		_		
76. 01 03020 OP PSYCH 0 0 0 1,007,007 0 911,322 76. 01 03030 WOUND CARE 0 0 365,010 0 383,691 88. 00 08800 MONROE FAMILY MEDICINE 0 0 1,903,251 0 2,640,860 88. 01 08800 MONROE FAMILY MEDICINE 0 0 1,293,123 0 1,816,272 88. 02 08801 WOODCREST 0 0 1,247,672 0 1,816,272 88. 03 08803 STAT CARE 2,251 0 1,147,285 0 1,668,464 88. 03 08803 BERNE FAMILY MEDICINE 0 0 1,247,672 0 1,950,473 89. 04 08804 HIGH STREET 0 0 474,729 0 1,950,473 90. 05 09000 CLINIC 0 0 0 3,169,456 0 2,527,426 90. 01 09001 CLINIC - AMD MEURO 0 0 3,169,456 0 2,527,426 90. 02 09002 CLINIC - AMD MEURO 0 0 869,971 0 276,305 90. 03 09003 GENERAL SURGERY OFFICE 0 0 1,478,983 0 599,357 90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH 0 0 0 0 0 91. 00 09000 0900 0900 0900 0900 0900 0900 95. 00 09000 0900 0900 0900 0900 0900 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 10100 1000 1000 1000 1000 1000 101. 00 10100 1000 1000 1000 1000 1000 101. 00 10100 1000 1000 1000 1000 1000 101. 00 10100 1000 1000 1000 1000 1000 101. 00 10100 1000 1000 1000 1000 1000 101. 00 10100 1000 1000 1000 1000 1000 101. 00 10100 1000 1000 1000 1000 1000 101. 00 10100 1000 1000 1000 1000 1000 101. 00 10100 1000 1000 1000 1000 1000 101. 00 10100 1000 1000 1000 1000 1000 1000 101. 00 10100 1000 1000 1000 1000 1000 1000 101. 00 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 101. 00 10000 10		1					, , ,	
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88.00 08800 MONROE FAMILY MEDICINE 0 0 1, 903, 251 0 2, 640, 860 88.01 08801 WODCREST 0 0 0 1, 239, 123 0 1, 816, 272 88.02 08802 STAT CARE 2, 251 0 1, 147, 285 0 1, 668, 464 88.03 08803 BERNE FAMILY MEDICINE 0 0 0 1, 247, 672 0 1, 950, 473 88.04 MIGH STREET 0 0 0 949, 239 0 1, 387, 462 90.01 09001 CLINIC 0 0 0 0 3, 169, 456 0 2, 527, 462 90.01 09001 CLINIC - AMO 0 0 0 2, 232, 528 0 686, 031 90.02 09002 CLINIC - AMO 0 0 0 0 0 0 0 0 0			C	0	365, 010	0		
88. 01 08801 WODCREST 0 0 1, 239, 123 0 1, 816, 272 88. 02 08802 STAT CARE 2, 251 0 1, 147, 285 0 1, 668, 464 88. 03 08803 BERNE FAMILLY MEDICINE 0 0 1, 247, 672 0 1, 950, 473 88. 04 08804 HI GH STREET 0 0 949, 239 0 1, 387, 462 90. 00 90000 CLI NI C 0 0 0 3, 169, 456 0 2, 527, 462 90. 01 09001 CLI NI C AMO 0 0 0 3, 169, 456 0 2, 527, 462 90. 01 09001 CLI NI C AMO 0 0 0 2, 232, 528 0 686, 031 90. 02 09002 CLI NI C AMH NEURO 0 0 0 869, 971 0 276, 305 90. 04 04950 INTENSIVE OP BEHAVI ORAL HEALTH 0 0 0 0 0 0 0 0 0								
88. 02 08802 STAT CARE			C	1				
88. 03 08803 BERNE FAMILY MEDICINE 0 0 1, 247, 672 0 1, 950, 473 88. 04 08804 HI GH STREET 0 0 0 9449, 239 0 1, 387, 462 90. 00 09000 CLINIC 0 0 0 3, 169, 456 0 2, 527, 426 90. 01 09001 CLINIC AMO 0 0 0 2, 232, 528 0 686, 031 90. 02 09002 CLINIC AMIH NEURO 0 0 0 869, 971 0 276, 305 90. 03 09003 GENERAL SURGERY OFFICE 0 0 1, 478, 983 0 599, 357 90. 04 04950 NTENSIVE OP BEHAVIORAL HEALTH 0 0 0 0 0 0 91. 00 09100 EMERGENCY 0 0 0 0 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0710 09700 AMBULANCE SERVICES 0 0 1, 476, 252 0 2, 329, 987 97. 00 09700 AMBULANCE SERVICES 0 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 108, 039 0 41, 254, 275 -14, 800, 992 58, 483, 364 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 1914. 01 07951 OTHER NRCC 0 0 0 0 0 0 194. 02 07952 OTHER MOBS 0 0 0 0 0 194. 02 07952 OTHER MOBS 0 0 0 0 0 194. 03 07954 OTHER MORS 0 0 0 0 0 194. 04 07954 OTHER MORS 0 0 0 0 0 194. 04 07954 OTHER MORS 0 0 0 0 0 194. 04 07954 OTHER MORS 0 0 0 0 0 194. 04 07954 OTHER MORS 0 0 0 0 0 194. 04 07954 OTHER MORS 0 0 0 0 0 194. 04 07954 OTHER MORS 0 0 0 0 0 194. 05 07954 OTHER MORS 0 0 0 0 0 194. 05 07954 OTHER MORS 0 0 0 0 0 195. 020. 00 Coss Foot Adjustments 0 0 0 0 200. 00 Coss Foot Adjustments 0 0 0 0 200. 00 Cost to be all located (per Wkst. B, 2, 033, 060 0 273, 530 14, 800, 992 200, 00 0 200. 00 Cost to be all located (per Wkst. B, 2, 033, 060 0 0 0 0 0 0 200. 00 CILTER OTHER MORS 0 0 0 0 0 0 200. 00 CILTER			2 251	1				
88. 04 08804 HI GH STREET			2, 231	ol ö				
90. 01 09001 CLINIC - AMO	88. 04	08804 HI GH STREET	C	0				
90. 02 09002 CLINIC - AMH NEURO 0 0 869, 971 0 276, 305 90. 03 09003 GENERAL SURGERY OFFICE 0 0 1, 478, 983 0 599, 357 90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH 0 0 0 0 0 91. 00 09100 EMERGENCY 5, 560 0 3, 010, 376 0 3, 279, 030 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0700 00 THER REI MBURSABLE COST CENTERS 0 0 1, 476, 252 0 2, 329, 987 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 101. 00 01000 HOME HEALTH AGENCY 0 0 0 0 0 116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) 108, 039 0 41, 254, 275 -14, 800, 992 58, 483, 364 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 654 0 0 0 0 0 191. 01 07951 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 194. 01 07951 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 194. 01 07951 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 194. 01 07952 OTHER NORE MBURSABLE COST CENTERS 0 0 0 0 195. 00 07950 OTHER NORE MBURSABLE COST CENTERS 0 0 0 0 195. 00 07950 OTHER NORE MBURSABLE COST CENTERS 0 0 0 0 195. 00 00 0 0 0 0 195. 00 00 0 0 0 195. 00 00 0 0 0 195. 00 00 0 0 0 195. 00 00 0 0 0 195. 00 00 0 0 0 195. 00 00 0 0 0 195. 00 00 0 0 195. 00 00 0 0 195. 00 00 0 0 0 195. 00 00 00 0 195. 00 00 00 0 195. 00 00 00 0 195. 00 00 0			C	0	3, 169, 456	0		1
90. 03 09003 GENERAL SURGERY OFFICE 0 0 1,478,983 0 599,357 90. 04 04950 INTENSI VE OP BEHAVI ORAL HEALTH 0 0 0 0 0 91. 00 09100 EMERGENCY 5,560 0 3,010,376 0 3,279,030 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 07HER REI MBURSABLE COST CENTERS 0 0 1,476,252 0 2,329,987 97. 00 09700 DURABLE MEDI CAL EQUIP-SOLD 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0700 DURABLE MEDI CAL EQUIP-SOLD 0 0 0 0 0 08 SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 108,039 0 41,254,275 -14,800,992 58,483,364 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 654 0 0 0 0 0 194. 01 07951 OTHER NRCC 0 0 0 0 0 1,182,177 194. 02 07952 OTHER NRCC 0 0 0 0 0 0 194. 03 07954 OTHER NBURSABLE COST CENTERS 0 0 0 0 0 194. 04 07954 OTHER MOBS 0 0 0 0 0 200. 00 Cross Foot Adjustments 200. 00 0 0 0 0 201. 00 Negative Cost Centers 200. 00 0 0 0 202. 00 Cost to be allocated (per Wkst. B, 2,033,060 0 273,530 14,800,992 200.			C	0				
90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH								
91. 00					1,470,700			90.04
OTHER REIMBURSABLE COST CENTERS O O 1, 476, 252 O 2, 329, 987			5, 560	0	3, 010, 376	0	3, 279, 030	
95. 00	92.00							92.00
97. 00	05 00		1		1 47/ 056			
101. 00			1	l				1
SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE		l		1	•			101.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 108,039 0 41,254,275 -14,800,992 58,483,364 1 1 1 1 1 1 1 1 1				,		,		1.000
NONRE MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 654 0 0 0 12, 233 194. 00 07950 TI TLE XX 0 0 0 0 0 0 194. 01 07951 OTHER NRCC 0 0 0 740, 270 0 1, 182, 177 194. 02 07952 OTHER MOBS 0 0 0 0 0 15, 532 194. 03 07953 DLE SPACE 0 0 0 0 0 0 15, 532 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 322, 219 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0	116.00	11600 HOSPI CE	C	0	C			116.00
190. 00	118.00	, ,	108, 039	0	41, 254, 275	-14, 800, 992	58, 483, 364	118.00
194. 00 07950 TI TLE XX	100 00						12 222	100 00
194. 01 07951 OTHER NRCC 0 0 740, 270 0 1, 182, 177 1 194. 02 07952 OTHER MOBS 0 0 0 0 0 15, 532 1 194. 03 07953 IDLE SPACE 0 0 0 0 0 0 0 0 1 194. 04 07954 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 322, 219 1 200. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 2, 033, 060 0 273, 530 14, 800, 992 2			1	1				194.00
194. 02 07952 OTHER MOBS 0 0 0 0 15, 532 1 194. 03 07953 IDLE SPACE 0 0 0 0 0 0 0 15, 532 1 194. 04 07954 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 322, 219 1 200. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 2,033, 060 0 273, 530 14, 800, 992 2 2 2 2 2 2 2 2 2 2 2 2 2 3 2 3 3 2 2 2 3				o o				
194. 04 07954 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 322, 219 1 200. 00 Cross Foot Adjustments Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 2,033,060 0 273,530 14,800,992 2	194. 02	07952 OTHER MOBS	C	0	C	0	15, 532	194. 02
200.00 Cross Foot Adjustments 2 2 2 2 2 2 2 2 2			C	0		0		194. 03
201.00 Negative Cost Centers 2			C	0		0	322, 219	
202.00 Cost to be allocated (per Wkst. B, 2,033,060 0 273,530 14,800,992 2		, , , , , , , , , , , , , , , , , , ,						200.00
Part I)		1 9	2. 033. 060		273 530		14.800 992	
	_ 52. 00	71	2, 330, 300		2,0,000		1.,555,772	
203.00 Unit cost multiplier (Wkst. B, Part I) 18.704608 0.000000 0.006513 0.246619 2	203.00		18. 704608	0. 000000	0. 006513	;	0. 246619	203.00

Health Fina	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 01/01/2023 To 12/31/2023		pared: 9 am
		CAPI TAL REL	LATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	
		FI XT	EQUI P	BENEFITS	n	E & GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT		(ACCUM. COST)	
				(GROSS			
				SALARI ES)			
		1.00	2.00	4.00	5A	5. 00	
204. 00	Cost to be allocated (per Wkst. B,			(184, 521	204. 00
005 00	Part II)			0.00000		0 000075	005 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000000)	0. 003075	205.00
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Heal th	Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provi der C	F	Period: From 01/01/2023 To 12/31/2023	Worksheet B-1 Date/Time Pre 5/29/2024 8:4	epared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	CAFETERIA (NOT USED)	
	T	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 9. 00 11. 00 13. 00 14. 00 15. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE 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	108, 029 1, 729 2, 861 6, 823 0 316 0 2, 232 2, 539	5, 819 0 0 0 0 0 0	102, 785 6, 823 (316 (2, 232	5, 433 0 0 0 0 0 0	0 0 0 0	13. 00 14. 00 15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	2,007		2,00	٦		10.00
30. 00 31. 00 40. 00 43. 00 44. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04300 NURSERY 04400 SKILLED NURSING FACILITY	16, 002 2, 874 0 1, 497	779 0 293	2, 874 (1, 497	779 0 0 7 0	0 0 0 0	31.00 40.00 43.00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	19, 820	0	19, 820	ol	0	50.00
52. 00 53. 00 54. 00 60. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	1, 497 0 3, 926 4, 089	93 0 0 0	1, 497 (3, 926 4, 089		0 0 0 0	52.00 53.00 54.00 60.00
65. 00 66. 00 67. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	9, 128 100 50	0	100	o	0 0 0	66.00
68. 00	06800 SPEECH PATHOLOGY	0	0	(o	0	68. 00
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0			0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	C	0	0	72.00
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03020 OP PSYCH	0	0			0	
76. 01	03030 WOUND CARE	0				0	1
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
88. 00 88. 01	08800 MONROE FAMILY MEDICINE 08801 WOODCREST	0		1		0	
88. 02	08802 STAT CARE	2, 251	0			0	00.02
88. 03 88. 04	08803 BERNE FAMILY MEDICINE 08804 HIGH STREET	0	0			0	
90. 00	09000 CLI NI C	9, 212	0	9, 212		0	1
90. 01	09001 CLINIC - AMO	2, 132	l .	2, 132		0	90. 01
90. 02	09002 CLINIC - AMH NEURO	1, 955	l .	1, 955		0	
90. 03 90. 04	09003 GENERAL SURGERY OFFICE 04950 INTENSIVE OP BEHAVIORAL HEALTH	2, 588	0	2, 588		0	
91. 00	09100 EMERGENCY	5, 560	Ö	1	1	0	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	,					92.00
05.00	OTHER REIMBURSABLE COST CENTERS		1	1	, al		
95.00	09500 AMBULANCE SERVI CES 09700 DURABLE MEDI CAL EQUI P-SOLD	0		l .		0	
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0		1			101.00
116. 00 118. 00	11600 H0SPI CE	99, 181					116. 00 118. 00
	NONREI MBURSABLE COST CENTERS	, , , , , , , ,	3,317	, , , , , ,	5, 155		1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	654	l e	1			190.00
	007950 TI TLE XX 07951 OTHER NRCC	0 4, 591	_	4, 591			194. 00 194. 01
	207952 OTHER MOBS	3, 603	l e	3, 603			194.01
	07953 I DLE SPACE	0	Ö	0,000			194. 03
194. 04 200. 00	07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	(0	0	194. 04 200. 00

4, 121, 805

38. 154616

288, 492

2. 670505

463, 212

37, 937

6. 519505

79. 603368

1, 404, 150

13.661040

0. 626045

64, 348

1, 842, 770

339. 180931

153, 788

28. 306276

200. 00 201. 00

0 202.00

0. 000000 203. 00 0 204. 00

0. 000000 205. 00

200.00 201.00

202.00

203.00

204.00

205.00

Cross Foot Adjustments Negative Cost Centers

Part I)

11)

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B, Part II)

Unit cost multiplier (Wkst. B, Part

Unit cost multiplier (Wkst. B, Part I)

Health Finar	ncial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1		
					From 01/01/2023			
					To 12/31/2023			
						5/29/2024 8: 4	9 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)							

				Fr To	om 01/01/2023 12/31/2023	Date/Time Prepared: 5/29/2024 8:49 am
	Cost Center Description	NURSI NG ADMI NI STRATI O N (GROSS SALARI ES)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	
		13. 00	14. 00	15. 00	16. 00	
4 00	GENERAL SERVICE COST CENTERS					1.00
14. 00 15. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE 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	10, 793, 405 0 0	0	100	447, 000, 04	1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	117, 238, 241	16.00
30. 00 31. 00 40. 00 43. 00 44. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04300 NURSERY 04400 SKILLED NURSING FACILITY	3, 828, 053 792, 995 0 7, 533 0	0 0 0 0 0	0 0 0 0 0	11, 203, 776 2, 936, 838 0 184, 508	30. 00 31. 00 40. 00 43. 00 44. 00
53.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	2, 554, 704 17, 078 0	0 0 0	0 0 0	11, 924, 727 184, 160 0	50. 00 52. 00 53. 00
54. 00 60. 00 65. 00 66. 00 67. 00	O5400	582, 666 0	0 0 0 0	0 0 0 0	24, 277, 487 17, 419, 118 4, 128, 809 5, 184, 297 2, 130, 190	54. 00 60. 00 65. 00 66. 00 67. 00
68. 00 69. 00 71. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0 0	0 0	0 0	1, 168, 844 0 0 4, 095, 129	68. 00 69. 00 71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS 03020 OP PSYCH 03030 WOUND CARE 0UTPATIENT SERVICE COST CENTERS	0 0 0	0 0 0	100 0 0	8, 892, 108 96, 383 419, 726	73. 00 76. 00 76. 01
88. 00	08800 MONROE FAMILY MEDICINE	0	0	0	2, 259, 889	88. 00
88. 01 88. 02 88. 03 88. 04	08801 WOODCREST 08802 STAT CARE 08803 BERNE FAMILY MEDICINE 08804 HIGH STREET	0 0 0 0	0 0 0 0	0 0 0	1, 951, 988 2, 221, 560 1, 827, 639 2, 203, 202	88. 01 88. 02 88. 03 88. 04
90. 02	09000 CLINIC 09001 CLINIC AMO 09002 CLINIC AMH NEURO 09003 GENERAL SURGERY OFFICE	0 0 0 0	0 0 0 0	0 0 0 0	2, 305, 617 672, 008 242, 497 406, 189	90. 00 90. 01 90. 02 90. 03
91.00	04950 INTENSIVE OP BEHAVIORAL HEALTH 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0 3, 010, 376	0	0	8, 800, 003	90. 04 91. 00 92. 00
97. 00	09500 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP-SOLD 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0 0 0	0 0 0	0 0 0	0 0 0	95. 00 97. 00 101. 00
118. 00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0 10, 793, 405	0	0 100	0 117, 136, 692	116. 00 118. 00
194. 00 194. 01 194. 02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 TITLE XX 07951 OTHER NRCC 07952 OTHER MOBS 07953 I DLE SPACE	0 0 0 0	0 0 0 0	0 0 0 0	0 0 101, 549 0 0	190. 00 194. 00 194. 01 194. 02 194. 03
	07954 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments Negative Cost Centers	1, 480, 516	0	2, 005, 993	0 881, 785	194. 04 200. 00 201. 00 202. 00
203. 00 204. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	0. 137169 10, 565	0. 000000	20, 059. 930000 53, 770	0. 007521 57, 712	203. 00 204. 00

Health Financial Systems		ADAMS MEMORIA	AL HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS			Provider CO		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	epared:	
	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	5/29/2024 8: 4	am	
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000979					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	Provider CCN: 15-1330	Peri od: Worksheet C
		From 01/01/2023 Part To 12/31/2023 Date/Time Prepared

				o 12/31/2023	Date/Time Pre 5/29/2024 8:4	pared:
		Title	XVIII	Hospi tal	Cost	, am
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	col . 26)	0.00	2.00	4.00	F 00	
LARATI ENT. DOUTING OFFINIOS COOT OFFITEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	11 500 010		11 500 010			
30. 00 03000 ADULTS & PEDI ATRI CS	11, 588, 243		11, 588, 243		0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	2, 714, 137		2, 714, 137		0	31.00
40. 00 04000 SUBPROVI DER - I PF	0		(0	0	40.00
43. 00 04300 NURSERY	147, 653		147, 653		0	43.00
44. 00 O4400 SKILLED NURSING FACILITY	0			0	0	44.00
ANCILLARY SERVICE COST CENTERS	7 (05 005	1	7 (05 005			
50. 00 05000 OPERATI NG ROOM	7, 625, 305		7, 625, 305		0	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	144, 991		144, 991		0	52.00
53. 00 05300 ANESTHESI OLOGY	0		4 050 046	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 852, 848		4, 852, 848		0	54.00
60. 00 06000 LABORATORY	6, 280, 078		6, 280, 078		0	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 526, 514	0	.,,		0	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 659, 118	0	-,,		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	899, 010	0	899, 010		0	67.00
68. 00 06800 SPEECH PATHOLOGY	435, 399	0	435, 399		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 I MPL. DEV. CHARGED TO PATIENT	1, 559, 311		1, 559, 311		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	3, 705, 011		3, 705, 011		0	73.00
76. 00 03020 OP PSYCH	1, 136, 796		1, 136, 796		0	76.00
76. 01 03030 WOUND CARE	481, 473		481, 473	8 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS	2 200 142		2 200 143			00.00
88. 00 08800 MONROE FAMILY MEDICINE	3, 309, 143		3, 309, 143		0	
88. 01 08801 WOODCREST	2, 278, 880		2, 278, 880	-	-	88. 01
88. 02 08802 STAT CARE	2, 213, 284		2, 213, 284		0	88. 02
88. 03 08803 BERNE FAMILY MEDICINE	2, 445, 243		2, 445, 243		0	88. 03
88. 04 08804 HI GH STREET	1, 746, 206		1, 746, 206		0	88. 04
90. 00 09000 CLINI C	3, 645, 404		3, 645, 404		0	90.00
90. 01 09001 CLINIC - AMO 90. 02 09002 CLINIC - AMH NEURO	970, 744		970, 744		0	90. 01 90. 02
	447, 570		447, 570		0	
90. 03 09003 GENERAL SURGERY OFFICE 90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH	884, 324 0		884, 324		0	90. 03 90. 04
91. 00 09100 EMERGENCY	4, 854, 911		4, 854, 911		0	90.04
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 824, 262		4, 824, 262		0	91.00
OTHER REIMBURSABLE COST CENTERS	4, 024, 202		4, 024, 202		0	92.00
95. 00 09500 AMBULANCE SERVICES	2, 904, 606		2, 904, 606	0	0	95. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	2, 904, 000		2, 904, 000		0	
101.00 10100 HOME HEALTH AGENCY	0				-	101.00
SPECIAL PURPOSE COST CENTERS	0			<u>'</u>		1101.00
116. 00 11600 HOSPI CE	0				n	116. 00
200.00 Subtotal (see instructions)	77, 280, 464	0	`	´l		200.00
201.00 Less Observation Beds	4, 824, 262		4, 824, 262			201.00
202.00 Total (see instructions)	72, 456, 202	0				202.00
	,, 202		,, _	١	· ·	, ,_,

				o 12/31/2023		pared:
		Title	xVIII	Hospi tal	Cost	7 dili
		Charges	, ,,,,,,	1.00p. tu.	0001	
Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	,		+ col . 7)	Ratio	Inpatient	
			,		Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	7, 008, 151		7, 008, 151			30.00
31.00 03100 INTENSIVE CARE UNIT	2, 852, 214		2, 852, 214			31.00
40. 00 04000 SUBPROVI DER - 1 PF	o		(40.00
43. 00 04300 NURSERY	230, 668		230, 668	s		43.00
44.00 04400 SKILLED NURSING FACILITY	o		(44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 427, 420	13, 062, 503	14, 489, 923	0. 526249	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	219, 683	7, 073	226, 756	0. 639414	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	l c	0. 000000	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 452, 385	27, 127, 809	28, 580, 194	0. 169798	0.000000	54.00
60. 00 06000 LABORATORY	2, 204, 995	17, 933, 565	20, 138, 560	0. 311843	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 268, 575	3, 531, 221	4, 799, 796	0. 318037	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	396, 118	5, 500, 855	5, 896, 973	0. 620508	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	436, 920	1, 937, 051	2, 373, 971	0. 378695	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	65, 588	1, 260, 428	1, 326, 016	0. 328351	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	o	0	d	0. 000000	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	ıl c	0. 000000	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	534, 945	3, 483, 873	4, 018, 818	0. 388002	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 661, 769	6, 612, 396	9, 274, 165	0. 399498	0.000000	73.00
76. 00 03020 OP PSYCH	o	66, 868	66, 868	17. 000598	0.000000	76.00
76. 01 03030 WOUND CARE	750	213, 758	214, 508	2. 244546	0.000000	76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 MONROE FAMILY MEDICINE	0	3, 179, 905	3, 179, 905	5		88. 00
88. 01 08801 WOODCREST	o	2, 198, 786	2, 198, 786			88. 01
88. 02 08802 STAT CARE	o	2, 093, 132	2, 093, 132	<u> </u>		88. 02
88.03 08803 BERNE FAMILY MEDICINE	0	2, 162, 034	2, 162, 034			88. 03
88. 04 08804 HI GH STREET	0	2, 445, 984	2, 445, 984			88. 04
90. 00 09000 CLI NI C	400	2, 369, 534	2, 369, 934	1. 538188	0.000000	90.00
90. 01 09001 CLINIC - AMO	0	739, 563	739, 563	1. 312591	0.000000	90. 01
90. 02 09002 CLINIC - AMH NEURO	0	283, 476	283, 476	1. 578864	0.000000	90.02
90. 03 09003 GENERAL SURGERY OFFICE	0	366, 070	366, 070	2. 415724	0.000000	90.03
90.04 04950 INTENSIVE OP BEHAVIORAL HEALTH	0	0	l c	0. 000000	0.000000	90.04
91. 00 09100 EMERGENCY	20, 000	10, 064, 871	10, 084, 871	0. 481405	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	251, 885	3, 681, 695	3, 933, 580	1. 226430	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0	2, 185, 077	2, 185, 077	1. 329292	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	0	0	C			101.00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 HOSPI CE	0	0	1		·	116. 00
200.00 Subtotal (see instructions)	21, 032, 466	112, 507, 527	133, 539, 993			200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	21, 032, 466	112, 507, 527	133, 539, 993	s		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
Period:
From 01/01/2023
To 12/31/2023
Date/Time Prepared:
5/29/2024 8:49 am

				10 12/31/2023	5/29/2024 8: 49 a	
			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	30.00
31.00	03100 INTENSIVE CARE UNIT				31	31. 0
40.00	04000 SUBPROVI DER - I PF				40	10.00
43.00	04300 NURSERY				43	13. 0
44.00	04400 SKILLED NURSING FACILITY				44	14. 0
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000			50	50.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52	52. 0
53.00	05300 ANESTHESI OLOGY	0. 000000			53	53.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54	54.00
60.00	06000 LABORATORY	0. 000000			60	50.00
65. 00	06500 RESPIRATORY THERAPY	0. 000000			65	55.0
66. 00	06600 PHYSI CAL THERAPY	0. 000000			66	66.0
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000			67	57. 0
68. 00	06800 SPEECH PATHOLOGY	0. 000000			68	68. 0
69. 00	06900 ELECTROCARDI OLOGY	0. 000000			69	59. 0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71	71. 0
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72	72. 0
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73	73. 0
76. 00	03020 OP PSYCH	0. 000000			76	76. 0
	03030 WOUND CARE	0. 000000			76	76. 0
	OUTPATIENT SERVICE COST CENTERS	<u> </u>				
88. 00	08800 MONROE FAMILY MEDICINE				88	38. 0
88. 01	08801 WOODCREST				88	38. 0
88. 02	08802 STAT CARE				88	38. 0
88. 03	08803 BERNE FAMILY MEDICINE				88	38. 0
88. 04	08804 HI GH STREET				88	38. 0
90.00	09000 CLI NI C	0. 000000			90	90.0
90. 01	09001 CLINIC - AMO	0. 000000			90	90.0
90. 02	09002 CLINIC - AMH NEURO	0. 000000			90	90.0
90. 03	09003 GENERAL SURGERY OFFICE	0. 000000			90	90.0
90. 04	04950 INTENSIVE OP BEHAVIORAL HEALTH	0. 000000			90	90.0
	09100 EMERGENCY	0. 000000			91	91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92	92. 0
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0. 000000			95	95.0
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000				7.0
101.00	10100 HOME HEALTH AGENCY				101	01.0
	SPECIAL PURPOSE COST CENTERS					
116.00	11600 H0SPI CE				116	16.00
200.00	Subtotal (see instructions)				200	0.00
201.00	Less Observation Beds				201	01.00
	Total (see instructions)	1				02.00

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	From 01/01/2023	
		To 12/31/2023	Date/Time Prepared:

			T	o 12/31/2023	Date/Time Pre 5/29/2024 8:4	
		Ti tl	e XIX	Hospi tal	PPS	, u
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,	,				
	col. 26)					
	1. 00	2.00	3.00	4.00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS	11, 588, 243		11, 588, 243	0	11, 588, 243	30.00
31.00 03100 INTENSIVE CARE UNIT	2, 714, 137		2, 714, 137	0	2, 714, 137	31.00
40. 00 04000 SUBPROVI DER - 1 PF	0		0	0	0	40.00
43. 00 04300 NURSERY	147, 653		147, 653	0	147, 653	43.00
44.00 04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	7, 625, 305		7, 625, 305	0	7, 625, 305	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	144, 991		144, 991	0	144, 991	52.00
53. 00 05300 ANESTHESI OLOGY	0		0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 852, 848		4, 852, 848	0	4, 852, 848	54.00
60. 00 06000 LABORATORY	6, 280, 078		6, 280, 078	0	6, 280, 078	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 526, 514	0	1, 526, 514	0	1, 526, 514	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 659, 118	0	3, 659, 118	0	3, 659, 118	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	899, 010	0	899, 010	0	899, 010	67.00
68.00 06800 SPEECH PATHOLOGY	435, 399	0	435, 399	0	435, 399	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, 559, 311		1, 559, 311	0	1, 559, 311	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 705, 011		3, 705, 011	0	3, 705, 011	73.00
76. 00 03020 OP PSYCH	1, 136, 796		1, 136, 796	0	1, 136, 796	76.00
76. 01 03030 WOUND CARE	481, 473		481, 473	0	481, 473	76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 MONROE FAMILY MEDICINE	3, 309, 143		3, 309, 143	0	3, 309, 143	88. 00
88. 01 08801 WOODCREST	2, 278, 880		2, 278, 880	0	2, 278, 880	88. 01
88. 02 08802 STAT CARE	2, 213, 284		2, 213, 284	0	2, 213, 284	88. 02
88.03 08803 BERNE FAMILY MEDICINE	2, 445, 243		2, 445, 243	0	2, 445, 243	88. 03
88. 04 08804 HI GH STREET	1, 746, 206		1, 746, 206	0	1, 746, 206	88. 04
90. 00 09000 CLI NI C	3, 645, 404		3, 645, 404	0	3, 645, 404	90.00
90. 01 09001 CLINIC - AMO	970, 744		970, 744	0	970, 744	90. 01
90. 02 09002 CLINIC - AMH NEURO	447, 570		447, 570	0	447, 570	90. 02
90. 03 09003 GENERAL SURGERY OFFICE	884, 324		884, 324	0	884, 324	90. 03
90.04 04950 INTENSIVE OP BEHAVIORAL HEALTH	0		0	0	0	90. 04
91. 00 09100 EMERGENCY	4, 854, 911		4, 854, 911	0	4, 854, 911	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 824, 262		4, 824, 262		4, 824, 262	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	2, 904, 606		2, 904, 606	0	2, 904, 606	95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
101.00 10100 HOME HEALTH AGENCY	0		0		0	101. 00
SPECIAL PURPOSE COST CENTERS	T		T	-		
116. 00 11600 HOSPI CE		_				116. 00
200.00 Subtotal (see instructions)	77, 280, 464	0		0	77, 280, 464	
201.00 Less Observation Beds	4, 824, 262	_	4, 824, 262	_	4, 824, 262	
202.00 Total (see instructions)	72, 456, 202	0	72, 456, 202	0	72, 456, 202	202.00

				j	To 12/31/2023	Date/Time Pre 5/29/2024 8:4	
			Ti tl	e XIX	Hospi tal	PPS	7 alli
			Charges	<u> </u>	110001 tui		
	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	
I	NPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			<u> </u>		
30.00	03000 ADULTS & PEDIATRICS	7, 008, 151		7, 008, 151			30.00
31.00	03100 INTENSIVE CARE UNIT	2, 852, 214		2, 852, 214	ı		31.00
	04000 SUBPROVI DER - I PF	o		(40.00
43.00	04300 NURSERY	230, 668		230, 668	3		43.00
44.00	04400 SKILLED NURSING FACILITY	0					44.00
A	NCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 427, 420	13, 062, 503	14, 489, 923	0. 526249	0.000000	50.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	219, 683	7, 073	226, 756	0. 639414	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0			0.000000	53.00
54.00 0	05400 RADI OLOGY-DI AGNOSTI C	1, 452, 385	27, 127, 809	28, 580, 194	0. 169798	0.000000	54.00
60.00	06000 LABORATORY	2, 204, 995	17, 933, 565	20, 138, 560	0. 311843	0.000000	60.00
65. 00 C	06500 RESPIRATORY THERAPY	1, 268, 575	3, 531, 221	4, 799, 796	0. 318037	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	396, 118	5, 500, 855	5, 896, 973	0. 620508	0.000000	66.00
67. 00 C	06700 OCCUPATI ONAL THERAPY	436, 920	1, 937, 051	2, 373, 97	0. 378695	0.000000	67.00
	06800 SPEECH PATHOLOGY	65, 588	1, 260, 428			0.000000	
	06900 ELECTROCARDI OLOGY	o	0	(0.000000	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0		0. 000000	0.000000	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	534, 945	3, 483, 873	4, 018, 818		0.000000	72.00
	07300 DRUGS CHARGED TO PATIENTS	2, 661, 769	6, 612, 396		0. 399498	0.000000	73.00
	03020 OP PSYCH	o	66, 868			0.000000	76.00
76. 01 C	03030 WOUND CARE	750	213, 758	214, 508	2. 244546	0.000000	76. 01
0	OUTPATIENT SERVICE COST CENTERS						
	08800 MONROE FAMILY MEDICINE	0	3, 179, 905	3, 179, 905	1. 040642	0.000000	88. 00
88. 01	08801 WOODCREST	o	2, 198, 786	2, 198, 786	1. 036426	0.000000	88. 01
88. 02	08802 STAT CARE	O	2, 093, 132		1.057403	0.000000	88. 02
88. 03	08803 BERNE FAMILY MEDICINE	O	2, 162, 034	2, 162, 034	1. 130992	0.000000	88. 03
88. 04	08804 HI GH STREET	O	2, 445, 984	2, 445, 984	0. 713907	0.000000	88. 04
90.00	09000 CLI NI C	400	2, 369, 534	2, 369, 934	1. 538188	0.000000	90.00
90. 01	09001 CLINIC - AMO	O	739, 563	739, 563	1. 312591	0.000000	90. 01
90. 02	09002 CLINIC - AMH NEURO	O	283, 476	283, 476	1. 578864	0.000000	90. 02
90. 03	09003 GENERAL SURGERY OFFICE	O	366, 070	366, 070	2. 415724	0.000000	90.03
90.04	04950 INTENSIVE OP BEHAVIORAL HEALTH	O	0		0. 000000	0.000000	90.04
91.00	09100 EMERGENCY	20, 000	10, 064, 871	10, 084, 87	0. 481405	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	251, 885	3, 681, 695	3, 933, 580	1. 226430	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS				<u>'</u>		
95.00	09500 AMBULANCE SERVI CES	0	2, 185, 077	2, 185, 077	1. 329292	0.000000	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	o	0		0. 000000	0.000000	97.00
101.001	10100 HOME HEALTH AGENCY	O	0				101.00
S	SPECIAL PURPOSE COST CENTERS						
116. 00 1	11600 HOSPI CE	0	0	(116. 00
200.00	Subtotal (see instructions)	21, 032, 466	112, 507, 527	133, 539, 993	3		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	21, 032, 466	112, 507, 527	133, 539, 993	3		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
Fer od:
From 01/01/2023
To 12/31/2023
To 12/31/2023
Period:
From 01/01/2023
To 12/31/2023
Part I
Date/Time Prepared:
5/29/2024 8: 49 am

				5/29/2024 8: 49 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31. 00 03100 INTENSIVE CARE UNIT				31.00
40. 00 04000 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. 526249			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 639414			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 169798			54.00
60. 00 06000 LABORATORY	0. 311843			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 318037			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 620508			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 378695			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 328351			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 388002			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 388002			73.00
76. 00 03020 OP PSYCH	17. 000598			76.00
76. 01 03030 WOUND CARE	2. 244546			76. 00
OUTPATIENT SERVICE COST CENTERS	2. 244340			76.01
88. 00 08800 MONROE FAMILY MEDICINE	1. 040642			88.00
	1. 036426			
88. 01 08801 WOODCREST				88. 01
88. 02 08802 STAT CARE	1. 057403			88. 02
88. 03 08803 BERNE FAMILY MEDICINE	1. 130992			88. 03
88. 04 08804 HI GH STREET	0. 713907			88. 04
90. 00 09000 CLINIC	1. 538188			90.00
90. 01 09001 CLINIC - AMO	1. 312591			90. 01
90. 02 09002 CLINIC - AMH NEURO	1. 578864			90. 02
90. 03 09003 GENERAL SURGERY OFFICE	2. 415724			90. 03
90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH	0. 000000			90.04
91. 00 09100 EMERGENCY	0. 481405			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 226430			92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	1. 329292			95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97.00
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Title XIX Hospital PPS	red: am
Cost Net of Capital Cost (col. 1 - col. 26) Cost Net of Capital Cost (col. 1 - col. 26) Cost Net of Capital Cost (col. 1 - col. 27) Cost Net Of Capital Cost (col. 1 - col. 27) Cost Net Of Capital Cost (col. 1 - col. 27) Cost Net Of Capital Cost (col. 1 - col. 27) Cost Net Of Capital Cost (col. 1 - col. 27) Cost Net Of Capital Cost (col. 1 - col. 27) Cost Net Of Capital Cost (col. 1 - col. 27) Cost Net Of Capital Cost (col. 1 - col. 27) Cost Net Of Capital Cost (col. 1 - col. 27) Cost Net Of Capital Cost (col. 1 - col. 27) Cost Net Of Capital Cost (col. 1 - col. 27) Cost Net Of Capital Cost (col. 2 - col. 27) Cost Net Of Capital Cost (col. 2 - col. 27) Cost Net Of Capital Cost (col. 2 - col. 27) Cost Net Of Capital Cost (col. 2 - col. 27) Cost Net Of Capital Cost (col. 2 - col. 2 - col. 28) Cost Net Of Capital Cost (col. 2 - col. 28) Cost Net Of Capital Cost (col. 2 - col. 28) Cost Net Of Capital Cost (col. 2 - col. 28) Cost Net Of Capital Cost (col. 2 - col. 28) Cost Net Of Capital Cost (col. 2 - col. 28) Cost Net Of	
Part I, col. Part II col. Capital Cost (col. 1 - col. 26) Reduction Amount	
AROULLLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00	
ANCI LLARY SERVICE COST CENTERS	
1.00 2.00 3.00 4.00 5.00 5.00	
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 7, 625, 305 293, 990 7, 331, 315 0 0 5200 DELIVERY ROOM & LABOR ROOM 144, 991 33, 789 111, 202 0 0 0 53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
50. 00 05000 OPERATI NG ROOM 7, 625, 305 293, 990 7, 331, 315 0 0 5 52. 00 05200 DELI VERY ROOM & LABOR ROOM 144, 991 33, 789 111, 202 0 <td< td=""><td></td></td<>	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 144, 991 33, 789 111, 202 0	
53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 5 5 0 <td>50.00</td>	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 4,852,848 201,564 4,651,284 0 0 5 60. 00 06000 LABORATORY 6,280,078 110,129 6,169,949 0 0 6 65. 00 06500 RESPI RATORY THERAPY 1,526,514 111,500 1,415,014 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 3,659,118 182,534 3,476,584 0 0 0 6 67. 00 06700 OCCUPATI ONAL THERAPY 899,010 5,255 893,755 0 <td>52.00</td>	52.00
60. 00 06000 LABORATORY 6, 280, 078 110, 129 6, 169, 949 0 0 6 6 6 6 6 6 6 6	53.00
65. 00 06500 RESPIRATORY THERAPY 1,526,514 111,500 1,415,014 0 0 6 6 6 0 0 6 0 0	54.00
66. 00 06600 PHYSI CAL THERAPY 3, 659, 118 182, 534 3, 476, 584 0 0 6 6 6 6 6 6 6 6	50.00
67. 00 06700 0CCUPATI ONAL THERAPY 899, 010 5, 255 893, 755 0 0 6 6 6 6 0 0 0 0	55.00
68. 00 06800 SPEECH PATHOLOGY 435, 399 2, 562 432, 837 0 0 6 6 6 6 6 6 6 6	56.00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 71. 00 071.0	57. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 1,559,311 5,785 1,553,526 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 3,705,011 62,171 3,642,840 0 0 0 7	58. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 1,559,311 5,785 1,553,526 0 0 7 7 7 7 7 7 7 7	59. 00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 3, 705, 011 62, 171 3, 642, 840 0 0 7	71. 00
	72.00
74 00 00000 00 DSVCH 1 124 704 2 040 1 122 047	73.00
76. 00 03020 0P PSYCH 1, 136, 796 2, 849 1, 133, 947 0 0 76. 00	76. 00
76. 01 03030 WOUND CARE 481, 473 1, 387 480, 086 0 0 76. 01	76. 01
OUTPATIENT SERVICE COST CENTERS	
88. 00 08800 MONROE FAMILY MEDICINE 3, 309, 143 9, 233 3, 299, 910 0 0 8	38. 00
88. 01 08801 WOODCREST 2, 278, 880 6, 545 2, 272, 335 0 0 8	38. 01
88. 02 08802 STAT CARE 2, 213, 284 55, 748 2, 157, 536 0 0 8	38. 02
88. 03 08803 BERNE FAMILY MEDICINE 2, 445, 243 6, 897 2, 438, 346 0 0 8	38. 03
88. 04 08804 HI GH STREET 1, 746, 206 5, 350 1, 740, 856 0 0 8	38. 04
90. 00 09000 CLI NI C 3, 645, 404 39, 274 3, 606, 130 0 9	90.00
90. 01 09001 CLI NI C - AMO 970, 744 9, 470 961, 274 0 0 9	90. 01
90. 02 09002 CLI NI C - AMH NEURO 447, 570 7, 414 440, 156 0 0 9	90. 02
90. 03 09003 GENERAL SURGERY OFFI CE 884, 324 10, 574 873, 750 0 0 9	90. 03
90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH 0 0 0 0 0	90. 04
91. 00 09100 EMERGENCY 4,854,911 139,687 4,715,224 0 0 9	91.00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 4,824,262 226,306 4,597,956 0 0 9	92.00
OTHER REIMBURSABLE COST CENTERS	
95. 00 09500 AMBULANCE SERVI CES 2, 904, 606 7, 165 2, 897, 441 0 0 9	95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 9 9 9 9 9 9 9	97.00
101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 10	01.00
SPECIAL PURPOSE COST CENTERS	
	16.00
200.00 Subtotal (sum of lines 50 thru 199) 62,830,431 1,537,178 61,293,253 0 0 20	00.00
201.00 Less Observation Beds 4,824,262 226,306 4,597,956 0 0/20	01.00
202.00 Total (line 200 minus line 201) 58,006,169 1,310,872 56,695,297 0 0 20	02.00

Health Financial Systems ADAMS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Provider CCN: 15-1330 Period: From 01/01/2023 Part II

12/31/2023

Date/Time Prepared:

201.00

202.00

5/29/2024 8: 49 am Title XIX Hospi tal PPS Total Charges Outpati ent Cost Center Description Cost Net of Capital and (Worksheet C, Cost to Operating Part I Charge Ratio Cost column 8) (col. 6 / Reducti on col. 7) 7.00 8.00 6.00 ANCILLARY SERVICE COST CENTERS 50 00 7, 625, 305 14, 489, 923 50 00 05000 OPERATING ROOM 0.526249 52.00 05200 DELIVERY ROOM & LABOR ROOM 144, 991 226, 756 0.639414 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 4, 852, 848 28, 580, 194 0.169798 54.00 54.00 06000 LABORATORY 60.00 6, 280, 078 20, 138, 560 0.311843 60.00 65.00 06500 RESPIRATORY THERAPY 1, 526, 514 4, 799, 796 0.318037 65.00 66.00 06600 PHYSI CAL THERAPY 3, 659, 118 5, 896, 973 0.620508 66.00 899, 010 06700 OCCUPATI ONAL THERAPY 2, 373, 971 67.00 0.378695 67.00 68.00 06800 SPEECH PATHOLOGY 435, 399 1, 326, 016 0.328351 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 4, 018, 818 1, 559, 311 0.388002 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 705, 011 9, 274, 165 0.399498 73.00 03020 OP PSYCH 76.00 1, 136, 796 66, 868 17.000598 76.00 03030 WOUND CARE 481, 473 214, 508 2. 244546 76.01 76.01 OUTPATIENT SERVICE COST CENTERS 08800 MONROE FAMILY MEDICINE 3, 309, 143 3, 179, 905 1. 040642 88.00 88.00 08801 WOODCREST 2, 278, 880 2, 198, 786 1.036426 88.01 88.01 08802 STAT CARE 88.02 2, 213, 284 2, 093, 132 1.057403 88.02 08803 BERNE FAMILY MEDICINE 88.03 2, 445, 243 2, 162, 034 1.130992 88.03 08804 HI GH STREET 1, 746, 206 2, 445, 984 88.04 0.713907 88.04 3, 645, 404 90.00 09000 CLI NI C 2, 369, 934 1.538188 90.00 09001 CLINIC - AMO 09002 CLINIC - AMH NEURO 970, 744 739, 563 90.01 1.312591 90.01 90.02 447, 570 283, 476 1.578864 90.02 09003 GENERAL SURGERY OFFICE 90.03 884, 324 366,070 2.415724 90.03 04950 INTENSIVE OP BEHAVIORAL HEALTH 0.000000 90 04 90 04 91.00 09100 EMERGENCY 4, 854, 911 10,084,871 0.481405 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 4, 824, 262 3, 933, 580 1. 226430 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 95 00 2, 904, 606 2, 185, 077 1 329292 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 97.00 101.00 10100 HOME HEALTH AGENCY 101.00 0.000000 SPECIAL PURPOSE COST CENTERS 0.000000 116.00 116. 00 11600 HOSPI CE 200.00 Subtotal (sum of lines 50 thru 199) 62, 830, 431 123, 448, 960 200.00

4, 824, 262

58, 006, 169

123, 448, 960

201.00

202.00

Less Observation Beds

Total (line 200 minus line 201)

Health Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	COSTS Provi der CCN: 15-1330		Peri od:	Worksheet D	
				From 01/01/2023	Part II	
				To 12/31/2023	Date/Time Pre	pared:
		Title	XVIII	Hospi tal	5/29/2024 8: 49 am Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
oost denter bescriptron	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)	orial ges	001 411111 1)	
	col. 26)	33.1 3)	331. 2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	293, 990	14, 489, 923	0. 02028	9 422, 395	8, 570	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	33, 789			0 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	201, 564	28, 580, 194	0.00705	3 456, 198	3, 218	54.00
60. 00 06000 LABORATORY	110, 129	20, 138, 560	0.00546	9 412, 052		
65. 00 06500 RESPIRATORY THERAPY	111, 500					
66. 00 06600 PHYSI CAL THERAPY	182, 534			113, 042		
67. 00 06700 OCCUPATI ONAL THERAPY	5, 255			4 114, 924	254	67.00
68.00 06800 SPEECH PATHOLOGY	2, 562				42	68.00
69. 00 06900 ELECTROCARDI OLOGY	0		0.00000		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l o	0. 00000	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	5, 785	4, 018, 818	0.00143	9 217, 319	313	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	62, 171	9, 274, 165	0. 00670	734, 359	4, 923	73.00
76. 00 03020 OP PSYCH	2, 849	66, 868	0. 04260	. 0	0	76.00
76. 01 03030 WOUND CARE	1, 387				0	76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 MONROE FAMILY MEDICINE	9, 233	3, 179, 905	0.00290	0	0	88. 00
88. 01 08801 WOODCREST	6, 545	2, 198, 786	0. 00297	7 0	0	88. 01
88. 02 08802 STAT CARE	55, 748	2, 093, 132	0. 02663	4 0	0	88. 02
88.03 08803 BERNE FAMILY MEDICINE	6, 897	2, 162, 034	0. 00319	0 0	0	88. 03
88. 04 08804 HI GH STREET	5, 350	2, 445, 984	0. 00218	7 0	0	88. 04
90. 00 09000 CLI NI C	39, 274	2, 369, 934	0. 01657	2 380	6	90.00
90. 01 09001 CLINIC - AMO	9, 470	739, 563	0. 01280	5 0	0	90. 01
90. 02 09002 CLINIC - AMH NEURO	7, 414	283, 476	0. 02615	4 0	0	90. 02
90. 03 09003 GENERAL SURGERY OFFICE	10, 574	366, 070	0. 02888	5 0	0	90.03
90.04 04950 INTENSIVE OP BEHAVIORAL HEALTH	0		1	0	0	90.04
91. 00 09100 EMERGENCY	139, 687	10, 084, 871	0. 01385	6, 382	88	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	226, 306		1	· ·	283	92.00
OTHER REIMBURSABLE COST CENTERS				•		1
95. 00 09500 AMBULANCE SERVICES						95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0. 00000	0	0	
200.00 Total (lines 50 through 199)	1, 530, 013	121, 263, 883		2, 948, 148	33, 769	200. 00

Health Financial Systems	ADAMS MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCI LLARY SERVI CE OTHER PASS Provi der CCN: 15-1330	Peri od: Worksheet D
THROUGH COSTS		From 01/01/2023 Part IV

TTIKOGO	66516				To 12/31/2023	Date/Time Pre 5/29/2024 8:4	
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	·	Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments		· ·		
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0)	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0 0	0	54.00
60.00	06000 LABORATORY	0	0	1	0 0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	1	0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	1	0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	1	0 0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	1	0 0	0	68. 00
69. 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	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	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	•		,	•		1
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	0		0 0	0	88. 02
88. 03	08803 BERNE FAMILY MEDICINE	0	0		0 0	0	88. 03
88. 04	08804 HI GH STREET	0	0		0 0	0	88. 04
90.00	09000 CLI NI C	0	0		0 0	0	90.00
90. 01	09001 CLI NI C - AMO	0	0		0 0	0	90. 01
90. 02	09002 CLINIC - AMH NEURO	0	0		0 0	0	90. 02
	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
	09100 EMERGENCY	0	0		0 0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	_		0	0	1
50	OTHER REIMBURSABLE COST CENTERS				-		1
95.00	09500 AMBULANCE SERVI CES						95.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	,	0 0	0	
200.00		0	Ö	1	0 0	-	200.00
	,	1		1	1		

Hea	Ith Financial Systems		ADAMS MEMORIAL H	HOSPI TAL	In Lieu	ı of Form CMS-2552-10
	PORTIONMENT OF INPATIENT/OUTPATIENT ROUGH COSTS	ANCILLARY SE	ERVICE OTHER PASS	Provider CCN: 15-1330	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared:

				1	To 12/31/2023	Date/Time Pre 5/29/2024 8:4	pared:
			Title	xVIII	Hospi tal	Cost	9 alli
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	oust defiter beschiptron	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)	
		0001	• ,	and 4)	33.1.07	(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(14, 489, 923	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(226, 756	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	(28, 580, 194	0.000000	54.00
60.00	06000 LABORATORY	0	0	(20, 138, 560	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	(4, 799, 796	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	(5, 896, 973	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(2, 373, 971	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	o	0	(1, 326, 016	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	o	0	(0	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(4, 018, 818	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(9, 274, 165	0.000000	73.00
76.00	03020 OP PSYCH	0	0	(66, 868	0.000000	76.00
76. 01	03030 WOUND CARE	0	0	(214, 508	0.000000	76. 01
	OUTPATIENT SERVICE COST CENTERS						
	08800 MONROE FAMILY MEDICINE	0	0			0. 000000	
88. 01	08801 WOODCREST	0	0		_,,	0. 000000	
	08802 STAT CARE	0	0	(2, 093, 132	0. 000000	
88. 03	08803 BERNE FAMILY MEDICINE	0	0	(_,,	0. 000000	
	08804 HI GH STREET	0	0	(_,,	0. 000000	1
90.00	09000 CLI NI C	0	0	(2, 369, 934	0.000000	
90. 01	09001 CLINIC - AMO	0	0	(739, 563	0. 000000	
90. 02	09002 CLINIC - AMH NEURO	0	0	(283, 476	0.000000	90. 02
	09003 GENERAL SURGERY OFFICE	0	0	(366, 070	0. 000000	1
	04950 INTENSIVE OP BEHAVIORAL HEALTH	0	0	(0	0. 000000	l
91. 00	09100 EMERGENCY	0	0	(10, 084, 871	0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(3, 933, 580	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0			0. 000000	
200.00	Total (lines 50 through 199)	0	0	(121, 263, 883		200. 00

Health Financial Systems	ADAMS MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provi der CCN: 15-1330	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/29/2024 8:49 am

TTIKOOC	W 60313			To	0 12/31/2023	Date/Time Pre 5/29/2024 8:4	
			Title	XVIII	Hospi tal	Cost	, all
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	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	,		,			
50.00	05000 OPERATING ROOM	0. 000000	422, 395		0	0	00.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	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	456, 198		0	0	54.00
60.00	06000 LABORATORY	0. 000000	412, 052		0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	444, 205		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	113, 042		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	114, 924	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	21, 981	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
	07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000	217, 319		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	734, 359	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	0	0	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 MONROE FAMILY MEDICINE	0. 000000	0	0	0	0	
88. 01	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
	08804 HI GH STREET	0. 000000	0		0	0	88. 04
90.00	09000 CLI NI C	0. 000000	380	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	6, 382	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	4, 911	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES						95. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0	0	0		
200.00	Total (lines 50 through 199)		2, 948, 148	0	0	0	200. 00

Health Financial Systems ADAMS MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1330 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/29/2024 8: 49 am Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 526249 3, 062, 804 05200 DELIVERY ROOM & LABOR ROOM 0.639414 0 52.00 0 0 0 0. 000000 05300 ANESTHESI OLOGY 0 53.00 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 169798 0 6, 902, 615 0 0 60.00 06000 LABORATORY 0. 311843 3, 947, 188 1, 228 0 06500 RESPIRATORY THERAPY 766, 982 65. NO 0.318037 0 0 66.00 06600 PHYSI CAL THERAPY 0.620508 1,606,616 0 0 67.00 06700 OCCUPATI ONAL THERAPY 0. 378695 431, 054 0 0 06800 SPEECH PATHOLOGY 0.328351 83, 572 0 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 0 07200 IMPL. DEV. CHARGED TO PATIENT 0. 388002 72.00 1, 134, 732 0 0

12/31/2023 Date/Time Prepared: 5/29/2024 8: 49 am Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 1, 611, 798 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 0 0 05300 ANESTHESI OLOGY 53.00 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 172, 050 0 54.00 60.00 06000 LABORATORY 1, 230, 903 383 60.00 06500 RESPIRATORY THERAPY 243, 929 65.00 65.00 Ω 66.00 06600 PHYSI CAL THERAPY 996, 918 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 163, 238 0 67.00 68.00 06800 SPEECH PATHOLOGY 27, 441 0 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 440, 278 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 625 896 11 585 73 00 76.00 03020 OP PSYCH 155, 674 C 76.00 76. 01 03030 WOUND CARE 8,774 0 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 MONROE FAMILY MEDICINE 08801 WOODCREST 88.01 88.01 88.02 08802 STAT CARE 88.02 08803 BERNE FAMILY MEDICINE 88.03 88.03 08804 HI GH STREET 88 04 88 04 90.00 09000 CLI NI C 488, 209 16, 239 90.00 90.01 09001 CLINIC - AMO 319, 087 90.01 09002 CLINIC - AMH NEURO 52, 854 90.02 90.02 0 09003 GENERAL SURGERY OFFICE 90.03 90.03 118, 511 0 90.04 04950 INTENSIVE OP BEHAVIORAL HEALTH 0 90.04 91.00 09100 EMERGENCY 792, 788 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 1, 430, 260 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 200.00 200.00 Subtotal (see instructions) 9, 878, 608 28, 207 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges

9, 878, 608

28, 207

202.00

202.00

Net Charges (line 200 - line 201)

			Component	CCN: 15-Z330 T	o 12/31/2023	Date/Time Pre 5/29/2024 8:4	pared: 9 am
			Title	XVIII S	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	Subject To		
		Part I, col.	,	Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2.00	3.00	4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 526249	0	C	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 639414	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 169798	0		0	0	54.00
60.00	06000 LABORATORY	0. 311843	0		0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 318037	0		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 620508	0		0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 378695	0		0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 328351	0		0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0	1	0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	1	0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 388002	0	1	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 399498	0		o o	Ö	73.00
76.00	03020 OP PSYCH	17. 000598	0	1	_	0	76.00
	03030 WOUND CARE	2. 244546	0		-	0	76.00
70.01	OUTPATIENT SERVICE COST CENTERS	2. 244340	0		, 0	0	70.01
88. 00	08800 MONROE FAMILY MEDICINE			I			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 CLINIC	1. 538188	0	_		0	90.00
90.00	09001 CLINIC - AMO	1. 312591	0			0	90.00
90.01	09001 CETNIC - AMO	1. 578864	0			0	90.01
	09003 GENERAL SURGERY OFFICE	2. 415724	0			0	90.02
	l l		0			_	
90.04	04950 INTENSIVE OP BEHAVIORAL HEALTH	0. 000000	0			0	90.04
91.00	09100 EMERGENCY	0. 481405	0		-	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 226430	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS			_			
	09500 AMBULANCE SERVICES	1. 329292	_	0		_	95.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0	1	1	0	
200.00			0	0			200. 00
201.00				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-Z330

To 12/31/2023

Date/Time Prepared:

		Component	CCN: 15-Z330	То	12/31/2023	Date/Time Pr 5/29/2024 8:	
		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.					
	(see inst.)	(see inst.)					
	6.00	7.00					
ANCILLARY SERVICE COST CENTERS	9.00						
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	o	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	0	0					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	o	0					67.00
68. 00 06800 SPEECH PATHOLOGY		0					68.00
69. 00 06900 SPEECH PATHOLOGY		0					69.00
+ !		0					71.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	- 1					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0					73.00
76. 00 03020 OP PSYCH	0	0					76.00
76. 01 03030 WOUND CARE OUTPATIENT SERVICE COST CENTERS	0	0					76. 01
88.00 08800 MONROE FAMILY MEDICINE	Т		I				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. 01 09001 CLINIC - AMO	0	0					90. 01
90. 02 09002 CLINIC - AMH NEURO	0	0					90. 02
90.03 O9003 GENERAL SURGERY OFFICE	0	0					90. 03
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	0	0					90. 04
91. 00 09100 EMERGENCY	0	0					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0					92.00
OTHER REIMBURSABLE COST CENTERS							
95. 00 09500 AMBULANCE SERVICES	0						95. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0					97.00
200.00 Subtotal (see instructions)	0	0					200.00
201.00 Less PBP Clinic Lab. Services-Program	ol						201.00
Only Charges							
202.00 Net Charges (line 200 - line 201)	0	0					202.00
1 1 1 1 3 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1	-1	-	1				

Heal th	Financial Systems	ADAMS MEMORIA	ADAMS MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
APPORT	TIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provi der C	<u> </u>	Period: From 01/01/2023 Fo 12/31/2023	Worksheet D Part I Date/Time Prepared: 5/29/2024 8:49 am			
			Ti tl	e XIX			PPS		
	Cost Center Description	Capi tal Related Cost	Swing Bed Adjustment	Reduced Capital	Total Patient Days	Per Diem (col. 3 /			
		(from Wkst.	riaj astilione	Related Cost		col . 4)			
		B, Part II,		(col . 1 -		001. 1)			
		col. 26)		col . 2)					
		1.00	2. 00	3.00	4. 00	5. 00			
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	ADULTS & PEDIATRICS	543, 599	107, 344	436, 25	3, 628	120. 25	30.00		
31.00	INTENSIVE CARE UNIT	97, 782		97, 782	2 779	125. 52	31.00		
40.00	SUBPROVIDER - IPF	0	0		0	0.00	40.00		
43.00	NURSERY	35, 053		35, 053	3 293	119. 63	43.00		
44.00	SKILLED NURSING FACILITY	0			0	0.00	44.00		
200.00 Total (lines 30 through 199)		676, 434		569, 090	4, 700		200.00		
	Cost Center Description	I npati ent	I npati ent						
		Program days	Program						
			Capital Cost						
			(col. 5 x						
		(00	col. 6)						
	INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00		.				
30. 00	ADULTS & PEDIATRICS		0				30.00		
31. 00	INTENSIVE CARE UNIT	131	16, 443	1			31.00		
40.00	SUBPROVIDER - IPF	131	10, 443	1			40.00		
43. 00	NURSERY	107	12, 800	1			43.00		
44. 00	SKILLED NURSING FACILITY	107	12,000	1			44.00		
	Total (lines 30 through 199)	238	-	1			200. 00		

Health Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-1330	Peri od: Worksheet D		
				From 01/01/2023	Part II	
			"	To 12/31/2023		
	T: +1	o VIV	Hooni tol	5/29/2024 8: 49 am		
C+ C+	C: +-1		e XIX	Hospi tal		
Cost Center Description	Capi tal		Ratio of Cost		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)					
ANOTHER ABOVE OF BUILDING OF STATERS	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS				_	_	
50. 00 05000 OPERATI NG ROOM	293, 990		•			
52.00 05200 DELIVERY ROOM & LABOR ROOM	33, 789	1				
53. 00 05300 ANESTHESI OLOGY	0		0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	201, 564				0	
60. 00 06000 LABORATORY	110, 129				0	
65. 00 06500 RESPIRATORY THERAPY	111, 500				0	
66. 00 06600 PHYSI CAL THERAPY	182, 534	5, 896, 973	0. 03095	4 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	5, 255	2, 373, 971	0. 00221	4 0	0	
68.00 06800 SPEECH PATHOLOGY	2, 562	1, 326, 016	0. 00193	2 0	0	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, 785	4, 018, 818	0. 00143	9 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	62, 171	9, 274, 165	0.00670	4 0	0	73.00
76. 00 03020 OP PSYCH	2, 849	66, 868	0.04260	6 0	0	76.00
76. 01 03030 WOUND CARE	1, 387	214, 508	0.00646	6 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS		·		<u>'</u>		1
88.00 08800 MONROE FAMILY MEDICINE	9, 233	3, 179, 905	0.00290	4 0	0	88.00
88. 01 08801 WOODCREST	6, 545	2, 198, 786	0. 00297	7 0	0	88. 01
88. 02 08802 STAT CARE	55, 748	2, 093, 132	0. 02663	4 0	0	88. 02
88. 03 08803 BERNE FAMILY MEDICINE	6, 897	2, 162, 034	0.00319	0	O	88. 03
88. 04 08804 HI GH STREET	5, 350				0	
90. 00 09000 CLI NI C	39, 274				0	
90. 01 09001 CLI NI C - AMO	9, 470				0	
90. 02 09002 CLI NI C - AMH NEURO	7, 414				o o	1
90. 03 09003 GENERAL SURGERY OFFICE	10, 574				0	
90. 04 04950 I NTENSI VE OP BEHAVI ORAL HEALTH	0	0			0	
91. 00 09100 EMERGENCY	139, 687	10, 084, 871			_	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	226, 306					
OTHER REIMBURSABLE COST CENTERS	220, 500	3,700,000	0.00700.	-1		1 /2.00
95. 00 09500 AMBULANCE SERVICES						95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0. 00000	o	o	
200.00 Total (lines 50 through 199)	1, 530, 013		•			200.00
200.00 10tal (11105 00 thi oagh 177)	1, 555, 515	1 121, 200, 000	Т	1	, 0	1-30.00

Health Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	ASS THROUGH COS			Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Pre 5/29/2024 8:4	pared:
	_	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 43. 00 04300 NURSERY	0 0 0 0	0 0 0		0 0 0 0 0 0 0 0	0 0 0 0	31. 00 40. 00 43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0)	0		44. 00
200.00 Total (lines 30 through 199)	0	0		0 0		200.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	t Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		•	•	<u> </u>	•	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSING FACILITY	0	000000000000000000000000000000000000000	3, 62 77 29	0. 00 0 0. 00	131 0 107	31. 00 40. 00 43. 00
200.00 Total (lines 30 through 199)			4,70			200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		,			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY	0 0 0 0					30.00 31.00 40.00 43.00 44.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	ADAMS MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCI LLARY SERVI CE OTHER PASS Provi der CCN: 15-1330	Peri od: Worksheet D
THROUGH COSTS		From 01/01/2023 Part IV

Cost Center Description Non Physician Anesthetist Cost Ost Center Description Non Physician Anesthetist Program Program Program Post-Stepdown Adjustments 1.00 2A 2.00 3A 3.00 ANCILLARY SERVICE COST CENTERS	, <u>a</u>
Anesthetist Program Program Post-Stepdown Adjustments Cost Post-Stepdown Adjustments 1.00 2A 2.00 3A 3.00 ANCILLARY SERVICE COST CENTERS	
Cost	
Adjustments	
1.00 2A 2.00 3A 3.00 ANCILLARY SERVICE COST CENTERS	
ANCILLARY SERVICE COST CENTERS	
	50.00
	52.00
53. 00 05300 ANESTHESI OLOGY 0 0 0 0 53. 00 0 0 0 0 0 0 0 0 0	53.00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0 0 0 0 0 54. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	54.00
60. 00 06000 LABORATORY 0 0 0 0 0 60.	60.00
65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 65. 00	65.00
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0	67.00
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY	68.00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 69.	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 0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 7	73.00
76. 00 03020 0P PSYCH 0 0 0 0 0 0 0 76.	76.00
76. 01 03030 WOUND CARE 0 0 0 0 76. 01 0 0 0 0 0 0 0 0 0	76. 01
OUTPATIENT SERVICE COST CENTERS	
88. 00 08800 MONROE FAMILY MEDICINE 0 0 0 0 0 0	88. 00
88. 01 08801 WOODCREST 0 0 0 0 0 0	88. 01
88. 02 08802 STAT CARE 0 0 0 0 0 0 0	88. 02
88. 03 08803 BERNE FAMILY MEDICINE 0 0 0 0 0 0	88. 03
88. 04 08804 HI GH STREET 0 0 0 0 0 0	88. 04
90. 00 09000 CLI NI C 0 0 0 0 0 9	90.00
90. 01 09001 CLINIC - AMO 0 0 0 9	90. 01
90. 02 09002 CLI NI C - AMH NEURO 0 0 0 0 9	90. 02
90. 03 09003 GENERAL SURGERY OFFICE 0 0 0 0 0 9	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 5	91.00
	92.00
OTHER REIMBURSABLE COST CENTERS	
	95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 9	97.00
200.00 Total (lines 50 through 199) 0 0 0 0 20	200. 00

Health Financial Systems	ADAMS MEMORIAL	HOSPI TAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1330		Worksheet D
THROUGH COSTS			From 01/01/2023	Part IV

THROUGH COSTS				To 12/31/2023	Date/Time Pre 5/29/2024 8:4	pared:
-		Ti tl	e XIX	Hospi tal	PPS	7 dili
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		,	0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(226, 756	0. 000000	l
53. 00 05300 ANESTHESI OLOGY	0	0	(0	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(28, 580, 194	0.000000	
60. 00 06000 LABORATORY	0	0	(20, 138, 560	0.000000	
65. 00 06500 RESPI RATORY THERAPY	0	0	(4, 799, 796	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	(5, 896, 973	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(2, 373, 971	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	(1, 326, 016	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	(0	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(4, 018, 818	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(9, 274, 165	0.000000	73.00
76. 00 03020 OP PSYCH	0	0	(66, 868	0.000000	76.00
76. 01 03030 WOUND CARE	0	0	(214, 508	0.000000	76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 MONROE FAMILY MEDICINE	0	0	(3, 179, 905	0.000000	88. 00
88. 01 08801 WOODCREST	0	0	(2, 198, 786	0.000000	88. 01
88. 02 08802 STAT CARE	0	0	(2, 093, 132	0.000000	88. 02
88.03 08803 BERNE FAMILY MEDICINE	0	0	(2, 162, 034	0.000000	88. 03
88. 04 08804 HI GH STREET	0	0	(2, 445, 984	0.000000	88. 04
90. 00 09000 CLI NI C	0	0	(2, 369, 934	0.000000	90.00
90. 01 09001 CLI NI C - AMO	0	0	(739, 563	0.000000	90. 01
90. 02 09002 CLI NI C - AMH NEURO	0	0	(283, 476	0.000000	90.02
90.03 09003 GENERAL SURGERY OFFICE	0	0	(366, 070	0.000000	90.03
90.04 04950 INTENSIVE OP BEHAVIORAL HEALTH	0	0	(o	0.000000	90.04
91. 00 09100 EMERGENCY	0	0		10, 084, 871	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		3, 933, 580	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS		<u> </u>	•			
95. 00 09500 AMBULANCE SERVI CES						95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0.000000	97.00
200.00 Total (lines 50 through 199)	0	l e		121, 263, 883		200.00
	1				1	•

Health Financial Systems	ADAMS MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provi der CCN: 15-1330	From 01/01/2023	Worksheet D Part IV Date/Time Prepared: 5/29/2024 8:49 am
		T VI.V		200

TIROUGH COSTS			To	12/31/2023	Date/Time Pre 5/29/2024 8:4	pared: 9 am
		Ti tl	e XIX	Hospi tal	PPS	
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						
50.00 05000 OPERATING ROOM	0. 000000	0	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	0	0	0	0	54.00
60. 00 06000 LABORATORY	0. 000000	0	0	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	0	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0	0	O	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0	0	o	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	0	o	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0	0	o	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0	0	o	0	73.00
76. 00 03020 OP PSYCH	0. 000000	0	0	0	0	76.00
76. 01 03030 WOUND CARE	0. 000000	0		0	0	76. 01
OUTPATIENT SERVICE COST CENTERS				-"		
88.00 08800 MONROE FAMILY MEDICINE	0. 000000	0	0	0	0	88. 00
88. 01 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	0	88. 04
90. 00 09000 CLI NI C	0. 000000	0	0	o	0	90.00
90. 01 09001 CLINIC - AMO	0. 000000	0	0	o	0	90. 01
90. 02 09002 CLINIC - AMH NEURO	0. 000000	0	0	o	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	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				-,		
95. 00 09500 AMBULANCE SERVI CES						95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0	0	0	0	97. 00
200.00 Total (lines 50 through 199)		0	0	Ö		200.00
, , , , , , , , , , , , , , , , , , , ,	1			- 1		

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 01/01/2023	Worksheet D-1	
			To 12/31/2023	Date/Time Pre 5/29/2024 8:4	
		Title XVIII	Hospi tal	Cost	
Cost Center Description					
· ·				1. 00	
PART I - ALL PROVIDER COMPONENTS					

	Title XVIII Hospital	Cost	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4, 654	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3, 628	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1, 746	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	885	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	ĭ	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	141	7.00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	0.40	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	840	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	458	10. 00
	through December 31 of the cost reporting period (see instructions)		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	o	13. 00
13. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	۷	13.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	ő	15. 00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17.00
10.00	reporting period		10.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	140. 00	19 00
. ,	report in g period	. 10. 00	. ,
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	140. 00	20.00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	11, 588, 243	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	٥Į	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
20.00	x line 18)	Ĭ	20.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	19, 740	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, 288, 322	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9, 299, 921	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	7,277,721	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3) 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 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	
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	9, 299, 921	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	2.5/2.07	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)	2, 563. 37 2, 153, 231	38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	2, 155, 251	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	2, 153, 231	
			•

COMPUTATION OF INPATIENT	OPERATING COST		NL HOSPITAL Provider C	CN: 15-1330	Peri od:	Worksheet D-1	2552-10
				From 01/01/2023 To 12/31/2023		Date/Time Pre 5/29/2024 8:4	
			Title	XVIII	Hospi tal	Cost	7 alli
Cost Center D	escri pti on	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	2.00		4.00		42.00
	Inpatient Hospital Units	<u> </u>		0.0	0		72.00
43. 00 I NTENSI VE CARE UNI		2, 714, 137	779	3, 484. 1	3 175	609, 723	43.00
44.00 CORONARY CARE UNIT							44.00
45. 00 BURN INTENSIVE CARE							45.00
46. 00 SURGI CAL I NTENSI VE							46.00
47. 00 OTHER SPECIAL CARE Cost Center D							47.00
oost ochter b	03011 pt1 011					1. 00	
48.00 Program inpatient a	ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			1, 077, 773	48. 00
	cellular therapy acquisiti				, column 1)	0	
	cient costs (sum of lines	41 through 48.0	01)(see instru	ctions)		3, 840, 727	49.00
PASS THROUGH COST A 50.00 Pass through costs	applicable to Program inp	ationt routing	corvi cos (fro	m Wks+ D su	m of Dorte L and	0	50. 00
III)	applicable to Plogram The	attent routine	services (110	II WKSt. D, Su	II OI PAILS I AIIC	0	30.00
,	applicable to Program inp	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	0	51.00
and IV)				•			
	udable cost (sum of lines			1_1		0	
	cient operating cost exclu costs (line 49 minus line		erated, non-phy	ysıcıan anest	netist, and	0	53.00
TARGET AMOUNT AND L		52)					1
54.00 Program di scharges	TIME TO SOME STATE OF					0	54.00
55.00 Target amount per of	li scharge					0. 00	55.00
1	nt amount per discharge					0. 00	1
1 3	per discharge (contractor	J ,				0.00	1
,	e 54 x sum of lines 55, 55			lino E4 minus	Lino E2)	0	
58.00 Bonus payment (see	adjusted inpatient operat	ing cost and ta	arget amount (i i i ie so iii i ius	111le 33)	0	58.00
	ser of line 53 ÷ line 54,	or line 55 from	n the cost rep	orting period	endi ng 1996,	0.00	1
	updated and compounded by the market basket)						
	sser of line 53 ÷ line 54,	or line 55 fro	om prior year o	cost report,	updated by the	0. 00	60.00
market basket) 61.00 Continuous improver	ant bonus novement (if lin	o E2 . lino E4	ic loss than	the lawest of	Linco EE pluo	0	61.00
	00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line						01.00
	expected costs (lines 54 x						
	enter zero. (see instructions)						
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	
	OUTINE SWING BED COST	ent (see instru	uctions)			0	63.00
	SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost report	ing period (See	1, 174, 023	64.00
instructions)(title					9 p (.,, -=-	
	SNF inpatient routine cos	ts after Decemb	per 31 of the o	cost reportin	g period (See	0	65.00
instructions)(title		no poeto (line	44 plus line	(E) (+; + o V)/	II anlul fan	1 174 000	44 00
66.00 Total Medicare swir	ng-bed SNF inpatient routi	ne costs (iine	64 prus rine (bb)(title XVI	ii oniy); ioi	1, 174, 023	00.00
	ng-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	0	67.00
(line 12 x line 19)		3					
	ng-bed NF inpatient routin	e costs after [December 31 of	the cost rep	orting period	0	68. 00
(line 13 x line 20) 69.00 Total title V or XI	X swing-bed NF inpatient	routing costs /	(lino 67 : lin	o 60)		0	69.00
	NURSING FACILITY, OTHER N					0	1 09.00
	cility/other nursing facil)		70.00
	npatient routine service c		ine 70 ÷ line	2)			71.00
<u> </u>	rvice cost (line 9 x line			05)			72.00
	/private room cost applic ral inpatient routine serv						73.00
9 9	at impatient routine serv	•			Part II column		74. 00 75. 00
26, line 45)	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1		. 55515 (1101111		C . I , GOI GIIIII		. 5. 55
76.00 Per diem capital -re	elated costs (line 75 ÷ li						76. 00
	ated costs (line 9 x line						77.00
	service cost (line 74 minu		rovidor roos	de)			78.00
	to beneficiaries for exces ne service costs for comp				nus line 70)		79. 00 80. 00
9	service costs for comp service cost per diem limi		Jose TimitatiO	. (11116 /0 IIII	1110 /7)		81.00
, ·	service cost limitation (1)				82.00
83.00 Reasonable inpatier	nt routine service costs (see instruction	* .				83.00
	ancillary services (see in	,					84.00
	- physician compensation						85.00
	<u>cient operating costs (sum</u> ON OF OBSERVATION BED PAS		ıı ougn 85)				86.00
ILANI IV - CUNEUIAII		S THROUGH COST					4
	oed days (see instructions)				1, 882	87.00

Health Financial Systems	ADAMS MEMORIAL HOSPITAL In L			In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od: From 01/01/2023	Worksheet D-1	
					Date/Time Pre 5/29/2024 8:4	pared: 9 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, 824, 262	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	543, 599	11, 588, 243	0. 04691	0 4, 824, 262	226, 306	90.00
91.00 Nursing Program cost	0	11, 588, 243	0. 00000	0 4, 824, 262	0	91.00
92.00 Allied health cost	0	11, 588, 243	0. 00000	0 4, 824, 262	0	92.00
93.00 All other Medical Education	0	11, 588, 243	0. 00000	0 4, 824, 262	0	93.00

Health Financial Systems	ADAMS MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1330	Peri od:	Worksheet D-1	
		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 8:4	pared: 9 am
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1 00	

PART I. A. IL PROVIDER COMPONENTS 1.00			Title XIX	Hospi tal	PPS	
BRATT - ALL PROVIDER COMPONENTS BRATTERI DMS		Cost Center Description		-	1 00	
IMPATIENT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpatt and days (Including private room days, excluding saring-bed and newborn days) 17 you have only private room days (occluding saring-bed and observation bed days) 17 you have only private room days (occluding saring-bed and observation bed days) 17 you have only private room days 18 you have only 18 you have						
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 0 3.00						•
do not complete this line. 4. 00 Sein-private room days (sectualing swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. 00 Sking-bed SNF type inpatient days applicable to the Program (excluding swing-bed and next period days) (see instructions) 10. 00 Sking-bed SNF type inpatient days applicable to the SNF type inpatient days applicable to SNF type services applicable to SNF type services through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 SNR type days (sNF type inpatient days applicable to services through December 31 of the cost reporting period (including private room days) 14. 00 SNR type services applicable to sNF type services applicable to services after December 31 of the cost reporting period (including priv						1
	3.00		ys). If you have only pr	rivate room days,	0	3.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	4. 00		ed davs)		1, 746	4.00
10tal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 7	5.00			er 31 of the cost	885	5.00
reporting period (if Calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 1 on reporting period (if Calendar year, enter 0 on this line) 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 1 on reporting period (if Calendar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Modically necessary private room days applicable to titles V or XX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Number of year (it is V or XX only) 16.00 Number of year (it is V or XX only) 17.00 Number of year (it is V or XX only) 18.00 Number of year (it is V or XX only) 18.00 Number of year (it is V or XX only) 18.00 Number of year (it is V or XX only) 18.00 Number of year (it is V or XX only) 18.00 Number of year (it is V or XX only) 18.00 Number of year (it is V or XX only) 18.00 Number of year (it is V or XX only) 18.00 Number of year (it is V or XX only) 18.00 Number of year (it is V or XX only) 18.00 Number of year (it is V or XX only) 18.00 Number of year (it is V or XX only) 18.00 Number of year (it is V or XX only) 18.00 Number of year (it is V or XX only) 18.00 Number of year (it is V or XX only) 18.00 Number of year (it is V or XX only) 18.00 Number of year (it is V or XX only) 18.00 Number of year (it is V or XX only) 18.00 Number of year						
Total swing-bed NF type inpatient days (including private room days) afrong becember 31 of the cost reporting period of Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and private room days applicable to the Program (excluding swing-bed and private room days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) 10.00 Swing-bed NF type inpatient days applicable to title XV or XIX only (including private room days) 10.00 Swing-bed NF type inpatient days applicable to title XV or XIX only (including private room days) 10.01 Total inverser/days (title V or XIX only) 10.01 Total inverser/days (title V or XIX only) 10.01 Total inverser/days (title V or XIX only) 10.02 Total inverser/days (title V or XIX only) 10.03 Swing-bed December 31 of the cost reporting period (including swing-bed days) 10.04 Medicare rate for swing-bed SW services applicable to services after December 31 of the cost reporting period (including swing-bed NF services applicable to services after December 31 of the cost reporting period (including period reporting period (including period reporting period (including swing-bed NF services applicable to services after December 31 of the cost reporting period (including applicable to SW type services through December 31 of the cost reporting period (including swing-bed cost applicable to SW type services after December 31 of the cost reporting period (including swing-bed wing-bed SW ty	6. 00		om days) after December	31 of the cost	0	6.00
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 0 9.00 newborn days) (see instructions) 10. 00 Swing-bed SNF type inpatient days applicable to titlex XVIII only (including private room days) of 10.00 New York (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to titlex XVIII only (including private room days) after 0 10.00 New York (including private room days) of 11.00 New York (including private room days) after 12.00 New York (including private room days) of 12.00 New York (including York (including Private room days) of 12.00 New York (including York (including Swing-bed days) of 12.00 New York (including York (including Swing-bed days) of 12.00 New York (including York (including Swing-bed days) of 12.00 New York (including York (including Swing-bed days) of 12.00 New York (including Swing-bed SW Swing-bed Swing-bed Swing-bed Swing-bed Swing-bed Swing-bed Swing-bed	7 00		m days) through December	: 31 of the cost	141	7 00
reporting period (if calendar year, énter 0 on this line) 10. 00 Swing-bed SW type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10. 00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 12. 00 Swing-bed W type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 Swing-bed W type inpatient days applicable to titles V or XIX only (including private room days) 14. 00 Swing-bed W type inpatient days applicable to titles V or XIX only (including private room days) 15. 00 Total nursery days (title V or XIX only) 16. 00 Nursery days (title V or XIX only) 17. 00 Modical nursery days (title V or XIX only) 18. 00 Modical nursery days (title V or XIX only) 18. 00 Modicare rate for swing-bed SW services applicable to services after December 31 of the cost reporting period 18. 00 Modicare rate for swing-bed SW services applicable to services after December 31 of the cost reporting period 19. 00 Modical rate for swing-bed WF services applicable to services after December 31 of the cost 19. 00 Modical rate for swing-bed WF services applicable to services after December 31 of the cost 19. 00 Modical rate for swing-bed WF services applicable to services after December 31 of the cost 19. 00 Swing-bed cost applicable to SW fype services through December 31 of the cost reporting period (line 0 22.00 19. 00 Swing-bed cost applicable to SW fype services through December 31 of the cost reporting period (line 0 22.00 19. 00 Swing-bed cost applicable to SW fype services after December 31 of the cost reporting period (line 0 22.00 19. 00 Swing-bed cost applicable to SW fype services after December 31 of the cost reporting period (line 0 22.00	7.00		days, t sag zssszs.	0. 0. 1.0 0001		,,,,,
1.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 0.00	8.00		m days) after December 3	1 of the cost	0	8. 00
newborn days) (see Instructions) 10.00 Swing-bed SMF type inpatient days applicable to fitle XVIII only (including private room days) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 15.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 16.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 16.00 Total nursery days (fitle V or XIX only) 16.00 Total nursery days (fitle V or XIX only) 17.00 Nursery days (fitle V or XIX only) 18.00 Nursery days (fitle V or XIX only) 18.00 Nursery days (fitle V or XIX only) 18.00 Nursery days (fitle V or XIX only) 19.00 Nursery days (fitle V or XIX only) 19.0	0.00		- th- D (0	0.00
10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (in Calendar year, enter 0 on this line) 12.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 0 through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) on through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) on 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) 15.00 Total nursery days (title V or XIX only) 17.00 SMIN BED ADUSTRIAN 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (if a december 31 of the cost reporting period (if a december 31 of the cost reporting period (if a draft for swing-bed NF services applicable to services after December 31 of the cost reporting period (including the cost reporting period (including december 31 of the cost reporting period (including the cost reporting period (including private room days) 11.588,243 21.00 12.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 140.00 period period (including swing-bed ost applicable to SNF type services after December 31 of the cost reporting period (line S x Iline 17) 15.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line S x Iline 18) 15.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line S x Iline 30) 16.00 Swing-bed cost applicable to NF type services after December	9.00		o the Program (excluding	swing-bed and	Ü	9.00
through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after 0 through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 through December 31 of the cost reporting period of through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically inecessary private room 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) 15.00 Total nursery days (title V or XIX only) 293 15.00 (on Nursery days) (title V or XIX only) 107 16.00 (on Nurser	10. 00		nly (including private r	room days)	0	10.00
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29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 299, 921) 37.00 FROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29.00 0 30.00 0 30.00 0 0.000000 31.00 0 0.00 32.00 33.00 0 0.00 33.00 0 0.00 33.00 0 0.00 34.00 35.00 36.00 37.00 36.00 37.00 38.00 38.00 39.00 40.00	28 00		d and observation bed ch	arges)	0	28 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 299, 921) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Program general inpatient routine service cost (line 9 x line 38) 0.0000000000000000000000000000000000	29. 00	Private room charges (excluding swing-bed charges)	a ana ozoo. vat. on zoa o.	iai goo)	-	
32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 299, 921) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 299, 921) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 0 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		,	÷ line 28)			1
Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34. 00 Average per diem private room cost differential (line 34 x line 31) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 299, 921) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 563. 37 38. 00 Program general inpatient routine service cost (line 9 x line 38) 0 39. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00						1
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 299, 921) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 0 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			nus line 33)(see instruc	tions)		1
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 299, 921 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 37.00 37.00 37.00 37.00 37.00						1
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 563. 37 38.00 Program general inpatient routine service cost (line 9 x line 38) 0 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	36.00	Private room cost differential adjustment (line 3 x line 35)	,		0	36.00
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, 563. 37 38. 00 39.00 Program general inpatient routine service cost (line 9 x line 38) 0 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00		and private room cost di	fferential (line	9, 299, 921	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 563. 37 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 0 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2,563.37 38.00 Program general inpatient routine service cost (line 9 x line 38) 0 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			USTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 39.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	38. 00				2, 563. 37	38.00
		Program general inpatient routine service cost (line 9 x line	38)			
41.00 Iotal Program general inpatient routine service cost (line 39 + line 40) 0 41.00						
	41. 00	lotal Program general inpatient routine service cost (line 39	+ line 40)	I	0	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-1330	Peri od:	Worksheet D-1	2552-10
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 8:4	
		Ti tl	e XIX	Hospi tal	PPS	7 aiii
Cost Center Description	Total	Total	Average Per		Program Cost	
	Inpatient	Inpatient	Diem (col. 1		(col. 3 x	
	1.00	<u>Days</u> 2.00	÷ col . 2) 3.00	4.00	col . 4) 5.00	
42.00 NURSERY (title V & XIX only)	147, 653	2.00				42.00
Intensive Care Type Inpatient Hospital Units		270	1 000. 7	107	00, 722	12.00
43. 00 INTENSIVE CARE UNIT	2, 714, 137	779	3, 484. 1	3 131	456, 421	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46. 00 SURGI CAL INTENSI VE CARE UNIT						46.00
47. 00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1. 00	
48.00 Program inpatient ancillary service cost (W	kst. D-3, col. 3	3, line 200)			0	48. 00
48.01 Program inpatient cellular therapy acquisit	ion cost (Worksh	neet D-6, Part	III, line 10	, column 1)	0	48. 01
49.00 Total Program inpatient costs (sum of lines	41 through 48.0	01)(see instru	ctions)		510, 343	49.00
PASS THROUGH COST ADJUSTMENTS						1
50.00 Pass through costs applicable to Program in	patient routine	services (fro	m Wkst. D, su	m of Parts I and	29, 243	50.00
III) 51.00 Pass through costs applicable to Program in	nationt ancilla	ry corvinos (f	rom Wkst D	cum of Darte II	0	51.00
and IV)	ратгент анстта	y services (ii	I OIII WKSt. D,	Sum of Parts II	0	31.00
52.00 Total Program excludable cost (sum of lines	50 and 51)				29, 243	52.00
53.00 Total Program inpatient operating cost excl		elated, non-ph	ysician anest	hetist, and	481, 100	
medical education costs (line 49 minus line	52)					
TARGET AMOUNT AND LIMIT COMPUTATION						F 4 00
54. 00 Program di scharges					0	
55.00 Target amount per discharge 55.01 Permanent adjustment amount per discharge					0. 00 0. 00	
55.02 Adjustment amount per discharge (contractor	use only)				0.00	1
56.00 Target amount (line 54 x sum of lines 55, 5	J ,)			0.00	1
57.00 Difference between adjusted inpatient opera			line 56 minus	line 53)	0	
58.00 Bonus payment (see instructions)	0				0	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					0.00	/
60.00 Expected costs (lesser of line 53 ÷ line 54 market basket)	, or line 55 tro	om prior year o	cost report,	updated by the	0.00	60.00
61.00 Continuous improvement bonus payment (if li	ne 53 - line 54	is less than	the lowest of	lines 55 nlus	0	61.00
55.01, or line 59, or line 60, enter the le					Ŭ	01.00
53) are less than expected costs (lines 54)						
enter zero. (see instructions)						
62.00 Relief payment (see instructions)		>			0	
63.00 Allowable Inpatient cost plus incentive pays PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see Instru	JCTI ONS)			0	63.00
64.00 Medicare swing-bed SNF inpatient routine co	sts through Dece	ember 31 of the	e cost renort	ing period (See	0	64.00
instructions)(title XVIII only)	oro tili odgir book	SINDER OF THE	c cost report	ing period (occ	Ŭ	01.00
65.00 Medicare swing-bed SNF inpatient routine co	sts after Decemb	oer 31 of the	cost reportin	g period (See	0	65.00
<pre>instructions)(title XVIII only)</pre>						
66.00 Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line	65)(title XVI	II only); for	0	66.00
CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31	of the cost r	enorting period	0	67.00
(line 12 x line 19)	ne costs through	i becember 51 v	or the cost r	epor tring perrou		07.00
68.00 Title V or XIX swing-bed NF inpatient routi	ne costs after [December 31 of	the cost rep	orting period	0	68.00
(line 13 x line 20)						
69.00 Total title V or XIX swing-bed NF inpatient					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER I 70.00 Skilled nursing facility/other nursing faci)		70. 00
71.00 Adjusted general inpatient routine service				,		70.00
72.00 Program routine service cost (line 9 x line			-/			72.00
73.00 Medically necessary private room cost appli		n (line 14 x li	ine 35)			73.00
74.00 Total Program general inpatient routine ser	vice costs (line	e 72 + line 73)			74.00
75.00 Capital-related cost allocated to inpatient	routine service	e costs (from)	Worksheet B,	Part II, column		75. 00
26, line 45)	ino 2)					74 00
76.00 Per diem capital-related costs (line 75 ÷ 1 77.00 Program capital-related costs (line 9 x lin						76. 00 77. 00
78.00 Inpatient routine service cost (line 74 min						78.00
79.00 Aggregate charges to beneficiaries for exce		orovi der recor	ds)			79.00
80.00 Total Program routine service costs for com				nus line 79)		80.00
81.00 Inpatient routine service cost per diem lim	itation			,		81.00
82.00 Inpatient routine service cost limitation (82.00
83.00 Reasonable inpatient routine service costs		ns)				83.00
84.00 Program inpatient ancillary services (see i 85.00 Utilization review - physician compensation	,	ne)				84. 00 85. 00
85.00 Utilization review - physician compensation 86.00 Total Program inpatient operating costs (su						86.00
PART IV - COMPUTATION OF OBSERVATION BED PAGE		Jugii 30)				1 55.50
87.00 Total observation bed days (see instruction					1, 882	87. 00
						88.00

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 01/01/2023 To 12/31/2023		
		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)			4, 824, 262	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	
				, i	instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	543, 599	11, 588, 243	0. 04691	0 4, 824, 262	226, 306	90.00
91.00 Nursing Program cost	0	11, 588, 243	0. 00000	00 4, 824, 262	0	91.00
92.00 Allied health cost	0	11, 588, 243	0. 00000			92.00
93.00 All other Medical Education	0	11, 588, 243	0. 00000			93.00

			Peri od:	Worksheet D-3)
			From 01/01/2023 To 12/31/2023	Date/Time Pre	nared:
			10 12/31/2023	5/29/2024 8: 4	9 am
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program Charges	Program Costs (col. 1 x	
		1.00	2.00	col . 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDI ATRI CS			1, 454, 778		30.00
31. 00 03100 NTENSI VE CARE UNI T			995, 892		31.00
40. 00 04000 SUBPROVI DER - I PF			0		40.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 5262		222, 285	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 6394		0	
53. 00 05300 ANESTHESI OLOGY		0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1697		77, 462	
50. 00 06000 LABORATORY		0. 3118		128, 496	
55. 00 06500 RESPI RATORY THERAPY		0. 3180		141, 274	
66. 00 06600 PHYSI CAL THERAPY		0. 6205		70, 143	
57. 00 06700 OCCUPATI ONAL THERAPY		0. 3786	·	43, 521	
58. 00 06800 SPEECH PATHOLOGY		0. 3283		7, 217	
59. 00 06900 ELECTROCARDI OLOGY		0.0000		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	
72. 00 O7200 I MPL. DEV. CHARGED TO PATIENT		0. 3880		84, 320	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3994		293, 375	
76. 00 03020 0P PSYCH		17. 0005		0	1
76. 01 03030 WOUND_CARE OUTPATIENT_SERVICE_COST_CENTERS		2. 2445	46 0	0	76. 01
38. 00 08800 MONROE FAMILY MEDICINE		0.0000	00	0	88. 00
38. 01 08801 WOODCREST		0.0000		o o	
38. 02 08802 STAT CARE		0.0000		Ö	
38. 03 08803 BERNE FAMILY MEDICINE		0.0000		Ō	
38. 04 08804 HI GH STREET		0.0000		0	1
90. 00 09000 CLI NI C		1. 5381		585	
90. 01 09001 CLINIC - AMO		1. 3125		0	
90. 02 09002 CLI NI C - AMH NEURO		1. 5788		0	
90. 03 09003 GENERAL SURGERY OFFICE		2. 4157		0	90.03
90.04 04950 INTENSIVE OP BEHAVIORAL HEALTH		0.0000	00 0	0	90.04
91. 00 09100 EMERGENCY		0. 4814	05 6, 382	3, 072	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 2264	30 4, 911	6, 023	92.00
OTHER REIMBURSABLE COST CENTERS		1			05 00
95. 00 09500 AMBULANCE SERVI CES		0.0000	00	_	95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0.0000			97.00
Total (sum of lines 50 through 94 and 96 through 98)	o (line (1)		2, 948, 148	1, 077, 773	1
201.00 Less PBP Clinic Laboratory Services-Program only charge	s (Tine of)	I	1 0		201.00

INPATIENT ANCILLARY SERVICE COST APPOR	TI ONMENT	Component	CCN: 15-Z330	Period: From 01/01/2023 To 12/31/2023	5/29/2024 8: 4	pared:
		Title		Swing Beds - SNF		
Cost Center Description			Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x	
			1.00	2.00	col . 2) 3.00	
INPATIENT ROUTINE SERVICE COST	CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	JEHTERO					30.00
31.00 03100 INTENSIVE CARE UNIT						31.00
40. 00 04000 SUBPROVI DER - I PF						40.00
43. 00 04300 NURSERY						43.0
ANCILLARY SERVICE COST CENTERS			•			1
50. 00 05000 OPERATING ROOM			0. 52624	19 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1		0. 63941	14 0	0	52.0
53. 00 05300 ANESTHESI OLOGY			0.00000	00	0	53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 16979	14, 664	2, 490	54.0
60. 00 06000 LABORATORY			0. 31184	13 57, 757	18, 011	60.0
65. 00 06500 RESPIRATORY THERAPY			0. 31803	57, 955	18, 432	65.0
66. 00 06600 PHYSI CAL THERAPY			0. 62050	83, 417	51, 761	66.0
57. 00 06700 OCCUPATI ONAL THERAPY			0. 37869	95 103, 572	39, 222	67.0
68.00 06800 SPEECH PATHOLOGY			0. 32835	· ·	1, 782	
69. 00 06900 ELECTROCARDI OLOGY			0.00000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED 7			0.00000		0	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATI	ENT		0. 38800		0	
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 39949		80, 518	
76. 00 03020 OP PSYCH			17. 00059		0	
76. 01 03030 WOUND CARE			2. 24454	16 203	456	76.0
OUTPATIENT SERVICE COST CENTERS					_	
88. 00 08800 MONROE FAMILY MEDICINE			0.00000		0	00.0
38. 01 08801 WOODCREST			0.00000		0	
38. 02 08802 STAT CARE			0.00000		0	88.0
38. 03 08803 BERNE FAMILY MEDICINE			0.00000		0	88.0
38. 04 08804 HI GH STREET			0.00000		0	88.0
90. 00 09000 CLI NI C			1. 53818		0	
90. 01 09001 CLINIC - AMO			1. 31259		0	
PO. 02 09002 CLINIC - AMH NEURO PO. 03 09003 GENERAL SURGERY OFFICE			1. 57886		0	
90.03 09003 GENERAL SURGERY OFFICE 90.04 04950 INTENSIVE OP BEHAVIORAL HE	ALTH		2. 41572 0. 00000		0	
90.04 04950 TNTENSIVE OP BEHAVTORAL HE 91.00 09100 EMERGENCY	ALIII		0. 00000		0	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DIST	INCT DART)		1. 22643		0	1
OTHER REIMBURSABLE COST CENTERS	INCI PART)		1. 22043	ου	0	92.00
95. 00 09500 AMBULANCE SERVICES						95. 0
97.00 09700 DURARIE MEDICAL FOLLP-SOLE	.		0 00000	0	0	

0.000000

524, 543 524, 543

97.00

212, 672 200. 00 201. 00 202. 00

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

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)

200. 00 201. 00 202. 00

Health Financial Systems	ADAMS MEMORIAL HOSPITAL			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1330	Peri od:	Worksheet D-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
				5/29/2024 8: 4	9 am
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient Program	Inpatient Program Costs	
		To Charges	Charges	(col. 1 x	
			Chai ges	col. 2)	
		1.00	2. 00	3.00	
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			0		40.00
43. 00 04300 NURSERY			0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 52624		0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 63941		1	
53. 00 05300 ANESTHESI OLOGY		0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 16979		0	54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY		0. 31184		0	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0. 31803 0. 62050		0	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 37869		0	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 32835		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 00000		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	S	0. 00000		0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 38800		o o	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 39949		Ö	73.00
76. 00 03020 OP PSYCH		17. 00059		0	76.00
76. 01 03030 WOUND CARE		2. 24454	16 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS					1
88.00 08800 MONROE FAMILY MEDICINE		1. 04064	12 0	0	88. 00
88. 01 08801 WOODCREST		1. 03642	26 0	0	88. 01
88. 02 08802 STAT CARE		1. 05740	0	0	88. 02
88.03 08803 BERNE FAMILY MEDICINE		1. 13099		0	88. 03
88. 04 08804 HI GH STREET		0. 71390		0	88. 04
90. 00 09000 CLI NI C		1. 53818		0	90.00
90. 01 09001 CLI NI C - AMO		1. 31259		0	90. 01
90. 02 09002 CLI NI C - AMH NEURO		1. 57886		0	90.02
90. 03 09003 GENERAL SURGERY OFFICE		2. 41572		0	90.03
90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH		0.00000		0	,
91. 00 09100 EMERGENCY		0. 48140		0	91.00

1. 226430

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)

	MS MEMORIAL HOSPITAL			u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od: From 01/01/2023	Worksheet D-3	3
	Component C		To 12/31/2023	Date/Time Pre	
	Ti tl e	× XIX	Swing Beds - SNF	5/29/2024 8: 4 PPS	19 am
Cost Center Description		Ratio of Cos		Inpati ent	
' '		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
LANDATI ENT. DOUTLINE OFFICE OF COOT, OFFITEDO		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 INTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF					31. 00 40. 00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 52624	9 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 63941		Ö	1
53. 00 05300 ANESTHESI OLOGY		0.00000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 16979	0 8	0	54.00
60. 00 06000 LABORATORY		0. 31184	3 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 31803	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 62050	0 8	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 37869		0	
68.00 O6800 SPEECH PATHOLOGY		0. 32835		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 00000		0	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 38800		0	1 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 39949		0	
76. 00 03020 0P PSYCH 76. 01 03030 WOUND CARE		17. 00059 2. 24454		0	
OUTPATIENT SERVICE COST CENTERS		2. 24434	·0 0	U	70.01
88. 00 08800 MONROE FAMILY MEDICINE		1. 04064	2 0	0	88. 00
88. 01 08801 WOODCREST		1. 03642		0	1 00.00
88. 02 08802 STAT CARE		1. 05740		0	
88. 03 08803 BERNE FAMILY MEDICINE		1. 13099		0	1
88. 04 08804 HI GH STREET		0. 71390	07	0	88. 04
90. 00 09000 CLINIC		1. 53818		0	1
90. 01 09001 CLINIC - AMO		1. 31259	0 0	0	90. 01
90. 02 09002 CLINIC - AMH NEURO		1. 57886		0	90.02
90. 03 09003 GENERAL SURGERY OFFICE		2. 41572		0	
90. 04 04950 INTENSIVE OP BEHAVIORAL HEALTH		0. 00000		0	1 ,0.0.
91. 00 09100 EMERGENCY		0. 48140		0	
as on masoningelouvitor pene (MAN INCLINCT DADT)	I	1 774/7		_ ^	u un 🔿

1. 226430

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)

Health Financial Systems	ADAMS MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1330	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 8:49 am

		Title XVIII	Hospi tal	5/29/2024 8: 4 Cost	9 alli
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			9, 906, 815	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruct OPPS or REH payments	ions)		0	2. 00 3. 00
4. 00	Outlier payment (see instructions)			0	4.00
4. 01	Outlier reconciliation amount (see instructions)	11		0	4.01
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instruction 2 times line 5	tions)		0.000	5. 00 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)	to a contrata de Parte de Contrata de		0	8.00
9. 00	Ancillary service other pass through costs including REH directives. D. Pt. IV, col. 13, line 200	t graduate medical educa	ition costs from	0	9. 00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			9, 906, 815	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Iii	ne 69)		0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14.00
15. 00	Aggregate amount actually collected from patients liable for particular parti	ayment for services on a	charge basis	0	15.00
16. 00	Amounts that would have been realized from patients liable for	1 3	a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000))		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			0	18.00
19. 00	Excess of customary charges over reasonable cost (complete only	y if line 18 exceeds lir	ne 11) (see	0	19. 00
20. 00	instructions) Excess of reasonable cost over customary charges (complete only	v if line 11 exceeds lin	ne 18) (see	0	20.00
20.00	instructions)	y <i></i>	.0 .0) (000	· ·	20.00
21.00	Lesser of cost or charges (see instructions)			10, 005, 883	
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instru	uctions)		0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	4011 0110)		0	24.00
05.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	\		104 101	05.00
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line	•	ıctions)	104, 121 3, 701, 738	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			6, 200, 024	
20.00	instructions)	no EO)		0	20.00
28. 00 28. 50	Direct graduate medical education payments (from Wkst. E-4, li REH facility payment amount (see instructions)	ne 50)		0	28. 00 28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)			6, 200, 024	1
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			16, 376 6, 183, 648	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	ES)		-,,	
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			101 004	33. 00 34. 00
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			181, 996 118, 297	
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		181, 996	36.00
37.00	Subtotal (see instructions)			6, 301, 945 0	
38. 00 39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38. 00 39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions))			39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replace	ed devices (see instruct	i ons)	0	39. 97 39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			6, 301, 945	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			126, 039 0	40. 01 40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs			· ·	40. 03
41.00	Interim payments			6, 838, 638	1
41. 01 42. 00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41. 01 42. 00
42. 01	Tentative settlement-PARHM (for contractor use only)			Ü	42. 01
43.00	Balance due provider/program (see instructions)			-662, 732	1
43. 01 44. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2 o	hanter 1	0	43. 01 44. 00
r -1 . 00	§115. 2	55 WI CH SWID LUD. 10-2, C	aptor 1,		1 7.00
00.05	TO BE COMPLETED BY CONTRACTOR				00.55
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
92. 00	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0	93.00

Health Financial Systems	ADAMS MEMORIAL I	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1330	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023		pared:
				5/29/2024 8: 4	<u>9 am </u>
		Title XVIII	Hospi tal	Cost	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days	-			0	200.00

Peri od: Worksheet E-1 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/29/2024 8:40 am Provider CCN: 15-1330

1.00 2.00 Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.04 3.05 Provider to Program	mm/dd/yyyy 1.00	Amount 2. 00 2, 993, 212 0	mm/dd/yyyy 3.00	Cost t B Amount 4.00 6,838,638 0	1.00
2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.04 3.05	mm/dd/yyyy	Amount 2.00 2,993,212	mm/dd/yyyy 3.00	Amount 4.00 6,838,638	
2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.04 3.05		2. 00 2, 993, 212	3.00	4. 00 6, 838, 638	
2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.04 3.05	1.00	2, 993, 212		6, 838, 638	
2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.04 3.05					
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 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.04 3.05		0		0	2 00
services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3. 01 3. 02 3. 03 3. 04 3. 05					2.00
write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3. 01 3. 02 3. 03 3. 04 3. 05					
3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider ADJUSTMENTS TO PROVIDER 3.01 3.02 3.03 3.04 3.05			l	(
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3. 01 3. 02 3. 03 3. 04 3. 05					
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 3. 03 3. 04 3. 05					3.00
payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3. 01 3. 02 3. 03 3. 04 3. 05		1			
Program to Provider 3. 01 3. 02 3. 03 3. 04 3. 05		l			
3. 01 3. 02 3. 03 3. 04 3. 05					
3. 02 3. 03 3. 04 3. 05	l				
3. 03 3. 04 3. 05	,	0		0	3. 01
3. 04 3. 05		0		0	3. 02
3. 05		0		0	3. 03
		0		0	3. 04
Drovi dor to Drogram		0		0	3. 05
		_		_	
3. 50 ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51		0		0	3. 51
3. 52		0		0	3. 52
3. 53		0		0	3. 53
3. 54		0		0	3.54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3. 99
4.00 Total interim payments (sum of lines 1, 2, and 3.99)		2, 993, 212		6, 838, 638	4.00
(transfer to Wkst. E or Wkst. E-3, line and column as		2, 773, 212		0, 030, 030	4.00
appropriate)					
TO BE COMPLETED BY CONTRACTOR					
5.00 List separately each tentative settlement payment after					5. 00
desk review. Also show date of each payment. If none,					
write "NONE" or enter a zero. (1)					
Program to Provider					
5. 01 TENTATI VE TO PROVI DER		0		0	5. 01
5. 02		0		o	5. 02
5. 03		0		0	5.03
Provider to Program					
5. 50 TENTATI VE TO PROGRAM		0		0	5. 50
5. 51		0		0	5. 51
5. 52		0		0	5. 52
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines		0		0	5. 99
5. 50-5. 98)					
6.00 Determined net settlement amount (balance due) based on					6. 00
the cost report. (1)					
6. 01 SETTLEMENT TO PROVI DER		448, 783		0	6. 01
6. 02 SETTLEMENT TO PROGRAM	ļ	0		662, 732	6. 02
7.00 Total Medicare program liability (see instructions)	Ì		1 1		7 00
		3, 441, 995		6, 175, 906	7. 00
		3, 441, 995	Contractor	NPR Date	7. UC
0 00 Name of Contractor			Contractor Number	NPR Date (Mo/Day/Yr)	7.00
8.00 Name of Contractor	C	3, 441, 995	Contractor	NPR Date	8. 00

Provi der CCN: 15-1330

		Component	CCN. 15-2330 1	0 12/31/2023	5/29/2024 8: 4	
		Title	XVIII S	wing Beds - SNF		
		Inpatien	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	T-1-1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	1. 00	2.00	3. 00	4. 00	1 00
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either		1, 118, 205		0	
2.00	submitted or to be submitted to the contractor for			,	0	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					
3. 01	ADJUSTMENTS TO PROVI DER	09/28/2023	39, 400		0	
3. 02			C		0	
3. 03			C		0	
3. 04			C		0	
3. 05)	0	3.05
2 50	Provi der to Program				1 0	2
3. 50 3. 51	ADJUSTMENTS TO PROGRAM				0	
3. 51					0	
3. 52					0	
3. 54					0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		39, 400		0	
0. 77	3. 50-3. 98)		07, 100			0. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 157, 605	5	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)]
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					-
5. 01	Program to Provider TENTATIVE TO PROVIDER				0	5.01
5. 01	TENTATIVE TO PROVIDER				0	
5. 02					0	
5. 05	Provider to Program			' I		3.03
5. 50	TENTATI VE TO PROGRAM				0	5.50
5. 51					Ö	
5. 52			d		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		c		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		208, 282		0	
6. 02	SETTLEMENT TO PROGRAM		4 0/5 00	1	0	
7. 00	Total Medicare program liability (see instructions)		1, 365, 887		0 NDD Data	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
)	1. 00	2. 00	
8. 00	Name of Contractor		9	1.00	2.00	8.00
0.00	1	I		I	I	1 0.00

Heal th	Financial Systems ADAMS MEMORIA	L HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-1330	Peri od: From 01/01/2023	Worksheet E-1 Part II	
			To 12/31/2023	Date/Time Pre 5/29/2024 8:4	
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI				1
1. 00	Total hospital discharges as defined in AARA §4102 from Wks	st. 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				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	n (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	lline 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 01/01/2023	
		Component CCN: 15-Z330	To 12/31/2023	Date/Time Prepared:
				5/29/2024 8:49 am
		T: +1 - \/\/1.1.1	Cool and Davids CNE	C+

Title XVIII Sering Beds - SNF Cost			Component CCN: 15-Z330	To 12/31/2023	Date/Time Pre 5/29/2024 8:4	
1.00 2.00			Title XVIII	Swing Beds - SNF		,
Comparison of the Troots of Comparison Services 1,185,763 0 1.00 Imputine in routine services - swing bed-Wr (see instructions) 1,185,763 0 1.00						
1.00 Inpatient routine services - swing bed-NF (see instructions) 1,185,763 0 1,00 0 0 0 0 0 0 0 0 0		COMPUTATION OF MET COOT OF COMPETE OFFINA		1. 00	2. 00	
2.00 Impart ent routine services - swing bod-NF (see instructions) 2.00 2.14,799 3.00 Ancillary services (From Mist.) - 3.00 3.11 2.00 3.10 2.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 3.00 4.00 3.0	1 00			1 105 742	0	1 00
0.00 Ancil Hary services (from West D-3, cel. 3. il line 200, for Part A, and sum of West. D. 214,799 0.3.00		, ,		1, 100, 703	U	
Part V, Cols. 6 and 7. Iline 202, For Part B) (For CAH and swing-bod pass-through, see Instructions) 3.01			t A and sum of Wkst D	214 799	0	1
Instructions	0.00		· ·	·	ŭ	0.00
4.00 Per of em cost for Interns and residents not in approved teaching program (see 0.00 4.00			3			
Instructions	3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
Program days	4.00	Per diem cost for interns and residents not in approved teach	ing program (see		0.00	4.00
1.6.00 Interns and rosidents not in approved teaching program (see Instructions) 0 6.00				_		
1.00				458		
Subtotal (sum of lines i through 3 plus lines 6 and 7) 1,400,562 0 8.00 0.00		11 91 9 1	,	0	Ü	
Primary payer payments (see instructions) 0 9,00			thou only	1 400 562	0	
1.400.562 0 10.00 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 11.00 0 0 0 0 0 0 0 0 0				1, 400, 502		
11.00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 11.00,562 012.00				1, 400, 562	-	
professional services) 10. 00 Subtotal (line 10 minus line 11) 110. 01 Subtotal (see instructions) 110. 00 Subtotal (see instructions) 110. 01 Sequestration adjustment (see instructions) 110. 01 Sequestration adjustment (see instructions) 110. 02 Sequestration adjustment (see instructions) 110. 03 Sequestration adjustment (see instructions) 110. 04 Subtotal (see instructions) 110. 05 Sequestration adjustment (see instructions) 110. 05 Sequestration adjustment (see instructions) 110. 06 Subtotal (see instructions) 110. 07 Sequestration adjustment (see instructions) 110. 07 Sequestration adjustment Applications (see instructions) 110. 08 Sequestration adjustment (see instructions) 110. 08 Sequestration of non-claims based amounts (see instructions) 110. 01 Subtotal (see instructions) 110. 01 Subtot	11. 00	· · · · · · · · · · · · · · · · · · ·	cable to physician	0	0	1
13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for prophysician professional services) 13.00 13.00 14.00 16.00 15.00 15.00 16.00		1 9 1	, J			
for physician professional services 14.00 B0% of Part B costs (line 12 x 80%) 15.00 Subtotal (see instructions) 1.393,762 0.15.00 15.00 OTHER ADJUSTNENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0.16.00 OTHER ADJUSTNENTS (SEE INSTRUCTIONS) (SPECIFY) 0 16.50 16.55 Rural community hospital demonstration payment adjustment (see instructions) 16.55 16.59 16.50	12.00	Subtotal (line 10 minus line 11)		1, 400, 562	0	12.00
14.00 80% of Part B costs (line 12 x 80%) 0 14.00	13.00) (exclude coinsurance	6, 800	0	13.00
15.00 Subtotal (see instructions) 1, 393, 762 0 15.00 10.00 OHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.55	4.4.00					
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16.50 Planeer ACO demonstration payment adjustment (see instructions) 16.55				1, 393, 762		1
16.55 Rural community hospital demonstration project (\$410A Demonstration) payment a giustment (see instructions) 0 16.55			c)	U	U	
adjustment (See Instructions) 0 16.99				0		1
16.99 Demonstration payment adjustment amount before sequestration 0 0 16.9%	10. 55	, , , , , , , , , , , , , , , , , , , ,	ration) payment			10.55
17.00 All owable bad debts (see instructions) 0 0 17.00 17	16. 99			0	0	16. 99
18.00 All owable bad debts for dual eligible beneficiaries (see instructions) 0 0 18.00				0	0	17.00
19.00 Total (see instructions) 1,393,762 0 19.00	17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
19.01 Sequestration adjustment (see instructions) 27,875 0 19.01			ructions)	0	0	18.00
19.02 Demonstration payment adjustment amount after sequestration 0 19.02 Sequestration adjustment-PARHM pass-throughs 19.03 19.						
19. 03 Sequestration adjustment-PARHM pass-throughs 19. 05 Sequestration for non-claims based amounts (see instructions) 0 0 19. 25 20. 00 Interim payments 1, 157, 605 0 20. 00 20. 01 Interim payments 1, 157, 605 0 20. 01 20. 01 10.		, ,				
19. 25 Sequestration for non-claims based amounts (see instructions) 0 19. 25		, , , , , , , , , , , , , , , , , , , ,		0	0	
20. 00 Interim payments 1,157,605 0 20. 00					0	
20.01 Interim payments-PARHM 20.01 Tentative settlement (for contractor use only) 0 21.01 Tentative settlement (for contractor use only) 0 21.01 Tentative settlement-PARHM (for contractor use only) 21.01 Tentative settlement-PARHM (for contractor use only) 21.01 22.00 Bal ance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 208,282 0 22.01 22.01 23.00 Protested amounts (nonall owable cost report items) in accordance with CMS Pub. 15-2, 0 0 23.00 Protested amounts (nonall owable cost report items) in accordance with CMS Pub. 15-2, 0 0 23.00 Contact 1, \$115.2 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 201.00 Cost Reimbursement 201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 202.00 203.00 204.00 Medicare swing-bed SNF discharges (see instructions) 203.00 204.00 Medicare swing-bed SNF discharges (see instructions) 204.00 205.00 Medicare swing-bed SNF target amount 205.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) 206.00 207.00 208.00 209.00 Adjustment to Medicare swing-bed SNF inpatient Reimbursement 207.00 208.00 209.00 Adjustment to Medicare swing-bed SNF PS payments (see instructions) 209.00 209.0				1 157 605		
Tentative settlement (for contractor use only)				1, 137, 003	O	1
21. 01 Tentative settlement-PARHM (for contractor use only) 22. 00 Balance due provider/program (line 19 minus lines 19. 01, 19. 02, 19. 25, 20, and 21) 22. 01 Balance due provider/program-PARHM (see instructions) 23. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 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 "\" for yes or "\" 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 20 (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 period) 205. 00 Medicare swing-bed SNF target amount 206. 00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement 207. 00 Program reimbursement under the \$410A Demonstration (see instructions) 208. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3) 209. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 209. 00 Reserved for future use Comparision of PPS versus Cost Reimbursement 215. 00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see				0	0	
22. 00 Bal ance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 208, 282 0 22. 01 Bal ance due provider/program-PARHM (see instructions) 22. 01 Bal ance due provider/program-PARHM (see instructions) 10 22. 01 Bal ance due provider/program-PARHM (see instructions) 22. 01 Bal ance due provider/program-PARHM (see instructions) 10 22. 01 Bal ance due provider/program-PARHM (see instructions) 11 208, 282 0 22. 01 22. 01 22. 01 22. 01 22. 01 22. 01 22. 01 22. 01 22. 01 22. 01 22. 01 22. 01 22. 01 22. 01 22. 01 22. 02. 02. 02. 02. 02. 02. 02. 02. 02.		,			ŭ	21.01
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chapter 1, §115. 2 Rural Communit by 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 period) 205. 00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement 207. 00 Program reimbursement under the §410A Demonstration (see instructions) 208. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3) 209. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 209. 00 Reserved for future use Comparision of PPS versus Cost Reimbursement 215. 00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see	22.01	Balance due provider/program-PARHM (see instructions)				22. 01
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205. 00 Medicare swing-bed SNF target amount 206. 00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement 207. 00 Program reimbursement under the §410A Demonstration (see instructions) 208. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3) 209. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 209. 00 Reserved for future use 209. 00 Reserved for future use 209. 00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215. 00			first year of the curre	nt 5-year demons	tration	
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210.00 Reserved for future use 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	209.00					209. 00
215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00						210. 00
						1
I nstructi ons)	215.00		209 plus line 210) (see			215. 00
		THIS CHUCK ONS)				I

		Component CCN. 15-2330	10 12/31/2023	5/29/2024 8:4	
		Title XIX	Swing Beds - SNF	PPS	
			Part A	Part B	
(COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2. 00	
	Inpatient routine services - swing bed-SNF (see instructions)		0		1.00
1	Inpatient routine services - swing bed-NF (see instructions)		o		2.00
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A, and sum of Wkst. D,	o		3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi	ng-bed pass-through, see			
	instructions)				
1	Nursing and allied health payment-PARHM (see instructions)	: (0.00		3.0
	Per diem cost for interns and residents not in approved teach	ing program (see	0.00		4.00
- 1	instructions) Program days		0		5.00
- 1	Interns and residents not in approved teaching program (see i	nstructions)			6.0
	Utilization review – physician compensation – SNF optional me		o		7.0
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	,	O		8.0
00	Primary payer payments (see instructions)		0		9.0
0. 00	Subtotal (line 8 minus line 9)		0		10.0
1.00	Deductibles billed to program patients (exclude amounts appli	cable to physician	0		11.0
1	professional services)				
1	Subtotal (line 10 minus line 11)		0		12.00
	Coinsurance billed to program patients (from provider records) (exclude coinsurance	0		13.00
	for physician professional services)		0		110
	80% of Part B costs (line 12 x 80%) Subtotal (see instructions)		0		14. 0
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				16.0
	Pioneer ACO demonstration payment adjustment (see instruction	s)	J		16.5
	Rural community hospital demonstration project (§410A Demonst	•			16. 5
	adjustment (see instructions)	restriction, perference			
	Demonstration payment adjustment amount before sequestration		0		16. 9
. 00	Allowable bad debts (see instructions)		0		17.0
	Adjusted reimbursable bad debts (see instructions)		0		17.0
1	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0		18.0
1	Total (see instructions)		0		19.0
1	Sequestration adjustment (see instructions)		0		19.0
1	Demonstration payment adjustment amount after sequestration)		0		19.0
	Sequestration adjustment-PARHM pass-throughs Sequestration for non-claims based amounts (see instructions)		o		19. 0 19. 2
1	Interim payments				20.0
1	Interim payments-PARHM				20.0
	Tentative settlement (for contractor use only)		o		21.0
1	Tentative settlement-PARHM (for contractor use only)				21.0
1	Balance due provider/program (line 19 minus lines 19.01, 19.0	2, 19.25, 20, and 21)	0		22.0
2. 01	Balance due provider/program-PARHM (see instructions)				22. 0
	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	0		23. 0
	chapter 1, §115.2				_
	Rural Community Hospital Demonstration Project (§410A Demonst				-
	Is this the first year of the current 5-year demonstration pe	riod under the 21st			200.0
	Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement				-
	Medicare swing-bed SNF inpatient routine service costs (from	Wkst D-1 Pt II line			201.0
	66 (title XVIII hospital))	most. B 1, 1t. 11, 111e			201.0
	Medicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst. D-3, col. 3, line	e		202.0
	200 (title XVIII swing-bed SNF))				
3.00	Total (sum of lines 201 and 202)				203. 0
	Medicare swing-bed SNF discharges (see instructions)				204. 0
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demons	trati on	
щ	peri od)				
- 1	Medicare swing-bed SNF target amount	1 11 204)			205.0
	Medicare swing-bed SNF inpatient routine cost cap (line 205 t				206. 0
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbur Program reimbursement under the §410A Demonstration (see inst				207 0
- 1	Program reimbursement under the 9410A bemonstration (see rist Medicare swing-bed SNF inpatient service costs (from Wkst. E-	•	1		207. 0 208. 0
	and 3)	z, cor. I, suil or Titles	'		200.0
	and 3) Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209. 0
- 1	Reserved for future use	31. 313)			210. 0
	Comparision of PPS versus Cost Reimbursement				1
	Total adjustment to Medicare swing-bed SNF PPS payment (line	200 nlus line 210) (see			215. 0
15. 00	Total adjustillerit to wedicale swillig-bed swill FFS payment (Title	207 prus rriic 210) (300	į.		

Heal	th Financial Systems	ADAMS MEMORIAL	HOSPI TAL			In Lieu	u of Form CMS-2552-10
CALC	ULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN:	15-1330	From 01/01/2023	Worksheet E-3 Part V Date/Time Prepared: 5/29/2024 8:49 am
			Ti t	le XV	111	Hospi tal	Cost

				5/29/2024 8: 4	9 am
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1. 00	Inpatient services			3, 840, 727	1.00
2. 00	Nursing and Allied Health Managed Care payment (see instructi	ons)		0	2.00
3. 00	Organ acqui si ti on			0	3.00
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4. 00	Subtotal (sum of lines 1 through 3.01)			3, 840, 727	4.00
5. 00	Primary payer payments		0	5.00	
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			3, 879, 134	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
7 00	Reasonable charges			0	7 00
7. 00 8. 00	Routine service charges			0	7. 00 8. 00
	Ancillary service charges			0	9.00
9. 00 10. 00	Organ acquisition charges, net of revenue Total reasonable charges			0	10.00
10.00	Customary charges			U	10.00
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				12.00
12.00	had such payment been made in accordance with 42 CFR 413.13(e		on a charge basis		12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	,		0. 000000	13.00
14. 00	Total customary charges (see instructions)			0.000000	14.00
15. 00	Excess of customary charges over reasonable cost (complete on	lvifline 14 exceeds Li	ne 6) (see	Ö	15.00
	instructions)) (_	
16.00	Excess of reasonable cost over customary charges (complete on	ly if line 6 exceeds lir	ne 14) (see	0	16.00
	instructions)	3	, ,		
17.00	Cost of physicians' services in a teaching hospital (see inst	ructi ons)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18. 00	Direct graduate medical education payments (from Worksheet E-	4, line 49)		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)			3, 879, 134	
20.00	Deductibles (exclude professional component)			372, 580	
21. 00	Excess reasonable cost (from line 16)			0	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			3, 506, 554	
23. 00	Coinsurance			0	23. 00
24.00	Subtotal (line 22 minus line 23)			3, 506, 554	
25.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		8, 748	
26. 00	Adjusted reimbursable bad debts (see instructions)			5, 686	
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		8, 748	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			3, 512, 240	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29.00
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	S)		0	29. 50
29. 98	Recovery of accelerated depreciation.			0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			3, 512, 240	30.00
30. 01	Sequestration adjustment (see instructions)			70, 245 0	
30. 02 30. 03	Demonstration payment adjustment amount after sequestration			U	30. 02 30. 03
31. 00	Sequestration adjustment-PARHM Interim payments			2, 993, 212	
31. 00	Interim payments Interim payments-PARHM			2, 773, 212	31.00
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	2 31 and 32)		448, 783	
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m		and 32,01)	110,700	33. 01
34.00	Protested amounts (nonallowable cost report items) in accorda			0	34.00
	§115. 2		,		
				•	•

Health Financial Systems

ADAMS MEMO
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 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/29/2024 8: 49 am

		General Fund	Specific	Endowment Fund	5/29/2024 8: 4 Plant Fund	9 am
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-94, 399		0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	41, 041, 746	١	0	0	3. 00 4. 00
5. 00	Other receivable	1 41,041,740	0	0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable	-28, 554, 179	-	Ö	0	6.00
7.00	Inventory	484, 240	1	О	0	7. 00
8.00	Prepai d expenses	1, 087, 334	0	0	0	8. 00
9. 00	Other current assets	22, 875	1	0	0	9. 00
10.00	Due from other funds	12 007 (17	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	13, 987, 617	l O	0	0	11.00
12. 00	Land	473, 119	0	O	0	12.00
13. 00	Land improvements	2, 267, 188		Ö	0	13.00
14.00	Accumulated depreciation	-1, 784, 248	0	O	0	14.00
15. 00	Bui I di ngs	43, 411, 045	I	0	0	15.00
16. 00	Accumulated depreciation	-27, 576, 735	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18. 00 19. 00	Accumulated depreciation Fixed equipment	9, 955, 859	0	0	0	18. 00 19. 00
20. 00	Accumulated depreciation	-6, 350, 988		0	0	20.00
21. 00	Automobiles and trucks	0,000,700	Ö	o	0	21.00
22. 00	Accumulated depreciation	0	0	Ö	0	22.00
23.00	Maj or movable equipment	23, 524, 622	0	0	0	23. 00
24.00	Accumulated depreciation	-18, 260, 415	0	0	0	24.00
25. 00	Mi nor equipment depreciable	0	0	0	0	25. 00
26.00	Accumulated depreciation	0	0	0	0	26.00
27. 00 28. 00	HIT designated Assets	0	0	0	0	27.00
29.00	Accumulated depreciation Minor equipment-nondepreciable	3, 759, 365	0	0	0	28. 00 29. 00
30. 00	Total fixed assets (sum of lines 12-29)	29, 418, 812	1	0	0	30.00
00.00	OTHER ASSETS	27, 110, 012	<u> </u>	<u> </u>		00.00
31.00	Investments	7, 434, 800	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33. 00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	9, 276, 285	1	0	0	34.00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	16, 711, 085 60, 117, 514	0	0	0	35. 00 36. 00
30.00	CURRENT LIABILITIES	00, 117, 314	0	<u> </u>	0	30.00
37.00	Accounts payable	109, 763	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2, 281, 012		О	0	38. 00
39. 00	Payroll taxes payable	0	0	0	0	39. 00
40. 00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42. 00 43. 00	Accel erated payments Due to other funds	0	0	0	0	42. 00 43. 00
44. 00	Other current liabilities	3, 611, 874	0	0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	6, 002, 649		Ö		
	LONG TERM LIABILITIES			- 1		
46.00	Mortgage payable	21, 015, 000	0	0	0	46. 00
47.00	Notes payable	0	0	0	0	47.00
48. 00	Unsecured Loans	0	0	0	0	48.00
49. 00	Other long term liabilities	1, 822, 273		0	0	49.00
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	22, 837, 273 28, 839, 922	I I	0	0	50. 00 51. 00
31.00	CAPITAL ACCOUNTS	20,037,722	0	U _I	0	31.00
52.00	General fund balance	31, 277, 592				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	57. 00 58. 00
50.00	replacement, and expansion				U	30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	31, 277, 592	0	o	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	60, 117, 514	1	ō	0	60.00
	[59]					

ADAMS MEMORIAL HOSPITAL

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-1330

					To 12/31/202	3 Date/Time Pro 5/29/2024 8:4	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
	I 	1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		39, 372, 135	1	1	0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		-8, 094, 543	1		o	2. 00 3. 00
3. 00 4. 00	Additions (credit adjustments) (specify)		31, 277, 592		0	٥	
5. 00	Additions (credit adjustments) (specify)				0		
6. 00					Ö		
7. 00		l ol			o		
8. 00		o			0	d	
9.00		o			0		9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11. 00	Subtotal (line 3 plus line 10)		31, 277, 592			0	11.00
12.00	Deductions (debit adjustments) (specify)	0			0	(
13.00		0			0		
14.00		0			0	C	
15. 00 16. 00		0			0		
16.00		U			0		
18.00	Total deductions (sum of lines 12-17)	١	0				18.00
19. 00	Fund balance at end of period per balance		31, 277, 592				19.00
171.00	sheet (line 11 minus line 18)		01/2///0/2				
		Endowment	PI ant	Fund		•	
		Fund		1			
		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	Additions (credit adjustments) (specify)		0	1			4.00
5. 00 6. 00			0				5. 00 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	Ü		0		10.00
11. 00	Subtotal (line 3 plus line 10)	o			0		11.00
12.00	Deductions (debit adjustments) (specify)		0	1			12.00
13.00			0	(13.00
14.00			0				14.00
15.00			0				15.00
16.00			0	1			16.00
17.00	T	_	0	1			17.00
18.00	Total deductions (sum of lines 12-17)	0			0		18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)				O		19.00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-1330

		1	5 12/31/2023	Date/lime Pre 5/29/2024 8:4	
	Cost Center Description	I npati ent	Outpati ent	Total	, diii
	'	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u>.</u>			
	General Inpatient Routine Services				
1.00	Hospi tal	6, 354, 156		6, 354, 156	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	884, 663		884, 663	6. 00
7.00	SKILLED NURSING FACILITY	0		0	7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	7, 238, 819		7, 238, 819	10.00
	Intensive Care Type Inpatient Hospital Services	<u>.</u>			
11. 00	INTENSIVE CARE UNIT	2, 852, 214		2, 852, 214	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14. 00	SURGICAL INTENSIVE CARE UNIT				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines	2, 852, 214		2, 852, 214	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	10, 091, 033		10, 091, 033	17. 00
18. 00	Ancillary services	10, 658, 398		91, 406, 548	18. 00
19. 00	Outpatient services	251, 885	17, 525, 609	17, 777, 494	19.00
20.00	MONROE FAMILY MEDICINE	0	3, 179, 905	3, 179, 905	20.00
20. 01	WOODCREST	0	2, 198, 786	2, 198, 786	20. 01
20. 02	STAT CARE	0	2, 093, 132	2, 093, 132	20. 02
20. 03	BERNE FAMILY MEDICINE	0	2, 162, 034	2, 162, 034	20. 03
20. 04	HI GH STREET	0	2, 445, 984	2, 445, 984	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21. 00
22. 00	HOME HEALTH AGENCY		0	0	22. 00
23. 00	AMBULANCE SERVICES	0	2, 185, 077	2, 185, 077	23. 00
24.00	CMHC				24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE	0	0	0	26.00
27. 00	PROFESSIONAL FEES	0	25, 969, 134	25, 969, 134	27. 00
27. 01	OTHER CLINICS	0	115, 598	115, 598	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wk	st. 21, 001, 316	138, 623, 409	159, 624, 725	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES		04 440 004		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		84, 118, 924		29. 00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35. 00	T	0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37. 00	DEDUCT (SPECIFY)	0			37.00
38. 00		0			38.00
39. 00		0			39.00
40.00		0			40.00
41.00	T-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	0			41.00
42.00	Total deductions (sum of lines 37-41)		04 440 000		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tra	nsrer'	84, 118, 924		43. 00
	to Wkst. G-3, line 4)	I	I		l

	Financial Systems	ADAMS MEMORIAL HOSP			u of Form CMS-2	
STATE	MENT OF REVENUES AND EXPENSES	Pro	ovider CCN: 15-1330	Peri od:	Worksheet G-3	
				From 01/01/2023 To 12/31/2023	Date/Time Pre	narod:
				10 12/31/2023	5/29/2024 8: 4	
	·					
					1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part	t I, column 3, line 28	3)		159, 624, 725	1.00
2.00	Less contractual allowances and discounts or	n patients' accounts			78, 886, 309	2.00
3.00	Net patient revenues (line 1 minus line 2)				80, 738, 416	3.00
4.00	Less total operating expenses (from Wkst. G-	-2, Part II, line 43)			84, 118, 924	4.00
5.00	Net income from service to patients (line 3	minus line 4)			-3, 380, 508	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				101, 469	6.00
7.00	Income from investments				256, 113	
8.00	Revenues from telephone and other miscellane	eous communication ser	vi ces		0	
9.00	Revenue from television and radio service				0	
10.00	Purchase di scounts				0	
11. 00	Rebates and refunds of expenses				0	
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13. 00
14.00	Revenue from meals sold to employees and gue	ests			410, 314	
15. 00	Revenue from rental of living quarters				0	15. 00
16. 00	Revenue from sale of medical and surgical su		pati ents		0	16. 00
17. 00	Revenue from sale of drugs to other than pat				507, 173	
18. 00	Revenue from sale of medical records and abs				23, 862	
19. 00	Tuition (fees, sale of textbooks, uniforms,				0	
20.00	Revenue from gifts, flowers, coffee shops, a	and canteen			0	20.00
21. 00	Rental of vending machines				0	21.00
22. 00	Rental of hospital space				183, 331	22. 00
23.00	Governmental appropriations				0	23.00
24.00	MI SC				1, 515, 409	
24. 01	CEDIT INCOME				1, 904, 187	
24. 02	FI TNESS REVENUE				97, 318	
24. 03					5, 542	
24. 50	3				0	24. 50
25.00	Total other income (sum of lines 6-24)				5, 004, 718	
26. 00	Total (line 5 plus line 25)				1, 624, 210	
27.00	BAD DEBTS				9, 718, 753	27.00

9, 718, 753 27. 00 9, 718, 753 28. 00 -8, 094, 543 29. 00

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

	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:	Worksheet M-1	
			Component	CCN: 15-8526	From 01/01/2023 To 12/31/2023		
					RHC I	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	676, 794	134, 168	810, 96	2 0	810, 962	1.00
2.00	Physician Assistant	115, 271	22, 851	138, 12	2 0	138, 122	2.00
3.00	Nurse Practitioner	651, 258	129, 106	780, 36	4 0	780, 364	3.00
4.00	Visiting Nurse	0	0	1	0	0	4.00
5.00	Other Nurse	374, 764	74, 294	449, 05	0 8	449, 058	5.00
6.00	Clinical Psychologist	0	0	1	0	0	6.00
7.00	Clinical Social Worker	0	0	1	0	0	
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8.00	Laboratory Techni ci an	0	0		0	0	
9.00	Other Facility Health Care Staff Costs	0	0		0	0	
10.00	Subtotal (sum of lines 1 through 9)	1, 818, 087	360, 419	2, 178, 50			
11. 00	Physician Services Under Agreement	0	0		0	0	
12. 00	Physician Supervision Under Agreement	0	0		0		
13.00	Other Costs Under Agreement	0	0	1	0	0	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	0	1	0	0	
15. 00	Medical Supplies	0	233, 249	233, 24		,	
16. 00	Transportation (Health Care Staff)	0	0	1	0	0	
17. 00	Depreciation-Medical Equipment	0	0	1	0		
18. 00	Professional Liability Insurance	0	0	1	0	0	18. 00
19. 00	Other Health Care Costs	0	0	1	0	0	
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	233, 249				1
22. 00	Total Cost of Health Care Services (sum of	1, 818, 087	593, 668	2, 411, 75	5 0	2, 411, 755	22. 00
	lines 10, 14, and 21)						-
23. 00	COSTS OTHER THAN RHC/FQHC SERVICES	0	0	ı	0 0	0	23. 00
24. 00	Pharmacy Dental	0	0		0 0		24.00
	Optometry	0	0		0 0	· -	
25. 00	1 '	J	807	4 03	0		1
25. 01 25. 02	Tel eheal th	4, 069 0	807	4, 87	0 0	4, 876	1
26. 00	Chronic Care Management All other nonreimbursable costs	0	0		0 0	0	26. 00
27. 00	Nonallowable GME costs	U	U	1	0	U	27.00
		1 040	907	1 07		1 074	
28. 00	Total Nonreimbursable Costs (sum of lines 23 through 27)	4, 069	807	4, 87	0	4, 876	28. 00
	FACILITY OVERHEAD						1
29. 00	Facility Costs	0	57, 262	57, 26	2 0	57, 262	29. 00
30.00	Administrative Costs	81. 095	73, 476				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	- ,	130, 738			,	
51.50	30)	31,073	155, 750	211,00		211,000	31.00

725, 213

1, 903, 251

2, 628, 464

2, 628, 464 32.00

30)

32.00 Total facility costs (sum of lines 22, 28 and 31)

Heal th	Financial Systems	ADAMS MEMORI	AL HOSPITAL		1	n Lie	u of Form CMS-:	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1330	Peri od:	(0000	Worksheet M-1	
			Component	CCN: 15-8526	From 01/01, To 12/31,		Date/Time Pre 5/29/2024 8:4	epared: 19 am
					RHC I		Cost	
		Adj ustments	Net Expenses for					
			Allocation (col. 5 +					
			col. 6)					
		6. 00	7.00	1				
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	C	810, 962	•				1.00
2.00	Physician Assistant	C	138, 122	•				2.00
3.00	Nurse Practitioner	C	780, 364					3.00
4.00	Visiting Nurse	C	0)				4.00
5.00	Other Nurse	0	449.058					5.00

	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 Co	CN: 15-1330	Peri od:	Worksheet M-1	
			Component	CCN: 15-8536	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 8:4	
					RHC II	Cost	
		Compensation	Other Costs		1 Reclassi ficat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
		4.00	0.00	2.00	4.00	col . 4)	
	FACILITY HEALTH CARE STAFF COSTS	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	Physician	494, 306	85, 741	580, 04	7 0	580, 047	1.00
2. 00	Physician Assistant	494, 300	05, 741	360, 04	0	360, 047	2.00
3. 00	Nurse Practitioner	278, 945	48, 385	327, 33	0	327, 330	
4. 00	Visiting Nurse	270, 943	40, 303 N	327, 30	0 0	327, 330	4.00
5. 00	Other Nurse	421, 886	73, 179	495, 06	0	495, 065	
6. 00	Clinical Psychologist	121,000	, , , , , ,	170,00	0 0	0	•
7. 00	Clinical Social Worker	0	0		0 0	0	1
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
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, 195, 137	207, 305	1, 402, 44	.2 0	1, 402, 442	10.00
11.00	Physician Services Under Agreement	0	0		0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0	0	
15. 00	Medical Supplies	0	235, 611			235, 611	
16. 00	Transportation (Health Care Staff)	0	0		0	0	
17.00	Depreciation-Medical Equipment	0	0		0	0	
18.00	Professional Liability Insurance	0	0		0 0	0	18. 00 19. 00
20.00	Other Health Care Costs Allowable GME Costs	U	0		0	0	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	235, 611	235, 61	1 0	235, 611	
22. 00	Total Cost of Health Care Services (sum of	1, 195, 137	442, 916			1, 638, 053	1
22.00	lines 10, 14, and 21)	1, 175, 157	442, 710	1, 030, 03	0	1, 030, 033	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
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	0	25.00
25. 01	Tel eheal th	66	11	7	7 0	77	25. 01
25. 02	Chronic Care Management	0	0		0 0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0	0	
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	66	11	7	7 0	77	28. 00
	through 27)						
20.00	FACILITY OVERHEAD	ام	70.050	70.05		70.050	20.00
29. 00 30. 00	Facility Costs Administrative Costs	0 43, 920	72, 950 53, 202			72, 950 97, 122	29. 00 30. 00
30.00	Total Facility Overhead (sum of lines 29 and		53, 202 126, 152			170, 072	
51.00	30)	45, 720	120, 132	1,3,0,		170,072	31.00

1, 239, 123

1, 808, 202

569, 079

32.00

1, 808, 202

and 31)

Health Financial Systems	ADAMS MEMORIAL HOSPITAL			In Lieu	of Form CMS-2	.552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1330	Peri od: From 01/01/2023	Worksheet M-1	
		Component	CCN: 15-8536	To 12/31/2023	Date/Time Prep 5/29/2024 8:49	pared: 9 am
				RHC II	Cost	
	Adjustments	Net Expenses				
		for				
		Allocation				
		(col. 5 +				
		col. 6)				
	6. 00	7.00				
FACILITY HEALTH CARE STAFF COSTS	· .					

		Auj us tillerits	Net Expenses		
			for		
			Allocation		
			(col. 5 +		
			col. 6)		
		6. 00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physi ci an	0	580, 047		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	327, 330		3.00
4.00	Visiting Nurse	0	ol		4.00
5.00	Other Nurse	0	495, 065		5.00
6.00	Clinical Psychologist	0	l ol		6.00
7. 00	Clinical Social Worker	0	0		7.00
7. 10	Marriage and Family Therapist	_]		7. 10
7. 11	Mental Health Counselor				7. 11
8. 00	Laboratory Techni ci an	0	l ol		8.00
9. 00	Other Facility Health Care Staff Costs	0		l .	9.00
10.00	Subtotal (sum of lines 1 through 9)	0		l .	10.00
	Physician Services Under Agreement	0	1, 402, 442		11.00
	Physician Supervision Under Agreement	0			12.00
	Other Costs Under Agreement	0	-	l .	13.00
	9	•	-		
	Subtotal (sum of lines 11 through 13)	0			14.00
	Medical Supplies	0			15.00
	Transportation (Health Care Staff)	0	0		16.00
	Depreciation-Medical Equipment	0	0		17.00
	Professional Liability Insurance	0	0		18.00
	Other Health Care Costs	0	0		19.00
	Allowable GME Costs	_			20.00
	Subtotal (sum of lines 15 through 20)	0			21.00
22. 00	Total Cost of Health Care Services (sum of	0	1, 638, 053		22. 00
	lines 10, 14, and 21)				_
	COSTS OTHER THAN RHC/FQHC SERVICES	_	1 -1		4
	Pharmacy	0		l .	23. 00
24. 00	Dental	0		l .	24. 00
	Optometry	0	0		25.00
	Tel eheal th	0	77		25. 01
	Chronic Care Management	0	0		25. 02
	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	77		28. 00
	through 27)				
	FACILITY OVERHEAD				
29. 00	Facility Costs	0			29. 00
30.00	Administrative Costs	0	97, 122		30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	170, 072		31.00
	30)				
32.00	Total facility costs (sum of lines 22, 28	0	1, 808, 202		32.00
	and 31)				

	Financial Systems SIS OF HOSPITAL-BASED RHC/FOHC COSTS	ADAMS MEMORIA		N. 1E 1220	Period:	u of Form CMS-2 Worksheet M-1	
ANALYS	DIS OF HUSELIAL-BASED KHU/FUHU UUSIS		Provi der C	JIV. 15-133U	From 01/01/2023		
			Component	CCN: 15-8537	To 12/31/2023	Date/Time Pre 5/29/2024 8:4	pared:
					RHC III	Cost	9 alli
		Compensation	Other Costs	Total (col.	1 Reclassificat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	290, 435	48, 449	338, 88		338, 884	1.00
2.00	Physician Assistant	43, 788	7, 305	51, 09		51, 093	2.00
3.00	Nurse Practitioner	213, 037	35, 538	248, 57		248, 575	3.00
4.00	Visiting Nurse	000 704	0	004.70	0 0	0	4.00
5.00	Other Nurse	329, 724	55, 003	384, 72	27 0	384, 727	5.00
6.00	Clinical Psychologist	0	0			0	0.00
7.00	Clinical Social Worker	U	0		0	0	7.00
7. 10 7. 11	Marriage and Family Therapist						7.10
8. 00	Mental Health Counselor Laboratory Technician	0	_		0	0	7. 11 8. 00
9.00	Other Facility Health Care Staff Costs	45, 394	7, 572	52, 9 <i>6</i>	٥	52, 966	
10.00	Subtotal (sum of lines 1 through 9)	922, 378	153, 867	1, 076, 24		1, 076, 245	
11. 00	Physician Services Under Agreement	722, 370 N	155,607	1,070,24	0 0	1, 070, 243	1
12. 00	Physician Supervision Under Agreement	0	0		0 0	0	1
13. 00	Other Costs Under Agreement	0	0		0 0	0	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15. 00	Medical Supplies	0	113, 926	113, 92	٥	113, 926	
16. 00	Transportation (Health Care Staff)	0	0	,	0 0	0	
17.00		0	0		0 0	0	l
18.00	1 1	0	0		0 0	0	18.00
19.00		0	0		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	113, 926	113, 92	26 0	113, 926	21.00
22.00	Total Cost of Health Care Services (sum of	922, 378	267, 793	1, 190, 17	71 0	1, 190, 171	22.00
	lines 10, 14, and 21)]
	COSTS OTHER THAN RHC/FQHC SERVICES						
	Pharmacy	0	0		0	0	23.00
24. 00	Dental	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	9	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	0	28. 00
	through 27) FACILITY OVERHEAD						1
20 00	FACILITY OVERHEAD FACILITY COSTS	0	25 358	25 35	58 0	25 358	29 00

224, 908 224, 908

1, 147, 286

25, 358 178, 451 203, 809

471, 602

25, 358 403, 359 428, 717

1, 618, 888

25, 358 403, 359 428, 717

1, 618, 888

29.00

30.00

31.00

32.00

0

29.00 Facility Costs
30.00 Administrative Costs

31.00

30)

and 31)

Total Facility Overhead (sum of lines 29 and

Health Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der (CCN: 15-1330	Peri od: From 01/01/2023	Worksheet M-1	
		Component	CCN: 15-8537			
				RHC III	Cost	
	Adjustments	Net Expenses				
		for				
		Allocation				

					RHC III	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS			ı			
1. 00	Physi ci an	0		•			1. 00
2.00	Physici an Assistant	0	51, 093	•			2.00
3.00	Nurse Practitioner	0	248, 575	•			3.00
4. 00	Visiting Nurse	0	0	l .			4. 00
5. 00	Other Nurse	0	384, 727				5.00
6.00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	0	0				7.00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8.00	Laboratory Techni ci an	0	0				8. 00
9.00	Other Facility Health Care Staff Costs	0	52, 966				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 076, 245				10.00
11. 00	Physician Services Under Agreement	0	0				11.00
12.00	Physician Supervision Under Agreement	0	0				12.00
13.00	Other Costs Under Agreement	0	0				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0				14.00
15.00	Medical Supplies	0	113, 926				15.00
16.00	Transportation (Health Care Staff)	0	0				16.00
17.00	Depreciation-Medical Equipment	0	0				17.00
18.00	Professional Liability Insurance	0	0				18.00
19.00	Other Health Care Costs	0	0				19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	113, 926				21.00
22.00	Total Cost of Health Care Services (sum of	0	1, 190, 171				22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0					23.00
24. 00	Dental	0	0				24.00
25.00	Optometry	0	0				25.00
25. 01	Tel eheal th	0	0				25. 01
25. 02	Chronic Care Management	0	0				25. 02
26. 00	All other nonreimbursable costs	0	0				26.00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0				28. 00
	through 27)						
00.05	FACILITY OVERHEAD		0= 5==				00.00
	Facility Costs	0					29. 00
30.00	Administrative Costs	0	403, 359	1			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	428, 717				31. 00
22.00	30)	_	1 /40 000				22.00
32. 00	Total facility costs (sum of lines 22, 28	0	1, 618, 888				32.00
	and 31)		I	I			

	Financial Systems	ADAMS MEMORIA				u of Form CMS-	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der CO		Peri od: From 01/01/2023	Worksheet M-1	
			Component (To 12/31/2023	Date/Time Pre 5/29/2024 8:4	
					RHC I V	Cost	
		Compensation	Other Costs		Reclassi 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	543, 292	121, 233	664, 52	5 0	664, 525	1.00
2. 00	Physician Assistant	343, 272	121, 233	004, 32	0 0	004, 323	1
3. 00	Nurse Practitioner	252, 436	56, 330	308, 76	-	308, 766	
4. 00	Visiting Nurse	0	0	000,70	0 0	0	4.00
5. 00	Other Nurse	391, 723	87, 411	479, 13	4 0	479, 134	
6. 00	Clinical Psychologist	0	0		o o	0	
7.00	Clinical Social Worker	o	0		0 0	0	7.00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8.00	Laboratory Techni ci an	0	0		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, 187, 451	264, 974	1, 452, 42	5 0	1, 452, 425	
11. 00	Physician Services Under Agreement	0	0		0	0	
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	
15.00	Medical Supplies	0	294, 798			294, 798	
16. 00 17. 00	Transportation (Health Care Staff) Depreciation-Medical Equipment	0	0		0 0	0	
17.00		0	0		0 0	0	
19. 00	,	0	0		0 0	0	
20. 00	Allowable GME Costs	o o	O		0	0	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	294. 798	294. 79	8 0	294, 798	
22. 00	Total Cost of Health Care Services (sum of	1, 187, 451	559, 772	1, 747, 22		1, 747, 223	
	lines 10, 14, and 21)	, , , , ,		, , ,		, , ,	
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0	0	23. 00
24.00	Dental	0	0		0	0	
25. 00	Optometry	0	0		0	0	
25. 01	Tel eheal th	217	48	26		265	
25. 02	Chronic Care Management	0	0		0	0	
26. 00	All other nonreimbursable costs	0	0		0	0	26.00
27. 00	Nonallowable GME costs			<u> </u>	_	ā	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	217	48	26	5 0	265	28. 00
	through 27) FACILITY OVERHEAD						1
29. 00	Facility Costs	ol	116, 343	116, 34	3 0	116, 343	29. 00
30.00	Administrative Costs	60, 004	72, 371	132, 37		132, 375	
31. 00	Total Facility Overhead (sum of lines 29 and		188, 714	248, 71			
2 30	30)		, , , ,	3, , .			

748, 534

1, 247, 672

1, 996, 206

32.00

1, 996, 206

30)

and 31)

Health Financial Systems	ADAMS MEMORI.	AL HOSPLTAL		In Lieu	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	ADAMO MEMORY		CN: 15-1330	Peri od: From 01/01/2023	Worksheet M-1	
		Component	CCN: 15-8559	To 12/31/2023	Date/Time Pre 5/29/2024 8:4	pared: 9 am
				RHC I V	Cost	
	Adj ustments	Net Expenses for				
		Allocation (col. 5 +				
	6, 00	col. 6) 7.00	-			
FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
1. 00 Physi ci an	0	664, 525				1.00
2.00 Physician Assistant	0	0				2.00

	Financial Systems	ADAMS MEMORIA		N. 45 4000		u of Form CMS-	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co		Period: From 01/01/2023	Worksheet M-1	
			Component		To 12/31/2023	Date/Time Pre 5/29/2024 8:4	pared: 9 am
					RHC V	Cost	
		Compensation	Other Costs	Total (col. + col. 2)	Reclassificat ions	Reclassified Trial Balance	
						(col. 3 + col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	467, 593	65, 761	533, 35			
2. 00	Physician Assistant	0	0		0	0	
3.00	Nurse Practitioner	174, 108	24, 486	198, 59		198, 594	
4.00	Visiting Nurse	240 271	24 404	204 07	0	0	4.00
5. 00 6. 00	Other Nurse Clinical Psychologist	260, 271	36, 604	296, 87	0 0	296, 875 0	
7. 00	Clinical Social Worker	0	0		0 0	0	
7. 10	Marriage and Family Therapist	J	O			Ĭ	7. 10
7. 11	Mental Health Counselor						7. 11
8.00	Laboratory Techni ci an	o	0		0 0	0	1
9.00	Other Facility Health Care Staff Costs	0	0		0 0	0	9. 00
10.00	Subtotal (sum of lines 1 through 9)	901, 972	126, 851	1, 028, 82	3 0	1, 028, 823	
11.00	Physician Services Under Agreement	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	1/0 205	1/0 20	0 0	1/0 205	
15. 00 16. 00	Medical Supplies Transportation (Health Care Staff)	0	168, 385 0	168, 38	0 0	168, 385 0	
17. 00	Depreciation (Hearth Care Starr)	0	0		0 0	0	
18. 00	Professional Liability Insurance	0	0		0 0	0	
19. 00	Other Health Care Costs	o	0		o o	o o	1
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	168, 385	168, 38	5 0	168, 385	21.00
22. 00	Total Cost of Health Care Services (sum of	901, 972	295, 236	1, 197, 20	8 0	1, 197, 208	22. 00
	lines 10, 14, and 21)						
00.00	COSTS OTHER THAN RHC/FQHC SERVICES	ما					00.00
23. 00 24. 00	Pharmacy Dental	0	0		0 0	0	
25.00	Optometry	ol Ol	0			0	
25. 00	Tel eheal th	332	47	37		379	
25. 01		0	0	_	0 0	0	
26. 00	All other nonreimbursable costs	0	0		0 0	o o	
27. 00	Nonallowable GME costs		_			_	27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	332	47	37	9 0	379	28. 00
	through 27)]
	FACILITY OVERHEAD	-					
29. 00	Facility Costs	0	130, 944				
30.00	Administrative Costs	46, 935	45, 457	92, 39		92, 392	
31. 00	Total Facility Overhead (sum of lines 29 and 30)	46, 935	176, 401	223, 33	6 0	223, 336	31.00

949, 239

471, 684

1, 420, 923

1, 420, 923

32.00

and 31)

Health Financial Systems	ADAMS MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-1
NALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der 0	CN: 15-1330	Peri od: From 01/01/2023	Worksheet M-1	
		Component	CCN: 15-8555	To 12/31/2023	Date/Time Pre 5/29/2024 8:4	pared: 9 am
				RHC V	Cost	
	Adjustments	Net Expenses				
		for				
		Allocation				
		(col. 5 +				
		col. 6)				
	6. 00	7. 00				
FACILITY HEALTH CARE STAFF COSTS	6.00	7.00				
1.00 Physi ci an	0	533, 354	1			1.
2 00 Dhysisian Assistant	0		sl.			2 /

		Adjustments	Net Expenses		
			for		
			Allocation		
			(col. 5 +		
			col. 6)		
		6. 00	7. 00		
	FACILITY HEALTH CARE STAFF COSTS				1
1. 00	Physi ci an	0	533, 354		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	198, 594		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	296, 875		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7. 10	Marriage and Family Therapist				7. 10
7. 11	Mental Health Counselor				7. 11
8. 00	Laboratory Techni ci an	0	0		8.00
9. 00	Other Facility Health Care Staff Costs	0	o o		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 028, 823		10.00
11. 00	Physician Services Under Agreement	0	1,020,023		11.00
	Physician Supervision Under Agreement	0	0		12.00
12.00		0			
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15. 00	Medical Supplies	0	168, 385		15.00
16. 00	Transportation (Health Care Staff)	0	0		16.00
17. 00	Depreciation-Medical Equipment	0	0		17. 00
18. 00	Professional Liability Insurance	0	0		18. 00
19. 00	Other Health Care Costs	0	0		19. 00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	168, 385		21.00
22.00	Total Cost of Health Care Services (sum of	0	1, 197, 208		22.00
	lines 10, 14, and 21)				
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25. 01	Tel eheal th	0	379		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	379		28. 00
20.00	through 27)	· ·	0.,		20.00
	FACILITY OVERHEAD				1
29 00	Facility Costs	-39, 643	91, 301		29. 00
30.00	Admi ni strati ve Costs	37, 043 N	92, 392		30.00
31.00	Total Facility Overhead (sum of lines 29 and	-39, 643			31.00
31.00	30)	-37,043	103, 093		31.00
32. 00	Total facility costs (sum of lines 22, 28	-39, 643	1, 381, 280		32.00
32.00	and 31)	-37,043	1, 301, 200		32.00
	lana 31)		I	I	I

	Financial Systems	ADAMS MEMORIA				u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der Co		Peri od:	Worksheet M-2	
			Component		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 8:4	
					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. 39					1.00
2.00	Physician Assistant	0. 57	,				2.00
3.00	Nurse Practitioner	2. 90					3.00
4.00	Subtotal (sum of lines 1 through 3)	4. 86	·		13, 125		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	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
7. 03	Marriage and Family Therapist						7. 03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4	4. 86	13, 852			13, 852	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE 1	TO HOSPI TAL-BASE	ED RHC/FQHC SEF	RVICES		1.00	
10.00	Total costs of health care services (from WI	kst. M-1, col.	7, line 22)			2, 411, 755	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line :	28)			4, 876	11.00
12.00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			2, 416, 631	12.00
13.00	Ratio of hospital-based RHC/FQHC services (0. 997982	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fi			ne 31)		211, 833	14.00
15.00	Parent provider overhead allocated to facili			,		680, 679	
16.00	Total overhead (sum of lines 14 and 15)	•	,			892, 512	
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					892, 512	18.00
19.00	Overhead applicable to hospital-based RHC/FG	QHC services (I	ine 13 x line 1	18)		890, 711	
	Total allowable cost of hospital-based RHC/I					3, 302, 466	

	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC:	ADAMS MEMORIA	Provider C	CN: 15-1330	Peri od:	u of Form CMS-2 Worksheet M-2	
, (LLOO)	THON OF OVERHELD TO HOOF THE BROLD KNOT WHO	SERVI SES	Trovider of		From 01/01/2023		
			Component	CCN: 15-8536	To 12/31/2023	Date/Time Pre 5/29/2024 8:4	
					RHC II	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)	,	col. 2 or	
		1.00	0.00	0.00	1 x col . 3)	col . 4	
	VICITE AND DECRUCTIVITY	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						1
1 00	Posi ti ons Physi ci an	1, 21	3, 453	4, 20	5, 082		1.00
1. 00 2. 00	Physician Assistant	0.00					2.00
3. 00	Nurse Practitioner	1. 12					3.00
4. 00	Subtotal (sum of lines 1 through 3)	2. 33			7, 434	9, 095	
5. 00	Visiting Nurse	0.00			7, 454	7, 075	
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. 02	Diabetes Self Management Training (FQHC	0.00				0	7. 02
	only)						
7. 03	Marriage and Family Therapist						7. 03
7. 04	Mental Health Counselor						7.04
8. 00	Total FTEs and Visits (sum of lines 4	2. 33	9, 095			9, 095	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SEF	RVICES		1.00	
10. 00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			1, 638, 053	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line:	28)			77	
12. 00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			1, 638, 130	12.00
13. 00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			0. 999953	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		170, 072	
15. 00	Parent provider overhead allocated to facili	ty (see instru	ctions)			470, 678	
16. 00	Total overhead (sum of lines 14 and 15)					640, 750	
17. 00	Allowable GME overhead (see instructions)					0	
18.00	Enter the amount from line 16			4.0)		640, 750	
19.00	The second secon					640, 720	
20.00	Total allowable cost of hospital-based RHC/F	·UHC services (:	sum of Lines 10	J and 19)		2, 278, 773	J 20.00

	Financial Systems	ADAMS MEMORIA				u of Form CMS-	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der Co	CN: 15-1330	Peri od: From 01/01/2023	Worksheet M-2	
			Component	CCN: 15-8537	To 12/31/2023	Date/Time Pre 5/29/2024 8:4	
					RHC III	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	0. 46					1.00
2.00	Physician Assistant	0. 21	1, 196				2.00
3.00	Nurse Practitioner	1. 15	6, 426	2, 10	2, 415		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.82			4, 788	11, 111	4.00
5.00	Visiting Nurse	0.00				0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7. 01
7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
7.03	Marriage and Family Therapist						7.03
7.04	Mental Health Counselor						7. 04
8.00	Total FTEs and Visits (sum of lines 4	1. 82	11, 111			11, 111	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						4 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SEF	RVICES		1. 00	
10.00	Total costs of health care services (from Wk	st. M-1, col.	7. line 22)			1, 190, 171	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,					0	1
12.00	Cost of all services (excluding overhead) (s					1, 190, 171	
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		428, 717	
15. 00	Parent provider overhead allocated to facili			- /		594, 396	
16.00	Total overhead (sum of lines 14 and 15)	· .	,			1, 023, 113	16.00
17. 00	Allowable GME overhead (see instructions)					0	
18.00	Enter the amount from line 16					1, 023, 113	18.00
19. 00	Overhead applicable to hospital-based RHC/FC	MC services (I	ine 13 x line '	18)		1, 023, 113	
	Total allowable cost of hospital-based RHC/F					2, 213, 284	

	Financial Systems	ADAMS MEMORIA			In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C	CN: 15-1330	Peri od:	Worksheet M-2	
			Component	CCN: 15-8559	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 8:4	
					RHC IV	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	,	col. 2 or	
		1.00	0.00	2.22	1 x col . 3)	col . 4	
	hu ou to the propulative to	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
1 00	Posi ti ons	0.04	2 (02	4, 20	2 (12		1 00
1. 00 2. 00	Physi ci an Physi ci an Assi stant	0. 86 0. 00					1.00 2.00
3. 00	Nurse Practitioner	1. 12					3.00
4. 00	Subtotal (sum of lines 1 through 3)	1. 12			5, 964	8, 539	4.00
5. 00	Visiting Nurse	0.00		•	3, 704	0, 337	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	7. 02
	only)						
7.03	Marriage and Family Therapist						7. 03
7.04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4	1. 98	8, 539			8, 539	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						4 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SEI	RVICES		1. 00	
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			1, 747, 223	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			265	11.00
12.00	Cost of all services (excluding overhead) (s					1, 747, 488	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 999848	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		194, 859	
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			502, 896	
16. 00	Total overhead (sum of lines 14 and 15)					697, 755	
17. 00	Allowable GME overhead (see instructions)					0	17.00
18. 00	Enter the amount from line 16					697, 755	
19.00	Overhead applicable to hospital-based RHC/FO					697, 649	
20.00	Total allowable cost of hospital-based RHC/F	UHC SERVICES (sum of lines 10	Jand 19)		2, 444, 872	20.00

	Financial Systems	ADAMS MEMORIA		N 45 4000 D		u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der Co		eriod: rom 01/01/2023	Worksheet M-2	
			Component		o 12/31/2023	Date/Time Pre 5/29/2024 8:4	
					RHC V	Cost	
		Number of FTE	Total Visits	Producti vi ty	Mi ni mum	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						1
	Posi ti ons		T				
1.00	Physi ci an	0. 76		4, 200		ļ	1.00
2. 00	Physician Assistant	0.00		_,			2.00
3.00	Nurse Practitioner	0. 56					3.00
4. 00	Subtotal (sum of lines 1 through 3)	1. 32	7, 764		4, 368	7, 764	
5.00	Visiting Nurse	0.00	0			0	
6.00	Clinical Psychologist	0.00				0	
7.00	Clinical Social Worker	0.00				0	
7. 01	Medical Nutrition Therapist (FOHC only)	0.00				0	
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
7. 03	Marriage and Family Therapist						7. 03
7. 04	Mental Health Counselor						7. 04
8. 00	Total FTEs and Visits (sum of lines 4	1. 32	7, 764			7, 764	8.00
	through 7)		_			_ !	
9. 00	Physician Services Under Agreements		0			0	9.00
					-	1 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPI TAL-BASI	FD RHC/FOHC SEE	RVICES		1. 00	
10.00	Total costs of health care services (from W					1, 197, 208	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1					379	
12.00	Cost of all services (excluding overhead) (1, 197, 587	12.00
13. 00	Ratio of hospital-based RHC/FQHC services (0. 999684	
14. 00	Total hospital-based RHC/FQHC overhead - (f			ne 31)		183, 693	
15. 00	Parent provider overhead allocated to facil					364, 926	
16. 00	Total overhead (sum of lines 14 and 15)	., (,			548, 619	
17. 00	Allowable GME overhead (see instructions)					0	1
	Enter the amount from line 16					548, 619	
		0110 (11		10)			
19.00	Overhead applicable to hospital-based RHC/F	unc services ci	ine is x iine	18)	1	548, 446	1 19.00

	Financial Systems ADAMS MEMORIAL I			u of Form CMS-2	
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1330	Peri od: From 01/01/2023	Worksheet M-3	
SERVI C	ES	Component CCN: 15-8526	To 12/31/2023	Date/Time Pre	pared
				5/29/2024 8: 4	9 am
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			3, 302, 466	
2. 00	Cost of injections/infusions and their administration (from W			71, 434	1
. 00	Total allowable cost excluding injections/infusions (line 1 m Total Visits (from Wkst. M-2, column 5, line 8)	ninus iine 2)		3, 231, 032 13, 852	1
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		13, 032	1
. 00	Total adjusted visits (line 4 plus line 5)			13, 852	
. 00	Adjusted cost per visit (line 3 divided by line 6)			233. 25	7.
			Cal cul ati on	of Limit (1)	
			Rate Period	Rate Period 1	
			N/A	(01/01/2023	
				through	
			1.00	12/31/2023)	
3. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20) 6 or your contractor)	1.00	2. 00 305. 57	8.0
. 00	Rate for Program covered visits (see instructions)	or or your contractor,	0.00	233. 25	1
	CALCULATION OF SETTLEMENT				
0. 00	Program covered visits excluding mental health services (from		0	4, 706	1
1.00	Program cost excluding costs for mental health services (line		0	1, 097, 675	1
2. 00 3. 00	Program covered visits for mental health services (from contr Program covered cost from mental health services (line 9 x li	,	0	0	1
4. 00	Limit adjustment for mental health services (see instructions	•	0	0	1
5.00	Graduate Medical Education Pass Through Cost (see instruction				15.
6. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	1, 097, 675	1
6. 01	Total program charges (see instructions) (from contractor's re			852, 764	1
6. 02 6. 03	Total program preventive charges (see instructions)(from prov Total program preventive costs ((line 16.02/line 16.01) times			30, 001 38, 617	1
6. 04	Total Program non-preventive costs ((Tine 10.02/Tine 10.07) times	•		814, 946	1
	(Titles V and XIX see instructions.)			2,	
6. 05	Total program cost (see instructions)		0	853, 563	1
7.00	Primary payer amounts	(6		0	1
8. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		40, 376	18.0
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		156, 478	19. (
	records)				
20.00	Net program cost excluding injections/infusions (see instruct	,		853, 563	1
1.00	Program cost of vaccines and their administration (from Wkst. Total program IOP OPPS payments (see instructions)	M-4, TTHE 16)		12, 218	21. 21.
1. 55	Total program IOP Costs (see instructions)				21.
1. 60	Program IOP deductible and coinsurance (see instructions)				21.
2. 00	Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21.60)		865, 781	1
3.00				0	1
4.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	rusti ons)		0	1
5. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	i uctions)		0	
5. 50	Pioneer ACO demonstration payment adjustment (see instruction	ıs)		0	1
5. 99	Demonstration payment adjustment amount before sequestration			0	25.
6.00	Net reimbursable amount (see instructions)			865, 781	
26. 01	Sequestration adjustment (see instructions)			17, 316	1
6. 02	Demonstration payment adjustment amount after sequestration Interim payments			0 597, 488	
8. 00	Tentative settlement (for contractor use only)			0	1
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		250, 977	
29.00		ince with CMS Pub. 15-II	1	0	30.

	Financial Systems ADAMS MEMORIAL I ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC FS		Peri od: From 01/01/2023	u of Form CMS-2 Worksheet M-3	
SERVIC	ES	Component CCN: 15-8536	To 12/31/2023	Date/Time Pre 5/29/2024 8:4	
		Title XVIII	RHC I I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			2, 278, 773	
2. 00 3. 00	Cost of injections/infusions and their administration (from W Total allowable cost excluding injections/infusions (line 1 m			94, 884 2, 183, 889	
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)	11103 11110 2)		9, 095	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.00
6. 00 7. 00	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)			9, 095 240. 12	6. 00 7. 00
7.00	najusted cost per visit (i'ile 3 divided by i'ile 0)		Cal cul ati on		7.00
			Rate Period N/A	Rate Period 1 (01/01/2023	
			IV/ A	through	
				12/31/2023)	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	6 or your contractor)	1. 00	2. 00 369. 33	8.00
9. 00	Rate for Program covered visits (see instructions)	. o or your contractor)	0.00		
	CALCULATION OF SETTLEMENT				
10. 00 11. 00	Program covered visits excluding mental health services (from		0		
12.00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr	•	0	318, 639 0	11. 00 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 16. 00	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	318, 639	15. 00 16. 00
16. 01	Total program charges (see instructions) (from contractor's re	,		305, 699	
16. 02	Total program preventive charges (see instructions)(from prov	•		7, 219	
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0			7, 525 219, 606	
10. 04	(Titles V and XIX see instructions.)	3 and 10) trilles . 00)		219,000	10.04
16. 05	Total program cost (see instructions)		0		
17. 00 18. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0	17. 00 18. 00
16.00	records)	(Troili contractor		36, 606	18.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		52, 336	19. 00
20. 00	Net program cost excluding injections/infusions (see instruct	*		227, 131	
21. 00 21. 50	Program cost of vaccines and their administration (from Wkst. Total program IOP OPPS payments (see instructions)	M-4, line 16)		11, 971	21. 00 21. 50
21. 55	Total program IOP Costs (see instructions)				21.55
21. 60	Program IOP deductible and coinsurance (see instructions)				21. 60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21.60)		239, 102	
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)		0	
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
25. 50 25. 99	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	S)		0	
26. 00	Net reimbursable amount (see instructions)			239, 102	
26. 01	Sequestration adjustment (see instructions)			4, 782	26. 01
26. 02	Demonstration payment adjustment amount after sequestration Interim payments			0 161 560	26.02
27. 00 28. 00	Tentative settlement (for contractor use only)			161, 569 0	27. 00 28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		72, 751	
30.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-II,		0	30.00

<u> </u>	L HOSPI TAL		u of Form CMS-2	
ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQI	HC Provider CCN: 15-1330	Peri od:	Worksheet M-3	
ERVI CES	Component CCN: 15-8537	From 01/01/2023 To 12/31/2023	Date/Time Pre	pared
	·		5/29/2024 8: 4	
	Title XVIII	RHC III	Cost	
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (f			2, 213, 284	1
.00 Cost of injections/infusions and their administration (from			292	
.00 Total allowable cost excluding injections/infusions (line 1	minus line 2)		2, 212, 992	1
.00 Total Visits (from Wkst. M-2, column 5, line 8) .00 Physicians visits under agreement (from Wkst. M-2, column 5	Line ()		11, 111 0	4. 5.
.00 Total adjusted visits (line 4 plus line 5)	5, TTHE 7)		11, 111	6.
.00 Adjusted cost per visit (line 3 divided by line 6)			199. 17	
		Cal cul ati on	of Limit (1)	
		Rate Period	Rate Period 1	
		N/A	(01/01/2023	
		.,,,,	through	
			12/31/2023)	
		1. 00	2. 00	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §	320.6 or your contractor)	0.00	182. 23	
.00 Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		0.00	182. 23	9.
0.00 Program covered visits excluding mental health services (fr	rom contractor records)	0	692	10.
1.00 Program cost excluding costs for mental health services (li		0	126, 103	
2.00 Program covered visits for mental health services (from cor	ntractor records)	0	0	12.
3.00 Program covered cost from mental health services (line 9 x	,	0	0	
4.00 Limit adjustment for mental health services (see instruction	•	0	0	
5.00 Graduate Medical Education Pass Through Cost (see instructi		0	10/ 102	15.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1,6.01 Total program charges (see instructions)(from contractor's		U	126, 103 104, 779	1
6.02 Total program preventive charges (see instructions)(from pr			5, 960	1
6.03 Total program preventive costs ((line 16.02/line 16.01) time			7, 173	
6.04 Total Program non-preventive costs ((line 16 minus lines 16	•		84, 366	
(Titles V and XIX see instructions.)				
6.05 Total program cost (see instructions)		0	91, 539	
7.00 Primary payer amounts	oo) (from contractor		12 472	1
8.00 Less: Beneficiary deductible for RHC only (see instruction records)	is) (from contractor		13, 472	18.
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruct	ions) (from contractor		17, 069	19.
records)				
0.00 Net program cost excluding injections/infusions (see instru	,		91, 539	
1.00 Program cost of vaccines and their administration (from Wks	st. M-4, line 16)		0	21.
1.50 Total program IOP OPPS payments (see instructions) 1.55 Total program IOP Costs (see instructions)				21.
1.60 Program IOP deductible and coinsurance (see instructions)				21.
2.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50), minus line 21.60)		91, 539	
3.00 Allowable bad debts (see instructions)	•		0	23.
3.01 Adjusted reimbursable bad debts (see instructions)			0	23.
4.00 Allowable bad debts for dual eligible beneficiaries (see in	nstructi ons)		0	
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	>		0	1
5.50 Pioneer ACO demonstration payment adjustment (see instructi 5.99 Demonstration payment adjustment amount before sequestration	,		0	
5.99 Demonstration payment adjustment amount before sequestration6.00 Net reimbursable amount (see instructions)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		91, 539	
6.01 Sequestration adjustment (see instructions)			1, 831	1
6.02 Demonstration payment adjustment amount after sequestration	1		0	
7.00 Interim payments			72, 350	27.
8.00 Tentative settlement (for contractor use only)			0	
9.00 Balance due component/program (line 26 minus lines 26.01, 2	· · · · · · · · · · · · · · · · · · ·		17, 358	
0.00 Protested amounts (nonallowable cost report items) in accor	dance with CMS Pub 15-11	1	0	30.

	Financial Systems ADAMS MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC FS		Peri od: From 01/01/2023	u of Form CMS-2 Worksheet M-3	
SERVIC	ES	Component CCN: 15-8559	To 12/31/2023	Date/Time Pre 5/29/2024 8:4	
		Title XVIII	RHC I V	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			2, 444, 872	1.00
2. 00 3. 00	Cost of injections/infusions and their administration (from W Total allowable cost excluding injections/infusions (line 1 m			94, 732 2, 350, 140	•
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)	irius Triic 2)		8, 539	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.00
6. 00 7. 00	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)			8, 539 275. 22	6. 00 7. 00
7.00	Adjusted cost per visit (iiile 3 divided by iiile 0)		Cal cul ati on		7.00
			Rate Period N/A	Rate Period 1	
			IN/ A	(01/01/2023 through	
				12/31/2023)	
0.00	Denoticit remark limit (from CNC Dub. 100 04 shorter 0. 600	. /	1.00	2. 00	0.00
8. 00 9. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 Rate for Program covered visits (see instructions)	. 6 or your contractor)	0. 00 0. 00		•
,, 00	CALCULATION OF SETTLEMENT		0.00	270.22	,,,,,
10.00	Program covered visits excluding mental health services (from		0		10.00
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr	•	0	327, 787 0	11. 00 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 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	327, 787	15. 00 16. 00
16. 00 16. 01	Total program charges (see instructions)(from contractor's re	,	0	237, 787	ı
16. 02	Total program preventive charges (see instructions) (from prov	•		23, 332	
16.03	Total program preventive costs ((line 16.02/line 16.01) times			32, 143	1
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	3 and 18) times .80)		213, 379	16. 04
16. 05	Total program cost (see instructions)		0	245, 522	16. 05
17. 00	Primary payer amounts			0	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		28, 920	18.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		37, 137	19. 00
20. 00	records) Net program cost excluding injections/infusions (see instruct	i ons)		245, 522	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	*		6, 540	
21.50	Total program IOP OPPS payments (see instructions)				21.50
21. 55	Total program IOP Costs (see instructions) Program IOP deductible and coinsurance (see instructions)				21. 55 21. 60
22. 00	Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21.60)		252, 062	1
23. 00				0	
23. 01	Adjusted reimbursable bad debts (see instructions)	ruoti ana)		0	
24. 00 25. 00	Allowable bad debts for dual eligible beneficiaries (see inst OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	24. 00 25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	25. 50
25. 99	Demonstration payment adjustment amount before sequestration			0	
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			252, 062 5, 041	26. 00 26. 01
26. 02	Demonstration payment adjustment amount after sequestration			0	26. 02
27. 00	Interim payments			99, 490	27.00
28.00	Tentative settlement (for contractor use only)	00 07 and 00\		0	28.00
		· · · · · · · · · · · · · · · · · · ·			29. 00 30. 00
29. 00 30. 00	Balance due component/program (line 26 minus lines 26.01, 26. Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	· · · · · · · · · · · · · · · · · · ·	,	147, 531 0	

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 01/01/2023	Worksheet M-3	
ERVI CES	Component CCN: 15-8555	To 12/31/2023	Date/Time Pre	pared
			5/29/2024 8: 4	9 am
	Title XVIII	RHC V	Cost	
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro			1, 745, 654	1. (
.00 Cost of injections/infusions and their administration (from W			70, 660	•
.00 Total allowable cost excluding injections/infusions (line 1 m .00 Total Visits (from Wkst. M-2, column 5, line 8)	ninus line 2)		1, 674, 994	3.
.00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		7, 764 0	4. 5.
.00 Total adjusted visits (line 4 plus line 5)	11116 7)		7, 764	6.
.00 Adjusted cost per visit (line 3 divided by line 6)			215. 74	7.
		Cal cul ati on	of Limit (1)	
		Rate Period	Rate Period 1	
		N/A	(01/01/2023	
			through	
		1. 00	12/31/2023) 2. 00	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20), 6 or vour contractor)	0.00	197. 72	8.
.00 Rate for Program covered visits (see instructions)		0.00		
CALCULATION OF SETTLEMENT				
0.00 Program covered visits excluding mental health services (from		0	1, 900	•
1.00 Program cost excluding costs for mental health services (line 2.00 Program covered visits for mental health services (from contr		0	375, 668 0	11. 12.
3.00 Program covered cost from mental health services (line 9 x li	•	0	0	13.
4.00 Limit adjustment for mental health services (see instructions		o	0	14.
5.00 Graduate Medical Education Pass Through Cost (see instruction	is)			15.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	375, 668	1
6.01 Total program charges (see instructions)(from contractor's re			331, 490	
6.02 Total program preventive charges (see instructions)(from prov 6.03 Total program preventive costs ((line 16.02/line 16.01) times			3, 810 4, 318	
6.04 Total Program non-preventive costs ((Time 10.02/Time 10.07) times	•		258, 510	
(Titles V and XIX see instructions.)			200, 0.10	
6.05 Total program cost (see instructions)		0	262, 828	16.
7.00 Primary payer amounts			0	17.
8.00 Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		48, 213	18.
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		55, 696	19. (
records)	, (55, 515	
0.00 Net program cost excluding injections/infusions (see instruct	,		262, 828	•
1.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		18, 270	1
1.50 Total program IOP OPPS payments (see instructions) 1.55 Total program IOP Costs (see instructions)				21.
1.60 Program IOP deductible and coinsurance (see instructions)				21.
2.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21.60)		281, 098	
3.00 Allowable bad debts (see instructions)	•		0	
3.01 Adjusted reimbursable bad debts (see instructions)			0	
4.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 5.50 Pioneer ACO demonstration payment adjustment (see instruction)	ne)		0	25. 25.
5.99 Demonstration payment adjustment amount before sequestration	15)		0	25.
6.00 Net reimbursable amount (see instructions)			281, 098	
6.01 Sequestration adjustment (see instructions)			5, 622	
6.02 Demonstration payment adjustment amount after sequestration			0	•
7.00 Interim payments			260, 654	
8.00 Tentative settlement (for contractor use only) 9.00 Balance due component/program (line 26 minus lines 26.01, 26.	02 27 and 201		0 14, 822	28.
9.00 Barance due component/program (Tine 26 minus Tines 26.01, 26. 0.00 Protested amounts (nonallowable cost report items) in accorda	•		14, 822	1
1. 11 1. 1113 tod dimeditto (nonditionable dost report realis) in decorde		'	0	١ ٥٠.

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC	CN: 15-1330	Peri od: From 01/01/2023	Worksheet M-4	
		Component (CCN: 15-8526	To 12/31/2023	Date/Time Pre 5/29/2024 8:4	
		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	
. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health	2, 178, 506 0, 001380	2, 178, 50 0, 0058	· · ·	2, 178, 506 0, 000000	
00	care staff time	0.001000	0.0000	0.00000	0.000000	2.0
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	3, 006	12, 73	0	0	3.00
1. 00	Injections/infusions and related medical supplies costs (from your records)	25, 516	10, 9	12 0	0	4.00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	28, 522	23, 64	45 0	0	5.00
. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2, 411, 755	2, 411, 75		2, 411, 755	6.0
. 00	Total overhead (from Wkst. M-2, line 19)	890, 711	890, 7	11 890, 711	890, 711	7.0
3. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 011826	0. 00980		0. 000000	8.0
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	10, 534	8, 73	33 0	0	9.0
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	39, 056	32, 3	78 0	0	10.0
1.00	Total number of injections/infusions (from your records)	138	70	09	0	11.0
2.00	Cost per injection/infusion (line 10/line 11)	283. 01	45. 6	67 0.00	0.00	12.0
3. 00	Number of injection/infusion administered to Program beneficiaries	23	12	25 0	0	13.0
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.0
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, 509	5, 70	0	0	14.00
					COST OF	
					INJECTIONS /	
					I NFUSI ONS AND	
					ADMI NI STRATI O	
				1. 00	N 2. 00	
5 00	Total cost of injections/infusions and their administratio	n costs (sum of	columns 1	1.00	71, 434	15. 0
5.00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	•	COLUMNIS 1,		/1,434	13.0
6. 00	Total Program cost of injections/infusions and their admin		s (sum of		12, 218	16.0
	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou				, =	

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC		Peri od: From 01/01/2023	Worksheet M-4	
		Component (To 12/31/2023	Date/Time Pre 5/29/2024 8:4	
		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, 402, 442 0. 003628	1, 402, 44 0. 01019		1, 402, 442 0. 000000	
3. 00	care staff time Injection/infusion health care staff cost (line 1 x line 2)	5, 088	14, 30	1 0	0	3.00
1. 00	Injections/infusions and related medical supplies costs (from your records)	39, 690	9, 12	6 0	0	4.00
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)	44, 778 1, 638, 053	23, 42 1, 638, 05		0 1, 638, 053	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)	640, 720 0. 027336	640, 72 0. 01430	·	640, 720 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)	17, 515 62, 293	9, 16 32, 59		0	
1.00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11)	211 295. 23	59 54. 9			11. 00 12. 00
3. 00	Number of injection/infusion administered to Program beneficiaries	21	10		0	1
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 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, 200	5, 77	1 0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		columns 1,		94, 884	15.00
16. 00	Total Program cost of injections/infusions and their admin		s (sum of		11, 971	16.0

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC		Period: From 01/01/2023	Worksheet M-4	
		Component (CCN: 15-8537	To 12/31/2023	Date/Time Pre 5/29/2024 8:4	
			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, 076, 245 0. 000000	1, 076, 24 0. 00008			1. 00 2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	0	9	5 0	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	0	6.	2 0	0	4.00
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, 190, 171	15 1, 190, 17		0 1, 190, 171	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)	1, 023, 113 0. 000000	1, 023, 11 0. 00013	· · · · ·		7. 00 8. 00
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	13 29.		0	
11. 00 12. 00 13. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	0 0.00 0	73. 0	0 0 0 0 0		11. 00 12. 00 13. 00
13. 01	beneficiaries 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)	0	•	0	0	14.00
					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)			292	15.00
16.00	Total Program cost of injections/infusions and their admin	istration costs nt to Wkst. M-3	s (sum of		0	16.0

OMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC	CN: 15-1330	Peri od: From 01/01/2023	Worksheet M-4	
		Component C		To 12/31/2023	Date/Time Pre 5/29/2024 8:4	
		Title		RHC IV	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	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health	1, 452, 425 0. 003460	1, 452, 42 0. 0126		1, 452, 425 0. 000000	
3. 00	care staff time Injection/infusion health care staff cost (line 1 x line 2)	5, 025	18, 3	67 0	0	3.0
. 00	Injections/infusions and related medical supplies costs (from your records)	34, 689	9, 6		0	4.00
. 00	Direct cost of injections/infusions (line 3 plus line 4)	39, 714	27, 98		0	5.0
. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 747, 223	1, 747, 2			
. 00	Total overhead (from Wkst. M-2, line 19)	697, 649	697, 6			
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 022730	0. 0160			
. 00	Overhead cost - injection/infusion (line 7 x line 8)	15, 858	11, 1		0	1
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	55, 572	39, 10		0	
1.00	Total number of injections/infusions (from your records)	171		25 0	0	1
2. 00	Cost per injection/infusion (line 10/line 11)	324. 98	62.			12.0
3.00	Number of injection/infusion administered to Program beneficiaries	2	•	94 0	0	
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees	(50		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)	650	5, 89	90 0	0	14.0
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI O	
				1. 00	N 2. 00	
5 00	Total cost of injections/infusions and their administration	n costs (sum of	columns 1	1.00	2. 00 94, 732	15. C
5.00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		COLUMNIS I,		74, /32	15.0
6 00	Total Program cost of injections/infusions and their admin		s (sum of		6, 540	16 (
00	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount				5,010	

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC	CN: 15-1330	Peri od: From 01/01/2023	Worksheet M-4	
		Component (CCN: 15-8555	To 12/31/2023	Date/Time Pre 5/29/2024 8:4	
		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	
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, 028, 823 0. 001518	1, 028, 82 0. 02452	· · ·	1, 028, 823 0. 000000	
3. 00	lnjection/infusion health care staff cost (line 1 x line 2)	1, 562	25, 23	31 0	0	3. 0
4. 00	Injections/infusions and related medical supplies costs (from your records)	9, 232	12, 43	35 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)	10, 794 1, 197, 208	37, 66 1, 197, 20		0 1, 197, 208	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)	548, 446 0. 009016	548, 44 0. 0314 <i>6</i>	·	548, 446 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)	4, 945 15, 739	17, 25 54, 92		0	
11. 00 12. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11)	50 314. 78	80 67. 9	08 97 0. 00	0 0. 00	12.0
13.00	Number of injection/infusion administered to Program beneficiaries	6	24	41 0	0	
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees Program cost of injections/infusions and their	1 000	17.00	0		13.0
14. 00	administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1, 889	16, 38	51 0	O	14.0
					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.	•	col umns 1,		70, 660	15.00
14 00	Total Program cost of injections/infusions and their admin		cum of		18, 270	16 0

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 BENEFICIARII		Provider CC Component (From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 8:49 am
				_

		Component CCN: 15-8526	10 12/31/2023	5/29/2024 8: 49	
			RHC I	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			597, 488	1. 0
. 00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero	period. If none, write		0	2.0
00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1) Program to Provider				3. (
01	1 rogi alii to 1 rovi dei			0	3. (
02					3. 0
03					3. (
04					3.
05				0	3.
US	Dravi dan ta Dragnam			U	3.
50	Provider to Program			0	3.
51					3.
51 52					
				0	3.
53				0	3.
54		00)		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 27)	rer to worksheet M-3, line	9	597, 488	4.
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des each payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date o	of		5.
	Program to Provider				
01				0	5.
02				0	5.
03				0	5.
	Provider to Program				
50				0	5.
51				0	5.
52				0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5.
00	Determined net settlement amount (balance due) based on the	cost report. (1)			6.
01	SETTLEMENT TO PROVIDER	•		250, 977	6.
02	SETTLEMENT TO PROGRAM			0	6.
	Total Medicare program liability (see instructions)			848, 465	7.
UU			Contractor	NPR Date	
00			Contractor	INFR Date 1	
00			Number		
. 00		0		(Mo/Day/Yr) 2.00	

Health Financial Systems	ADAMS MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 15-1330 Component CCN: 15-8536	Period: From 01/01/2023 To 12/31/2023	
				_

		Component Con. 13-8330	10 12/31/2023	5/29/2024 8: 4	
			RHC II	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			161, 569	1.
00	Interim payments payable on individual bills, either submit	tted 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	t based on subsequent			3
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
)1				0	3
)2				0	3
3				0	3
)4				0	3
5				0	3
	Provider to Program				
0				0	3
1				0	3
2				0	3
3				0	3
4				0	3
9	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		161, 569	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	sk review. Also show date o	of		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				_
0				0	5
1				0	5
2		00)		0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5
0	Determined net settlement amount (balance due) based on the	e cost report. (I)		70 754	6
1	SETTLEMENT TO PROPERTY			72, 751	6
2	SETTLEMENT TO PROGRAM			0	6
0	Total Medicare program liability (see instructions)			234, 320	7
			Contractor	NPR Date	
		0	Number	(Mo/Day/Yr)	
20	No. 10 Construction	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 RHC/FQHI SERVICES RENDERED TO PROGRAM BENEFICIARIES	C PROVIDER FOR	Provi der CCN: 15-1330 Component CCN: 15-8537	Peri od: From 01/01/2023 To 12/31/2023	

				5/29/2024 8: 4	9 am
			RHC III	Cost	
	<u> </u>		Par	t B	
			mm/dd/yyyy	Amount	
			1, 00	2, 00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			72, 350	1.00
2.00	Interim payments payable on individual bills, either submit	tted or to be submitted to		0	2.00
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount	t based on subsequent			3.00
0.00	revision of the interim rate for the cost reporting period.				0.00
	payment. If none, write "NONE" or enter a zero. (1)	7.1. 35 3.131 data 31 3da.1			
	Program to Provider				
3. 01	1 Togram to 11 ovi dei			0	3. 01
3. 02				0	
3. 02					3.03
3. 04					
3. 04					
3.05	Dravi dan ta Dragnam			0	3.05
2 50	Provider to Program				2 50
3.50				0	
3. 51				0	3. 51
3. 52				0	
3. 53				0	3. 53
3. 54				0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		72, 350	4. 00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5. 01				0	5. 01
5.02				0	5. 02
5.03				0	5. 03
	Provider to Program				
5.50				0	5. 50
5. 51				0	5. 51
5. 52				0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5. 99
6.00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6.00
6. 01	SETTLEMENT TO PROVIDER			17, 358	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)			89, 708	ı
	(222 :::23 35 (210))		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
8. 00	Name of Contractor	-			8.00
5. 55	1		1	1	1 0.00

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: 15-8559	From 01/01/2023	

		Component Con. 13-8339	10 12/31/2023	5/29/2024 8: 49	
			RHC IV	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			99, 490	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 p	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
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 3.50-3.49			0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line	•	99, 490	4
	27)				
00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desl	k savi aw Alaa ahaw data s	.e		5
00	each payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date c)1		כ
	Program to Provider				
01	11 ogram to 11 ovrder			0	5
02				0	5
03					5
	Provider to Program				
50	<u> </u>			0	5
51				0	5
52				0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.49	98)		0	5
00	Determined net settlement amount (balance due) based on the	cost report. (1)			6
01	SETTLEMENT TO PROVIDER	•		147, 531	6
)2	SETTLEMENT TO PROGRAM			0	6
00	Total Medicare program liability (see instructions)			247, 021	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1, 00	2.00	

Health Financial Systems	ADAMS MEMORIAL I	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA		Provi der CCN: 15-1330 Component CCN: 15-8555	Peri od: From 01/01/2023 To 12/31/2023	
				_

				5/29/2024 8: 4	9 am
			RHC V	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			260, 654	1. C
2. 00	Interim payments payable on individual bills, either submit	ted or to be submitted to		l ol	2.0
	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.				
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		•	•	
. 01				0	3. (
3. 02				l ol	3. (
3. 03				l ol	3. (
3. 04				0	3. (
3. 05					3. (
. 05	Provider to Program				J. 1
. 50	11 ovi dei 10 ogi dili			0	3.
. 51					3.
. 52					3.
. 52 . 53					3.
. 53 . 54					3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	00)			3.
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			260, 654	3. 4.
. 00	27)	ster to worksheet w-s, title		200, 034	4.
	TO BE COMPLETED BY CONTRACTOR				
. 00	List separately each tentative settlement payment after des	sk review Also show date o	F		5. (
. 00	each payment. If none, write "NONE" or enter a zero. (1)				5.
	Program to Provider				
. 01	11 ogi alli to 11 ovi dei			0	5.
. 02					5.
. 02					5.
. 03	Provider to Program			0	٥.
. 50	Trovider to frogram			I 0	5.
. 51					5.
. 52					5.
. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	00)			5. 5.
	Determined net settlement amount (balance due) based on the cost report. (1)			١	5. 6.
. 00	SETTLEMENT TO PROVIDER			14 000	
. 01	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			14, 822	6.
. 02				0	6.
. 00	Total Medicare program liability (see instructions)		0	275, 476	7.
			Contractor	NPR Date	
		0	Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
3. 00	Name of Contractor			1	8. (