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: 14-0160 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/30/2024 4: 39 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/30/2024 4:39 pm use only] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da 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 FHN MEMORIAL HOSPITAL (14-0160) 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	SI GNATURE STATEMENT	
1	Mich	ael C Clark	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	Michael C Clark			2
3	Signatory Title	EVP AND CFO			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-16, 733	-65, 200	0	0	1. 00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
200.00	TOTAL	0	-16, 733	-65, 200	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA

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

FHN MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-0160 Peri od: Worksheet S-2 From 01/01/2023 To 12/31/2023 Part I Date/Time Prepared: 5/30/2024 4:39 pm 4. 00 3.00 Hospital and Hospital Health Care Complex Address:
Street: 1405 WEST STEPHENSON STREET PO Bo.
City: FREEPORT State 1.00 PO Box: 1.00 2.00 State: IL Zip Code: 64032 County: STEPHENSON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

V XVIII XIX Number Number Certi fied Type 6.00 7.00 8.00 1.00 2.00 3.00 4.00 5.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal FHN MEMORIAL HOSPITAL 99914 140160 07/01/1966 0 3.00 Subprovi der - IPF 4.00 4.00

4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Hospital-Based OLTC Hospital-Based HHA Separately Certified ASC Hospital-Based Hospice Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC)	FHN MEMORIAL - HOSPICE	141560	999	14	08/12/1993		4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
						From: 1.00	To: 2. 00	_
20. 00	Cost Reporting Period (mm/dd/yyyy)					01/01/202		20. 00
21. 00	Type of Control (see instructions)					2		21. 00
					1. 00	2. 00	3.00	
22.00	Inpatient PPS Information					N.		22.00
22. 00	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo	stment, in accordance wi or yes or "N" for no. Is 412.106(c)(2)(Pickle ame or yes or "N" for no.	th 42 CFF this endment	2	Y	N		22.00
22. 01	Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or cost reporting period occurring on c instructions)	column 1, "Y" for yes on the column securing prior or the port or the port."	or "N" for to Octob	no er	Y	Y		22. 01
22. 02	Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in for the portion of the cost reportin	? (see instructions) Ent be portion of the cost re column 2, "Y" for yes or	er in col porting "N" for		N	N		22.02
22. 03	Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in cofor the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	ic reclassification from ds for delineating stati column 1, "Y" for yes or ug period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49	n urban to stical ar "N" for r er 1. Ente ne cost ructions) 19 beds (2	reas io er	N	N	N	22. 03
22. 04	Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49	stical are "N" for er 1. Ente ne cost ructions) 19 beds (a	eas no er				22.04
23. 00	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, ente	of admission, 2 if censu of identifying the days method used in the prior	is days, c in this c cost	r 3		1 N		23. 00

Health Financial Systems FHN MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0160 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 4: 39 pm 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion 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. Y/N IMF Direct GME IME Direct GME 1. 00 2. 00 3. 00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA 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 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) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 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 Code Unweighted IME Unweighted Program Name 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 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 63.00

Health Financial Systems	FHN M	EMORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provider CC		eriod: fom 01/01/2023 0 12/31/2023	Worksheet S-2 Part I Date/Time Prep 5/30/2024 4:39	
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2.00	3.00	
Section 5504 of the ACA Base Year period that begins on or after J			This base year	is your cost r	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	ry trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0. 00	0. 000000	64.00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	55	2.00	0.00	0.00		65. 00
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Settings	sEffective fo	r cost reporti	ng periods	
66.00 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 (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. Ty care resident B the ratio of	0.00	0. 00	0. 000000	66. 00
(Cost anni)	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
67 00 Enter in column 1 the program	1. 00	2.00	3. 00	4. 00	5. 00 0. 000000	67.00
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	G. 000000	67.00

Health Financial Systems FHN MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0160 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 4:39 pm 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 (August 10, 2022)? 68.00 68.00 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 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.

76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 75.00 76.00 0 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 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 85.00 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 Ν 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Adjustment Permanent (Y/N) Adjustments 1.00 2.00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target Ν 0 88.00 amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments. Wkst. A Line Effective Date Approved No. Permanent Adjustment Amount Per Di scharge 1.00 2.00 3.00 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0.00 0 89.00 on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per di scharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. XI X 1 00 2 00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for N 90.00 Υ yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in 91.00 91.00 Ν N full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92.00 Ν 92.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 93.00 Ν Ν Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν 94.00 94.00 Ν applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 95.00 0.00 0.00 95.00 96.00 Ν Ν 96.00 applicable column. 97.00 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00

117. 00

118. 00

117.00 is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

118.00|s the mal practice insurance a claims-made or occurrence policy? Enter 1

if the policy is claim-made. Enter 2 if the policy is occurrence.

Health Financial Systems	FHN MEMORIAL	HOSPI TAL	In Lie	eu of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE	COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0160	Peri od:	Worksheet S	
			From 01/01/2023 To 12/31/2023		repared:
		Diagrami comp		5/30/2024 4	: 39 pm
		Premi ums	Losses	Insurance	
		1.00	2.00	2.00	
118.01 List amounts of malpractice	e premiums and paid Losses:	1.00	2.00	3.00	78 118. 01
	promoting and part of the promoting and the prom				
110 02 Are mal proeti ce premiume er	ad poid league paparted in a cost	contag ather than the	1. 00 N	2.00	110.00
	nd paid losses reported in a cost o ? If yes, submit supporting schedu		IN		118. 02
and amounts contained there	3	g			
119. 00 DO NOT USE THIS LINE				Υ	119.00
	qualifies for the Outpatient Hold ments? (see instructions) Enter in			Y	120. 00
"N" for no. Is this a rural	hospital with < 100 beds that qua	alifies for the Outpatien			
	ACA §3121 and applicable amendment	ts? (see instructions)			
Enter in column 2, "Y" for 121.00 Did this facility incur and	yes or in formo. Direport costs for high cost implar	ntable devices charged to	N		121. 00
patients? Enter "Y" for yes	s or "N" for no.	Ü			
	n healthcare related taxes as defi				122. 00
	N" for no in column 1. If column 1 where these taxes are included.	is i, enter in corumn	2		
123.00 Did the facility and/or its	s subproviders (if applicable) purc		Y	N	123. 00
	ounting, tax preparation, bookkeepi				
for yes or "N" for no.	ces, from an unrelated organization	on? In corumn i, enter Y			
If column 1 is "Y", were th	ne majority of the expenses, i.e.,	3	ı		
	nses, for services purchased from u				
"N" for no.	of the main hospital CBSA? In colum	iii 2, eiitei 1 Toi yes o	"		
Certified Transplant Center					
	a Medicare-certified transplant ce		N		125. 00
	ter certification date(s) (mm/dd/yy fied kidney transplant program, er		te		126. 00
in column 1 and termination	n date, if applicable, in column 2.				
	fied heart transplant program, ent n date, if applicable, in column 2.		е		127. 00
	fied liver transplant program, en		e		128. 00
in column 1 and termination	n date, if applicable, in column 2.				
	fied lung transplant program, ente n date, if applicable, in column 2.				129. 00
	fied pancreas transplant program,				130. 00
	nation date, if applicable, in colu				
	fied intestinal transplant program nation date, if applicable, in colu		in		131. 00
	fied islet transplant program, ent		е		132. 00
	n date, if applicable, in column 2.				100.00
133.00 Removed and reserved	d organ procurement organization ((OPO) enter the OPO numbe	r		133. 00 134. 00
in column 1 and termination	n date, if applicable, in column 2.		•		
All Providers	nization or home office	ofined in CMC Dub 15 1	Y		140.00
	nization or home office costs as de yes or "N" for no in column 1. If y				140. 00
are claimed, enter in colum	nn 2 the home office chain number.	(see instructions)			
1.00	2.00 f a chain organization, enter on li		3.00	of the	
,	nome office contractor name and co	<u> </u>	maille and address	or the	
141.00 Name:	Contractor's Name:		tor's Number:		141. 00
142.00 Street: 143.00 City:	PO Box: State:	Zip Cod	0.		142. 00 143. 00
143. 00 C1 ty.	State.	Z1 μ cou	е		143.00
				1.00	
144.00 Are provider based physicia	ans' costs included in Worksheet A?	?		Y	144. 00
			1. 00	2.00	
	s are claimed on Wkst. A, line 74,		Y	N	145. 00
	nter "Y" for yes or "N" for no in o				
period? Enter "Y" for yes	ity include Medicare utilization for "N" for no in column 2.	tor this cost reporting			
146.00 Has the cost allocation met	thodology changed from the previous		N		146. 00
	or no in column 1. (See CMS Pub. 15	5-2, chapter 40, §4020) I	f		
lyes, enter the approval dat	te (mm/dd/yyyy) in column 2.		I	I	I

Health Financial Systems	FHN ME	MORIAL	HOSPI TAL			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Ā	Provi der CC	CN: 14-0160		riod: om 01/01/2023 12/31/2023	Worksheet S- Part I Date/Time Pr 5/30/2024 4:	epared:
							1.00	\dashv
147.00 Was there a change in the statisti	cal basis? Enter "Y"	for ve	s or "N" for	no.			1.00 N	147. 00
148.00 Was there a change in the order of							N	148. 00
149.00 Was there a change to the simplifi					for no		N	149. 00
			Part A	Part	В	Title V	Title XIX	
			1. 00	2.00		3. 00	4. 00	
Does this facility contain a provi or charges? Enter "Y" for yes or '			nt for Part A	and Part		e 42 CFR §413	. 13)	
155. 00 Hospi tal			N	N N		N	N	155. 00
156.00 Subprovi der - IPF 157.00 Subprovi der - IRF			N	N N		N	N	156. 00
157. 00 Subprovider - TRF 158. 00 SUBPROVIDER			N	N N		N	N	157. 00 158. 00
159. 00 S0BPROVI DER 159. 00 SNF			N	l N	-	N	N	159. 00
160.00HOME HEALTH AGENCY			N	N N	1	N	N N	160. 00
161. OOICMHC			14	l N		N	N N	161. 00
- To the Composition of the Comp						·	1. 00	-
Multicampus								
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ımpus hospital that h	nas one	or more campu	uses in di			N	165. 00
	Name		County	State	Zip C		FTE/Campus	_
166.00 If line 165 is yes, for each	0		1. 00	2. 00	3. 0	0 4.00	5. 00	00 166. 00
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0. 0	100.00
							1.00	+
Health Information Technology (HI	(incentive in the A	Ameri car	Recovery and	d Reinvest	ment A	ict		
167.00 is this provider a meaningful user 168.00 if this provider is a CAH (line 10 reasonable cost incurred for the H	05 is "Y") and is a m	neani ngf	ul user (line			nter the	Y	167. 00 168. 00
168.01 If this provider is a CAH and is rexception under §413.70(a)(6)(ii)	not a meaningful user	, does	this provider			hardshi p	N	168. 01
169.00 If this provider is a meaningful utransition factor. (see instruction	•	') and i	s not a CAH ((line 105	is "N"), enter the	9. 9	99169.00
						Begi nni ng	Endi ng	
				.,		1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR Legeriod respectively (mm/dd/yyyy)	eginning date and en	nding da	te for the re	eporting				170. 00
						1. 00	2.00	-
171.00 If line 167 is "Y", does this prov	ider have any days f	or indi	viduals enrol	Led in		1. 00 N	2.00	0 171. 00
section 1876 Medicare cost plans in "Y" for yes and "N" for no in column 2. (s	reported on Wkst. S-3 umn 1. If column 1 is	3, Pt. I	, line 2, col	. 6? Ente		IV		0171.00

Health Financial Systems FHN MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-0160 Peri od: Worksheet S-2 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/30/2024 4:39 pm 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 1.00 N reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 2.00 Ν yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Υ 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 4 00 4 00 Α Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 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. Y/N Legal Oper. 1.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider Ν 6.00 the legal operator of the program? 7 00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N 7.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 Ν 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 Ν 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions. Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting 13.00 Ν 13.00 period? If yes, submit copy. 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 Ν 15.00 Part B Y/N Y/N Date Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? N N 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R Report for Υ 03/28/2024 03/28/2024 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 Ν Ν 18.00 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 Ν Ν 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

	Financial Systems FHN MEMORIAL AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 14-0160	Peri od:	u of Form CMS- Worksheet S-:	
				From 01/01/2023 To 12/31/2023	Part II Date/Time Pro	
		Descr	iption	Y/N	5/30/2024 4: Y/N	39 pili
			0	1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
	Nopor C data For Ctrist I Bossi Fac the Ctrist day detinority	Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	HOSPI TALS)		1. 00	
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, see		aala mada dur	ing the cost		22. 0
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sais illade dui	ing the cost		23. 0
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	d into during	this cost re	eporting period?		24. 00
5. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	rting period?	Plf yes, see		25. 0
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the		26. 00			
27. 00	instructions. Has the provider's capitalization policy changed during the	cost reportir	ng period? If	yes, submit		27. 00
00.00	copy. Interest Expense	* ! - *	-: +1			20.00
8. 00	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.		3			28. 0
9. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instru		ebt Service k	Reserve Fund)		29. 0
80. 00	Has existing debt been replaced prior to its scheduled matu instructions.	rity with new	debt? If yes	s, see		30.0
31. 00	Has debt been recalled before scheduled maturity without is instructions.	suance of new	debt? If yes	s, see		31.00
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser		ed through co	ontractual		32. 0
33. 00	arrangements with suppliers of services? If yes, see instru- If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If		33. 0
	Provi der-Based Physi ci ans					
4. 00	Were services furnished at the provider facility under an a	rrangement wi	th provider-b	based physicians?		34.0
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exists.	sting agreemer	nts with the	nrovi der-hased		35. 0
75. 00	physicians during the cost reporting period? If yes, see in:		its with the	provider based		33.0
				Y/N	Date	
	N 066: 0t-			1. 00	2. 00	
36 00	Home Office Costs Were home office costs claimed on the cost report?			Υ		36. 00
37. 00	If line 36 is yes, has a home office cost statement been pro-	epared by the	home office?			37. 00
	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home off				12/31/2023	38. 0
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe	of the home of	offi ce.			39.00
10. 00	see instructions. If line 36 is yes, did the provider render services to the		,	Y		40. 0
	instructions.	Tiome office.		·		10.00
		1.	00	2.	00	
	Cost Report Preparer Contact Information					
1. 00	held by the cost report preparer in columns 1, 2, and 3,	DAVI D		MCCLUNG		41.00
12. 00	. , , , , , , , , , , , , , , , , , , ,	RSM US LLP				42.00
13. 00	preparer. Enter the telephone number and email address of the cost	641-494-2144		DAVID MCCLUMCA	DSWIIS COM	43. 0
13.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	U41-474-2144		DAVI D. MCCLUNG@I	NOWIUS. COM	43.0

Heal th Fi	nancial Systems	FHN MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI TAL	AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 14-0160	Peri od: From 01/01/2023		
					To 12/31/2023	Date/Time Pre 5/30/2024 4:3	
				3. 00			
Cos	st Report Preparer Contact Information						
41. 00 En	iter the first name, last name and the t	itle/position	MANAGER				41. 00
he	eld by the cost report preparer in colum	nns 1, 2, and 3,					
re	especti vel y.						
42. 00 En	iter the employer/company name of the co	st report					42. 00
pr	reparer.						
43. 00 En	iter the telephone number and email addr	ress of the cost					43.00
re	port preparer in columns 1 and 2, respe	ecti vel y.					

Provider CCN: 14-0160

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | Part | | Part

						0 12/31/2023	5/30/2024 4:39	
	·						I/P Days / 0/P	<i>у</i> Ып
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH/REH Hours	Title V	
	Component	Li ne No.	INO.	or beas	Avai I abl e	OAII/ KEIT HOULS	11 11 6 7	
		1.00		2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA	1.00		2.00	0.00	1. 00	0.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		92	33, 580	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and	00.00		, -	00,000	0.00		
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						ol	5.00
6.00	Hospital Adults & Peds. Swing Bed NF						o	6. 00
7. 00	Total Adults and Peds. (exclude observation			92	33, 580	0.00		7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		8	2, 920	0.00	o	8.00
9.00	CORONARY CARE UNIT				·			9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					ol	13.00
14.00	Total (see instructions)			100	36, 500	0.00	ol	14.00
15.00	CAH vi si ts						ol	15.00
15. 10	REH hours and visits					0.00	o	15. 10
16.00	SUBPROVI DER - I PF							16.00
17.00	SUBPROVI DER - I RF							17.00
18.00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
22.00	HOME HEALTH AGENCY							22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPI CE	116. 00		0	C)		24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25.00
26.00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			100				27.00
28. 00	Observation Bed Days						0	28.00
29. 00	Ambul ance Tri ps							29.00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	C)		32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges							33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	()	0	34. 00

Provider CCN: 14-0160

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared:

				'	0 12/31/2023	5/30/2024 4: 3	
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents) piii
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA	0.00	7.00	0.00	7. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	3, 888	1, 851	12, 369			1.00
1.00	8 exclude Swing Bed, Observation Bed and	0,000	1,001	12,007			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	5, 018	0				2.00
3.00	HMO IPF Subprovider	0	o				3. 00
4.00	HMO IRF Subprovider	o	o				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	o	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		o	0			6, 00
7. 00	Total Adults and Peds. (exclude observation	3, 888	1, 851	12, 369			7. 00
	beds) (see instructions)	.,	.,	,			
8.00	INTENSIVE CARE UNIT	189	116	1, 286			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		364	508			13.00
14. 00	Total (see instructions)	4, 077	2, 331	14, 163		557. 38	1
15.00	CAH vi si ts	o	0	. 0			15. 00
15. 10	REH hours and visits	o	o	0			15. 10
16.00	SUBPROVI DER - I PF						16. 00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22.00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	o	O	0	0.00	23. 34	24. 00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	580. 72	27. 00
28. 00	Observation Bed Days		0	5, 611			28. 00
29.00	Ambul ance Trips	O					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)	О	0	167			32. 00
32. 01	Total ancillary labor & delivery room	1	آ ا	0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	o					33. 00
33. 01	LTCH site neutral days and discharges	O					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	o	0			34. 00

Provider CCN: 14-0160

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared:

					12/31/2023	5/30/2024 4: 3	
		Full Time Equivalents		Di sch	arges	, ., .,	
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12.00	13. 00	14.00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	920	562	3, 183	1. 00
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			1, 104	0		2. 00
3.00	HMO I PF Subprovi der				0		3. 00
4.00	HMO I RF Subprovi der				O		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8. 00	I NTENSI VE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		_				13. 00
14. 00	Total (see instructions)	0. 00	0	920	562	3, 183	•
15. 00	CAH visits						15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33. 00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care						34. 00

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 14-0160

					T	12/31/2023	Date/Time Pre 5/30/2024 4:3	
		Wkst. A Line	Amount	Reclassificati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries (from Wkst.	Sal ari es (col . 2 ± col .	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
		1 00	0.00	A-6)	3)	col . 4	, 00	
	PART II - WAGE DATA	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	SALARI ES							
1. 00	Total salaries (see instructions)	200. 00	44, 270, 721	0	44, 270, 721	1, 085, 108. 00	40. 80	1.00
2. 00	Non-physician anesthetist Part		C	0	0	0. 00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		C	0	0	0.00	0.00	3. 00
4.00	Physician-Part A -		C	0	0	0.00	0.00	4. 00
4. 01 5. 00	Administrative Physicians - Part A - Teaching Physician and Non		4, 124, 721	0 0		0. 00 22, 751. 00		
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		C	0	0	0.00	0.00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	C	0	0	0.00	0.00	7. 00
7. 01	Contracted interns and residents (in an approved programs)		C	0	0	0.00	0.00	7. 01
8. 00	Home office and/or related organization personnel		C	0	0	0.00	0. 00	8. 00
9.00	SNF	44. 00	C	0	0	0.00		
10. 00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		1, 328, 253	22, 667	1, 350, 920	39, 357. 00	34. 32	10. 00
11. 00	Contract Labor: Direct Patient		3, 640, 411	0	3, 640, 411	34, 600. 00	105. 21	11. 00
12. 00	Care Contract labor: Top level management and other management and administrative		C	0	0	0.00	0.00	12. 00
13. 00	services Contract Labor: Physician-Part		C	0	0	0.00	0. 00	13. 00
14. 00	A - Administrative Home office and/or related organization salaries and		C	0	0	0.00	0.00	14. 00
14. 01	wage-related costs Home office salaries		5, 800, 092	2 0	5, 800, 092	138, 393. 00	/1 01	14. 01
14. 02	Related organization salaries		3, 000, 072	o o	0,000,072	0.00		
15. 00	Home office: Physician Part A		C	0	0	0.00	0.00	15. 00
16. 00	- Administrative Home office and Contract		C	0	0	0.00	0.00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		C	0	0	0.00	0.00	16. 01
16. 02			C	0	0	0.00	0.00	16. 02
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		9, 755, 957	0	9, 755, 957			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		375, 333 C	0 0	375, 333 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		C	0	0			21. 00
22. 00	Physician Part A -		C	0	0			22. 00
22. 01	Administrative Physician Part A - Teaching		C	0	0			22. 01
23. 00 24. 00 25. 00	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		216, 963 0	0 0	216, 963 0 0			23. 00 24. 00 25. 00
25. 50	approved program) Home office wage-related		1, 909, 449	0	1, 909, 449			25. 50
25. 51	(core) Related organization		C	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A		C	0	0			25. 52
	- Administrative - wage-related (core)							

FHN MEMORIAL HOSPITAL

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 14-0160

					T	o 12/31/2023	Date/Time Prep 5/30/2024 4:39	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4	, i	
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00	Employee Benefits Department	4. 00	1, 983	l .	1, 983			26. 00
27. 00	Administrative & General	5. 00	2, 436, 997	-15, 057	2, 421, 940	87, 936. 00		
28. 00	Administrative & General under		0	0	0	0. 00	0. 00	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30.00	Operation of Plant	7. 00	389, 119	0	389, 119			
31. 00	Laundry & Linen Service	8. 00	0	0	0	0. 00		
32.00	Housekeepi ng	9. 00	0	0	0	0. 00		32. 00
33.00	Housekeeping under contract		396, 673	0	396, 673	25, 766. 00	15. 40	33. 00
	(see instructions)							
34. 00	Di etary	10. 00	0	0	0	0. 00	l .	34.00
35. 00	Dietary under contract (see		566, 125	0	566, 125	29, 264. 00	19. 35	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	0	0	0	0. 00		36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0. 00		37. 00
38. 00	Nursing Administration	13. 00	777, 584		777, 584	,		
39. 00	Central Services and Supply	14. 00	113, 096		113, 096	,		
40.00	Pharmacy	15. 00	1, 380, 896		1, 380, 896			
41. 00	Medical Records & Medical	16. 00	1, 213, 036	0	1, 213, 036	36, 961. 00	32. 82	41. 00
	Records Library							
42. 00	Soci al Servi ce	17. 00	0	0	0	0. 00		42. 00
43.00	Other General Service	18. 00	0	0	0	0. 00	0.00	43.00

FHN MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Health Financial Systems HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 14-0160 Peri od:

Worksheet S-3 Part III Date/Time Prepared: From 01/01/2023 To 12/31/2023 5/30/2024 4:39 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . (from Salaries in col . 5) Works<u>heet A-6)</u> 3) col. 4 1.00 2.00 5.00 6.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 41, 108, 798 41, 108, 798 1, 117, 387. 00 36. 79 1.00 instructions) 2.00 Excluded area salaries (see 1, 328, 253 22, 667 1, 350, 920 39, 357. 00 34. 32 2.00 instructions) 3.00 Subtotal salaries (line 1 39, 780, 545 -22, 667 39, 757, 878 1, 078, 030. 00 36.88 3.00 minus line 2) 4.00 Subtotal other wages & related 9, 440, 503 9, 440, 503 172, 993. 00 54.57 4.00 costs (see inst.) Subtotal wage-related costs 5.00 11, 665, 406 C 11, 665, 406 0.00 29. 34 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 60, 886, 454 -22, 667 60, 863, 787 1, 251, 023. 00 48 65 7.00 Total overhead cost (see 7, 275, 509 -15, 057 7, 260, 452 256, 595. 00 28.30 7.00

instructions)

Health Financial Systems	FHN MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 14-0160	Peri od: Worksheet S-3 From 01/01/2023 Part IV To 12/31/2023 Date/Time Prepared:			

	To 12/31/2023	Date/Time Prep 5/30/2024 4:39	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	835, 616	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8.03	Health Insurance (Purchased)	5, 955, 956	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	42, 171	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	146, 266	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	230, 059	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumul ati ve porti on)		
	TAXES		
	FICA-Employers Portion Only	3, 130, 054	17. 00
	Medicare Taxes - Employers Portion Only	0	
	Unempl oyment Insurance	8, 131	1
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))	_ '	
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23. 00
24. 00	Total Wage Related cost (Sum of Lines 1 -23)	10, 348, 253	24. 00
0= 0-	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	FHN MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-			
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Pre 5/30/2024 4:3	pared:	
Cost Center Description		Contract Labor 1.00	Benefit Cost 2.00		
DADT V Control to the control Description	·				

			5/30/2024 4: 3	9 pm
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	7, 222, 683	12, 163, 988	1.00
2.00	Hospi tal	7, 222, 683	12, 163, 988	2.00
3.00	SUBPROVI DER - I PF			3.00
4.00	SUBPROVI DER - I RF			4. 00
5.00	Subprovi der - (0ther)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	SKILLED NURSING FACILITY			8. 00
9.00	NURSING FACILITY			9. 00
10.00	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	RENAL DIALYSIS I	0	0	17.00
18. 00	Other	0	0	18. 00

Heal th Fir	nancial Systems		FHN MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
	BASED HOSPICE IDENTIFICATION	DATA	-	Provi der CC Hospi ce CCI		Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-9 PARTS I THROU Date/Time Pre	GH IV pared:
							5/30/2024 4: 3	9 pm
		Unduplicated				Hospi ce I		
		Days						
	-	Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng	7 0 21.101	col s. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility			,	
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
	RT I - ENROLLMENT DAYS FOR CO	ST REPORTING F	ERIODS BEGINNI	NG BEFORE OCTO	BER 1, 2015			
	spice Continuous Home Care							1. 00
	spice Routine Home Care							2. 00
	spice Inpatient Respite Care							3. 00
	spice General Inpatient Care							4. 00
	tal Hospice Days	DEDORTING DEDI	000 0501 1111 110	DEFORE COTORER				5.00
	rt II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015			
	mber of patients receiving							6. 00
	spice care Ital number of unduplicated							7. 00
	intinuous Care hours billable							7.00
	Medicare							
	verage Length of Stay (line 5						•	8.00
	line 6)							
9. 00 Und	duplicated census count							9. 00
NOTE: Par	ts I and II, columns 1 and 2	also include	the days report	ted in columns	3 and 4.			
				Title XVIII	Title XIX	0ther	Total (sum of	
							col s. 1	
							through 3)	
				1.00	2.00	3. 00	4. 00	
	RT III - ENROLLMENT DAYS FOR	COST REPORTING	PERLODS BEGLN	INING ON OR AFT	ER OCTOBER 1,		_	
	spice Continuous Home Care			0		0 0	0	
	spice Routine Home Care			14, 381	ئ ا	66 671	15, 418	
	spice Inpatient Respite Care			156		0 30		12.00
	spice General Inpatient Care			12 14, 549	2	0 0 66 701	15, 616	13.00
	rtal Hospice Days RT IV - CONTRACTED STATISTICA	I DATA FOR COS	T DEDODTING DE					14.00
	ri IV - CONTRACTED STATISTICA Espice Inpatient Respite Care	L DATA FUR CUS	I KEPUKITNO PE	O BEGINNIN	O ON OR AFTER	0 0 0		15. 00
	spice impatrent kespite care					0 0	0	1
10.00 [110.	spree serierar riipatrent care			1	1	9	1	1 10.00

HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Provid	er CCN: 14-0160	Peri od: From 01/01/2023 To 12/31/2023		pared:		
				1. 00			
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA			11.00			
	Uncompensated and Indigent Care Cost-to-Charge Ratio				1		
1.00	Cost to charge ratio (see instructions)			0. 205091	1.00		
	Medicaid (see instructions for each line)						
2. 00	Net revenue from Medicaid			8, 973, 250	2.00		
3. 00	Did you receive DSH or supplemental payments from Medicaid?			Y	3. 00		
1. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental pay		cai d?	N	4.00		
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from Med	di cai d		4, 328, 293			
5. 00	Medi cai d charges			105, 156, 317	6. 00		
7. 00	Medicaid cost (line 1 times line 6)			21, 566, 614			
3. 00	Difference between net revenue and costs for Medicaid program (see in			8, 265, 071	8.00		
	Children's Health Insurance Program (CHIP) (see instructions for each	i iine)		0	9.00		
9. 00 10. 00	Net revenue from stand-alone CHIP Stand-alone CHIP charges						
1. 00	Stand-alone CHIP cost (line 1 times line 10)						
2. 00	Difference between net revenue and costs for stand-alone CHIP (see in	nstructions)					
2.00	Other state or local government indigent care program (see instruction		5)	Ü	12.0		
3. 00	Net revenue from state or local indigent care program (Not included of	0	13.0				
4. 00	Charges for patients covered under state or local indigent care progr	0	1				
	10)	•					
5.00	State or local indigent care program cost (line 1 times line 14)			0	15.0		
6.00	Difference between net revenue and costs for state or local indigent care program (see instructions) 0 1						
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and	state/local ind	gent care program	ns (see			
7 00	instructions for each line)	-1		0	17.0		
7. 00 8. 00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita	-			17. 0 18. 0		
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indicates the support of nospital total unreimbursed cost for Medicaid , CHIP and state and local indicates the support of nospital unreimbursed cost for Medicaid , CHIP and state and local indicates the support of nospital unreimbursed cost for Medicaid , CHIP and state and local indicates the support of nospital unreimbursed cost for Medicaid , CHIP and state and local indicates the support of nospital unreimbursed cost for Medicaid , CHIP and state and local indicates the support of nospital unreimbursed cost for Medicaid , CHIP and state and local indicates the support of nospital unreimbursed cost for Medicaid , CHIP and state and local indicates the support of nospital unreimbursed cost for Medicaid , CHIP and state and local indicates the support of		me (sum of lings	8, 265, 071			
7. 00	8, 12 and 16)	gent care progra	iis (suiii or rrites	0, 203, 071	19.0		
		Uni nsured	I Insured	Total (col. 1			
		pati ents	pati ents	+ col . 2)			
		1.00	2. 00	3. 00			
	Uncompensated care cost (see instructions for each line)	1 0 007	- 1 0-1 010	2 550 007			
0.00	Charity care charges and uninsured discounts (see instructions)	2, 307,			1		
1. 00	Cost of patients approved for charity care and uninsured discounts (sinstructions)	see 473,	257 1, 251, 849	1, 725, 106	21.0		
2. 00	Payments received from patients for amounts previously written off as		0 0	o	22. 0		
2.00	charity care	'	0	١	22.0		
3. 00	Cost of charity care (see instructions)	473,	257 1, 251, 849	1, 725, 106	23.0		
			, , , , ,	, , , , ,			
				1. 00			
4. 00	Does the amount on line 20 col. 2, include charges for patient days be		of stay limit	N	24. 0		
- 05	imposed on patients covered by Medicaid or other indigent care progra			_ !			
5. 00	If line 24 is yes, enter the charges for patient days beyond the indi	gent care progra	am's length of	0	25. 0		
E 01	stay limit (harges for incured nationts' limbility (see instructions)				25 0		
5. 01	Charges for insured patients' liability (see instructions)			0 020 142			
6. 00	Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions)			8, 929, 142 340, 587			
	HWEGI COLE LETHNAL 30N E DOU UENTS 13EE THSTI UCTIONS!			1 340,3071	Z/. U		
	· · · · · · · · · · · · · · · · · · ·			523 970	27 0		
27. 00 27. 01 28. 00	Medicare allowable bad debts (see instructions)			523, 979 8, 405, 163			

1, 907, 215 3, 632, 321 30. 00 11, 897, 392 31. 00

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (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)

Heal th	Financial Systems FHN MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10			
H0SPI 7	FAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co	CN: 14-0160	Peri od:	Worksheet S-10	0			
				From 01/01/2023	Parts I & II				
				To 12/31/2023	Date/Time Prep 5/30/2024 4:39				
					3/30/2024 4.3	7 DIII			
					1. 00				
	PART II - HOSPITAL DATA				1.00				
	Uncompensated and Indigent Care Cost-to-Charge Ratio								
1.00									
	Medicaid (see instructions for each line)				0. 201677				
2.00	Net revenue from Medicaid					2. 00			
3.00	Did you receive DSH or supplemental payments from Medicaid?					3. 00			
4.00	If line 3 is yes, does line 2 include all DSH and/or supplem	nental payment	s from Medica	ıi d?		4. 00			
5.00	If line 4 is no, then enter DSH and/or supplemental payments					5. 00			
6.00	Medi cai d charges					6. 00			
7.00	Medicaid cost (line 1 times line 6)					7. 00			
8.00	Difference between net revenue and costs for Medicaid progra	m (see instru	ıcti ons)			8. 00			
	Children's Health Insurance Program (CHIP) (see instructions	for each lin	ie)						
9.00	Net revenue from stand-alone CHIP		,			9. 00			
10.00	Stand-alone CHIP charges					10.00			
11. 00	Stand-alone CHIP cost (line 1 times line 10)					11. 00			
12.00	Difference between net revenue and costs for stand-alone CHI	P (see instru	ıcti ons)			12. 00			
	Other state or local government indigent care program (see i	nstructions f	or each line)						
13.00	Net revenue from state or local indigent care program (Not i	ncluded on li	nes 2, 5 or 9	')		13. 00			
14.00	Charges for patients covered under state or local indigent of	are program (Not included	in lines 6 or		14. 00			
	10)								
15.00	State or local indigent care program cost (line 1 times line	14)				15. 00			
16.00	Difference between net revenue and costs for state or local	indigent care	program (see	instructions)		16. 00			
	Grants, donations and total unreimbursed cost for Medicaid,	CHIP and stat	e/Local indig	ent care progran	ns (see				
	instructions for each line)								
17. 00	Private grants, donations, or endowment income restricted to	funding char	ity care			17. 00			
18. 00	Government grants, appropriations or transfers for support of					18. 00			
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and Id	ocal indigent	care programs	(sum of lines		19. 00			
	8, 12 and 16)		1						
			Uni nsured	Insured	Total (col. 1				
			pati ents	pati ents	+ col . 2)				
			1.00	2. 00	3. 00				
20. 00	Uncompensated care cost (see instructions for each line)	una)	277 2/	2 222 101	F00 FE4	20. 00			
	Charity care charges and uninsured discounts (see instruction		377, 36						
21. 00	Cost of patients approved for charity care and uninsured distinstructions)	scourts (see	76, 10	222, 191	298, 296	21. 00			
22. 00	Payments received from patients for amounts previously writing	on off as		0 0	o	22. 00			
22.00	charity care	.en on as			ا	22.00			
23. 00	Cost of charity care (see instructions)		76, 10	222, 191	298, 296	23 00			
23.00	oust or chartly care (see thistructions)		70, 10	75 222, 171	270, 270	23.00			
					1. 00				
24. 00	N N	24. 00							
21.00	Does the amount on line 20 col. 2, include charges for paticimposed on patients covered by Medicaid or other indigent ca	, ,	ia a rengtii oi	Stay Trim t		21.00			
25. 00			care program	's Lenath of	0	25. 00			
20.00	5.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit								
25. 01	Charges for insured patients' liability (see instructions)				o	25. 01			
26. 00	Bad debt amount (see instructions)				8, 929, 142				
27. 00	Medicare reimbursable bad debts (see instructions)				340, 587				
27. 01	Medicare allowable bad debts (see instructions)				523, 979				
28. 00	Non-Medicare bad debt amount (see instructions)				8, 405, 163				
	Cost of non Modicaro and non roimbursable Modicaro had dobt	amounts (soo	instructions)		1 878 520				

1, 878, 520 29. 00 2, 176, 816 30. 00 2, 176, 816 31. 00

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (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)

Health Financial Systems	FHN MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provi der CO		eri od:	Worksheet A	
				rom 01/01/2023 o 12/31/2023	Date/Time Pre	pared:
Cook Control Doors' atting	C-1	0+1	T-+-1 (1 1	D1: £:+:	5/30/2024 4: 3	9 pm
Cost Center Description	Sal ari es	Other	+ col . 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance	
			1 (01. 2)	0113 (See A 0)	(col. 3 +-	
					col . 4)	
OSNEDAL OSDINOS COOT OSNESDO	1.00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS		0		1 200 2/0	1 200 2/0	1 00
1. 00 00100 CAP REL COSTS-BLDG & FLXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP		4, 065, 205		.,,		1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 983	11, 121, 062			11, 123, 045	4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	2, 436, 997	23, 148, 540			25, 569, 340	5. 00
7.00 OO700 OPERATION OF PLANT	389, 119	3, 138, 876			3, 527, 995	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	325, 845			325, 845	8. 00
9. 00 00900 HOUSEKEEPI NG	0	2, 062, 366			2, 062, 366	9. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	0	2, 175, 589	2, 175, 589			1
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMINI STRATI ON	777, 584	170, 092	947, 676	72.7200	927, 206 947, 676	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	113, 096	500, 413			613, 509	14. 00
15. 00 01500 PHARMACY	1, 380, 896	5, 958, 360			2, 898, 635	
16.00 01600 MEDICAL RECORDS & LIBRARY	1, 213, 036	684, 726			1, 897, 762	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	14, 575, 707	4, 137, 371	18, 713, 078		18, 703, 644	30. 00
31. 00 03100 INTENSIVE CARE UNIT	1, 503, 911	430, 113				31.00
43. 00 O4300 NURSERY ANCI LLARY SERVICE COST CENTERS	0	0	C	0	0	43. 00
50. 00 05000 OPERATING ROOM	2, 400, 234	8, 544, 805	10, 945, 039	0	10, 945, 039	50.00
50. 01 05001 GI LAB	609, 878	562, 536			1, 172, 414	•
50. 02 05002 AMBULATORY CARE UNIT	1, 748, 297	1, 341, 170			3, 089, 467	50. 02
51.00 05100 RECOVERY ROOM	512, 034	20, 362	532, 396	0	532, 396	51. 00
53. 00 05300 ANESTHESI OLOGY	0	2, 104, 469			2, 104, 469	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	3, 228, 182	5, 508, 247			8, 736, 429	54.00
60. 00 06000 LABORATORY	1, 641, 729	4, 700, 232			6, 341, 961	1
65. 00 06500 RESPI RATORY THERAPY	983, 701	363, 742			1, 347, 443	
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	2, 597, 325 233, 487	294, 573 294, 732			2, 891, 898 528, 219	66. 00 69. 00
69. 01 06901 CATH LAB	514, 812	725, 222			1, 240, 034	•
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	Ö	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	О	0	C	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	4, 440, 621	4, 440, 621	73. 00
74. 00 07400 RENAL DIALYSIS	0	261, 301	261, 301			74.00
76. 00 03950 DI ABETI C EDUCATI ON 76. 01 03480 CANCER CENTER	1, 751, 071	75, 800 10, 651, 667			,	76. 00 76. 01
OUTPATIENT SERVICE COST CENTERS	1, 751, 071	10, 051, 007	12, 402, 730	0	12, 402, 730	70.01
90. 00 09000 CLINIC	4, 996	1, 292, 134	1, 297, 130	0	1, 297, 130	90.00
91. 00 09100 EMERGENCY	4, 324, 393	5, 872, 215				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE	4 000 050	0	0 (01 007	0		113.00
116. 00 11600 HOSPI CE	1, 328, 253	1, 273, 734			2, 601, 987	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	44, 270, 721	101, 805, 499	146, 076, 220	-25, 631	146, 050, 589	1118.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	O	0		0	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	Ö	0		0		192. 00
192. 01 19201 JANE ADDAMS BLDG	o	0		o		192. 01
192. 02 19202 SENI OR PROGRAM	o	0	0	0		192. 02
192. 03 19203 NA VOLUNTEER SERVICES	o	0	0	16, 197	16, 197	
192. 04 19204 SMART STEPS	0	0	0	0		192. 04
192. 05 19205 RESPITE CARE	0	0		9, 434		192. 05 193. 00
193.00 19300 NONPAID WORKERS 200.00 TOTAL (SUM OF LINES 118 through 199)	44, 270, 721	101, 805, 499	146, 076, 220	0		
233.33 101/12 (30m of Elites 110 till ough 177)	11,210,121	101, 000, 477	1 10,070,220	١	1 10,070,220	1=00.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 14-0160 Per

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

5/30/2024 4:39 pm Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 0 1, 380, 269 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 0 2, 684, 936 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 11, 123, 045 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 -7, 703, 731 17, 865, 609 5 00 7.00 00700 OPERATION OF PLANT -263 3, 527, 732 7.00 00800 LAUNDRY & LINEN SERVICE 325, 845 8.00 8.00 9.00 00900 HOUSEKEEPI NG 2.062.366 9.00 0 01000 DI ETARY 10.00 -7, 905 10.00 1, 240, 478 11.00 01100 CAFETERI A -1,777 925, 429 11.00 13 00 01300 NURSING ADMINISTRATION -39,000 908, 676 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 0 613, 509 15.00 01500 PHARMACY 0 2, 898, 635 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY -375 1, 897, 387 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS -5, 410, 159 13, 293, 485 31.00 03100 INTENSIVE CARE UNIT -99, 130 1, 834, 894 31.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50 00 10, 651, 078 05000 OPERATING ROOM -293, 961 50.00 50.01 05001 GI LAB 1, 172, 414 50.01 05002 AMBULATORY CARE UNIT 50.02 0 3, 089, 467 50.02 05100 RECOVERY ROOM 51.00 0 532, 396 51.00 53.00 05300 ANESTHESI OLOGY -1, 929, 884 174, 585 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C -3, 189, 827 5, 546, 602 54.00 60.00 06000 LABORATORY 6, 341, 961 60.00 06500 RESPIRATORY THERAPY 65.00 -78.240 1, 269, 203 65.00 66.00 06600 PHYSI CAL THERAPY -5, 335 2, 886, 563 66.00 06900 ELECTROCARDI OLOGY 528, 219 69.00 0 69.00 0 06901 CATH LAB 1, 240, 034 69.01 69.01 07000 ELECTROENCEPHALOGRAPHY 0 70.00 C 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 Ω 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 4, 440, 621 73 00 07300 DRUGS CHARGED TO PATIENTS 73 00 07400 RENAL DIALYSIS 74.00 261, 301 74.00 76.00 03950 DIABETIC EDUCATION 0 75, 800 76.00 -1, 712<u>,</u> 712 76.01 03480 CANCER CENTER 10, 690, 026 76.01 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 1, 297, 130 90.00 90.00 91.00 09100 EMERGENCY -4, 980, 759 5, 215, 849 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 0 113.00 116. 00 11600 HOSPI CE 0 2,601,987 116.00 SUBTOTALS (SUM OF LINES 1 through 117) -25, 453, 058 120, 597, 531 118 00 118, 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 192.01 19201 JANE ADDAMS BLDG 192. 01 0 192. 02 19202 SENI OR PROGRAM 0 0 192. 02 192. 03 19203 NA VOLUNTEER SERVICES 0 192. 03 16, 197 192.04 19204 SMART STEPS 0 192. 04 C 192. 05 19205 RESPITE CARE 0 9 434 192 05 193. 00 19300 NONPALD WORKERS 193.00 200.00 TOTAL (SUM OF LINES 118 through 199) -25, 453, 058 120, 623, 162 200.00

Heal th	Financial Systems		FHN MEMORIA	L HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLAS	SSIFICATIONS			Provi der C	CCN: 14-0160	Peri od:	Worksheet A-	6
						From 01/01/2023 To 12/31/2023	Date/Time Pr 5/30/2024 4:	epared: 39 pm
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3.00	4. 00	5. 00				
	A - CHARGEABLE DRUGS							
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	4, 440, 621				1.00
	TOTALS		0	4, 440, 621				
	B - SHARED DIETARY EXPENSES							
1.00	CAFETERI A	11. 00	0	927, 206				1.00
	TOTALS		0	927, 206				
	C - RESPITE CARE							
1.00	RESPITE CARE	192.05	7, 610	1, 824				1.00
	TOTALS		7, 610	1, 824				
	D - NON PATIENT VOLUNTEER ADI	AI N						
1.00	NA_VOLUNTEER_SERVICES	192.03	<u> </u>	1, 140				1. 00
	TOTALS		15, 057	1, 140				
	E - BUILDING DEPRECIATION							
1 00	CAD DEL COSTS_BLDG & FLYT	1 00	Λ	1 380 260				1 00

___ 0 0

22, 667

1.00

1, 380, 269 1, 380, 269

6, 751, 060

1.00

500.00

1.00

CAP REL COSTS-BLDG & FIXT
TOTALS

500.00 Grand Total: Increases

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

RECLASSIFICATIONS Provider CCN: 14-0160 Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared:

						To 12/31/2023	Date/Time Pr 5/30/2024 4:	epared: 39 pm
		Decreases						
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref	· .		
	6. 00	7. 00	8. 00	9. 00	10.00			
	A - CHARGEABLE DRUGS							
1.00	PHARMACY	1500	0	4, 440, 621		o		1. 00
	TOTALS		0	4, 440, 621				
	B - SHARED DIETARY EXPENSES							
1.00	DI ETARY	10.00	0	927, 206		o		1. 00
	TOTALS		0	927, 206				
	C - RESPITE CARE							
1.00	ADULTS & PEDIATRICS	30. 00	<u>7, 6</u> 10	1, 824		o		1. 00
	TOTALS		7, 610	1, 824				
	D - NON PATIENT VOLUNTEER ADM							
1.00	ADMINISTRATIVE & GENERAL	<u>5.</u> 00	1 <u>5, 0</u> 57	<u>1, 1</u> 40		ol		1. 00
	TOTALS		15, 057	1, 140				
	E - BUILDING DEPRECIATION							
1. 00	CAP REL COSTS-MVBLE EQUIP		0	<u>1, 380, 2</u> 69		9		1. 00
	TOTALS		0	1, 380, 269				
500.00	Grand Total: Decreases		22, 667	6, 751, 060				500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS FHN MEMORIAL HOSPITAL Provider CCN: 14-0160

					To 12/31/2023	Date/Time Prep 5/30/2024 4:39	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00	Land	944, 945	0		0	0	1.00
2.00	Land Improvements	2, 222, 791	17, 480		0 17, 480		2.00
3.00	Buildings and Fixtures	55, 977, 981	1, 513, 552		0 1, 513, 552	0	3.00
4.00	Building Improvements	0	0		0	0	4.00
5.00	Fixed Equipment	1, 417, 175	14, 535		0 14, 535		5.00
6.00	Movable Equipment	33, 699, 548	1, 761, 967		0 1, 761, 967	0	6.00
7.00	HIT designated Assets	8, 402, 457	0		0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	102, 664, 897	3, 307, 534		0 3, 307, 534	0	8.00
9.00	Reconciling Items	0	0		0	0	9. 00
10. 00	Total (line 8 minus line 9)	102, 664, 897	3, 307, 534		0 3, 307, 534	0	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	T	6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1. 00	Land	944, 945	0				1. 00
2.00	Land Improvements	2, 240, 271	0				2. 00
3.00	Buildings and Fixtures	57, 491, 533	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	1, 431, 710	0				5. 00
6.00	Movable Equipment	35, 461, 515	0				6. 00
7. 00	HIT designated Assets	8, 402, 457	0				7. 00
8.00	Subtotal (sum of lines 1-7)	105, 972, 431	0				8. 00
9. 00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	105, 972, 431	0				10.00

Heal th	Financial Systems	FHN MEMORIAL	_ HOSPITAL		In Lieu of Form CMS-2552		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der CC	CN: 14-0160	Peri od: From 01/01/2023 To 12/31/2023		pared:
			SU	IMMARY OF CAF	PITAL	3/30/2024 4.3	7 pili
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	,	
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4, 065, 205	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	4, 065, 205	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	· ·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4, 065, 205			ļ	2. 00
3. 00	Total (sum of lines 1-2)	0	4, 065, 205				3. 00

Health Financial Systems	FHN MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2023 Fo 12/31/2023	Worksheet A-7 Part III Date/Time Prep 5/30/2024 4:39	
	COMI	PUTATION OF RAT	ALLOCATION OF	OTHER CAPITAL		
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio (col. 1 - col. 2)	instructions)		
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				_		
1.00 CAP REL COSTS-BLDG & FLXT	70, 510, 916		70, 510, 91			1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	35, 461, 515		35, 461, 51			2. 00
3.00 Total (sum of lines 1-2)	105, 972, 431		105, 972, 43			3. 00
	ALLOCA	TION OF OTHER (SUMMARY O	SUMMARY OF CAPITAL		
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)			
DADT 1.1. DECONOLITATION OF CARLETY COOTS OF	6.00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				4 000 040		1 00
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP	0	0		1, 380, 269		1. 00 2. 00
3.00 Total (sum of lines 1-2)	0	0)	2, 684, 936		2. 00 3. 00
3.00 Total (Suiii of Titles 1-2)	0	<u> </u>	JMMARY OF CAPI	4, 065, 205	U	3.00
		30	JIVIIVIART OF CAPT	IAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
DADT III DECONCILIATION OF CADITAL COCTO OF	11. 00	12.00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS 0	0	1	0	1, 380, 269	1. 00
2.00 CAP REL COSTS-BLDG & FIXT] /		2, 684, 936	2. 00
3.00 Total (sum of lines 1-2)]		4, 065, 205	3. 00
o. oo proteir (sum of filles i 2)	1		1	ار	4, 000, 200	5. 00

					5 12/31/2023	Date/lime Prep 5/30/2024 4:39	
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
		D					
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FLXT	1.00	0.00	1. 00
	COSTS-BLDG & FIXT (chapter 2)						
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	Investment income - other		0		0. 00	0	3. 00
	(chapter 2)						
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5. 00	Refunds and rebates of		0		0. 00	0	5. 00
	expenses (chapter 8)						
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Telephone services (pay		О		0. 00	0	7. 00
	stations excluded) (chapter						
8. 00	21) Television and radio service		0		0. 00	0	8. 00
0.00	(chapter 21)		Ĭ		0.00	Ŭ	0.00
9. 00	Parking Lot (chapter 21)		0		0. 00		9. 00
10. 00	Provider-based physician adjustment	A-8-2	-17, 981, 607			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
40.00	(chapter 23)						40.00
12. 00	Related organization transactions (chapter 10)	A-8-1	-1, 204, 814			0	12. 00
13. 00	Laundry and linen service		0		0.00	О	13. 00
14. 00	Cafeteria-employees and guests		0		0. 00	1	14. 00
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00	Sale of medical and surgical		О		0.00	0	16. 00
	supplies to other than						
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
	patients				0.00		.,. 00
18. 00	Sale of medical records and		0		0. 00	0	18. 00
19. 00	abstracts Nursing and allied health		o		0. 00	0	19. 00
	education (tuition, fees,						
20. 00	books, etc.) Vending machines		0		0. 00	0	20. 00
21. 00	Income from imposition of		0		0.00	0	21. 00
	interest, finance or penalty						
22. 00	charges (chapter 21)		0		0. 00	0	22.00
22.00	Interest expense on Medicare overpayments and borrowings to	,	U		0.00	U	22. 00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		О	*** Cost Center Deleted ***	114.00		25. 00
	physicians' compensation						
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
20.00	COSTS-BLDG & FLXT			5/11 N.E. 00010 BESO & 1.7/1.			20.00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		O	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		О		0. 00	0	29. 00
30. 00	Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	67. 00		30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
21 00	instructions)	A 0 2		*** Coot Conton Dal-+ ***	(0.00		21 00
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	o	*** Cost Center Deleted ***	68. 00		31. 00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0. 00	0	32. 00
	I bebreciation and interest	1	I				I

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

					10 12/31/2023	5/30/2024 4:3	
				Expense Classification or	Worksheet A	0,00,2021 110	, p
				To/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2.00	3. 00	4. 00	5. 00	
33.00	TRADE, QUANTITY AND TIME	В	-9, 233	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
	DI SCOUNTS						
33. 01	SALE OF MEDICAL RECORDS &	В	-375	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 01
	ABSTRACTS						
33. 02	VENDING MACHINES	В	·	CAFETERI A	11. 00	0	33. 02
33. 03	PHYSICIAN COLLECTIONS EXPENSES		·	ADMINISTRATIVE & GENERAL	5.00	0	33. 03
33. 04	DI ETARY CONSULTI NG	В		DI ETARY	10.00	0	33. 04
33. 05	TELEPHONE CAPITAL COSTS	A		ADMINISTRATIVE & GENERAL	5.00	0	33. 05
33. 06	TV CAPITAL COSTS	Α		ADMINISTRATIVE & GENERAL	5.00	0	33. 06
33. 07	ASSOC LOBBYING FEES	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	MEALS ON WHEELS	В	·	DI ETARY	10.00	0	33. 08
33. 09	OTHER REVENUE MISC	В	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33. 10	OB MISC INCOME	В		ADULTS & PEDIATRICS	30.00	0	33. 10
33. 11	RENTAL INCOME	В	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
33. 12	RADI OLOGY MED RECORD REVENUE	В		RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 12
33. 13	PT, OT, SPORTS MED MISC INCOME	В	·	PHYSI CAL THERAPY	66. 00	0	33. 13
33. 14	PROVI DER TAX COST	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 15	FMH OP. FINANCE MISCELLANEOUS	В	-22, 274	ADMINISTRATIVE & GENERAL	5. 00	0	33. 15
	INCOME						
33. 16	FMH EMERG MGT PROG	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	33. 16
	MI SCELLANEOUS						
33. 17	FMH MAINTENANCE MISCELLANEOUS	В	-263	OPERATION OF PLANT	7. 00	0	33. 17
	INCOME		05 450				
50. 00	TOTAL (sum of lines 1 thru 49)		-25, 453, 058				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Heal th	Financial Systems	FHN MEMORIA	AL HOSPITAL	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Peri od:	Worksheet A-8	3-1
OFFICE	COSTS			From 01/01/2023 To 12/31/2023		
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5. 00	ADMINISTRATIVE & GENERAL	CORPORATE ALLOCATION	12, 637, 928	13, 842, 742	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4. 00
5.00	TOTALS (sum of lines 1-4).			12, 637, 928	13, 842, 742	5.00
	Transfer column 6, line 5 to					

* 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.

 p	THE FIGURE THE COLUMN TO THE COLUMN THE COLU							
			Related Organization(s) and/	or Home Office				
Symbol (1)	Name	Percentage of	Name	Percentage of				
		Ownershi p		Ownershi p				
1. 00	2. 00	3. 00	4. 00	5. 00				
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME 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	A	FREEPORT MEMORI	100.00 FREEPORT HEALTH	100.00	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-financial) specify:				

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

Worksheet A-8, column 2,

line 12.

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

Heal th	Financial Syste	ems		FHN	I MEMORIAL	HOSPI TAL			In Lie	u of Form CMS-	2552-10
	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI ONS	AND HOME	Provi der	CCN:	14-0160	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS								From 01/01/2023 To 12/31/2023	Date/Time Pro	enared:
									10 12/31/2023	5/30/2024 4:	
	Net	Wkst. A-7 Ref.									
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
	A. COSTS INCUR	RED AND ADJUSTM	MENTS REC	QUIRED AS A RE	SULT OF TR	ANSACTI ONS	WI TH	RELATED C	ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:									
1.00	-1, 204, 814	0									1.00
2.00	0	0									2.00
3.00	0	0									3.00
4.00	0	0									4.00
5.00	-1, 204, 814										5. 00
* The	amounts on line	es 1-4 (and sub	scripts	as appropriat	e) are tra	nsferred in	deta	ail to Wor	ksheet A, column	6. lines as	
									ganization or hom		whi ch
									ated in column 4		
	Related Orga	ani zati on(s)								,	
		me Office									

Related Organization(s)
and/or Home Office

Type of Business

6.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	HEALTH CARE PARENT CO	6. 00
7.00		7. 00
8.00		8. 00
9.00		9. 00
10.00		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.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Period: Worksheet A-8-2 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 4:39 pm

							5/30/2024 4: 3	39 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				'			Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1. 00		ADULTS & PEDIATRICS	2, 467, 558					1. 00
2.00		INTENSIVE CARE UNIT	99, 130				-	2. 00
3.00		OPERATING ROOM						
			28, 461	28, 461		U	1	3. 00
4.00		NURSING ADMINISTRATION	39, 000			0	0	4. 00
5. 00		RADI OLOGY-DI AGNOSTI C	3, 189, 817	3, 189, 817	0	0	0	5. 00
6.00	65. 00	RESPI RATORY THERAPY	78, 240	78, 240	0	0	0	6. 00
7.00	91.00	EMERGENCY	4, 980, 759	4, 980, 759	0	0	0	7. 00
8. 00	76. 01	CANCER CENTER	1, 712, 712	1, 712, 712	0	0	0	8. 00
9.00	30.00	ADULTS & PEDIATRICS	2, 942, 601	2, 942, 601	0	0	0	9. 00
10.00		ADMINISTRATIVE & GENERAL	245, 322			179, 000	16	10.00
11. 00		ANESTHESI OLOGY	1, 929, 884			0		11. 00
12. 00		OPERATING ROOM	265, 500			0		12. 00
13. 00		PHYSICAL THERAPY				0	0	13. 00
	00.00	PHISICAL INERAPI	4, 000			0	-	
200.00		0 1 0 1 (5)	17, 982, 984	17, 969, 984			16	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		ldenti fi er	Limit		Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13.00	14.00	
1. 00	30.00	ADULTS & PEDIATRICS	0	C	0	0	0	1. 00
2.00	31.00	INTENSIVE CARE UNIT	l o	1	0	0	0	2. 00
3.00	50, 00	OPERATING ROOM	l o	1	0	0	0	3. 00
4. 00		NURSI NG ADMI NI STRATI ON	0	7		0	0	4. 00
5. 00		RADI OLOGY-DI AGNOSTI C	0			0	o o	5. 00
6. 00		RESPI RATORY THERAPY	0		1	0	0	6. 00
7. 00		EMERGENCY				0	0	7. 00
			0			0		
8.00		CANCER CENTER	0	C	1	0	0	8. 00
9.00		ADULTS & PEDIATRICS	0		-	0	0	9. 00
10. 00		ADMINISTRATIVE & GENERAL	1, 377	69		0	0	10. 00
11. 00		ANESTHESI OLOGY	0	C	0	0	0	11. 00
12.00	50.00	OPERATING ROOM	0	C	0	0	0	12. 00
13.00	66. 00	PHYSI CAL THERAPY	0	l c	0	0	0	13. 00
200.00			1, 377	69	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance	7.ag ao emorre		
		1 45.11.11.51	Share of col.	2	Di Gai i Gilano			
			14					
	1.00	2.00	15. 00	16. 00	17. 00	18. 00		
1.00		ADULTS & PEDIATRICS	15.00					1. 00
					-	_,,		
2.00		INTENSIVE CARE UNIT			-	,		2.00
3.00		OPERATING ROOM	-		0	28, 461		3. 00
4.00		NURSING ADMINISTRATION	0	[C	0	39, 000		4. 00
5. 00		RADI OLOGY-DI AGNOSTI C	0	[C	0	3, 189, 817		5. 00
6.00		RESPI RATORY THERAPY	0	[C	0	78, 240		6. 00
7.00	91.00	EMERGENCY	0	[C	0	4, 980, 759		7. 00
8.00		CANCER CENTER	0	[c	0	1, 712, 712		8. 00
9. 00		ADULTS & PEDIATRICS	0	C	0	2, 942, 601		9. 00
10. 00		ADMINISTRATIVE & GENERAL	0		11, 623	· · ·		10.00
11. 00		ANESTHESI OLOGY	0			1, 929, 884		11. 00
12. 00		OPERATING ROOM			,			12. 00
13. 00		PHYSICAL THERAPY				4, 000		13. 00
	00.00	FIII SI CAL I TEKAPI			11 (00			
200.00			0	1, 377	11, 623	17, 981, 607		200. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-0160 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 4:39 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1, 380, 269 1 00 1 00 00100 CAP REL COSTS-BLDG & FLXT 1, 380, 269 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2, 684, 936 2, 684, 936 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 11, 123, 045 8, 384 11, 131, 429 4.00 00500 ADMINISTRATIVE & GENERAL 299, 887 608, 999 18, 936, 532 5 00 17, 865, 609 162, 037 5 00 00700 OPERATION OF PLANT 7.00 3, 527, 732 150, 616 27, 195 97, 844 3, 803, 387 7.00 10, 091 8.00 00800 LAUNDRY & LINEN SERVICE 325, 845 335, 936 8.00 9.00 00900 HOUSEKEEPI NG 2,062,366 22, 140 o 2,084,506 9.00 C 01000 DI ETARY 10.00 1, 240, 478 49, 836 0 1, 296, 440 10 00 6, 126 11.00 01100 CAFETERI A 925, 429 42, 533 967, 962 11.00 01300 NURSING ADMINISTRATION 908, 676 1, 609 15, 509 195, 524 1, 121, 318 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 613, 509 28, 438 14.00 14.00 3.848 645, 806 11 01500 PHARMACY 2, 898, 635 15.00 15.00 10, 462 112, 599 347, 228 3, 368, 924 01600 MEDICAL RECORDS & LIBRARY 1, 897, 387 2, 976 305, 019 2, 205, 382 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 13, 293, 485 247, 293 17, 422, 589 218, 638 3, 663, 173 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 834, 894 18, 601 18, 638 378, 160 2, 250, 293 31 00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 93, 240 438, 733 50.00 10, 651, 078 603, 541 11, 786, 592 50.00 05001 GI LAB 50.01 1, 172, 414 30,078 88.980 153, 354 1, 444, 826 50.01 05002 AMBULATORY CARE UNIT 3, 089, 467 40, 415 29, 051 439, 611 3, 598, 544 50.02 50.02 51.00 05100 RECOVERY ROOM 532, 396 7, 191 8, 440 128, 751 676, 778 51.00 3, 709 53.00 05300 ANESTHESI OLOGY 174.585 62, 474 240, 768 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 5, 546, 602 75, 417 488, 689 811, 730 6, 922, 438 54.00 06000 LABORATORY 6, 341, 961 7, 038, 573 60.00 38, 198 245, 600 412, 814 60.00 65.00 06500 RESPIRATORY THERAPY 1, 269, 203 31, 829 58, 561 247, 353 1, 606, 946 65.00 06600 PHYSI CAL THERAPY 66.00 2, 886, 563 67, 266 83, 776 653, 100 3, 690, 705 66.00 666, 072 06900 ELECTROCARDI OLOGY 528, 219 7,611 71, 531 58, 711 69.00 69.00 69.01 06901 CATH LAB 1, 240, 034 2,682 151, 100 129, 450 1, 523, 266 69.01 07000 ELECTROENCEPHALOGRAPHY 70 00 70 00 0 \cap Ω 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 C 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 4, 440, 621 o 4, 440, 621 73.00 0 73.00 C 07400 RENAL DIALYSIS n 0 74.00 261, 301 1, 327 262, 628 74.00 76.00 03950 DIABETIC EDUCATION 75,800 1, 327 179 0 77, 306 76.00 76.01 03480 CANCER CENTER 10, 690<u>, 026</u> 35, 753 206, 862 440, 309 11, 372, 950 76.01 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1, 297, 130 12,648 10, 225 1, 256 1, 321, 259 90.00 09100 EMERGENCY 5, 215, 849 59, 056 166, 604 1, 087, 373 6, 528, 882 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 2, 601, 987 13, 378 333, 991 2, 949, 356 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 120, 597, 531 1, 376, 023 2, 684, 936 11, 125, 729 120, 587, 585 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 3, 419 3, 419 190. 00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 827 192.00 827 192. 01 19201 JANE ADDAMS BLDG 0 0 0 0 192. 01 C 192. 02 19202 SENI OR PROGRAM 0 0 192, 02 0 0 0 192. 03 19203 NA VOLUNTEER SERVICES 0 0 3, 786 19, 983 192. 03 16, 197 192. 04 19204 SMART STEPS 0 0 0 192. 04 11, 348 192. 05 192. 05 19205 RESPITE CARE 1, 914 0 9.434 Ω 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 200.00 0 200. 00 Cross Foot Adjustments 0 201. 00 201.00 Negative Cost Centers TOTAL (sum lines 118 through 201) 120, 623, 162 1, 380, 269 2, 684, 936 120, 623, 162 202. 00 202.00 11, 131, 429

Provider CCN: 14-0160

			T	o 12/31/2023	Date/Time Pre 5/30/2024 4:3	
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	7 pili
oust contain bescription	& GENERAL	PLANT	LINEN SERVICE	HOUSEREEFFING	DIEMMI	
	5. 00	7. 00	8.00	9. 00	10.00	
GENERAL SERVICE COST CENTERS			•			
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	18, 936, 532					5. 00
7.00 00700 OPERATION OF PLANT	708, 282	4, 511, 669				7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	62, 559	49, 414	1			8. 00
9. 00 00900 HOUSEKEEPI NG	388, 185	108, 413	1			9. 00
10. 00 01000 DI ETARY	241, 428	244, 027	1	144, 668	1, 926, 563	10. 00
11. 00 01100 CAFETERI A	180, 258	208, 269	1		0	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	208, 816	7, 878	1	4, 670	0	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	120, 265	18, 842	1		0	14. 00
15. 00 01500 PHARMACY	627, 375	51, 230	1	l '	0	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	410, 695		1		0	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	410,093	14, 575	0	0,040	0	10.00
30. 00 03000 ADULTS & PEDIATRICS	3, 244, 545	1, 210, 899	164, 821	717, 863	1, 826, 318	30. 00
	419, 059		l			
		91, 081	13, 735	· ·	100, 245 0	31.00
43. 00 04300 NURSERY	0	0	0	U	0	43. 00
ANCILLARY SERVICE COST CENTERS	2 104 044	457.573	17.5/5	270 ///	0	FO 00
50. 00 05000 OPERATI NG ROOM	2, 194, 946	456, 563			0	50.00
50. 01 05001 GI LAB	269, 061	147, 279	1		0	50. 01
50. 02 05002 AMBULATORY CARE UNIT	670, 135	197, 896	1		0	50. 02
51. 00 05100 RECOVERY ROOM	126, 032	35, 211	1		0	51. 00
53. 00 05300 ANESTHESI OLOGY	44, 837	18, 164	1	10, 768	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 289, 124	369, 291	1	218, 928	0	54. 00
60. 00 06000 LABORATORY	1, 310, 751	187, 042	1	,	0	60. 00
65. 00 06500 RESPI RATORY THERAPY	299, 252	155, 857	1		0	65. 00
66. 00 06600 PHYSI CAL THERAPY	687, 298	329, 374	1		0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	124, 039	37, 268	0	22, 094	0	69. 00
69. 01 06901 CATH_LAB	283, 669	13, 130	13, 735	7, 784	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	826, 950	0	0	0	0	73. 00
74.00 07400 RENAL DIALYSIS	48, 908	6, 500	0	3, 853	0	74.00
76.00 03950 DIABETIC EDUCATION	14, 396	6, 500	0	3, 853	0	76. 00
76. 01 03480 CANCER CENTER	2, 117, 916	175, 071	16, 926	103, 788	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	246, 050	61, 931	0	36, 715	0	90.00
91. 00 09100 EMERGENCY	1, 215, 835	289, 174	1		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	, , , , , , , , , , , , , , , , , , , ,	,		,		92.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	549, 241	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		4, 490, 879	_	_	1, 926, 563	
NONREI MBURSABLE COST CENTERS	10,727,701	1, 170, 077	117,707	2,000,777	1, 720, 000	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	637	16, 741	0	9, 925	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	154	4, 049				192. 00
192. 01 19201 JANE ADDAMS BLDG	0	1,047	1	2, 400	0	192. 01
192. 02 19202 SENI OR PROGRAM	0	0		0		192. 02
192. 03 19203 NA VOLUNTEER SERVICES	3, 721	0		0		192. 02
192. 04 19204 SMART STEPS	3,721		1	0		192. 04
192. 05 19205 RESPITE CARE	2 112					192. 04
193. 00 19300 NONPALD WORKERS	2, 113					192. 05
1 1		١	1	"	Ü	200. 00
, ,		,			^	200.00
201.00 Negative Cost Centers	10 024 522	U 4 E11 //0	447 000	2 501 104	1, 926, 563	
202.00 TOTAL (sum lines 118 through 201)	18, 936, 532	4, 511, 669	447, 909	2, 581, 104	1, 920, 563	2U2. UU

Provider CCN: 14-0160

			10	12/31/2023	5/30/2024 4:3	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	, p
, , , , , , , , , , , , , , , , , , ,		ADMI NI STRATI ON	SERVICES &	-	RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13.00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 O0700 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	1, 479, 958					11. 00
13.00 O1300 NURSING ADMINISTRATION	25, 285	1, 367, 967				13. 00
14.00 O1400 CENTRAL SERVICES & SUPPLY	7, 148	0	803, 231			14. 00
15. 00 01500 PHARMACY	49, 420	이	12, 290	4, 139, 610		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	51, 606	0	0	0	2, 690, 898	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	414, 280	1, 210, 021	201, 042	2, 767	174, 493	30. 00
31.00 03100 INTENSIVE CARE UNIT	54, 073	157, 946	40, 077	565	20, 499	31. 00
43. 00 04300 NURSERY	0	0	0	0	0	43. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	102, 792	. 0	29, 547	10, 915	426, 276	50. 00
50. 01 05001 GI LAB	38, 712	. 0	82, 699	587	69, 647	50. 01
50. 02 05002 AMBULATORY CARE UNIT	67, 472	. 0	32, 907	347, 203	32, 302	50. 02
51.00 05100 RECOVERY ROOM	26, 798	0	2, 000	71	14, 760	51. 00
53. 00 05300 ANESTHESI OLOGY	0	0	31, 603	2, 236	45, 322	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	149, 240	0	66, 637	995	519, 732	54.00
60. 00 06000 LABORATORY	73, 275	0	35, 984	916	302, 045	60.00
65. 00 06500 RESPIRATORY THERAPY	37, 338	0	36, 223	3, 102	59, 371	65. 00
66. 00 06600 PHYSI CAL THERAPY	103, 184	. 0	12, 563	28	90, 940	66. 00
69. 00 06900 ELECTROCARDI OLOGY	7, 344	. 0	481	0	48, 098	69. 00
69. 01 06901 CATH LAB	19, 230	o	352	68	77, 432	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	o	0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	ol ol	0	o	48	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	ol ol	0	o	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	ol ol	0	1, 255, 067	289, 314	73. 00
74. 00 07400 RENAL DI ALYSI S	0	ol ol	157	0	8, 368	74. 00
76.00 03950 DIABETIC EDUCATION	0	ol ol	14	0	0	76. 00
76. 01 03480 CANCER CENTER	45, 383	ol ol	38, 294	2, 457, 337	220, 280	76. 01
OUTPATIENT SERVICE COST CENTERS	·					
90. 00 09000 CLI NI C	0	0	58, 255	5, 984	41, 001	90.00
91. 00 09100 EMERGENCY	141, 111	o	112, 430	4, 850	213, 481	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	65, 426		9, 676	46, 919	37, 489	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 479, 117	1, 367, 967	803, 231	4, 139, 610	2, 690, 898	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	ol ol	0	0	0	192. 00
192.01 19201 JANE ADDAMS BLDG	0	ol	0	0	0	192. 01
192. 02 19202 SENI OR PROGRAM	0	ol	0	0	0	192. 02
192. 03 19203 NA VOLUNTEER SERVICES	813	o	0	0	0	192. 03
192. 04 19204 SMART STEPS	0		0	0	0	192. 04
192. 05 19205 RESPITE CARE	28	ol	0	o		192. 05
193. 00 19300 NONPALD WORKERS	0	ol	0	o		193. 00
200.00 Cross Foot Adjustments]		1		200. 00
201.00 Negative Cost Centers	0	ol ol	O	ol	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 479, 958	1, 367, 967	803, 231	4, 139, 610	2, 690, 898	

Heal th Financial Systems

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0160
Period:
From 01/01/2023
To 12/31/2023
Part I
Date/Time Prepared:
5/30/2024 4: 39 pm

Cost Center Description

Subtotal Intern & Residents Cost & Post Stepdown Adjustments
24.00 25.00 26.00

GENERAL SERVICE COST CENTERS

1.00
00100 CAP REL COSTS-BLDG & FIXT
002.00
00200 CAP REL COSTS-MVBLE EQUIP

			Residents Cost		
			& Post		
			Stepdown		
			Adjustments		
		24. 00	25. 00	26.00	
GE	NERAL SERVICE COST CENTERS				
1.00 00	100 CAP REL COSTS-BLDG & FIXT				1.00
2.00 00	200 CAP REL COSTS-MVBLE EQUIP				2. 00
	400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
1	500 ADMINISTRATIVE & GENERAL				5. 00
	700 OPERATION OF PLANT				7. 00
	•				1
	800 LAUNDRY & LINEN SERVICE				8. 00
	900 HOUSEKEEPI NG				9. 00
	000 DI ETARY				10.00
	100 CAFETERI A				11. 00
	300 NURSING ADMINISTRATION				13. 00
14. 00 01	400 CENTRAL SERVICES & SUPPLY				14. 00
15. 00 01	500 PHARMACY				15. 00
16. 00 01	600 MEDICAL RECORDS & LIBRARY				16. 00
IN	PATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03	000 ADULTS & PEDIATRICS	26, 589, 638	0	26, 589, 638	30.00
1	100 INTENSIVE CARE UNIT	3, 201, 569	0	3, 201, 569	31. 00
	300 NURSERY	0, 201, 007	o	0, 201, 007	43. 00
	CILLARY SERVICE COST CENTERS		<u> </u>	<u> </u>	43.00
	000 OPERATING ROOM	15 205 042	ام	15 205 042	50.00
		15, 295, 862	0	15, 295, 862	1
	001 GI LAB	2, 153, 977	0	2, 153, 977	50. 01
	002 AMBULATORY CARE UNIT	5, 076, 588	0	5, 076, 588	50. 02
	100 RECOVERY ROOM	911, 770	0	911, 770	51. 00
1	300 ANESTHESI OLOGY	393, 698	0	393, 698	53. 00
	400 RADI OLOGY-DI AGNOSTI C	9, 618, 796	0	9, 618, 796	54. 00
	000 LABORATORY	9, 059, 471	0	9, 059, 471	60.00
65.00 06	500 RESPI RATORY THERAPY	2, 295, 064	0	2, 295, 064	65.00
66.00 06	600 PHYSI CAL THERAPY	5, 123, 091	0	5, 123, 091	66. 00
69. 00 06	900 ELECTROCARDI OLOGY	905, 396	ol	905, 396	69. 00
69. 01 06	901 CATH LAB	1, 938, 666	ol	1, 938, 666	69. 01
	000 ELECTROENCEPHALOGRAPHY	0	ol	0	70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	48	o	48	71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	0	Ö	0	72. 00
	300 DRUGS CHARGED TO PATIENTS	6, 811, 952	o	6, 811, 952	73. 00
			-		
	400 RENAL DIALYSIS	330, 414	0	330, 414	74. 00
	950 DI ABETI C EDUCATI ON	102, 069	0	102, 069	76. 00
	480 CANCER CENTER	16, 547, 945	0	16, 547, 945	76. 01
	TPATIENT SERVICE COST CENTERS				
90. 00 09	000 CLI NI C	1, 771, 195	0	1, 771, 195	90. 00
91. 00 09	100 EMERGENCY	8, 761, 688	0	8, 761, 688	91. 00
92. 00 09	200 OBSERVATION BEDS (NON-DISTINCT PART		0		92. 00
SP	ECIAL PURPOSE COST CENTERS				
113, 00 11	300 INTEREST EXPENSE				113. 00
	600 HOSPI CE	3, 658, 107	О	3, 658, 107	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	120, 547, 004	o	120, 547, 004	118. 00
	NREI MBURSABLE COST CENTERS	120, 347, 004	<u> </u>	120, 347, 004	1110.00
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	30, 722	0	30, 722	190. 00
					1
	200 PHYSI CLANS' PRI VATE OFFI CES	7, 430	0	7, 430	192. 00
	201 JANE ADDAMS BLDG	0	0	0	192. 01
	202 SENI OR PROGRAM	0	0	0	192. 02
	203 NA VOLUNTEER SERVICES	24, 517	0	24, 517	192. 03
	204 SMART STEPS	0	0	0	192. 04
	205 RESPITE CARE	13, 489	0	13, 489	192. 05
193. 00 19	300 NONPALD WORKERS	0	0	0	193. 00
200.00	Cross Foot Adjustments	0	o	0	200. 00
201.00	Negative Cost Centers	o	O	0	201.00
202.00	TOTAL (sum lines 118 through 201)	120, 623, 162	-	120, 623, 162	202. 00
			٩	.,, .02	

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Provider CCN: 14-0160

				То	12/31/2023	Date/Time Prep 5/30/2024 4:39	
			CAPI TAL REI	LATED COSTS		3/30/2024 4.3	y piii
	Cook Cooks Decoristics	D:+1	DIDC & FLVT	M/DLE FOLLD	Ch.tt1	EMDL OVEE	
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs					
	CENEDAL CEDULCE COCT CENTEDO	0	1. 00	2.00	2A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS BEDG & TTAT						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	8, 384	0	8, 384	8, 384	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	299, 887		461, 924	458	5. 00
7.00	00700 OPERATION OF PLANT	0	150, 616		177, 811	74	7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	10, 091 22, 140		10, 091 22, 140	0	8. 00 9. 00
10. 00	01000 DI ETARY	0	49, 836		55, 962	0	10.00
11. 00	01100 CAFETERI A	0	42, 533		42, 533	0	11. 00
13. 00	01300 NURSING ADMINISTRATION	0	1, 609		17, 118	147	13. 00
14.00	01400 CENTRAL SERVI CES & SUPPLY	0	3, 848		3, 859	21	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0	10, 462 2, 976		123, 061 2, 976	261 229	15. 00 16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	2, 970	<u> </u>	2, 770	227	10.00
30.00	03000 ADULTS & PEDIATRICS	0	247, 293	218, 638	465, 931	2, 772	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	18, 601		37, 239	284	31. 00
43.00	04300 NURSERY	0	0	0	0	0	43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS O5000 OPERATI NG ROOM	0	93, 240	438, 733	531, 973	454	50. 00
50. 00	05001 GI LAB	0	30, 078		119, 058	115	50.00
50. 02	05002 AMBULATORY CARE UNIT	0	40, 415		69, 466	330	1
51. 00	05100 RECOVERY ROOM	0	7, 191		15, 631	97	51.00
53.00	05300 ANESTHESI OLOGY	0	3, 709		66, 183	0	53. 00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	75, 417 38, 198		564, 106 283, 798	610 310	ł
65. 00	06500 RESPIRATORY THERAPY	0	31, 829		90, 390	186	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	67, 266		151, 042	491	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	7, 611	71, 531	79, 142	44	69. 00
69. 01	06901 CATH LAB	0	2, 682		153, 782	97	69. 01
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	_	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	O	o	0	73. 00
74.00	07400 RENAL DIALYSIS	0	1, 327	0	1, 327	0	74. 00
76. 00	03950 DI ABETI C EDUCATI ON	0	1, 327		1, 506	0	76. 00
76. 01	03480 CANCER CENTER] 0	35, 753	206, 862	242, 615	331	76. 01
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	12, 648	10, 225	22, 873	1	90.00
91. 00	09100 EMERGENCY	0	59, 056		225, 660	817	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
	SPECIAL PURPOSE COST CENTERS	ı					
	11300 NTEREST EXPENSE 11600 HOSPI CE		0	13, 378	13, 378		113. 00 116. 00
118.00		0	-		4, 060, 959		118.00
110.00	NONREI MBURSABLE COST CENTERS	ı	1,070,020	2,001,700	1, 000, 707	0, 000	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 419	0	3, 419	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	827		827		192. 00
	19201 JANE ADDAMS BLDG 19202 SENIOR PROGRAM	0	0		0		192. 01
	19202 SENTUR PROGRAM 19203 NA VOLUNTEER SERVICES		0		O O		192. 02 192. 03
	19204 SMART STEPS		Ö	ő	ol		192. 04
192.05	19205 RESPI TE CARE	0	0	0	o	1	192. 05
	19300 NONPALD WORKERS	0	0	0	0		193. 00
200.00			_		0		200. 00
201. 00 202. 00		0	1, 380, 269	0 2, 684, 936	0 4, 065, 205		201. 00 202. 00
202.00	1.01/12 (30m 11/103 110 till ough 201)	١	1, 300, 207	2, 304, 730	1, 303, 203	0, 304	1-02.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Provider CCN: 14-0160

				To	12/31/2023	Date/Time Pre 5/30/2024 4:3	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	, p
	'	& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	462, 382					5. 00
7.00	00700 OPERATION OF PLANT	17, 294	195, 179				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 528	2, 138	13, 757			8. 00
9.00	00900 HOUSEKEEPI NG	9, 478	4, 690	0	36, 308		9. 00
10.00	01000 DI ETARY	5, 895	10, 557	0	2, 035	74, 449	10. 00
11. 00	01100 CAFETERI A	4, 401	9, 010	0	1, 737	0	11. 00
13.00	01300 NURSING ADMINISTRATION	5, 099	341	0	66	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	2, 936	815	0	157	0	14. 00
15.00	01500 PHARMACY	15, 318	2, 216	0	427	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	10, 028	631	0	122	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	79, 230	52, 385	5, 062	10, 097	70, 575	30. 00
31.00	03100 INTENSIVE CARE UNIT	10, 232	3, 940	422	760	3, 874	31.00
43.00	04300 NURSERY	0	0	0	0	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	53, 594	19, 751	539	3, 807	0	50. 00
	05001 GI LAB	6, 570	6, 371	426	1, 228	0	50. 01
	05002 AMBULATORY CARE UNIT	16, 363		393	1, 650	0	50. 02
	05100 RECOVERY ROOM	3, 077	1, 523		294	0	51. 00
53. 00	05300 ANESTHESI OLOGY	1, 095			151	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	31, 476			3, 080	0	54. 00
	06000 LABORATORY	32, 004	8, 092		1, 560	0	60.00
	06500 RESPI RATORY THERAPY	7, 307	6, 743		1, 300		65. 00
66. 00	06600 PHYSI CAL THERAPY	16, 782	14, 249		2, 747	0	66. 00
	06900 ELECTROCARDI OLOGY	3, 029			311	0	69. 00
	06901 CATH LAB	6, 926			109		69. 01
	07000 ELECTROENCEPHALOGRAPHY	0	0		0	-	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	20, 192	0		0	0	73.00
	07400 RENAL DIALYSIS	1, 194		0	54	0	74.00
	03950 DI ABETI C EDUCATI ON	352			54	0	76.00
	03480 CANCER CENTER	51, 713	7, 574	520	1, 460	0	76. 01
	OUTPATIENT SERVICE COST CENTERS	/ 000	2 (70		F1/		00.00
	09000 CLI NI C 09100 EMERGENCY	6,008			516		90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	29, 687	12, 510	2, 595	2, 412	U	91. 00 92. 00
	SPECIAL PURPOSE COST CENTERS						92.00
	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	13, 411	0	0	0	n	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	462, 219	1		36, 134		118. 00
110.00	NONREI MBURSABLE COST CENTERS	402,217	174, 200	13,737	30, 134	/ 7, 77/	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	16	724	0	140	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFICES	4	175		34		192. 00
	19201 JANE ADDAMS BLDG	0	0		0		192. 01
	19202 SENI OR PROGRAM	0	1 0	ő	0		192. 02
	19203 NA VOLUNTEER SERVICES	91	1 0	ő	0		192. 03
	19204 SMART STEPS	0	1 0	ő	0		192. 04
	19205 RESPITE CARE	52	0		0		192. 05
	19300 NONPALD WORKERS	0	l 0	Ō	0		193. 00
200.00		1]			200. 00
201.00		0	0	0	0	0	201. 00
202.00		462, 382	195, 179	13, 757	36, 308		202. 00
		*	•			•	

Provider CCN: 14-0160

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/30/2024 4:39 pm

				12/31/2023	5/30/2024 4: 3	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
·		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
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	57, 681					11. 00
13.00 01300 NURSING ADMINISTRATION	985	23, 756				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	279	o	8, 067			14.00
15. 00 01500 PHARMACY	1, 926	o	123	143, 332		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	2, 011	o	0	0	15, 997	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	'	,	,	•	
30. 00 03000 ADULTS & PEDIATRICS	16, 147	21, 013	2, 019	96	1, 029	30.00
31.00 03100 INTENSIVE CARE UNIT	2, 107	2, 743	403	20	121	31.00
43. 00 04300 NURSERY	0	o	0	o	0	43.00
ANCILLARY SERVICE COST CENTERS	'		,	,		1
50. 00 05000 OPERATING ROOM	4, 006	0	297	378	2, 514	50. 00
50. 01 05001 GI LAB	1, 509	o	831	20	411	50. 01
50. 02 05002 AMBULATORY CARE UNIT	2, 630	o	330	12, 022	191	50. 02
51.00 05100 RECOVERY ROOM	1, 044	o	20	2	87	51.00
53. 00 05300 ANESTHESI OLOGY	0	o	317	77	267	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 817	О	669	34	3, 193	54.00
60. 00 06000 LABORATORY	2, 856	o	361	32	1, 781	
65. 00 06500 RESPIRATORY THERAPY	1, 455	o	364	107	350	65. 00
66. 00 06600 PHYSI CAL THERAPY	4, 022	o	126	1	536	66.00
69. 00 06900 ELECTROCARDI OLOGY	286	o	5	0	284	69. 00
69. 01 06901 CATH LAB	749	ol	4	2	457	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	o	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	o	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	o	0	43, 457	1, 706	73. 00
74.00 07400 RENAL DIALYSIS	0	o	2	0	49	74.00
76. 00 03950 DI ABETI C EDUCATION	0	o	0	0	0	76. 00
76. 01 03480 CANCER CENTER	1, 769	o	385	85, 084	1, 299	76. 01
OUTPATIENT SERVICE COST CENTERS		,	*	•		
90. 00 09000 CLI NI C	0	0	585	207	242	90.00
91. 00 09100 EMERGENCY	5, 500	o	1, 129	168	1, 259	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	2, 550	o	97	1, 625	221	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	57, 648	23, 756	8, 067	143, 332	15, 997	118. 00
NONREI MBURSABLE COST CENTERS]
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	o	0	O	0	192. 00
192.01 19201 JANE ADDAMS BLDG	0	0	0	0	0	192. 01
192. 02 19202 SENI OR PROGRAM	0	0	0	0	0	192. 02
192.03 19203 NA VOLUNTEER SERVICES	32	0	0	0	0	192. 03
192.04 19204 SMART STEPS	0	0	0	0	0	192. 04
192. 05 19205 RESPITE CARE	1	o	0	0	0	192. 05
193.00 19300 NONPALD WORKERS	0	O	0	o	0	193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	o	0	o		201. 00
202.00 TOTAL (sum lines 118 through 201)	57, 681	23, 756	8, 067	143, 332	15, 997	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS FHN MEMORIAL HOSPITAL

| Period: | Worksheet B | From 01/01/2023 | Part II | To | 12/31/2023 | Date/Time Prepared: Provider CCN: 14-0160

				Ť	o 12/31/2023	
	Cost Contor Doscription	Subtotal	Intern &	Total		5/30/2024 4: 39 pm
	Cost Center Description		Residents Cost	iotai		
			& Post			
			Stepdown			
			Adjustments			
		24. 00	25.00	26. 00		
	GENERAL SERVI CE COST CENTERS				T.	
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL					5.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00	00900 HOUSEKEEPING					9.00
10. 00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11.00
	01300 NURSI NG ADMI NI STRATI ON					13. 00
	01400 CENTRAL SERVICES & SUPPLY					14. 00
	01500 PHARMACY					15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY					16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	726, 356	0	726, 356		30.00
31.00	03100 I NTENSI VE CARE UNI T	62, 145	0	62, 145		31.00
43.00	04300 NURSERY	0	0	0		43. 00
	ANCILLARY SERVICE COST CENTERS				1	
50. 00	05000 OPERATING ROOM	617, 313	0	617, 313		50.00
	05001 GI LAB	136, 539	0	136, 539		50. 01
	05002 AMBULATORY CARE UNIT	111, 936	0	111, 936		50. 02
	05100 RECOVERY ROOM	22, 059	0	22, 059		51.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	68, 876 627, 492	0	68, 876 627, 492		53. 00 54. 00
60. 00	06000 LABORATORY	330, 794	0	330, 794		60.00
65. 00	06500 RESPIRATORY THERAPY	108, 343	0	108, 343		65. 00
	06600 PHYSI CAL THERAPY	190, 418	0	190, 418		66.00
	06900 ELECTROCARDI OLOGY	84, 713	0	84, 713		69. 00
	06901 CATH LAB	163, 116	o	163, 116		69. 01
	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	O	0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	65, 355	0	65, 355		73. 00
74.00	07400 RENAL DIALYSIS	2, 907	0	2, 907		74. 00
	03950 DI ABETI C EDUCATI ON	2, 193	0	2, 193		76. 00
76. 01	03480 CANCER CENTER	392, 750	0	392, 750		76. 01
	OUTPATIENT SERVICE COST CENTERS				T	
	09000 CLINIC	33, 111	0	33, 111		90.00
	09100 EMERGENCY	281, 737	0	281, 737		91.00
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS		0			92. 00
113 00	11300 INTEREST EXPENSE					113. 00
	11600 HOSPI CE	31, 533	0	31, 533		116. 00
118. 00	1	4, 059, 686		4, 059, 686		118. 00
	NONREI MBURSABLE COST CENTERS	1,007,000	<u> </u>	1, 007, 000		7.5.55
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 299	0	4, 299		190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	1, 040	0	1, 040		192. 00
	19201 JANE ADDAMS BLDG	0	0	0		192. 01
	19202 SENIOR PROGRAM	0	0	0		192. 02
	19203 NA VOLUNTEER SERVICES	126	0	126		192. 03
	19204 SMART STEPS	0	0	0		192. 04
	19205 RESPITE CARE	54	0	54		192. 05
	19300 NONPAI D WORKERS	0	0	0		193. 00
200. 00 201. 00	1 1	0	0	0		200. 00 201. 00
201.00		4, 065, 205	0 0	4, 065, 205		201.00
202.00	TIVIAL (Sum Times 110 through 201)	4,000,200	ı Y	4, 000, 200	I	J202. 00

					rom 01/01/2023 o 12/31/2023		
		CAPITAL RE	LATED COSTS			5/30/2024 4: 3	9 pm
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP		Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS DEPARTMENT		& GENERAL (ACCUM. COST)	
				(GROSS SALARI ES)			
OFN	EDAL CEDIUSE COST CENTERS	1.00	2.00	4.00	5A	5. 00	
	ERAL SERVICE COST CENTERS OO CAP REL COSTS-BLDG & FIXT	308, 842					1.00
	00 CAP REL COSTS-MVBLE EQUIP		2, 684, 931				2. 00
	OO EMPLOYEE BENEFITS DEPARTMENT OO ADMINISTRATIVE & GENERAL	1, 876 67, 101	0 162, 037	44, 268, 738 2, 421, 940		101, 686, 630	4. 00 5. 00
7.00 007	OO OPERATION OF PLANT	33, 701	27, 195	389, 119	0	3, 803, 387	7. 00
	00 LAUNDRY & LINEN SERVICE 00 HOUSEKEEPING	2, 258 4, 954		0		335, 936 2, 084, 506	1
10. 00 010	00 DI ETARY	11, 151	6, 126			1, 296, 440	10. 00
	OO CAFETERIA OO NURSING ADMINISTRATION	9, 517 360	1	0 777, 584	_	967, 962 1, 121, 318	1
14. 00 014	00 CENTRAL SERVICES & SUPPLY	861	11	113, 096			1
	00 PHARMACY 00 MEDICAL RECORDS & LIBRARY	2, 341 666	112, 599 0				1
	ATIENT ROUTINE SERVICE COST CENTERS	1 000	<u> </u>	1, 213, 030	0	2, 200, 362	10.00
	00 ADULTS & PEDIATRICS	55, 333					1
	00 INTENSIVE CARE UNIT 00 NURSERY	4, 162					1
ANC	ILLARY SERVICE COST CENTERS			0 400 004		11 70/ 500	
	00 OPERATING ROOM 01 GL LAB	20, 863 6, 730		· ·			1
50. 02 050	02 AMBULATORY CARE UNIT	9, 043	29, 051	1, 748, 297	0	3, 598, 544	50. 02
	00 RECOVERY ROOM 00 ANESTHESI OLOGY	1, 609 830		512, 034 0		676, 778 240, 768	1
54. 00 054	00 RADI OLOGY-DI AGNOSTI C	16, 875				6, 922, 438	1
	00 LABORATORY 00 RESPI RATORY THERAPY	8, 547				.,,	1
	00 PHYSI CAL THERAPY	7, 122 15, 051	58, 561 83, 776			1, 606, 946 3, 690, 705	1
	00 ELECTROCARDI OLOGY	1, 703	71, 531	233, 487	0	666, 072	69. 00
	01 CATH_LAB 00 ELECTROENCEPHALOGRAPHY	600	151, 100 0	514, 812 0		1, 523, 266 0	1
71. 00 071	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö	0	0	0	71. 00
	00 IMPL. DEV. CHARGED TO PATIENTS 00 DRUGS CHARGED TO PATIENTS	0	0	0	_	0 4, 440, 621	
	00 RENAL DIALYSIS	297	0	0	_	1	1
	50 DIABETIC EDUCATION 80 CANCER CENTER	297 8, 000			0		
	PATIENT SERVICE COST CENTERS	8,000	206, 862	1, 751, 071	0	11, 372, 930	76.01
90.00 090	00 CLI NI C 00 EMERGENCY	2, 830					1
	OO OBSERVATION BEDS (NON-DISTINCT PART	13, 214	166, 604	4, 324, 393	0	6, 528, 882	91. 00 92. 00
	CIAL PURPOSE COST CENTERS	I			I		140.00
113.00 113	00 I NTEREST EXPENSE 00 HOSPI CE	0	13, 378	1, 328, 253	0	2, 949, 356	113. 00 116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	307, 892	2, 684, 931			101, 651, 053	118. 00
	REIMBURSABLE COST CENTERS OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	765	O	0	0	3, 419	190. 00
192. 00 192	00 PHYSICIANS' PRIVATE OFFICES	185	О	0	0	827	192. 00
	01 JANE ADDAMS BLDG 02 SENIOR PROGRAM	0	0	0			192. 01 192. 02
	03 NA VOLUNTEER SERVICES	0	Ö	15, 057		19, 983	192. 03
	04 SMART STEPS	0	0	7 (10	0		192. 04
	05 RESPITE CARE 00 NONPAID WORKERS		0	7, 610 0	0		192. 05 193. 00
200. 00	Cross Foot Adjustments						200. 00
201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	1, 380, 269	2, 684, 936	11, 131, 429		18, 936, 532	201. 00 202. 00
	Part I)						
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	4. 469175	1. 000002	0. 251451 8, 384		0. 186224 462, 382	1
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000189		0. 004547	
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0160 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 4:39 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE (SQUARE FEET) (MEALS SERVED) PLANT (FTE'S) (SQUARE FEET) (POUNDS OF LAUNDRY) 7.00 9.00 10.00 11.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 206, 164 7.00 00800 LAUNDRY & LINEN SERVICE 2, 258 8.00 507, 072 8.00 00900 HOUSEKEEPI NG 9.00 4, 954 198, 952 9.00 10.00 01000 DI ETARY 11, 151 11, 151 61, 845 10.00 11.00 01100 CAFETERI A 9,517 9, 517 52, 796 C 11.00 01300 NURSING ADMINISTRATION 13.00 360 902 13.00 360 C 0 14.00 01400 CENTRAL SERVICES & SUPPLY 861 C 861 0 255 14.00 15.00 01500 PHARMACY 2, 341 2, 341 1,763 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 1.841 16.00 666 666 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 55, 333 186, 592 55, 333 58, 627 14, 779 30.00 03100 INTENSIVE CARE UNIT 31.00 4, 162 15, 549 4, 162 3, 218 1, 929 31.00 04300 NURSERY 43 00 Ω 43 00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 20, 863 19, 885 20, 863 0 3, 667 50.00 0 50.01 05001 GI LAB 6,730 15, 684 6,730 1, 381 50.01 05002 AMBULATORY CARE UNIT 9, 043 2, 407 14, 502 9,043 50 02 50 02 0 51.00 05100 RECOVERY ROOM 1,609 10, 467 1,609 956 51.00 53.00 05300 ANESTHESI OLOGY 830 830 0 0 0 0 0 0 0 0 0 53.00 0 54 00 05400 RADI OLOGY-DI AGNOSTI C 16.875 93, 296 16 875 5 324 54 00 06000 LABORATORY 60.00 8,547 8,547 2, 614 60.00 06500 RESPIRATORY THERAPY 7, 122 5, 183 7, 122 1, 332 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 15,051 15, 549 15, 051 3, 681 66.00 06900 ELECTROCARDI OLOGY 1, 703 69 00 1, 703 69 00 262 69.01 06901 CATH LAB 600 15, 549 600 686 69.01 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 C 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 0 0 Ω 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 C 0 0 73.00 07400 RENAL DIALYSIS 0 74.00 297 297 74.00 76.00 03950 DIABETIC EDUCATION 297 297 0 76, 00 0 03480 CANCER CENTER 19<u>, 162</u> 1, 619 76.01 8.000 8,000 0 76.01 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 2,830 2,830 0 90.00 09100 EMERGENCY 5, 034 91.00 91.00 13, 214 95, 654 13, 214 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 2, 334 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 507, 072 118.00 205, 214 198,002 61,845 52, 766 118. 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 765 765 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192. 00 185 0 185 192. 01 19201 JANE ADDAMS BLDG 0 0 192. 01 0 C 192. 02 19202 SENI OR PROGRAM 0 0 0 0 0 192. 02 192. 03 19203 NA VOLUNTEER SERVICES 0 29 192, 03 0 0 192.04 19204 SMART STEPS 0 C 0 0 0 192. 04 192. 05 19205 RESPITE CARE 0 C 0 0 192.05 193. 00 19300 NONPALD WORKERS 0 193.00 0 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 201. 00 1, 479, 958 202. 00 202.00 Cost to be allocated (per Wkst. B, 4, 511, 669 447, 909 2, 581, 104 1, 926, 563 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 21. 883884 0.883324 12. 973501 31. 151475 28. 031631 203. 00 204.00 Cost to be allocated (per Wkst. B, 195, 179 13, 757 36, 308 74.449 57, 681 204. 00 Part II) Unit cost multiplier (Wkst. B, Part 0.182496 1. 092526 205. 00 205.00 0.946717 0.027130 1.203800 II) 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)

00017				1100140		From 01/01/2023 Fo 12/31/2023	Date/Time Pre 5/30/2024 4:3	pared:
		Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHAR GES)		
			13.00	14.00	15. 00	16. 00		
1.00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1.00
2.00		CAP REL COSTS-BEDG & TTAT						2.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	1	ADMINISTRATIVE & GENERAL						5. 00
7.00		OPERATION OF PLANT						7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING						8. 00 9. 00
10.00		DI ETARY						10.00
11. 00		CAFETERI A						11. 00
13.00		NURSI NG ADMINI STRATI ON	347, 565	2 204 (20				13.00
14. 00 15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY	0	2, 384, 638 36, 486				14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0	0		587, 773, 439		16. 00
		ENT ROUTINE SERVICE COST CENTERS						
30.00	1	ADULTS & PEDIATRICS	307, 435	596, 856				30.00
31. 00 43. 00		INTENSIVE CARE UNIT NURSERY	40, 130 0	118, 982 0		3 4, 477, 751 0 0		31. 00 43. 00
43.00		LARY SERVICE COST CENTERS	<u> </u>	0		5 0		43.00
50.00	05000	OPERATING ROOM	0	87, 720	36, 832	93, 114, 054		50. 00
50. 01		GI LAB	0	245, 518				50. 01
50. 02 51. 00		AMBULATORY CARE UNIT RECOVERY ROOM	0	97, 694 5, 937				50. 02 51. 00
53. 00		ANESTHESI OLOGY	0	93, 824				53.00
54. 00	1	RADI OLOGY-DI AGNOSTI C	O	197, 831				54.00
60.00		LABORATORY	0	106, 830				60.00
65. 00		RESPI RATORY THERAPY	0	107, 539				65. 00
66. 00 69. 00		PHYSI CAL THERAPY ELECTROCARDI OLOGY	0	37, 297 1, 428		19, 864, 540 10, 506, 338		66. 00 69. 00
69. 01		CATH LAB	0	1, 045				69. 01
70. 00		ELECTROENCEPHALOGRAPHY	0	0		0		70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		10, 574		71.00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0	4, 235, 16	0 9 63, 196, 622		72. 00 73. 00
74. 00		RENAL DIALYSIS	o o	466		1, 827, 864		74. 00
76. 00		DIABETIC EDUCATION	0	41	(0		76. 00
76. 01		CANCER CENTER TIENT SERVICE COST CENTERS	0	113, 688	8, 292, 16	7 48, 117, 137		76. 01
90. 00		CLINIC	O	172, 947	20, 194	8, 956, 095		90. 00
91.00		EMERGENCY	0	333, 784				91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
112 00		AL PURPOSE COST CENTERS INTEREST EXPENSE						113. 00
		HOSPI CE	0	28, 725	158, 320	8, 188, 972		116. 00
118.00)	SUBTOTALS (SUM OF LINES 1 through 117)	347, 565	2, 384, 638				118. 00
400.00		MBURSABLE COST CENTERS	1					
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	0	0		0 0		190. 00 192. 00
		JANE ADDAMS BLDG	0	0				192. 00
192. 02	19202	SENIOR PROGRAM	0	0	(0		192. 02
	1	NA VOLUNTEER SERVICES	0	0		0		192. 03
		SMART STEPS RESPITE CARE	0	0				192. 04 192. 05
		NONPALD WORKERS	0	0				193. 00
200.00		Cross Foot Adjustments	1					200. 00
201.00		Negative Cost Centers						201. 00
202.00	,	Cost to be allocated (per Wkst. B, Part I)	1, 367, 967	803, 231	4, 139, 610	2, 690, 898		202. 00
203.00		Unit cost multiplier (Wkst. B, Part I)	3. 935859	0. 336836	0. 29634	0. 004578		203. 00
204.00		Cost to be allocated (per Wkst. B,	23, 756	8, 067				204. 00
205 00		Part II)	0.0(0350	0.002202	0.01007	0 000007		205 00
205.00	,	Unit cost multiplier (Wkst. B, Part II)	0. 068350	0. 003383	0. 01026	0. 000027		205. 00
206.00		NAHE adjustment amount to be allocated						206. 00
		(per Wkst. B-2)						
207. 00)	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
	T	, a. to 111 and 117	ı	l	ı			1

Health Financial Systems	FHN MEMORIAL	_ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/30/2024 4:3	pared: 9 pm
		Title	: XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2.00	3.00	4. 00	5. 00	

		II ti e	XVIII	ноѕрі таі	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	26, 589, 638	}	26, 589, 638	0	26, 589, 638	30. 00
31.00 03100 INTENSIVE CARE UNIT	3, 201, 569		3, 201, 569	o	3, 201, 569	31. 00
43. 00 04300 NURSERY	0)	0	o	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	15, 295, 862)	15, 295, 862	0	15, 295, 862	50. 00
50. 01 05001 GI LAB	2, 153, 977	1	2, 153, 977	o	2, 153, 977	50. 01
50. 02 05002 AMBULATORY CARE UNIT	5, 076, 588		5, 076, 588	o	5, 076, 588	50. 02
51.00 05100 RECOVERY ROOM	911, 770)	911, 770	o	911, 770	51.00
53. 00 05300 ANESTHESI OLOGY	393, 698		393, 698	o	393, 698	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 618, 796	,	9, 618, 796	o	9, 618, 796	54. 00
60. 00 06000 LABORATORY	9, 059, 471		9, 059, 471	o	9, 059, 471	60.00
65. 00 06500 RESPIRATORY THERAPY	2, 295, 064	. 0	2, 295, 064	o	2, 295, 064	65. 00
66. 00 06600 PHYSI CAL THERAPY	5, 123, 091	0	5, 123, 091	o	5, 123, 091	66. 00
69. 00 06900 ELECTROCARDI OLOGY	905, 396	,	905, 396	o	905, 396	69. 00
69. 01 06901 CATH LAB	1, 938, 666	,	1, 938, 666	o	1, 938, 666	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0)	0	o	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	48	8	48	o	48	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	o	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 811, 952		6, 811, 952	o	6, 811, 952	73. 00
74. 00 07400 RENAL DIALYSIS	330, 414		330, 414	o	330, 414	74. 00
76.00 03950 DIABETIC EDUCATION	102, 069)	102, 069	o	102, 069	76. 00
76. 01 03480 CANCER CENTER	16, 547, 945		16, 547, 945	o	16, 547, 945	76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 771, 195	i	1, 771, 195	0	1, 771, 195	90. 00
91. 00 09100 EMERGENCY	8, 761, 688	8	8, 761, 688	o	8, 761, 688	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	8, 297, 827	1	8, 297, 827		8, 297, 827	92. 00
SPECIAL PURPOSE COST CENTERS				•		
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	3, 658, 107	1	3, 658, 107		3, 658, 107	116. 00
200.00 Subtotal (see instructions)	128, 844, 831			o	128, 844, 831	
201.00 Less Observation Beds	8, 297, 827		8, 297, 827		8, 297, 827	
202.00 Total (see instructions)	120, 547, 004	. 0	120, 547, 004	o	120, 547, 004	202. 00
		•		'		•

Health Financial Systems	FHN MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Period: Worksheet C From 01/01/2023 Part I
		To 12/31/2023 Date/Time Prepared:

					To 12/31/2023	Date/Time Pre 5/30/2024 4:3	
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
	INDATIONE DOUTING CERVICE COCT CENTERS	6.00	7. 00	8. 00	9. 00	10. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	20.040.000		20.0/0.00			20.00
	03000 ADULTS & PEDI ATRI CS	28, 060, 992		28, 060, 99			30.00
	03100 INTENSIVE CARE UNIT	4, 477, 751		4, 477, 75			31.00
	04300 NURSERY	0			0		43. 00
	ANCILLARY SERVICE COST CENTERS	22 270 41/	(0.024./20	02 114 05	0 1/4070	0.000000	F0 00
	05000 OPERATING ROOM	23, 279, 416	69, 834, 638				
	05001 GI LAB	2, 060, 627	13, 152, 776				
	05002 AMBULATORY CARE UNIT	10, 749	7, 045, 258				
51.00	05100 RECOVERY ROOM	838, 857	2, 385, 298				
53.00	05300 ANESTHESI OLOGY	2, 293, 463	7, 606, 510				
	05400 RADI OLOGY-DI AGNOSTI C	20, 506, 238	93, 005, 915				
	06000 LABORATORY	15, 693, 541	50, 283, 884				
65.00	06500 RESPIRATORY THERAPY	9, 016, 054	3, 952, 810			0. 000000	
66.00	06600 PHYSI CAL THERAPY	3, 324, 892	16, 539, 648			0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY	3, 333, 318	7, 173, 020				
	06901 CATH LAB	7, 702, 016	9, 211, 977				
	07000 ELECTROENCEPHALOGRAPHY	0	0		0. 000000		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 194	2, 380	10, 57			
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0. 000000		
	07300 DRUGS CHARGED TO PATIENTS	26, 903, 070	36, 293, 552				
	07400 RENAL DI ALYSI S	1, 686, 080	141, 784	1			
	03950 DI ABETI C EDUCATI ON	0	0		0. 000000		
	03480 CANCER CENTER	9, 592	48, 107, 545	48, 117, 13	7 0. 343910	0. 000000	76. 01
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	50, 644	8, 905, 451				
	09100 EMERGENCY	8, 678, 963	37, 952, 959				
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 400, 478	7, 654, 127	10, 054, 60	5 0. 825276	0. 000000	92. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	8, 188, 972				116. 00
200.00		160, 334, 935	427, 438, 504	587, 773, 43	9		200. 00
201.00					_[201. 00
202. 00	Total (see instructions)	160, 334, 935	427, 438, 504	587, 773, 43	9		202. 00

Health Financial Systems	FHN MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 14-0160	From 01/01/2023	Worksheet C Part I Date/Time Prepared: 5/30/2024 4:39 pm
		Title XVIII	Hospi tal	PPS

				5/30/2024 4:39 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 I NTENSI VE CARE UNI T				31.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 164270			50.00
50. 01 05001 GI LAB	0. 141584			50. 01
50. 02 05002 AMBULATORY CARE UNIT	0. 719470			50. 02
51.00 O5100 RECOVERY ROOM	0. 282793			51.00
53. 00 05300 ANESTHESI OLOGY	0. 039768			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 084738			54. 00
60. 00 06000 LABORATORY	0. 137312			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 176967			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 257901			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 086176			69. 00
69. 01 06901 CATH LAB	0. 114619			69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 004539			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 107790			73. 00
74.00 07400 RENAL DIALYSIS	0. 180765			74. 00
76.00 03950 DIABETIC EDUCATION	0. 000000			76. 00
76. 01 03480 CANCER CENTER	0. 343910			76. 01
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 197764			90.00
91. 00 09100 EMERGENCY	0. 187890			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 825276			92. 00
SPECIAL PURPOSE COST CENTERS	·			
113. 00 11300 I NTEREST EXPENSE				113. 00
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

Heal th Financial Systems FHN MEMORIAL HOSPITAL In Lieu of Form CMS-255 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-0160 Period: From 01/01/2023 To 12/31/2023 Part I To 12/31/2023 To 12/31/2023 Provider CCN: 14-0160 Period: From 01/01/2023 To 12/31/2023 Part I To 12/31/2023 To 12/							
From 01/01/2023 Part I Date/Time Prepare Title XIX Hospital Cost	Health Financial Systems	FHN MEMORIAL	_ HOSPITAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description Total Cost (from Wkst. B, Part I, col.) Therapy Limit Total Costs RCE Disallowance Disallowance	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC		From 01/01/2023	Part I Date/Time Pre	pared: 9 pm
Cost Center Description Total Cost (from Wkst. B, Part I, col.) Total Costs Therapy Limit Total Costs RCE Total Costs Disallowance Disallowanc			Ti tl	e XIX	Hospi tal	Cost	
(from Wkst. B, Adj. Disallowance Part I, col.					Costs		
	Cost Center Description	(from Wkst. B, Part I, col.		Total Costs		Total Costs	
1.00 2.00 3.00 4.00 5.00		1.00	2. 00	3. 00	4. 00	5. 00	

			E XIX	nespi tui	9631	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	26, 589, 638		26, 589, 638	0	26, 589, 638	30. 00
31.00 03100 INTENSIVE CARE UNIT	3, 201, 569		3, 201, 569	0	3, 201, 569	31. 00
43. 00 04300 NURSERY	0		0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	15, 295, 862		15, 295, 862	0	15, 295, 862	50. 00
50. 01 05001 GI LAB	2, 153, 977		2, 153, 977	o	2, 153, 977	50. 01
50. 02 05002 AMBULATORY CARE UNIT	5, 076, 588		5, 076, 588	o	5, 076, 588	50. 02
51. 00 05100 RECOVERY ROOM	911, 770		911, 770	o	911, 770	
53. 00 05300 ANESTHESI OLOGY	393, 698	l .	393, 698	o	393, 698	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 618, 796	l .	9, 618, 796	0	9, 618, 796	54. 00
60. 00 06000 LABORATORY	9, 059, 471		9, 059, 471	0	9, 059, 471	60.00
65. 00 06500 RESPIRATORY THERAPY	2, 295, 064			0	2, 295, 064	65. 00
66. 00 06600 PHYSI CAL THERAPY	5, 123, 091		5, 123, 091	0	5, 123, 091	
69. 00 06900 ELECTROCARDI OLOGY	905, 396		905, 396	o o	905, 396	
69. 01 06901 CATH LAB	1, 938, 666	l .	1, 938, 666	0	1, 938, 666	
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 700, 000		1, 700, 000	o o	1, 755, 555	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	48		48	0	48	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	40		40	0	40	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	6, 811, 952		6, 811, 952	0	6, 811, 952	73. 00
74. 00 07400 RENAL DIALYSIS	330, 414		330, 414	0	330, 414	74.00
	1		· ·	0		76.00
	102, 069		102, 069	0	102, 069	
76. 01 03480 CANCER CENTER	16, 547, 945		16, 547, 945	0	16, 547, 945	76. 01
OUTPATIENT SERVICE COST CENTERS	4 774 405	1	4 774 405	ام	4 774 405	00.00
90. 00 09000 CLI NI C	1, 771, 195		1, 771, 195	0	1, 771, 195	
91. 00 09100 EMERGENCY	8, 761, 688	l .	8, 761, 688	0	8, 761, 688	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	8, 297, 827		8, 297, 827		8, 297, 827	92. 00
SPECIAL PURPOSE COST CENTERS	_	1				
113.00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 H0SPI CE	3, 658, 107		3, 658, 107		3, 658, 107	
200.00 Subtotal (see instructions)	128, 844, 831		. = = , = , = = .	0	128, 844, 831	
201.00 Less Observation Beds	8, 297, 827	l .	8, 297, 827		8, 297, 827	
202.00 Total (see instructions)	120, 547, 004	0	120, 547, 004	0	120, 547, 004	202. 00

Health Financial Systems	FHN MEMORIAL HOSPITAL	In Lieu of	f Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 14-0160	Peri od: Wol From 01/01/2023 Pai	rksheet C rt I
		To 12/31/2023 Da	te/Time Prepared:

				-	Го 12/31/2023	Date/Time Pre 5/30/2024 4:3	
			Titl	e XIX	Hospi tal	Cost	<u> </u>
			Charges	<u>. </u>	·		
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Rati o	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	NPATIENT ROUTINE SERVICE COST CENTERS						1
	D3000 ADULTS & PEDIATRICS	28, 060, 992		28, 060, 99			30. 00
	03100 INTENSIVE CARE UNIT	4, 477, 751		4, 477, 75	1		31. 00
-	04300 NURSERY	0		()		43. 00
	ANCILLARY SERVICE COST CENTERS						4
	O5000 OPERATING ROOM	23, 279, 416	69, 834, 638				
	05001 GI LAB	2, 060, 627	13, 152, 776				1
	D5002 AMBULATORY CARE UNIT	10, 749	7, 045, 258				
	D5100 RECOVERY ROOM	838, 857	2, 385, 298				
	D5300 ANESTHESI OLOGY	2, 293, 463	7, 606, 510				
	D5400 RADI OLOGY-DI AGNOSTI C	20, 506, 238	93, 005, 915				
	D6000 LABORATORY	15, 693, 541	50, 283, 884				
	D6500 RESPI RATORY THERAPY	9, 016, 054	3, 952, 810			0. 000000	
	D6600 PHYSI CAL THERAPY	3, 324, 892	16, 539, 648			0. 000000	
	D6900 ELECTROCARDI OLOGY	3, 333, 318	7, 173, 020				
	D6901 CATH LAB	7, 702, 016	9, 211, 977	16, 913, 99			
	07000 ELECTROENCEPHALOGRAPHY	0	0		0. 000000	0. 000000	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 194	2, 380	10, 57			
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0. 000000		
	D7300 DRUGS CHARGED TO PATIENTS	26, 903, 070	36, 293, 552				
	D7400 RENAL DIALYSIS	1, 686, 080	141, 784	1, 827, 86			
	D3950 DIABETIC EDUCATION	0	0		0. 000000		
	03480 CANCER CENTER	9, 592	48, 107, 545	48, 117, 13	0. 343910	0. 000000	76. 01
	OUTPATIENT SERVICE COST CENTERS						1
	09000 CLI NI C	50, 644	8, 905, 451				
	D9100 EMERGENCY	8, 678, 963	37, 952, 959				1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 400, 478	7, 654, 127	10, 054, 60	0. 825276	0. 000000	92. 00
	SPECIAL PURPOSE COST CENTERS						1
	11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	8, 188, 972				116. 00
200.00	Subtotal (see instructions)	160, 334, 935	427, 438, 504	587, 773, 43	9		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	160, 334, 935	427, 438, 504	587, 773, 43	9		202. 00

Heal t	h Financial Systems	FHN MEMORIAL	HOSPI TAI	In lie	u of Form CMS-	2552-10
	TTATION OF RATIO OF COSTS TO CHARGES	THE MEMORITAE	Provi der CCN: 14-0160	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I	pared:
			Title XIX	Hospi tal	Cost	
	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
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					1
50.00	05000 OPERATING ROOM	0. 000000				50.00
50. 01	05001 GI LAB	0. 000000				50. 01
50. 02	05002 AMBULATORY CARE UNIT	0. 000000				50. 02
	05100 RECOVERY ROOM	0. 000000				51. 00
53.00	05300 ANESTHESI OLOGY	0. 000000				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54. 00
60.00	06000 LABORATORY	0. 000000				60.00
65.00	06500 RESPIRATORY THERAPY	0. 000000				65. 00
66.00		0. 000000				66. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000				69. 00
69. O´		0. 000000				69. 01
70 00	A TABLE EL FOTBOFNIOFBULL CODABUNA	0 00000				l = a a a

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74.00

76.00

76. 01

90. 00 91. 00

92.00

113.00

116. 00

200.00

201. 00 202. 00

71.00

72.00

74.00

76. 01

90.00

92.00

200.00

201.00

202.00

70. 00 07000 ELECTROENCEPHALOGRAPHY

07400 RENAL DIALYSIS

76. 00 03950 DI ABETI C EDUCATION

09000 CLI NI C 91. 00 09100 EMERGENCY

116. 00 11600 HOSPI CE

113. 00 11300 INTEREST EXPENSE

03480 CANCER CENTER

73.00 07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

SPECIAL PURPOSE COST CENTERS

07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS

09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Health Financial Systems	FHN MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co	Provider CCN: 14-0160		Worksheet D	
				From 01/01/2023	Part I	
				To 12/31/2023	Date/Time Pre 5/30/2024 4:3	
		Title	XVIII	Hospi tal	PPS	, p
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost		·	
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	726, 356	0	726, 35	6 17, 980	40. 40	30. 00
31.00 INTENSIVE CARE UNIT	62, 145		62, 14	5 1, 286	48. 32	31.00
43. 00 NURSERY	0			0 508	0.00	43.00
200.00 Total (lines 30 through 199)	788, 501		788, 50	1 19, 774		200.00
Cost Center Description	I npati ent	I npati ent		•		
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	3, 888	157, 075				30. 00
31.00 INTENSIVE CARE UNIT	189	9, 132				31.00
43. 00 NURSERY	0	0				43. 00
200.00 Total (lines 30 through 199)	4, 077	166, 207				200. 00

Health Financial Systems	FHN MEMORIA	I HUSDITAI		Inlie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der Co		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre 5/30/2024 4:3	pared:
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	-					
50.00 05000 OPERATING ROOM	617, 313				· ·	50. 00
50. 01 05001 GI LAB	136, 539	15, 213, 403	0.00897	5 755, 232	6, 778	50. 01
50. 02 05002 AMBULATORY CARE UNIT	111, 936	7, 056, 007	0. 01586	4 3, 583	57	50. 02
51.00 O5100 RECOVERY ROOM	22, 059	3, 224, 155	0. 00684	2 192, 494	1, 317	51.00
53. 00 05300 ANESTHESI OLOGY	68, 876	9, 899, 973	0.00695	7 545, 726	3, 797	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	627, 492	113, 512, 153	0. 00552	8 6, 387, 248	35, 309	54.00
60. 00 06000 LABORATORY	330, 794	65, 977, 425	0. 00501	4 4, 607, 590	23, 102	60.00
65. 00 06500 RESPIRATORY THERAPY	108, 343	12, 968, 864	0.00835	4 2, 777, 117	23, 200	65. 00
66. 00 06600 PHYSI CAL THERAPY	190, 418	19, 864, 540	0. 00958	1, 087, 601	10, 426	66. 00
69. 00 06900 ELECTROCARDI OLOGY	84, 713	10, 506, 338	0. 00806	3 1, 207, 689	9, 738	69. 00
69. 01 06901 CATH LAB	163, 116	16, 913, 993	0.00964	4 2, 036, 605	19, 641	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	10, 574	0.00000	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1	1	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	65, 355	63, 196, 622			7, 535	
74. 00 07400 RENAL DI ALYSI S	2, 907		1		959	
76. 00 03950 DI ABETI C EDUCATION	2, 193		1		0	76. 00
76. 01 03480 CANCER CENTER	392, 750		1		78	
OUTPATIENT SERVICE COST CENTERS	072,700	10, 117, 107	0.00010	7,072	,,,	70.01
90. 00 09000 CLINIC	33, 111	8, 956, 095	0.00369	7 37, 310	138	90.00
91. 00 09100 EMERGENCY	281, 737					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	226, 672		1			
200.00 Total (lines 50 through 199)	3, 466, 324		1	37, 606, 170		
200.00 10tal (11100 00 through 177)	0, 100, 024	317,010,724	1	07,000,170	217,274	1-30. 00

Health Financial Systems	FHN MEMORIAL	HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST			Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 4:3	
		Ti tl e	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown	, and the second	Adjustments		Education Cost	
	Adjustments					
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	l ol	0)	ol o	0	31. 00
43. 00 04300 NURSERY	0	0	,	0	0	43.00
200.00 Total (lines 30 through 199)	أم	0	1	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,		,		
		minus col. 4)				
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>		•	<u>'</u>		
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	17, 98	0.00	3, 888	30.00
31.00 03100 INTENSIVE CARE UNIT		0	1, 28		189	31. 00
43. 00 04300 NURSERY		0	50		0	1
200.00 Total (lines 30 through 199)		0	l .			200. 00
Cost Center Description	Inpatient					
'	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9, 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T						31. 00
43. 00 04300 NURSERY						43. 00
200.00 Total (lines 30 through 199)						200. 00
200.00	١					1200.00

Health Financial S	Systems		FHN MEMORIA	L HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTI ONMENT OF I	NPATI ENT/OUTPATI ENT	ANCI LLARY SEI	RVICE OTHER PASS	S Provi der Co	CN: 14-0160	Peri od:	Worksheet D	
THROUGH COSTS						From 01/01/2023		
						To 12/31/2023	Date/Time Pre	
							5/30/2024 4: 3	9 pm
				Title	XVIII	Hospi tal	PPS	
Cost (Center Description		Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
			Anestheti st	Program	Program	Post-Stepdown		
			Cost	Post-Stepdown		Adjustments		
				Adiustments		-		

		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	(0	0	50.00
50. 01 05001 GI LAB	0	0	(0	0	50. 01
50. 02 05002 AMBULATORY CARE UNIT	0	0	(0	0	50. 02
51.00 O5100 RECOVERY ROOM	0	0	(0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0	0	(0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54. 00
60. 00 06000 LABORATORY	0	0	(0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	(0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
69. 01 06901 CATH LAB	0	0	(0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	(0	0	74.00
76.00 03950 DIABETIC EDUCATION	0	0	(0	0	76. 00
76. 01 03480 CANCER CENTER	0	0	(0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	(0	0	90. 00
91. 00 09100 EMERGENCY	0	0		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	92.00
200.00 Total (lines 50 through 199)	0	0	(0	0	200. 00

Heal th Financial Systems	Prepared: :39 pm
Cost Center Description	st
Medical Education Cost 1, 2, 3, and 2, 3, and 4) Cost (sum of col s. 1, 2, 3, and 4) Cost (sum of col s. 2, 3, and 2, 3,	
Education Cost 1, 2, 3, and Cost (sum of cols. 2, 3, and 4) Part I, col. (col. 5 ÷ cols. 2, 3, and 4) Reverse Part I, col. (col. 5 ÷ cols. 2, 3, and 4) Reverse Part I, col. (col. 5 ÷ cols. 2, 3, and 4) Reverse Part I, col. (col. 5 ÷ cols. 2, 3, and 4) Reverse Part I, col. (col. 5 ÷ cols. 2, 3, and 4) Reverse Part I, col. (col. 5 ÷ cols. 2, 3, and 4) Reverse Part I, col. (col. 5 ÷ cols. 2, 3, and 4) Reverse Part I, col. (col. 5 ÷ cols. 2, 3, and 4) Reverse Part I, col. Reverse Part	
4) col s. 2, 3, and 4) 7) (see instruction 4.00 5.00 6.00 7.00 8.00	
ANCI LLARY SERVI CE COST CENTERS ANCI LLARY SERVI CE COST CENTERS ANCI LLARY SERVI CE COST CENTERS	1.
ANCI LLARY SERVI CE COST CENTERS	
ANCI LLARY SERVI CE COST CENTERS	
ANCI LLARY SERVI CE COST CENTERS 50. 00	5)
50. 00 05000 OPERATI NG ROOM 0 0 93, 114, 054 0.000 50. 01 05001 GI LAB 0 0 0 15, 213, 403 0.000 50. 02 05002 AMBULATORY CARE UNIT 0 0 0 7, 056, 007 0.000 51. 00 05100 RECOVERY ROOM 0 0 3, 224, 155 0.000	
50. 01 05001 GI LAB 0 0 0 15, 213, 403 0.000 50. 02 05002 AMBULATORY CARE UNIT 0 0 0 7, 056, 007 0.000 51. 00 05100 RECOVERY ROOM 0 0 0 3, 224, 155 0.000	
50. 02 05002 AMBULATORY CARE UNIT 0 0 0 7,056,007 0.000 51. 00 05100 RECOVERY ROOM 0 0 3,224,155 0.000	
51.00 05100 RECOVERY ROOM 0 0 3,224,155 0.000	
53 ON INSTANCTHEST OF OR A SECTION OF A SECT	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 113, 512, 153 0. 000	
60. 00 06000 LABORATORY 0 0 65, 977, 425 0. 000	
65. 00 06500 RESPI RATORY THERAPY 0 0 0 12, 968, 864 0. 000	
66. 00 06600 PHYSI CAL THERAPY 0 0 0 19, 864, 540 0. 000	
69. 00 06900 ELECTROCARDI OLOGY 0 0 10, 506, 338 0. 000	
69. 01 06901 CATH LAB 0 0 16, 913, 993 0. 000	
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0. 000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 10, 574 0.000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0.000	
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 63, 196, 622 0.000	
74. 00 07400 RENAL DI ALYSI S 0 0 1, 827, 864 0. 000	
76. 00 03950 DI ABETI C EDUCATION 0 0 0 0 0 0 0 0 0 0 0	00 76.00
76. 01 03480 CANCER CENTER 0 0 0 48, 117, 137 0.000	00 76. 01
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C 0 0 8, 956, 095 0. 000	00 90.00
91. 00 09100 EMERGENCY 0 0 46, 631, 922 0.000	
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 10, 054, 605 0.000	
200.00 Total (Lines 50 through 199) 0 0 547,045,724	

Health Financial Systems	Hoal +h	Financial Systems	EUN MEMODIAI	HOCDI TAI		ln lio	u of Form CMS 1	2552 10
Cost Center Description	APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER				Period: From 01/01/2023	Worksheet D Part IV Date/Time Pre	pared:
Ratio of Cost to Charges to Charge to C				Title	XVIII	Hospi tal		
to Charges (col. 6 + cot.) To Pass-Through Costs (col. 8 x col. 10) To x col. 10, 10, 10, 10, 10, 10, 10, 10, 10, 10,		Cost Center Description						
Costs (col. 8 X col. 10) X col. 12)								
ANCILLARY SERVICE COST CENTERS				Charges				
ANCILLARY SERVICE COST CENTERS			,		,	3		
ANCILLARY SERVICE COST CENTERS								
50. 00 05000 OPERATI NG ROOM 0.000000 6,572,259 0 14,918,629 0 50.00 50. 01 05001 GI LAB 0.000000 755,232 0 2,722,582 0 50.01 50. 02 05002 AMBULATORY CARE UNIT 0.000000 3,583 0 3,157,340 0 50.02 51. 00 05100 RECOVERY ROOM 0.000000 192,494 0 422,073 0 51.00 53. 00 05300 AMESTHESI OLOGY 0.000000 545,726 0 1,595,326 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 6,387,248 0 16,546,937 0 54.00 60. 00 06600 LABORATORY 0.000000 4,607,590 0 3,459,998 0 60.00 65. 00 06500 RESPI RATORY THERAPY 0.000000 2,777,117 0 598,335 0 65.00 66. 00 06690 DELECTROCARDI OLOGY 0.000000 1,087,689 0 2,191,602 0 69.01 70.			9. 00	10. 00	11. 00	12. 00	13. 00	
50. 01 05001 GI LAB 0.000000 755, 232 0 2,722,582 0 50. 01					•			
50. 02 05002 AMBULATORY CARE UNIT 0.000000 3,583 0 3,157,340 0 50.02 51. 00 05100 RECOVERY ROOM 0.000000 192,494 0 422,073 0 51.00 53. 00 05300 ANESTHESI OLOGY 0.000000 545,726 0 1,595,326 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 6,387,248 0 16,546,937 0 54.00 60. 00 06000 LABORATORY 0.000000 4,607,590 0 3,459,998 0 60.00 65. 00 06500 RESPI RATORY THERAPY 0.000000 2,777,117 0 598,335 0 65.00 66. 00 06600 PHYSI CAL THERAPY 0.000000 1,207,689 0 2,191,602 0 69.01 69. 01 06901 CATH LAB 0.000000 1,207,689 0 2,701,127 0 69.01 70. 00 07000 MEDI CAL SUPPLI ES CHARGED TO PATIENT 0.0000							_	
51.00 05100 RECOVERY ROOM 0.000000 192,494 0 422,073 0 51.00 53.00 05300 ANESTHESI OLOGY 0.000000 545,726 0 1,595,326 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 6,387,248 0 16,546,937 0 54.00 60.00 06500 RESPI RATORY 0.000000 4,607,590 0 3,459,998 0 60.00 65.00 06500 RESPI RATORY THERAPY 0.000000 2,777,117 0 598,335 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 1,087,601 0 1,274,827 0 66.00 69.01 06901 CATH LAB 0.000000 1,207,689 0 2,191,602 0 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0				· ·			0	
53. 00 05300 ANESTHESI OLOGY 0.000000 545, 726 0 1,595,326 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 6,387,248 0 16,546,937 0 54. 00 60. 00 06000 LABORATORY 0.000000 4,607,590 0 3,459,998 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.000000 2,777,117 0 598,335 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 1,087,601 0 1,274,827 0 66. 00 69. 01 06900 ELECTROCARDI OLOGY 0.000000 1,207,689 0 2,191,602 0 69. 00 69. 01 O6901 CATH LAB 0.000000 2,036,605 0 2,701,127 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI				· ·			0	
54. 00				192, 494		· ·	0	
60. 00		05300 ANESTHESI OLOGY		545, 726		0 1, 595, 326	0	53. 00
65. 00	54.00					0 16, 546, 937	0	
66. 00	60.00	06000 LABORATORY	0. 000000	4, 607, 590		0 3, 459, 998	0	60.00
69. 00	65.00	06500 RESPI RATORY THERAPY	0. 000000	2, 777, 117		0 598, 335	0	65. 00
69. 01	66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 087, 601		0 1, 274, 827	0	66. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0. 000000 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 000000 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 7, 287, 671 0 8, 765, 047 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0. 000000 603, 280 0 18, 983 0 74. 00 76. 00 03950 DI ABETI C EDUCATI ON 0. 000000 0 0 0 0 0 76. 01 03480 CANCER CENTER 0. 000000 9, 592 0 15, 357, 632 0 76. 01 00TPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0. 000000 2, 736, 036 0 4, 585, 354 0 91. 00 91. 00 09200 DRERGENCY 0. 000000 759, 137 0 1, 474, 146 0 92. 00 92. 00 09200 DRERCENCTION 0. 000000 759, 137 0 1, 474, 146 0 92. 00 90. 00 00000 00000 000000 000000 000000	69.00	06900 ELECTROCARDI OLOGY	0. 000000	1, 207, 689		0 2, 191, 602	0	69. 00
71. 00	69. 01	06901 CATH LAB	0. 000000	2, 036, 605		0 2, 701, 127	0	69. 01
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 7, 287, 671 0 8, 765, 047 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0.000000 603, 280 0 18, 983 0 74. 00 76. 00 03950 DI ABETI C EDUCATI ON 0.000000 0 0 0 0 0 76. 01 03480 CANCER CENTER 0.000000 9, 592 0 15, 357, 632 0 76. 01 00TPATIENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 0.000000 37, 310 0 3, 777, 231 0 90. 00 91. 00 09100 EMERGENCY 0.000000 2, 736, 036 0 4, 585, 354 0 91. 00 92. 00 09200 DRESERVATI ON BEDS (NON-DI STI NCT PART 0.000000 759, 137 0 1, 474, 146 0 92. 00	70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 7,287,671 0 8,765,047 0 73.00 74. 00 07400 RENAL DI ALYSIS 0.000000 603,280 0 18,983 0 74.00 76. 00 03950 DI ABETI C EDUCATION 0.000000 0 0 0 0 0 76. 01 03480 CANCER CENTER 0.000000 9,592 0 15,357,632 0 76. 01 00TPATIENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 0.000000 37,310 0 3,777,231 0 90.00 91. 00 09100 EMERGENCY 0.000000 2,736,036 0 4,585,354 0 91.00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 759,137 0 1,474,146 0 92.00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0	0	71. 00
74. 00 07400 RENAL DIALYSIS 0.000000 603, 280 0 18, 983 0 74. 00 76. 00 03450 DIABETI C EDUCATION 0.000000 0 0 0 0 0 0 76. 00 03480 CANCER CENTER 0.000000 9, 592 0 15, 357, 632 0 76. 01 000000 CLI NI C 0.0000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
76. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	7, 287, 671		0 8, 765, 047	0	73. 00
76. 01 03480 CANCER CENTER 0. 000000 9, 592 0 15, 357, 632 0 76. 01 000000 00000 00000 00000 00000 00000 0000	74.00	07400 RENAL DIALYSIS	0. 000000	603, 280		0 18, 983	0	74. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0.000000 37,310 0 3,777,231 0 90.00 91. 00 09100 EMERGENCY 0.000000 2,736,036 0 4,585,354 0 91.00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0.000000 759,137 0 1,474,146 0 92.00	76.00	03950 DIABETIC EDUCATION	0. 000000	0		0	0	76. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0.000000 37, 310 0 3,777, 231 0 90. 00 91. 00 09100 EMERGENCY 0.000000 2,736,036 0 4,585,354 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.000000 759,137 0 1,474,146 0 92. 00	76. 01	03480 CANCER CENTER	0. 000000	9, 592		0 15, 357, 632	0	76. 01
90. 00 09000 CLI NI C 0. 000000 37, 310 0 3, 777, 231 0 90. 00 91. 00 09100 EMERGENCY 0. 000000 2, 736, 036 0 4, 585, 354 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0. 000000 759, 137 0 1, 474, 146 0 92. 00		OUTPATIENT SERVICE COST CENTERS	<u> </u>	·				
91. 00 09100 EMERGENCY	90.00		0. 000000	37, 310		0 3, 777, 231	0	90.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0. 000000 759, 137 0 1, 474, 146 0 92. 00	91.00	09100 EMERGENCY	0. 000000	· ·			0	91.00
	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000					92.00
		· · · · · · · · · · · · · · · · · · ·		· ·			0	200.00

Health Financial Systems	FHN MEMORIAL H	OSPI TAL	In I	Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0160	Peri od:	Worksheet D

From 01/01/2023 | Part V | Date/Time Prepared: 5/30/2024 4:39 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 164270 14, 918, 629 2, 450, 683 50.00 50.01 05001 GI LAB 0.141584 2, 722, 582 0 385, 474 50.01 05002 AMBULATORY CARE UNIT 0 2, 271, 611 50 02 0 719470 3, 157, 340 50 02 3 463 0 51.00 05100 RECOVERY ROOM 0. 282793 422, 073 0 119, 359 51.00 53.00 05300 ANESTHESI OLOGY 0.039768 1, 595, 326 63, 443 53.00 16, 546, 937 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.084738 0 1, 402, 154 54.00 610 3, 459, 998 0 06000 LABORATORY 60.00 0.137312 0 475, 099 60.00 65.00 06500 RESPIRATORY THERAPY 0. 176967 598, 335 0 0 105, 886 65.00 06600 PHYSI CAL THERAPY 0 0 66.00 0. 257901 1, 274, 827 328, 779 66.00 06900 ELECTROCARDI OLOGY 188, 863 2, 191, 602 0 69 00 69 00 0.086176 69.01 06901 CATH LAB 0.114619 2, 701, 127 0 309, 600 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.004539 0 71.00 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72 00 0.000000 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 107790 8, 765, 047 0 15, 960 944, 784 73.00 07400 RENAL DIALYSIS 0. 180765 0 3, 431 74.00 18, 983 74.00 76. 00 03950 DIABETIC EDUCATION 0.000000 0 76.00 0 5, <u>281, 643</u> 03480 CANCER CENTER 15, 357, 632 19, 573 76.01 0. 343910 76.01 OUTPATIENT SERVICE COST CENTERS 0. 197764 0 747, 000 90.00 09000 CLI NI C 3, 777, 231 384 90.00 0 861, 542 91.00 09100 EMERGENCY 0.187890 4, 585, 354 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.825276 92 00 1, 474, 146 0 1, 216, 577 0 200.00 Subtotal (see instructions) 83, 567, 169 39, 990 17, 155, 928 200. 00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges 0 202.00 Net Charges (line 200 - line 201) 83, 567, 169 39, 990 17, 155, 928 202. 00

Health Financial Systems	FHN MEMORIAL H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der CC	CN: 14-0160	From 01/01/2023	Worksheet D Part V Date/Time Pre 5/30/2024 4:3	
		Title	XVIII	Hospi tal	PPS	
	Costs					

					10 12/31/2023	5/30/2024 4:3	
			Titl∈	XVIII	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)	-			
	ANGLE ARY OFRIGOR COOK OFFITERS	6.00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	Ü	2			50.00
	05001 GI LAB	0	0	2			50. 01
	05002 AMBULATORY CARE UNIT	0	2, 492				50. 02
	05100 RECOVERY ROOM	0	Ü	2			51.00
	05300 ANESTHESI OLOGY	0	0)			53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	52	2			54.00
	06000 LABORATORY	0	0)			60. 00
	06500 RESPI RATORY THERAPY	0	0)			65. 00
	06600 PHYSI CAL THERAPY	0	0)			66. 00
	06900 ELECTROCARDI OLOGY	0	0)			69. 00
	06901 CATH LAB	0	0)			69. 01
	07000 ELECTROENCEPHALOGRAPHY	0	0)			70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)			71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0)			72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 720	1			73. 00
	07400 RENAL DIALYSIS	0	0	2			74. 00
	03950 DI ABETI C EDUCATI ON	0	(704)			76. 00
	03480 CANCER CENTER	0	6, 731				76. 01
	OUTPATIENT SERVICE COST CENTERS	1 0	7.	T			
	09000 CLINIC	0	76	2			90.00
	09100 EMERGENCY	0	0	()			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	11 071	'			92. 00
200.00	Subtotal (see instructions)	0	11, 071				200. 00
201. 00	Less PBP Clinic Lab. Services-Program	0					201. 00
202.00	Only Charges (Line 200 Line 201)		11 071				202.00
202.00	Net Charges (line 200 - line 201)	ا ا	11, 071				202. 00

Health Financial Systems	FHN MEMORIAL HOSPITAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0160	Peri od: From 01/01/2023	Worksheet D-1	
			Date/Time Pre 5/30/2024 4:3	
	Title XVIII	Hospi tal	PPS	
Cook Cooker December 1				

		Title XVIII	Hospi tal	PPS	7 PIII
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			17, 980 17, 980	1. 00 2. 00
3.00	Private room days (excluding swing-bed and observation bed day		vate room days.	17, 480	3. 00
	do not complete this line.		12.00		
4.00	Semi-private room days (excluding swing-bed and observation be		24 6 11	12, 369	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roc reporting period	om days) through December	31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	, daya) through Dagambar	21 of the cost	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	aays) through becember	31 of the cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3°	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)			2 222	0.00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swing-bed and	3, 888	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days)	0	10. 00
11 00	through December 31 of the cost reporting period (see instruct			0	11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		oom days) arter	0	11. 00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13. 00
14.00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	f the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of t	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng period (line	26, 589, 638 0	21. 00 22. 00
22.00	5 x line 17)	or or the cost reports	ng perrou (rrne	Ü	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reportin	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ([line 21 minus line 26)		26, 589, 638	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		,		
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	l and observation bed cha	arges)	0	28. 00 29. 00
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	· line 28)		0. 000000	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)	•		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	and not voto re !!!	Fforontial (I:	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	inu private room cost dii	rerential (IINe	26, 589, 638	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
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38. 00	Adjusted general inpatient routine service cost per diem (see			1, 478. 85	38. 00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		5, 749, 769 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	,		5, 749, 769	
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From To Title XVIII	eri od:	Worksheet D-1	2552
Cost Center Description Inpatient Cost Inpatient Description Inpatient Cost Inpatient Description (Cost. 1.2)	om 01/01/2023	B B Date/Time Pre	epare
Cost Center Description Total Total Total Average Per Inpatient Cost Inpatient Days Inpatient Cost Inpatient	Hospi tal	5/30/2024 4: 3 PPS	39 pn
Inpati ent Cost Inpati ent Days Diem (Col. 1)	Hospital Program Days	+	
2.00 NURSERY (title V & XIX only)	og. a bayo	(col . 3 x col . 4)	
intensive Care Type Inpatient Hospital Units Intensive Care Unit	4. 00	5. 00	
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market basket) Continuous improvement bonus payment (if line 53 * line 54 is less than the lowest of line 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating or 533 are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), enter zero. (see instructions) Relief payment (see instructions) Relief payment (see instructions) Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting perinstructions) (title XVIII only) COME (and Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII on CAH, see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, ADD LEFT/IID ONLY Adjusted general inpatient routine service cost per diem (line 70 + line 2) Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35) Total Program general inpatient routine service costs (from Worksheet B, Part 26, line 45) Der diem capital -related costs (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Dougland -related costs (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Dougland -related costs (line 74 minus line 77) Dropram capital -related costs (line 75 + line 2) Program capital -related costs (line 76 minus line 77) Dropram capital -related costs (line 78 minus line 77) Dropram capital -related costs (line 78 minu		0.00	
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Relief payment (see instructions) Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting plus instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting per instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII on CAH, see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost report (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost report (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost report (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 + line 2) Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35) Total Program general inpatient routine service costs (from Worksheet B, Part 26, line 45) Program capital-related costs (line 75 + line 2) Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service cost per diem limitation Inpatient routine service cost per diem limitation Inpatient routine service cost per diem limitation Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions)	costs (line	0	61
Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST 4.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting instructions) (title XVIII only) 5.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting perinstructions) (title XVIII only) 6.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only) 7.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only) 7.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost report (line 12 x line 19) 7.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost report (line 13 x line 20) 7.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 7.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 7.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 7.00 Program routine service cost (line 9 x line 71) 7.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 7.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part 26, line 45) 7.00 Per diem capital-related costs (line 75 + line 2) 7.00 Program capital-related costs (line 75 + line 2) 7.00 Program capital-related costs (line 77 + line 2) 7.00 Program capital-related costs (line 9 x line 76) 7.01 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 77) 7.01 Inpatient routine service cost see instructions) 7.02 Program inpatient ancillary services (see instructions) 7.03 Program inpatient ancillary services (see instructions) 7.04 Utilization review - physician compensation (see instructions)		0	62
Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting provided instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting per instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only) Total Vor XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting (line 12 x line 19) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Adjusted general inpatient routine service cost per diem (line 70 + line 2) Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35) Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part 26, line 45) Per diem capital-related costs (line 9 x line 76) Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 10, patient routine service cost for comparison to the cost limitation (line 78 minus line 10, patient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)		0	63
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Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35) Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service cost per diem limitation Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine services (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)		0	69
Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35) Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus linpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)			70
Medically necessary private room cost applicable to Program (line 14 x line 35) Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 70) Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)			71
Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 76) Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine services (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)			72
Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 78) Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)			73
26, line 45) Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 78 minus line 79) Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)	rt II column		74
Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 70) Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)	c ii, corumii		'3
Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus linpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)			76
Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus 1 line) Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)			77
Total Program routine service costs for comparison to the cost limitation (line 78 minus line) Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)			78
.00 Inpatient routine service cost per diem limitation .00 Inpatient routine service cost limitation (line 9 x line 81) .00 Reasonable inpatient routine service costs (see instructions) .00 Program inpatient ancillary services (see instructions) .00 Utilization review - physician compensation (see instructions) .00 Total Program inpatient operating costs (sum of lines 83 through 85)	line 79)		80
Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)	, ,		81
Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)			82
5.00 Utilization review - physician compensation (see instructions) 5.00 Total Program inpatient operating costs (sum of lines 83 through 85)			83
5.00 Total Program inpatient operating costs (sum of lines 83 through 85)			84
			85
			86
7.00 Total observation bed days (see instructions)		5, 611	87
3.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		1, 478. 85	

Health Financial Systems	FHN MEMORIAL	. HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 4:3	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	726, 356	26, 589, 638	0. 02731	7 8, 297, 827	226, 672	90.00
91.00 Nursing Program cost	0	26, 589, 638	0.00000	8, 297, 827	0	91.00
92.00 Allied health cost	0	26, 589, 638	0.00000	8, 297, 827	0	92.00
93.00 All other Medical Education	0	26, 589, 638	0.00000	8, 297, 827	0	93. 00

<i>J</i>	AL HOSPITAL			u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 14-0160	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Pre 5/30/2024 4:3	pared:
	Ti tl e	e XVIII	Hospi tal	PPS	•
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00 03000 ADULTS & PEDI ATRI CS			7, 003, 761		30.00
31. 00 03100 I NTENSI VE CARE UNIT			975, 519		31.00
43. 00 04300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM		0. 1642	70 6, 572, 259	1, 079, 625	50.00
50. 01 05000 GPERATTING ROOM 50. 01 05001 GI LAB		0. 1642			
50. 02 05002 AMBULATORY CARE UNIT		0. 7194		· ·	
51. 00 05100 RECOVERY ROOM		0. 28279			
53. 00 05300 ANESTHESI OLOGY		0. 03976			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 08473			
60. 00 06000 LABORATORY		0. 1373			
65. 00 06500 RESPIRATORY THERAPY		0. 17696		491, 458	
66. 00 06600 PHYSI CAL THERAPY		0. 25790		280, 493	
59. 00 06900 ELECTROCARDI OLOGY		0. 08617	76 1, 207, 689	104, 074	69.00
69. 01 06901 CATH LAB		0. 1146	19 2, 036, 605	233, 434	69. 01
70.00 07000 ELECTROENCEPHALOGRAPHY		0.00000	00	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 00453		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000		0	1
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 10779		785, 538	
74. 00 07400 RENAL DI ALYSI S		0. 1807			1
76.00 03950 DIABETIC EDUCATION		0.00000		0	
76. 01 03480 CANCER CENTER		0. 3439	10 9, 592	3, 299	76. 01
OUTPATIENT SERVICE COST CENTERS		1			
90. 00 09000 CLI NI C		0. 1977			90.00
91. 00 09100 EMERGENCY		0. 18789	, , , , , , , , , , , , , , , , , , , ,		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 8252		626, 498	
Total (sum of lines 50 through 94 and 96 through 98)			37, 606, 170	5, 594, 489	
201.00 Less PBP Clinic Laboratory Services-Program only cha	arges (line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)		1	37, 606, 170		202. 00

	Title XVIII Hospital	PPS	<u> у рііі</u>
		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	1. 00	
1. 00	DRG Amounts Other than Outlier Payments	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see	5, 727, 858	1. 01
4 00	instructions)	0 404 005	4 00
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2, 134, 825	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October	0	1. 03
	1 (see instructions)		
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after	0	1. 04
2. 00	October 1 (see instructions) Outlier payments for discharges. (see instructions)		2. 00
2. 01	Outlier reconciliation amount	0	2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2. 02
2. 03	Outlier payments for discharges occurring prior to October 1 (see instructions)	64, 442	2. 03
2. 04 3. 00	Outlier payments for discharges occurring on or after October 1 (see instructions) Managed Care Simulated Payments	28, 907 0	2. 04 3. 00
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions)	84. 63	4. 00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on	0. 00	5. 00
5. 01	or before 12/31/1996. (see instructions) FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0. 00	5. 01
6. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for	0.00	6. 00
	new programs in accordance with 42 CFR 413.79(e)		
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of	0. 00	6. 26
7 00	the CAA 2021 (see instructions)	0.00	7 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the	0. 00 0. 00	7. 00 7. 01
7.01	cost report straddles July 1, 2011 then see instructions.	0.00	,
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural	0.00	7. 02
	track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b)		
8. 00	and 87 FR 49075 (August 10, 2022) (see instructions) Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for	0. 00	8. 00
0.00	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,	0.00	0.00
	1998), and 67 FR 50069 (August 1, 2002).		
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost	0. 00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital	0.00	8. 02
0.02	under § 5506 of ACA. (see instructions)	0.00	0.02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see	0. 00	8. 21
9. 00	instructions) Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or	0. 00	9. 00
9.00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	
11. 00	FTE count for residents in dental and podiatric programs.		11. 00
12. 00 13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.		12. 00 13. 00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,	0.00	
	otherwise enter zero.		
15. 00			15. 00
16.00			16.00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count		17. 00 18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).	0. 000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0. 000000	20. 00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)	0. 000000	
22. 00 22. 01	IME payment adjustment (see instructions)	0	22. 00 22. 01
22.01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA	0	22.01
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105	0.00	23. 00
	(f)(1)(iv)(C).		
24. 00	IME FTE Resident Count Over Cap (see instructions)	0.00	24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24 (see instructions)	0. 00	25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)	0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)	0. 000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)	0	28. 00
28. 01 29. 00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment (sum of lines 22 and 28)	0	28. 01 29. 00
29. 00	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29. 00
	Di sproporti onate Share Adjustment	Ů	
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4. 75	
31.00	Percentage of Medicaid patient days (see instructions)	16. 27	31.00
32. 00 33. 00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)	21. 02 6. 56	32. 00 33. 00
	Disproporti onate share adjustment (see instructions)	128, 948	
	· · · · · · · · · · · · · · · · · · ·		

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0160	Peri od:	Worksheet E	
			From 01/01/2023 To 12/31/2023	Part A Date/Time Pre	parec
		Title XVIII	Hospi tal	5/30/2024 4: 3 PPS	9 PIII
			Prior to 10/1		
			1. 00	2. 00	
	Uncompensated Care Payment Adjustment				
5. 00	Total uncompensated care amount (see instructions)		0	0	
5. 01	Factor 3 (see instructions)		0. 000098580	0. 000098253	•
5. 02	Hospital UCP, including supplemental UCP (see instructions)	(acc instructions)	677, 679	583, 429	1
5. 03 6. 00	Pro rata share of the hospital UCP, including supplemental UCP Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	(See Thistructions)	506, 867 653, 521	146, 654	35. 36.
5. 00	Additional payment for high percentage of ESRD beneficiary dis	charges (lines 40 throu			30.
0. 00	Total Medicare discharges (see instructions)	charges (Times to threa	0		40.
1. 00	Total ESRD Medicare discharges (see instructions)		ol		41.
1. 01	Total ESRD Medicare covered and paid discharges (see instructi	ons)	o		41.
2. 00	Divide line 41 by line 40 (if less than 10%, you do not qualif		0.00		42.
3. 00	Total Medicare ESRD inpatient days (see instructions)		o		43.
4. 00	Ratio of average length of stay to one week (line 43 divided b days)	y line 41 divided by 7	0. 000000		44.
5. 00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.
5. 00	Total additional payment (line 45 times line 44 times line 41.	01)	0		46.
7. 00	Subtotal (see instructions)		8, 738, 501		47.
8. 00	Hospital specific payments (to be completed by SCH and MDH, sm only. (see instructions)	all rural hospitals	8, 961, 058		48.
				Amount 1.00	
. 00	Total payment for inpatient operating costs (see instructions)			8, 905, 419	10
). 00	Payment for inpatient program capital (from Wkst. L, Pt. I and			593, 500	
. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	
2. 00	Direct graduate medical education payment (from Wkst. E-4, lin			0	52.
3. 00	Nursing and Allied Health Managed Care payment			0	53.
1. 00	Special add-on payments for new technologies			28, 576	54.
4. 01	Islet isolation add-on payment			0	54.
5. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	
5. 01	Cellular therapy acquisition cost (see instructions)			0	55.
5. 00	Cost of physicians' services in a teaching hospital (see intru	*	h	0	56.
7.00	Routine service other pass through costs (from Wkst. D. Pt. II		nrougn 35).	0	
3. 00 9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58)	v, cor. If time 200)		9, 527, 495	
). 00	Primary payer payments			14, 699	
. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		9, 512, 796	
2. 00	Deductibles billed to program beneficiaries			1, 104, 868	
3. 00	Coinsurance billed to program beneficiaries			83, 123	
1. 00	Allowable bad debts (see instructions)			244, 207	
5. 00	Adjusted reimbursable bad debts (see instructions)			158, 735	65.
6. 00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		197, 561	
	Subtotal (line 61 plus line 65 minus lines 62 and 63)			8, 483, 540	ı
3. 00	Credits received from manufacturers for replaced devices for a			0	
00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	For SCH see instruction	S)	0	
). 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ration) adjustment (cas	instructions)	0	70.
). 50). 75	Rural Community Hospital Demonstration Project (§410A Demonstr N95 respirator payment adjustment amount (see instructions)	ation, adjustment (see	1 113 L1 UC L1 0115)	0	
). 73). 87	Demonstration payment adjustment amount before sequestration			0	
0. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	
0. 89	Pioneer ACO demonstration payment adjustment amount (see instr	uctions)			70.
0. 90	HSP bonus payment HVBP adjustment amount (see instructions)			87	•
0. 91	HSP bonus payment HRR adjustment amount (see instructions)			-2, 582	•
0. 92	Bundled Model 1 discount amount (see instructions)			0	1
0. 93	HVBP payment adjustment amount (see instructions)			4, 410	•
0. 94	HRR adjustment amount (see instructions)			-119, 852	70.
	Recovery of accelerated depreciation			_	70

Health Financial Contant	FUN MEMODIAL HOCDITAL		1-1:-	6 F OMC /	DEED 40
Health Financial Systems	FHN MEMORIAL HOSPITAL		in Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CCN: 14-0160	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Pre 5/30/2024 4:3	
	Ti tl e	e XVIII	Hospi tal	PPS	
		FFY	['] (уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal			2024	581, 876	70. 96

					5/30/2024 4: 30	9 pm
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0	2	024	581, 876	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in		2	023	159, 651	70. 97
	the corresponding federal year for the period ending on or aft	er 10/1)				
70. 98	Low Volume Payment-3			0	0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	9 & 70)			9, 107, 130	71. 00
71. 01	Sequestration adjustment (see instructions)				182, 143	71. 01
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71.03	Sequestration adjustment-PARHM pass-throughs					71. 03
72.00	Interim payments				8, 941, 720	72. 00
72. 01	Interim payments-PARHM					72. 01
73.00	Tentative settlement (for contractor use only)				ol	73. 00
73. 01	Tentative settlement-PARHM (for contractor use only)					73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02	72 and			-16, 733	
, ,, ,,	73)	, , <u>, , , , , , , , , , , , , , , , , </u>			10,700	7 11 00
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordan	nce with			367, 036	
73.00	CMS Pub. 15-2, chapter 1, §115.2	ice wi tii			307,030	73.00
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	of 2 ∩3			0	90. 00
90.00	plus 2.04 (see instructions)	01 2.03			U	90.00
01 00					0	91. 00
91. 00 92. 00	Capital outlier from Wkst. L, Pt. I, line 2	iati ana)			0	
	Operating outlier reconciliation adjustment amount (see instru					92.00
93.00	Capital outlier reconciliation adjustment amount (see instruct				0	93. 00
94. 00	The rate used to calculate the time value of money (see instru	ıcti ons)			0. 00	
95. 00	Time value of money for operating expenses (see instructions)				0	
96.00	Time value of money for capital related expenses (see instruct	i ons)			0	96. 00
				Prior to 10/1	On/After 10/1	
				11101 1011		
				1. 00	2. 00	
	HSP Bonus Payment Amount			1.00	2. 00	
100.00	HSP bonus amount (see instructions)					100. 00
	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1.00	2. 00	100. 00
	HSP bonus amount (see instructions)			1.00	2. 00	
101. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions	3)		1. 00	2. 00 42, 072 1. 0020655127	
101. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	3)		1. 00 124, 846 1. 0000000000	2. 00 42, 072 1. 0020655127	101. 00
101. 00 102. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions	3)		1. 00 124, 846 1. 0000000000	2. 00 42, 072 1. 0020655127	101. 00 102. 00
101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			1. 00 124, 846 1. 000000000 0	2. 00 42, 072 1. 0020655127 87 0. 9959	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)		stment	1. 00 124, 846 1. 0000000000 0	2. 00 42, 072 1. 0020655127 87 0. 9959	101. 00 102. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr	ration) Adju		1. 00 124, 846 1. 000000000 0	2. 00 42, 072 1. 0020655127 87 0. 9959 -172	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) RURA adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration bereits)	ration) Adju		1. 00 124, 846 1. 000000000 0	2. 00 42, 072 1. 0020655127 87 0. 9959 -172	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	ration) Adju		1. 00 124, 846 1. 000000000 0	2. 00 42, 072 1. 0020655127 87 0. 9959 -172	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	ration) Adjur iod under t		1. 00 124, 846 1. 000000000 0	2. 00 42, 072 1. 0020655127 87 0. 9959 -172	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	ration) Adjur iod under t		1. 00 124, 846 1. 000000000 0	2. 00 42, 072 1. 0020655127 87 0. 9959 -172	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions)	ration) Adjur iod under t		1. 00 124, 846 1. 000000000 0	2. 00 42, 072 1. 0020655127 87 0. 9959 -172	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	ration) Adju riod under t	he 21st	1. 00 124, 846 1. 0000000000 0 0. 9807 -2, 410	2. 00 42, 072 1. 0020655127 87 0. 9959 -172	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	ration) Adju riod under t	he 21st	1. 00 124, 846 1. 0000000000 0 0. 9807 -2, 410	2. 00 42, 072 1. 0020655127 87 0. 9959 -172	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	ration) Adju riod under t	he 21st	1. 00 124, 846 1. 0000000000 0 0. 9807 -2, 410	2.00 42,072 1.0020655127 87 0.9959 -172	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	ration) Adju riod under t	he 21st	1. 00 124, 846 1. 0000000000 0 0. 9807 -2, 410	2. 00 42, 072 1. 0020655127 87 0. 9959 -172	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	ration) Adju riod under t	he 21st	1. 00 124, 846 1. 0000000000 0 0. 9807 -2, 410	2. 00 42, 072 1. 0020655127 87 0. 9959 -172	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	ration) Adju riod under t	he 21st	1. 00 124, 846 1. 0000000000 0 0. 9807 -2, 410	2.00 42,072 1.0020655127 87 0.9959 -172	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	ration) Adjuriod under t	he 21st	1. 00 124, 846 1. 0000000000 0 0. 9807 -2, 410	2. 00 42, 072 1. 0020655127 87 0. 9959 -172 :rati on	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)	ration) Adjuriod under te 49) first year of tructions)	he 21st	1. 00 124, 846 1. 0000000000 0 0. 9807 -2, 410	2.00 42,072 1.0020655127 87 0.9959 -172	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	ration) Adjuriod under te 49) first year of tructions)	he 21st	1. 00 124, 846 1. 0000000000 0 0. 9807 -2, 410	2.00 42,072 1.0020655127 87 0.9959 -172	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	ration) Adjuriod under te 49) first year of tructions)	he 21st	1. 00 124, 846 1. 0000000000 0 0. 9807 -2, 410	2.00 42,072 1.0020655127 87 0.9959 -172	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	ration) Adjuriod under te 49) first year of tructions)	he 21st	1. 00 124, 846 1. 0000000000 0 0. 9807 -2, 410	2. 00 42, 072 1. 0020655127 87 0. 9959 -172	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	ration) Adjuriod under te 49) first year of tructions)	he 21st	1. 00 124, 846 1. 0000000000 0 0. 9807 -2, 410	2. 00 42, 072 1. 0020655127 87 0. 9959 -172	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	ration) Adjuriod under te 49) first year of tructions)	he 21st	1. 00 124, 846 1. 0000000000 0 0. 9807 -2, 410	2. 00 42, 072 1. 0020655127 87 0. 9959 -172	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	ration) Adjuriod under te 49) first year (he 21st	1. 00 124, 846 1. 0000000000 0 0. 9807 -2, 410	2. 00 42, 072 1. 0020655127 87 0. 9959 -172 :rati on	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ration) Adjuriod under te 49) first year (he 21st	1. 00 124, 846 1. 0000000000 0 0. 9807 -2, 410	2. 00 42, 072 1. 0020655127 87 0. 9959 -172	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (from line 2 Low-volume adjustment (see instructions)	ration) Adjuriod under to the 49) first year of the first year of the 59)	of the curren	1. 00 124, 846 1. 0000000000 0 0. 9807 -2, 410	2.00 42,072 1.0020655127 87 0.9959 -172	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2	ration) Adjuriod under to the 49) first year of the first year of the 59)	of the curren	1. 00 124, 846 1. 0000000000 0 0. 9807 -2, 410	2.00 42,072 1.0020655127 87 0.9959 -172	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 211. 00 212. 00 213. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2023 | Part A Exhibit 4 | To 12/31/2023 | Date/Time Prepared: | 5/30/2024 4:39 pm Provider CCN: 14-0160

						0 12/31/2023	5/30/2024 4: 39	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
1.00	DRG amounts other than outlier	0 1. 00	1. 00	2.00	3.00	4.00	5. 00 0	1. 00
1.00	payments	1.00	U	U		, o	U	1.00
1. 01	DRG amounts other than outlier	1. 01	5, 727, 858	0	5, 727, 858		5, 727, 858	1. 01
	payments for discharges							
	occurring prior to October 1							
1. 02	DRG amounts other than outlier	1. 02	2, 134, 825	0		2, 134, 825	2, 134, 825	1. 02
	payments for discharges							
	occurring on or after October							
1. 03	DRG for Federal specific	1. 03	0	0	0	,	0	1. 03
1.00	operating payment for Model 4	1.00	J	O			Ŭ	1.00
	BPCI occurring prior to							
	October 1							
1. 04	DRG for Federal specific	1. 04	0	0		0	0	1. 04
	operating payment for Model 4							
	BPCI occurring on or after October 1							
2.00	Outlier payments for	2. 00						2. 00
2.00	discharges (see instructions)	2.00						2.00
2.01	Outlier payments for	2. 02	0	0	C	0	0	2. 01
	discharges for Model 4 BPCI							
2. 02	Outlier payments for	2. 03	64, 442	0	64, 442		64, 442	2. 02
	discharges occurring prior to							
2. 03	October 1 (see instructions) Outlier payments for	2. 04	28, 907	0		28, 907	28, 907	2. 03
2.03	discharges occurring on or	2. 04	20, 907	U		20, 907	20, 907	2.03
	after October 1 (see							
	instructions)							
3.00	Operating outlier	2. 01	0	0	C	0	0	3.00
	reconciliation							
4.00	Managed care simulated	3. 00	0	0	C	0	0	4. 00
	payments	Lotmont .						
5. 00	Indirect Medical Education Adj Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0.000000	0. 000000		5. 00
3.00	A, line 21 (see instructions)	21.00	0.000000	0.000000	0.00000	0.000000		3.00
6.00	IME payment adjustment (see	22. 00	0	0	C	o	0	6. 00
	instructions)							
6. 01	IME payment adjustment for	22. 01	0	0	C	0	0	6. 01
	managed care (see							
	instructions) Indirect Medical Education Adj	ustmont for the	Add on for So	otion 122 of t	ho MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000		0. 000000		7. 00
7.00	(see instructions)	27.00	0.000000	0. 000000	0.00000	0.00000		7.00
8.00	ÎME adjustment (see	28. 00	0	0	C	0	0	8. 00
	instructions)							
8. 01	IME payment adjustment add on	28. 01	0	0	C	0	0	8. 01
	for managed care (see							
9. 00	instructions) Total IME payment (sum of	29. 00	0	0			0	9. 00
9.00	lines 6 and 8)	29.00	U	0		, o	U	7.00
9. 01	Total IME payment for managed	29. 01	О	0	C	o	0	9. 01
	care (sum of lines 6.01 and							
	8. 01)							
10.00	Disproportionate Share Adjustm		2 2/5/	0.0454	1 0005	0.0/5/		10.00
10.00	Allowable disproportionate share percentage (see	33. 00	0. 0656	0. 0656	0. 0656	0. 0656		10. 00
	instructions)							
11. 00	Di sproporti onate share	34.00	128, 948	0	93, 937	35, 011	128, 948	11. 00
	adjustment (see instructions)		,			33, 311	,	
11. 01	Uncompensated care payments	36.00	653, 521	0	506, 867	146, 654	653, 521	11. 01
	Additional payment for high pe		D beneficiary					
12. 00	Total ESRD additional payment	46. 00	0	0	C	0	0	12. 00
13. 00	(see instructions)	47.00	8, 738, 501	0	4 202 104	2, 345, 397	0 720 504	12 00
14. 00	Subtotal (see instructions) Hospital specific payments	47. 00 48. 00	8, 738, 501 8, 961, 058	0		1 1		
17.00	(completed by SCH and MDH,	+0.00	5, 701, 030	0	0, 301, 440	2, 377, 010	0, 701, 030	17.00
	small rural hospitals only.)							
	(see instructions)							
15. 00	Total payment for inpatient	49. 00	8, 905, 419	0	6, 519, 362	2, 386, 057	8, 905, 419	15. 00
	operating costs (see							
4, 25	instructions)	50.00	500 5	=				4, 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	593, 500	0	428, 243	165, 257	593, 500	16.00
	if applicable)							
	,pp 332. 5)	1	ı I		1	1	!	

						o 12/31/2023	Date/Time Pre	pared:
				Title	xVIII	Hospi tal	5/30/2024 4: 3 PPS	9 piii
		W/S E. Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
17. 00	Special add-on payments for new technologies	54.00	28, 576	0	28, 576	0	28, 576	17. 00
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	(0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see		О	0	C	0	0	18. 00
19. 00	instructions) SUBTOTAL			0	6, 976, 181	2, 551, 314	9, 527, 495	19. 00
		W/S L, line	(Amounts from L)					
		0	1.00	2. 00	3.00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	592, 031	0	426, 774	165, 257	592, 031	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	(0	0	20. 01
21. 00	Capital DRG outlier payments	2. 00	1, 469	0	1, 469	0	1, 469	
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	(0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0	(0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0.0000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0	(0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	593, 500	0	428, 243	165, 257	593, 500	26. 00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2. 00	3. 00	4. 00	5. 00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 083409 581, 876		581, 876	27. 00 28. 00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				159, 651	159, 651	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Provider CCN: 14-0160 Peri od: Worksheet E From 01/01/2023 Part A Exhibit 5 Date/Time Prepared: 12/31/2023 5/30/2024 4:39 pm Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1.00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 5, 727, 858 5, 727, 858 5, 727, 858 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 2, 134, 825 2. 134. 825 2, 134, 825 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 C 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 O 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 64 442 64 442 64 442 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 28, 907 28, 907 28, 907 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 C 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.0656 0.0656 0.0656 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 128.948 93. 937 35.011 128.948 11.00 instructions) 11.01 Uncompensated care payments 36 00 653, 521 524, 782 196, 521 721, 303 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 2, 395, 264 13 00 8, 738, 501 6, 343, 237 8, 738, 501 Subtotal (see instructions) 13 00 14.00 Hospital specific payments (completed by SCH 48.00 8, 961, 058 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 8, 905, 419 6, 510, 155 2, 395, 264 8, 905, 419 15.00 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50 00 593, 500 428, 243 165, 257 593, 500 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 28, 576 28, 576 28, 576 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 0 replaced devices for applicable MS-DRGs

93.00

6, 966, 974

2, 560, 521

0 18.00

9, 527, 495 19. 00

18.00

19.00

SUBTOTAL

Capital outlier reconciliation adjustment

amount (see instructions)

Heal th	Financial Systems	FHN MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-:	2552-10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA		Provider Co	F	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibi Date/Time Pre 5/30/2024 4:3	t 5 pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2.00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1.00	592, 031	426, 774	165, 257	592, 031	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	C	0	0	20. 01
21. 00	Capital DRG outlier payments	2.00	1, 469	1, 469	0	1, 469	21. 00
	Model 4 BPCI Capital DRG outlier payments	2. 01	0	C	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0.0000	0.0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	C	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	0	С	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	593, 500	428, 243	165, 257	593, 500	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1. 00	2.00	3. 00	4. 00	
27.00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	581, 876	·		581, 876	1
29. 00	Low volume adjustment on or after October 1	70. 97	159, 651		159, 651	159, 651	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	4, 410	[C	4, 410	'	
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	87	C	87	87	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-119, 852	-111, 099	-8, 753	-119, 852	31. 00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	-2, 582	-2, 410	-172	-2, 582	31. 01

0

70. 99

(Amt. to Wkst. E, Pt. A) 4.00

0 32.00

100.00

3. 00

0

2.00

0

1.00

Ν

instructions)

32.00 HAC Reduction Program adjustment (see

instructions)

100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

Health Financial Systems	FHN MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0160		Worksheet E Part B Date/Time Prepared: 5/30/2024 4:39 pm		
	T1.1. \0.01.1.		555		

		Title XVIII	Hospi tal	5/30/2024 4: 3° PPS	9 pm
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	.:>		11, 071	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruct OPPS or REH payments		17, 155, 928 12, 308, 201		
4. 00	Outlier payment (see instructions)		137, 453		
4. 01	Outlier reconciliation amount (see instructions)		0	1	
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 822	5. 00
6.00	Line 2 times line 5			14, 102, 173	1
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			88. 25	
8. 00 9. 00	Transitional corridor payment (see instructions)	et araduata madical adua	ation costs from	0	
9.00	Ancillary service other pass through costs including REH direc Wkst. D, Pt. IV, col. 13, line 200	t graduate medicar educa	ation costs iron		9. 00
10. 00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			11, 071	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
40.00	Reasonable charges			20.000	40.00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	no 40)		39, 990 0	
14. 00	Total reasonable charges (sum of lines 12 and 13)	116 04)		39, 990	1
00	Customary charges			07/770	1 00
15. 00	Aggregate amount actually collected from patients liable for p	payment for services on a	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16. 00
47.00	had such payment been made in accordance with 42 CFR §413.13(6	e)		0 000000	47.00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	v if line 18 exceeds lin	ne 11) (see	39, 990 28, 919	1
17.00	instructions)	y II IIIIe Io execeds III	(300	20, 717	17.00
20.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20. 00
	instructions)				
21. 00	Lesser of cost or charges (see instructions)			11, 071	
22. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instr	suctions)		0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	uctions)		12, 445, 654	1
21.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			12, 110, 001	21.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions			0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line			2, 169, 093	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	olus the sum of lines 22	and 23] (see	10, 287, 632	27. 00
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
	REH facility payment amount (see instructions)	110 00)			28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	1
	Subtotal (sum of lines 27, 28, 28.50 and 29)			10, 287, 632	1
31. 00	Primary payer payments			98	
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	·FC)		10, 287, 534	32. 00
33 00	Composite rate ESRD (from Wkst. I-5, line 11)	.L3)		0	33.00
	Allowable bad debts (see instructions)			279, 772	
35.00	Adjusted reimbursable bad debts (see instructions)			181, 852	
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		217, 634	
	Subtotal (see instructions)			10, 469, 386	1
	MSP-LCC reconciliation amount from PS&R			0	
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	:)		0	39. 00 39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)	•)		0	ı
39. 97	Demonstration payment adjustment amount before sequestration			Ō	ı
39. 98	Partial or full credits received from manufacturers for replac	ced devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	
	Subtotal (see instructions)			10, 469, 386	1
40. 01	Sequestration adjustment (see instructions)			209, 388	1
40. 02	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs				40. 02
	Interim payments			10, 325, 198	1
	Interim payments-PARHM				41. 01
42.00	Tentative settlement (for contractors use only)		0		
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43. 00	Balance due provider/program (see instructions)			-65, 200	1
43. 01	Balance due provider/program-PARHM (see instructions)	aco with CMS Dub 1E 2	chantor 1	224 070	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	ice with CMS Pub. 15-2, (chapter I,	226, 970	44. 00
	TO BE COMPLETED BY CONTRACTOR				1
90. 00	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	1
73.00	Time Value of Money (see instructions)				93. 00

Health Financial Systems	FHN MEMORIAL H	OSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0160	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre	
-				5/30/2024 4: 3	9 pm
		Title XVIII	Hospi tal	PPS	
				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

Provider CCN: 14-0160

Title XVIII						5/30/2024 4: 39	9 pm
Total interim payments payable on individual bills, either 1.00 2.00 3.00 4.00 1.0381,537 1.00 1.00 1.00 3.00 4.00 1.00 3.00 4.00 1.00 3.00 4.00 1.00 3.00 4.00 1.00 3.00 4.00 1.00 3.00 4.00 1.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 3.00 4.00 3.00 3.00 4.00 3.0							
Total interim payments paid to provider 1,00 2,00 3,00 4,00			Inpatien	t Part A	Par	t B	
Total interim payments paid to provider 1,00 2,00 3,00 4,00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
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 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 O				2.00	3. 00	4.00	
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero write "NONE" or enter a zero write "NONE" or enter a zero write "NoNE" or enter a zero. (1) Program to Provider	1.00	Total interim payments paid to provider		8, 993, 82	3	10, 381, 537	1. 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 ADJUSTMENTS TO PROVIDER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00				0	0	2.00
write "NONE" or enter a zero							
List separately each retroactive lump sum adjustment and ununt 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)							
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)							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider NONE" or enter a zero. (1) Program to Provider NONE" or enter a zero. (1) O	3.00						3. 00
payment. If none, write "NONE" or enter a zero. (1) Program to Provider		amount based on subsequent revision of the interim rate					
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02 3.03 3.04 3.05 3.04 3.05 3.05 3.06 3.06 3.06 3.06 3.06 3.06 3.06 3.06 3.06 3.06 3.06 3.06 3.06 3.06 3.07	3 01				n	0	3. 01
3.03 3.04 3.04 3.06 0 0 0 0 0 0 0 0 0		7.B3331MENT3 TO TROVIDER					3. 02
3.04 3.05					-	- 1	3. 03
3.05 Provider to Program					~	- 1	3. 04
3.50 ADJUSTMENTS TO PROGRAM 09/07/2023 52, 103 09/07/2023 56, 339 3.51 3.52 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.55 3.54 0 0 0 3.57 3.58 0 0 0 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines -52, 103 -56, 339 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 8, 941, 720 10, 325, 198 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 0 0 0 5.02 5.03 0 0 0 5.50 5.50 0 0 0 5.51 5.50 5.50 0 0 5.51 5.52 0 0 0 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 5. 50 5. 50-5.98 0 6.01 SETTLEMENT TO PROVIDER 0 0 0 SETTLEMENT TO PROVIDER 0 0 0 0 SETT							3. 05
3.50 ADJUSTMENTS TO PROGRAM 09/07/2023 52, 103 09/07/2023 56, 339 3.51 3.52 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.55 3.54 0 0 0 3.57 3.58 0 0 0 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines -52, 103 -56, 339 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 8, 941, 720 10, 325, 198 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 0 0 0 5.02 5.03 0 0 0 5.50 5.50 0 0 0 5.51 5.50 5.50 0 0 5.51 5.52 0 0 0 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 5. 50 5. 50-5.98 0 6.01 SETTLEMENT TO PROVIDER 0 0 0 SETTLEMENT TO PROVIDER 0 0 0 0 SETT		Provider to Program			<u> </u>		
3.52 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.50		09/07/2023	52, 10	3 09/07/2023	56, 339	3. 50
3.53 3.54 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.51				0	0	3. 51
3.54 3.95 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 8,941,720 10,325,198 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3.52				0	0	3. 52
3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98) -52, 103 -56, 339 3. 50-3. 98) 8, 941, 720 10, 325, 198 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 0 0 0 0 0 0 0 0 0	3.53				0	0	3. 53
3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 5.02 0 0 0 5.03 Provider to Program 5.50 TENTATIVE TO PROGRAM 0 0 0 5.51 5.52 0 0 0 0 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0	1	3. 54
Total interim payments (sum of lines 1, 2, and 3.99) 8, 941, 720 10, 325, 198	3. 99	,		-52, 10	3	-56, 339	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 0 5.02 0 0 7.03 Provider to Program TENTATIVE TO PROGRAM 0 0 0 5.51 0 0 0 5.52 0 0 0 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
appropriate TO BE COMPLETED BY CONTRACTOR	4. 00			8, 941, 72	0	10, 325, 198	4. 00
TO BE COMPLÉTED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER Drovider to Program TENTATIVE TO PROGRAM TO TENTATIVE TO PROGRAM TENTATIVE TO PROGRAM TO TENTATIVE TO PROGRAM T							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROVIDER 5.00 Provider to Program TENTATIVE TO PROGRAM O D S.51 S.50 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5 00	list separately each tentative settlement navment after					5. 00
Write "NONE" or enter a zero. (1) Program to Provider	3.00						3.00
Program to Provider							
TENTATI VE TO PROVI DER		Program to Provider					
5.03 Provider to Program 5.50 TENTATIVE TO PROGRAM 5.51 0 0 0 5.52 0 0 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 01				0	0	5. 01
Provider to Program	5.02				0	0	5. 02
5.50 TENTATIVE TO PROGRAM 0 0 5.51 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.03				0	0	5. 03
5.51							
5.52 0 0 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0		TENTATI VE TO PROGRAM			-	- 1	5. 50
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0							5. 51
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0						- 1	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0	5. 99	,			U	0	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0							4 00
6. 01 SETTLEMENT TO PROVIDER 0	6.00	, , ,					6. 00
	6 01						6. 01
6 02 SETTLEMENT TO DDOGDAM 16 722 1 45 2001	6. 02	SETTLEMENT TO PROVIDER		16, 73	~	65, 200	6. 02
7. 00 Total Medicare program liability (see instructions) 8,924,987 10,259,998							7. 00
7.00 Total medicale program Trability (see instructions) 0,724,707 10,257,700 Contractor NPR Date	,. 00	Total mode od o program readility (see restructions)		0, 724, 70			7.00
Number (Mo/Day/Yr)							
0 1.00 2.00			()			
8.00 Name of Contractor	8. 00	Name of Contractor					8. 00

Heal th	Financial Systems FHN MEMORIAL H	HOSPI TAL	In Lie	u of Form CMS-	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0160	Peri od:	Worksheet E-1		
			From 01/01/2023 To 12/31/2023		narod.	
			10 12/31/2023	5/30/2024 4: 3		
		Title XVIII	Hospi tal	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-	
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		44		4 00	
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	14		1.00	
2.00	Medicare days (see instructions)				2.00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00	
4.00	Total inpatient days (see instructions)				4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00	
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 l				6. 00	
7. 00	CAH only - The reasonable cost incurred for the purchase of c	ertified HII technology	WKST. S-2, PT. I		7. 00	
8. 00	line 168				8.00	
	Calculation of the HIT incentive payment (see instructions)				9. 00	
	9.00 Sequestration adjustment amount (see instructions)					
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					
20.00	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH				1 20 00	
	Initial/interim HIT payment adjustment (see instructions)				30.00	
	Other Adjustment (specify)	i 21)	->		31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (See Instruction	(S)		32.00	

Heal th	Health Financial Systems FHN MEMORIAL HOSPITAL In Lieu of					
OUTLI E	OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT Provider CCN: 14-0160 Period: W					
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 4:39		
		Title XVIII		PPS		
				1. 00		
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03 plus 2.04 (see i	nstructions)	0	1.00	
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00	
3.00	Operating outlier reconciliation adjustment amount (see instr	uctions)		0	3.00	
4.00 Capital outlier reconciliation adjustment amount (see instructions)					4.00	
5.00 The rate used to calculate the time value of money (see instructions)					5.00	
6.00	Time value of money for operating expenses (see instructions)			0	6.00	
7.00	Time value of money for capital related expenses (see instruc	tions)		0	7.00	

dealth Financial Systems FHN MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

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

Provider CCN: 14-0160 Period From

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/30/2024 4:39 pm

				1	5/30/2024 4: 3	9 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1 00	Purpose Fund	2 00	4.00	
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1. 00	Cash on hand in banks	32, 809, 933		0	0	1.00
2. 00	Temporary investments	8, 770, 624	•		0	
3.00	Notes receivable	0,770,024		, i	0	
4. 00	Accounts receivable	22, 323, 420	-		0	
5. 00	Other recei vable	2, 540, 996			0	
6. 00	Allowances for uncollectible notes and accounts receivable	2, 340, 770			0	6. 00
7. 00	Inventory	0			0	
8. 00	Prepaid expenses				0	8.00
9. 00	Other current assets	5, 780, 576			0	9. 00
10. 00	Due from other funds	3, 760, 370			0	10.00
11. 00		72, 225, 549	1	, 1	0	11.00
11.00	Total current assets (sum of lines 1-10)	12, 223, 349		J U		111.00
12 00	FI XED ASSETS			0	0	12 00
12.00	Land	0	1	-	-	1
13.00	Land improvements	0	(13.00
14.00	Accumulated depreciation	10 700 (4)	(0	0	14.00
15. 00	Buildings	18, 738, 646		0	0	15.00
16.00	Accumulated depreciation	0		0	0	16.00
17. 00	Leasehold improvements	0		0	0	17. 00
18.00	Accumulated depreciation	0	(0	0	18.00
19. 00	Fi xed equipment	0		0	0	19. 00
20. 00	Accumulated depreciation	0	(0	0	20. 00
21. 00	Automobiles and trucks	0	C	0	0	21. 00
22. 00	Accumul ated depreciation	0	(0	0	22. 00
23. 00	Major movable equipment	0	(0	0	23. 00
24. 00	Accumulated depreciation	0	(0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	(0	0	25. 00
26.00	Accumul ated depreciation	0	C	0	0	26. 00
27.00	HIT designated Assets	0	C	0	0	27. 00
28. 00	Accumul ated depreciation	0	(0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	(o	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	18, 738, 646	l c	o	0	30.00
	OTHER ASSETS					
31.00	Investments	7, 300, 051	(0	0	31. 00
32.00	Deposits on Leases	0	(o	0	32. 00
33.00	Due from owners/officers	0		o	0	33. 00
34.00	Other assets	3, 460, 312	1	o	0	34.00
35. 00	Total other assets (sum of lines 31-34)	10, 760, 363		0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	101, 724, 558		0		
	CURRENT LIABILITIES	, , , , , , , , , , , , , , , , , , , ,		-1		
37.00	Accounts payable	503, 788		0	0	37. 00
38. 00	Salaries, wages, and fees payable	5, 471, 774	1	0	0	38. 00
39. 00	Payroll taxes payable	0	1	0	Ō	39. 00
40. 00	Notes and Loans payable (short term)	0	1	0	Ō	40.00
41. 00	Deferred income	0			ő	41. 00
42. 00	Accel erated payments	0			Ŭ	42. 00
43. 00	Due to other funds	0			0	
44. 00	Other current liabilities	19, 200, 249			0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	25, 175, 811				
73.00	LONG TERM LIABILITIES	25, 175, 011) 0	<u> </u>	1 73.00
46. 00	Mortgage payable	<u> </u>			0	46. 00
47. 00	Notes payable			, i		47. 00
48. 00	Unsecured Loans	0				
49. 00	Other long term liabilities	5, 948, 952		-		
50.00	Total long term liabilities (sum of lines 46 thru 49)		•		0	
	,	5, 948, 952		-		51.00
51. 00	Total liabilities (sum of lines 45 and 50)	31, 124, 763		0	U	51.00
F2 00	CAPI TAL ACCOUNTS	70 500 705	1			F2 00
52.00	General fund balance	70, 599, 795				52.00
53. 00	Specific purpose fund		()		53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					l
59. 00	Total fund balances (sum of lines 52 thru 58)	70, 599, 795	•	-	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	101, 724, 558	C	0	0	60.00
	[59]	I	l			I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES FHN MEMORIAL HOSPITAL

Provider CCN: 14-0160

					To 12/31/2023		
		Genera	l Fund	Special F	Purpose Fund	Endowment Fund	-
		1.00	2.00	3. 00	4. 00	5. 00	
1. 00 2. 00	Fund balances at beginning of period		76, 806, 462	l .	C)	1. 00 2. 00
3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		22, 376, 160 99, 182, 622				3. 00
4. 00	PRI OR PERI OD ADJ	-673, 338			0	l ol	4. 00
5. 00	TRIOR TERROD ADS	073,330			0		5. 00
6. 00		0			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10. 00	Total additions (sum of line 4-9)		-673, 338		C	1	10.00
11. 00	Subtotal (line 3 plus line 10)	07.045.400	98, 509, 284		C	1	11.00
12.00	TRANSFER TO AFFILIATE	27, 945, 489			0	0	12.00
13. 00 14. 00		0			0	0	13. 00 14. 00
15. 00		0			0		15. 00
16. 00		0			0		16. 00
17. 00		0			0	l ő	17. 00
18. 00	Total deductions (sum of lines 12-17)		27, 945, 489				18. 00
19.00	Fund balance at end of period per balance		70, 563, 795		C)	19.00
	sheet (line 11 minus line 18)			L			
		Endowment Fund	PI ant	Fund			
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3. 00 4. 00	Total (sum of line 1 and line 2) PRIOR PERIOD ADJ	0	0		0		3. 00 4. 00
4. 00 5. 00	PRIOR PERIOD ADJ		0				4. 00 5. 00
6.00			0				6. 00
7. 00			Ö				7. 00
8.00			0				8. 00
9.00			0				9. 00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11. 00	Subtotal (line 3 plus line 10)	0			0		11. 00
12.00	TRANSFER TO AFFILIATE		0				12.00
13.00			0				13.00
14. 00 15. 00			0				14. 00 15. 00
16. 00							16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0			0		18. 00
19. 00	Fund balance at end of period per balance	0	•		0		19. 00
	sheet (line 11 minus line 18)						

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-0160

		1	o 12/31/2023	Date/Time Pre 5/30/2024 4:3	pared:
	Cost Center Description	I npati ent	Outpati ent	Total) piii
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	•			
	General Inpatient Routine Services				
1.00	Hospi tal	49, 987, 163	3	49, 987, 163	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF)	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8. 00 9. 00	NURSING FACILITY				8. 00 9. 00
10.00	OTHER LONG TERM CARE Total general inpatient care services (sum of lines 1-9)	49, 987, 163	,	49, 987, 163	9. 00 10. 00
10.00	Intensive Care Type Inpatient Hospital Services	49, 907, 103		49, 907, 103	10.00
11. 00	INTENSIVE CARE UNIT	4, 743, 010		4, 743, 010	11. 00
12. 00	CORONARY CARE UNIT	4, 745, 616	′	4, 743, 010	12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	4, 743, 010		4, 743, 010	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	54, 730, 173		54, 730, 173	17. 00
18. 00	Ancillary services	121, 306, 919		510, 596, 787	18. 00
19. 00	Outpati ent servi ces	11, 634, 040		75, 004, 114	19. 00
20. 00	RURAL HEALTH CLINIC		′I "I	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00 25. 00	CMHC AMBULATORY SURGICAL CENTER (D. P.)				24. 00 25. 00
26. 00	HOSPICE		8, 188, 972	8, 188, 972	26. 00
27. 00	OTHER (SPECIFY)		0, 100, 972	0, 188, 472	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	187, 671, 132	460, 848, 914	648, 520, 046	28. 00
20.00	G-3, line 1)	107, 071, 102	100,010,711	010, 020, 010	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		146, 076, 220		29. 00
30.00	ADD (SPECIFY)				30.00
31.00					31.00
32. 00					32. 00
33. 00					33. 00
34. 00					34.00
35. 00)		35. 00
36. 00	Total additions (sum of lines 30-35)		이		36. 00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00					38. 00
39. 00 40. 00					39. 00 40. 00
40.00			(40.00
41.00	Total deductions (sum of lines 37-41)	1	را ا		41.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		146, 076, 220		43. 00
13. 00	to Wkst. G-3, line 4)		1 10, 070, 220		10.00

		N MEMORIAL HOSPITAL		u of Form CMS-2	
STATE	MENT OF REVENUES AND EXPENSES	Provi der CCN: 14-0160	Peri od:	Worksheet G-3	
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 4:3	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, co			648, 520, 046	1.00
2.00	Less contractual allowances and discounts on patie	ents' accounts		493, 623, 729	2. 00
3.00	Net patient revenues (line 1 minus line 2)			154, 896, 317	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Par			146, 076, 220	
5.00	Net income from service to patients (line 3 minus	line 4)		8, 820, 097	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			66, 254	
7.00	Income from investments			1, 770, 941	
8.00	Revenues from telephone and other miscellaneous co	ommunication services		0	
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			0	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies	s to other than patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts	S		0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and can	nteen		0	20.00
21.00	Rental of vending machines			0	21. 00
22.00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER OPERATING REVENUE			191, 465	24. 00
24. 01	MEDICALD ASSESSMENT REV			10, 399, 946	24. 01
24. 02	SALE OF ASSETS			6, 000	
24. 03	OTHER			18, 514	•
24. 04	NET ASSETS RELEASED			1, 102, 943	
24. 50	COVI D-19 PHE Fundi ng			0	24. 50
25. 00	Total other income (sum of lines 6-24)			13, 556, 063	
	Total (line 5 plus line 25)			22, 376, 160	
	OTHER EXPENSES (SPECIEV)				27 00

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

0 28.00 22, 376, 160 29.00

27.00

From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 4:39 pm Hospi ce CCN: 14-1560

						5/30/2024 4: 3	9 pm
	,				Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 plus col. 2)	CATI ONS		
		1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT*		C) 0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		C	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	10, 897	10, 897	0	10, 897	3. 00
4.00	ADMINISTRATIVE & GENERAL*	0	105, 539	105, 539	0	105, 539	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	C	o o	0	0	5. 00
6.00	LAUNDRY & LINEN SERVICE*	0	C	o o	0	0	6.00
7.00	HOUSEKEEPI NG*	0	C	ol o	0	0	7. 00
8.00	DI ETARY*	0	C	o o	0	0	8. 00
9.00	NURSI NG ADMI NI STRATI ON*	o	C	ol o	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	51	51	0	51	10.00
11. 00	MEDI CAL RECORDS*		٥.		0	0	11.00
12. 00	STAFF TRANSPORTATION*		46, 309	46, 309	0	46, 309	12.00
13. 00	VOLUNTEER SERVICE COORDINATION*	59, 627	40, 30 <i>i</i>	59, 627	0	59, 627	13. 00
14. 00	PHARMACY*	37,027	158, 327		0	158, 327	14.00
15. 00			130, 327	130, 327	0		15.00
	PHYSICIAN ADMINISTRATIVE SERVICES*	242 025		242 025	0	0	•
16.00	OTHER GENERAL SERVICE*	242, 835	C	242, 835	U	242, 835	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00	INPATIENT CARE-CONTRACTED**	_	C	0			25. 00
26. 00	PHYSI CI AN SERVI CES**	0	C	0		0	26. 00
27. 00	NURSE PRACTITIONER**	126, 974	C	126, 974	0	126, 974	27. 00
28. 00	REGI STERED NURSE**	642, 624	906, 655	1	0	1, 549, 279	28. 00
29. 00	LPN/LVN**	110, 489	C	110, 489	0	110, 489	29. 00
30.00	PHYSI CAL THERAPY**	0	C) 0	0	0	30. 00
31. 00	OCCUPATIONAL THERAPY**	0	C) 0	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	C	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES**	145, 704	C	145, 704	0	145, 704	33. 00
34.00	SPIRITUAL COUNSELING**	0	C	0	0	0	34.00
35.00	DI ETARY COUNSELI NG**	0	C	0	0	0	35. 00
36.00	COUNSELING - OTHER**	0	C	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	C	o o	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	28, 656	28, 656	0	28, 656	38. 00
39.00	PATI ENT TRANSPORTATION**	0	17, 300	17, 300	0	17, 300	39. 00
40.00	I MAGI NG SERVI CES**	o		o .	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	C		0	0	41.00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**		Č		0	Ö	42. 00
42. 50	DRUGS CHARGED TO PATIENTS**		Č		0	Ö	42. 50
43. 00	OUTPATIENT SERVICES**		Č		0	0	43. 00
44. 00	PALLIATIVE RADIATION THERAPY**				0	0	44. 00
45. 00	PALLIATIVE CHEMOTHERAPY**				0	0	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**				0	0	46.00
40.00		J V)	U	U	46.00
(0.00	NONREI MBURSABLE COST CENTERS				0		40.00
60.00	BEREAVEMENT PROGRAM *	0	C			0	60.00
61.00	VOLUNTEER PROGRAM *	0	C	0	0	0	61.00
62. 00	FUNDRAI SI NG*	0	C) 0	0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	C) 0	0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM*	0	C	0	0	0	64. 00
65. 00	OTHER PHYSI CI AN SERVI CES*	0	C	0 ا	0	0	65. 00
66. 00	RESI DENTI AL CARE*	0	C	0	0	0	66. 00
67. 00	ADVERTI SI NG*	0	C	0	0	0	67. 00
68. 00	All controls and the control of the	0	C) 0	0	0	68. 00
69. 00	THRI FT STORE*	0	C) 0	0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD*	0	C	0	0	0	70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	C	0	0	0	71. 00
100.00	TOTAL	1, 328, 253	1, 273, 734	2, 601, 987	0	2, 601, 987	100.00

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

					Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5			
		4.00	± col. 6)	-		
	GENERAL SERVICE COST CENTERS	6. 00	7. 00			
1.00	CAP REL COSTS-BLDG & FIXT*	O	0			1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	ő	0	•		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	10, 897	,		3. 00
4.00	ADMINISTRATIVE & GENERAL*	0	105, 539			4. 00
5.00	PLANT OPERATION & MAINTENANCE*	0	0			5. 00
6.00	LAUNDRY & LINEN SERVICE*	0	0			6. 00
7.00	HOUSEKEEPI NG*	0	0			7. 00
8.00	DI ETARY*	0	0	1		8. 00
9.00	NURSING ADMINISTRATION*	0	0	1		9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0	51			10.00
11.00	MEDICAL RECORDS*	0	0	2		11.00
12.00	STAFF TRANSPORTATION*	0	46, 309	1		12.00
13. 00 14. 00	VOLUNTEER SERVICE COORDINATION* PHARMACY*	0	59, 627	1		13. 00 14. 00
15. 00	PHYSI CI AN ADMINI STRATI VE SERVI CES*	0	158, 327			15. 00
16. 00	OTHER GENERAL SERVICE*	0	242, 835			16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		242, 033	1		17. 00
17.00	DIRECT PATIENT CARE SERVICE COST CENTERS			1		17.00
25. 00	INPATIENT CARE-CONTRACTED**	0	0)		25. 00
26. 00	PHYSI CI AN SERVI CES**	O	0			26.00
27.00	NURSE PRACTITIONER**	0	126, 974			27. 00
28. 00	REGI STERED NURSE**	0	1, 549, 279			28. 00
29. 00	LPN/LVN**	0	110, 489)		29. 00
30.00	PHYSI CAL THERAPY**	0	0			30. 00
31. 00	OCCUPATI ONAL THERAPY**	0	0			31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY**	0	0			32. 00
33.00	MEDICAL SOCIAL SERVICES**	0	145, 704			33.00
34. 00	SPI RI TUAL COUNSELI NG**	0	0			34. 00
35. 00 36. 00	DI ETARY COUNSELI NG** COUNSELI NG - OTHER**	0	0			35. 00 36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0			37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	28, 656			38.00
39. 00	PATIENT TRANSPORTATION**	o	17, 300			39. 00
40. 00	IMAGING SERVICES**	ő	0	1		40.00
41. 00	LABS & DI AGNOSTI CS**	0	0	1		41. 00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	O	0			42. 00
42.50	DRUGS CHARGED TO PATIENTS**	0	0			42. 50
43.00	OUTPATIENT SERVICES**	0	0			43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0)		44. 00
45.00	PALLI ATI VE CHEMOTHERAPY**	0	0	•		45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0)		46. 00
(0.05	NONREI MBURSABLE COST CENTERS		=	J		
60.00	BEREAVEMENT PROGRAM *	0	0	1		60.00
61. 00 62. 00	VOLUNTEER PROGRAM * FUNDRAI SI NG*	0	0	1		61.00
62.00	FUNDRALSING^ HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	1		62.00
64. 00	PALLIATIVE CARE PROGRAM*	0	0	1		64. 00
65. 00	OTHER PHYSICIAN SERVICES*	0	0	1		65. 00
66. 00	RESI DENTI AL CARE*	o	0	•		66.00
67. 00	ADVERTI SI NG*	ő	Ö	1		67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*	ő	Ö	1		68. 00
69. 00	THRI FT STORE*	0	0			69. 00
70. 00	NURSING FACILITY ROOM & BOARD*	0	0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0)		71. 00
100.00	TOTAL	0	2, 601, 987	'		100. 00

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 14-0160

Peri od: Worksheet 0-2 From 01/01/2023

Hospi ce CCN: 14-1560 12/31/2023 To Date/Time Prepared: 5/30/2024 4:39 pm Hospi ce I SUBTOTAL (col SALARI ES OTHER RECLASSI FI -SUBTOTAL 1 + col. CATI ONS 2) 1.00 2.00 5. 00 3 00 4 00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 25.00 PHYSICIAN SERVICES 0 26.00 26.00 NURSE PRACTITIONER 125, 380 125, 380 27.00 125, 380 27.00 Ω 0 28.00 REGISTERED NURSE 634, 557 895, 274 1, 529, 831 1, 529, 831 28.00 29.00 LPN/LVN 109, 102 109, 102 109, 102 29.00 30.00 PHYSI CAL THERAPY 0 30.00 0 0 OCCUPATIONAL THERAPY 0 31.00 0 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 32.00 33.00 MEDICAL SOCIAL SERVICES 143, 875 0 143, 875 143, 875 33.00 34.00 SPIRITUAL COUNSELING 0 0 0 0 34.00 35.00 DIETARY COUNSELING 0 0 0 0 35.00 36.00 COUNSELING - OTHER 0 0 0 36.00 0 HOSPICE AIDE & HOMEMAKER SERVICES 37.00 37.00 0 0 28, 297 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 28. 297 28, 297 38.00 39. 00 PATIENT TRANSPORTATION 0 0 0 0 0 0 0 17, 083 17, 083 17, 083 39.00 40.00 I MAGING SERVICES 40.00 41.00 LABS & DIAGNOSTICS 0 0 0 41.00 MEDICAL SUPPLIES-NON-ROUTINE 0 42.00 C 0 42.00 42.50 DRUGS CHARGED TO PATIENTS 42.50 OUTPATIENT SERVICES 0 43.00 0 0 43.00 PALLIATIVE RADIATION THERAPY 44.00 C 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY C 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 46.00 1, 012, 914 100.00 TOTAL * 940, 654 1, 953, 568 1, 953, 568 100. 00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	INPATIENT CARE-CONTRACTED			25. 00
26.00	PHYSI CI AN SERVI CES	0	0	26. 00
27.00	NURSE PRACTITIONER	0	125, 380	27. 00
28. 00	REGI STERED NURSE	0	1, 529, 831	28. 00
29. 00	LPN/LVN	0	109, 102	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	143, 875	33. 00
34.00	SPIRITUAL COUNSELING	0	o	34.00
35.00	DI ETARY COUNSELING	0	o	35. 00
36.00	COUNSELING - OTHER	0	o	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	o	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	28, 297	38. 00
39.00	PATIENT TRANSPORTATION	0	17, 083	39.00
40.00	I MAGING SERVICES	0	o	40.00
41.00	LABS & DIAGNOSTICS	0	o	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	o	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	o	42. 50
43.00	OUTPATIENT SERVICES	0	ol	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	o	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	o	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	o	46.00
100.00	TOTAL *	0	1, 953, 568	100. 00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATTENT RESPITE CARE

Hospi ce CCN: 14-1560

Peri od: Worksheet 0-3 From 01/01/2023 To 12/31/2023 Date/Ti me Prepared:

5/30/2024 4:39 pm Hospi ce I SUBTOTAL (col SALARI ES OTHER RECLASSI FI -SUBTOTAL 1 + col. CATI ONS 2) 1.00 2.00 5. 00 3 00 4.00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 0 25.00 0 PHYSICIAN SERVICES 26.00 0 0 26.00 NURSE PRACTITIONER 1, 513 1, 513 27.00 1.513 27.00 o 28.00 REGISTERED NURSE 7,655 10,800 18, 455 18, 455 28.00 0 29.00 LPN/LVN 1, 316 1, 316 1, 316 29.00 30.00 PHYSI CAL THERAPY 0 30.00 0 0 0 OCCUPATIONAL THERAPY 0 31.00 0 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 32.00 33.00 MEDICAL SOCIAL SERVICES 1,736 0 1,736 1,736 33.00 SPIRITUAL COUNSELING 34.00 0 0 34.00 0 0 35.00 DIETARY COUNSELING 0 0 0 0 35.00 36.00 COUNSELING - OTHER 0 0 0 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 0 0 0 0 0 0 0 0 0 37.00 0 37.00 0 0 341 DURABLE MEDICAL EQUIPMENT/OXYGEN 38.00 38.00 341 341 39.00 PATIENT TRANSPORTATION 206 206 206 39.00 40.00 I MAGING SERVICES 40.00 0 LABS & DIAGNOSTICS 41.00 0 0 41.00 0 MEDICAL SUPPLIES-NON-ROUTINE 0 42.00 C 0 42.00 42.50 DRUGS CHARGED TO PATIENTS 0 42.50 OUTPATIENT SERVICES 0 0 43.00 0 43.00 PALLIATIVE RADIATION THERAPY 44.00 C 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY C 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 46.00 100.00 TOTAL * 12, 220 11, 347 23, 567 100. 00 23, 567

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		AD ILICTATIVE	TOTAL (L E	
		ADJUSTMENTS	TOTAL (col. 5	
		6. 00	± col. 6)	
- Ir	DIRECT PATIENT CARE SERVICE COST CENTERS	6.00	7.00	
-				25. 00
	INPATIENT CARE-CONTRACTED	0	0	
	PHYSI CI AN SERVI CES	0	4 540	26. 00
	NURSE PRACTITIONER	0	1, 513	27. 00
	REGI STERED NURSE	0	18, 455	28. 00
	LPN/LVN	0	1, 316	29. 00
	PHYSI CAL THERAPY	0	0	30.00
	OCCUPATI ONAL THERAPY	0	0	31. 00
32. 00	SPEECH/LANGUAGE PATHOLOGY	0	0	32. 00
33. 00	MEDICAL SOCIAL SERVICES	0	1, 736	33. 00
34. 00	SPIRITUAL COUNSELING	0	0	34.00
35. 00	DI ETARY COUNSELING	0	o	35. 00
36. 00	COUNSELING - OTHER	0	o	36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES	0	ol	37.00
	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	341	38. 00
39. 00	PATI ENT TRANSPORTATION	0	206	39.00
40. 00	I MAGI NG SERVI CES	0	o	40.00
	LABS & DIAGNOSTICS	0	0	41.00
1	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
	DRUGS CHARGED TO PATIENTS	0	o	42. 50
	OUTPATIENT SERVICES			43.00
	PALLIATIVE RADIATION THERAPY			44. 00
	PALLIATIVE CHEMOTHERAPY			45. 00
	OTHER PATIENT CARE SERVICES (SPECIFY)			46. 00
	TOTAL *		23, 567	100.00
100.00	TOTAL	L	25,507	1100.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE

Hospi ce CCN: 14-1560

Peri od: Worksheet 0-4 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

5/30/2024 4:39 pm Hospi ce I SALARI ES OTHER SUBTOTAL (col RECLASSI FI -SUBTOTAL CATI ONS 1 + col.1.00 2.00 5. 00 3 00 4.00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 0 25.00 PHYSICIAN SERVICES 26.00 0 0 0 26.00 NURSE PRACTITIONER 81 81 27.00 81 27.00 C 28.00 REGISTERED NURSE 412 581 993 993 28.00 29.00 LPN/LVN 71 71 71 29.00 30.00 PHYSI CAL THERAPY 0 0 0 0 30.00 OCCUPATIONAL THERAPY 0 31.00 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 32.00 33.00 MEDICAL SOCIAL SERVICES 93 0 93 93 33.00 0 0 0 0 0 0 0 0 0 0 0 SPIRITUAL COUNSELING 34.00 0 0 0 34.00 0 35.00 DIETARY COUNSELING 0 0 35.00 36.00 COUNSELING - OTHER 0 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 0 37.00 37.00 0 0 DURABLE MEDICAL EQUIPMENT/OXYGEN 18 18 18 38.00 38.00 39.00 PATIENT TRANSPORTATION 11 11 11 39.00 40.00 I MAGING SERVICES 40.00 0 LABS & DIAGNOSTICS 0 0 41.00 41.00 0 MEDICAL SUPPLIES-NON-ROUTINE 0 0 42.00 0 42.00 42.50 DRUGS CHARGED TO PATIENTS 0 42.50 OUTPATIENT SERVICES 0 0 43.00 0 43.00 PALLIATIVE RADIATION THERAPY 0 44.00 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 46.00 100.00 TOTAL * 1, 267 100. 00 657 610

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	INPATIENT CARE-CONTRACTED	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES	0	0	26. 00
27. 00	NURSE PRACTITIONER	0	81	27. 00
28. 00	REGI STERED NURSE	0	993	28. 00
29. 00	LPN/LVN	0	71	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	93	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELING	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	18	38. 00
39. 00	PATIENT TRANSPORTATION	0	11	39. 00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
43. 00	OUTPATIENT SERVICES	0	0	43.00
44. 00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45. 00	PALLI ATI VE CHEMOTHERAPY	0	0	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)	1 0	l o	46. 00
100.00	TOTAL *	0	1, 267	100. 00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

Heal th Financi al Systems PHM MEMORIAL HOSPITAL HOSPITAL							
Hospice CN: 14-1560 From 01/01/2023 Date/Time Prepared: 5/30/2024 4:39 pm	Heal th	Financial Systems FHN MEMORIAL H	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
Hospice CCN: 14-1560 To 12/31/203 Date/Time Prepared:			Provi der C	CN: 14-0160			
Descriptions	EXPENS	SES FOR ALLOCATION	Hospi ce CC	N: 14-1560		Date/Time Pre	
EXPENSES (See INSTRUCTIONS) SERVICE CSUM OF COLS. CS					Hospi ce I		
Instructions EXPENSES FROM WIKST B PART		Descriptions		HOSPICE DIREC	T GENERAL	TOTAL EXPENSES	
SEMERAL SERVICE COST CENTERS 1.00 2.00 3.00 1.00 2.00 3.00 1.00 2.00 3.00 1.00 2.00 3.00 1.00 2.00 3.00 1.00 3.00				EXPENSES (se	e SERVI CE	(sum of cols.	
CSOE INSTRUCTIONS 1.00 2.00 3.00				instructions	EXPENSES FROM	1 + 2)	
CAP REL COSTS-BLDG & FIXT 0 0 0 0 0 1.00					WKST B PART I		
CENERAL SERVICE COST CENTERS					(see		
CAP REL COSTS - ENDIG & FIXT 0 0 0 0 1,00							
1.00		I		1.00	2. 00	3. 00	
2.00 CAP REL COSTS-MYBLE EQUIP 0 13, 378 13, 378 2.00	4 00						1 4 00
3.00 MPLOYEE BENEFITS DEPARTMENT 10,897 333,991 344,888 3.00 A.00 ADMINISTRATIVE & GENERAL 105,539 614,667 720,206 4.00 6.0							
A. OD ADMIN IN STRATIVE & GENERAL 105, 539 614, 667 720, 206 4.00 5.00 PLANT OPERATION & MAINTENANCE 0 0 0 0 0 0 5.00 6.00 LAUNDRY & LINEN SERVICE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				40.00			ı
5. 00 PLANT OPERATI ON & MAINTENANCE 0 0 5.00 6. 00 LAUNDRY & LINEN SERVI CE 0 1 0 0 0 1 0 0 1 0 0 0 1 0 0 1 0 0 1 </td <td></td> <td></td> <td></td> <td></td> <td>·</td> <td></td> <td>1</td>					·		1
CAUNDRY & LINEN SERVICE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				105, 53			
NUSEKEEPING							•
8. 00 DI ETARY					-		l
9.00 NURSING ADMINISTRATION 0 0 0 9.00 10.00 ROUTI NE MEDICAL SUPPLIES 51 9,676 9,727 10.00 11.00 MEDICAL RECORDS 0 37,489 37,489 11.00 12.00 STAFF TRANSPORTATION 46,309 46,309 46,309 12.00 13.00 VOLUNTEER SERVICE COORDINATION 59,627 59,627 13.00 14.00 PHARMACY 158,327 46,919 205,246 14.00 15.00 PHYSI CIAN ADMINISTRATIVE SERVICES 0 242,835 0 242,835 16.00 17.00 OTHER GENERAL SERVICES 242,835 0 242,835 16.00 17.00 PATI ENT/RESI DENTI AL CARE SERVICES 0 0 0 17.00 LEVEL OF CARE EVEL OF CARE 0 0 50.00 51.00 HOSPI CE ROUTI NUOUS HOME CARE 1,953,568 1,953,568 1,953,568 1,953,568 1,00 52.00 HOSPI CE ROUTI NE HOME CARE 1,267 52.00							
10. 00 ROUTINE MEDICAL SUPPLIES 51 9,676 9,727 10. 00 11. 00 MEDICAL RECORDS 0 37,489 37,489 11. 00 12. 00 STAFF TRANSPORTATION 46,309 46,309 12. 00 13. 00 VOLUNTEER SERVICE COORDINATION 59,627 59,627 13. 00 14. 00 PHARMACY 158,327 46,919 205,246 14. 00 15. 00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 15. 00 15. 00 0 0 0 0 0 0 0 0 0						-	
11. 00 MEDI CAL RECORDS 0 37, 489 37, 489 11. 00 12. 00 STAFF TRANSPORTATION 46, 309 12. 00 13. 00 VOLUNTEER SERVI CE COORDINATION 59, 627 59, 627 13. 00 14. 00 PHARMACY 158, 327 46, 919 205, 246 14. 00 15. 00 PHYSI CI AN ADMINISTRATIVE SERVI CES 0 0 0 15. 00 16. 00 OTHER GENERAL SERVI CE 0 242, 835 0 242, 835 16. 00 17. 00 PATIENT/RESI DENTI AL CARE SERVI CES 0 0 0 0 15. 00 HOSPI CE CONTI INOUS HOME CARE 0 0 0 0 15. 00 HOSPI CE ROUTI INE HOME CARE 1, 953, 568 1, 953, 568 1, 953, 568 51. 00 15. 00 HOSPI CE GENERAL I NPATI ENT CARE 23, 567 23, 567 52. 00 15. 00 HOSPI CE GENERAL I NPATI ENT CARE 0 0 0 0 15. 00 HOSPI CE FABLEL I NPATI ENT CARE 0 0 0 0 15. 00 HOSPI CE FABLEL I NPATI ENT CARE 0 0 0 0 15. 00 HOSPI CE FABLEL I NPATI ENT CARE 0 0 0 0 15. 00 HOSPI CE FABLEL I NPATI ENT CARE 0 0 0 15. 00 HOSPI CE FABLEL I NPATI ENT CARE 0 0 0 15. 00 HOSPI CE FABLEL I NPATI ENT CARE 0 0 0 15. 00 HOSPI CE FABLEL I NPATI ENT CARE 0 0 0 15. 00 0 0 0 15. 00 0 0 0 15. 00 0 0 0 15. 00 0 0 0 15. 00 0 0 15. 00 0 0 15. 00 0 0 15. 00 0 0 15. 00 0 0 0 15. 00 0							
12.00 STAFF TRANSPORTATION 46, 309 46, 309 12.00 13.00 VOLUNTEER SERVICE COORDINATION 59, 627 59, 627 13.00 14.00 PHARMACY 158, 327 46, 919 205, 246 14.00 15.00 PHYSI CIAN ADMINISTRATIVE SERVICES 0 0 15.00 16.00 OTHER GENERAL SERVICE 242, 835 0 242, 835 16.00 17.00 EVEL OF CARE 0 0 0 0 17.00 18.00 HOSPI CE CONTI NUOUS HOME CARE 1, 953, 568 1, 953, 568 1, 953, 568 15.00 HOSPI CE ROUTINE HOME CARE 1, 953, 568 1, 953, 568 51.00 17.00 HOSPI CE ROUTINE HOME CARE 1, 953, 568 1, 953, 568 51.00 18.00 HOSPI CE ROUTINE HOME CARE 1, 267 23, 567 52.00 18.00 HOSPI CE ROUTINE HOME CARE 1, 267 1, 267 18.00 HOSPI CE ROUTINE HOME CARE 1, 267 1, 267 18.00 HOSPI CE ROUTINE HOME CARE 1, 267 1, 267 18.00 HOSPI CE ROUTINE HOME CARE 1, 267 1, 267 18.00 HOSPI CE ROUTINE HOME CARE 1, 267 1, 267 18.00 HOSPI CE PORTAL INPATIENT CARE 1, 267 1, 267 18.00 HOSPI CE PORTAL INPATIENT CARE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1			•
13.00 VOLUNTEER SERVI CE COORDINATION 59, 627 13.00 14.00 PHARMACY 158, 327 46, 919 205, 246 14.00 15.00 OTHER GENERAL SERVI CE S 0 242, 835 16.00 17.00 OTHER GENERAL SERVI CE 0 0 17.00 17.00 EVEL OF CARE 0 0 0 17.00 HOSPI CE CONTI NUOUS HOME CARE 0 0 0 17.00 HOSPI CE ROUTI NE HOME CARE 1, 953, 568 1, 953, 568 51.00 17.00 HOSPI CE GENERAL INPATI ENT CARE 23, 567 23, 567 23, 567 17.00 HOSPI CE GENERAL INPATI ENT CARE 1, 267 1, 267 17.00 HOSPI CE GENERAL INPATI ENT CARE 1, 267 1, 267 17.00 HOSPI CE GENERAL INPATI ENT CARE 0 0 0 17.00 HOSPI CE GENERAL INPATI ENT CARE 0 0 0 17.00 HOSPI CE GENERAL INPATI ENT CARE 0 0 0 18.00 HOSPI CE GENERAL INPATI ENT CARE 0 0 0 18.00 HOSPI CE GENERAL INPATI ENT CARE 0 0 0 18.00 HOSPI CE GENERAL INPATI ENT CARE 0 0 0 18.00 HOSPI CE FROGRAM 0 0				14 20			
14.00 PHARMACY 158, 327 46, 919 205, 246 14.00 15.00 15.00 16.00 0 15.00 16.00 0 15.00 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 0 0 0 0 0 0 0 0							
15.00 PHYSI CI AN ADMINISTRATI VE SERVI CES 0 15.00 16.00 OTHER GENERAL SERVI CE 242,835 0 242,835 16.00 17.00 PATI ENT/RESI DENTI AL CARE SERVI CES 0 0 0							•
16. 00				130, 32			1
17. 00				242.83			•
LEVEL OF CARE				242,00			
50.00 HOSPI CE CONTI NUOUS HOME CARE 0 0 50.00 51.00 HOSPI CE ROUTI NE HOME CARE 1,953,568 1,953,568 51.00 52.00 HOSPI CE INPATI ENT RESPI TE CARE 23,567 23,567 52.00 53.00 HOSPI CE GENERAL I NPATI ENT CARE 1,267 1,267 NONREI MBURSABLE COST CENTERS	17.00						17.00
51.00 HOSPI CE ROUTI NE HOME CARE 1, 953, 568 1, 953, 568 51.00 52.00 HOSPI CE INPATI ENT RESPI TE CARE 23, 567 23, 567 52.00 53.00 HOSPI CE GENERAL INPATI ENT CARE 1, 267 1, 267 53.00 NONREI MBURSABLE COST CENTERS	50.00				0	0	50.00
HOSPICE GENERAL INPATIENT CARE 1,267 1,267 53.00 NONREI MBURSABLE COST CENTERS	51. 00			1, 953, 56	8	1, 953, 568	51.00
HOSPICE GENERAL INPATIENT CARE 1, 267 1, 267 53.00							ł
60. 00 BEREAVEMENT PROGRAM 0 0 0 61. 00 61. 00 VOLUNTEER PROGRAM 0 0 61. 00 62. 00 FUNDRAI SI NG 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES 0 0 0 66. 00 67. 00 ADVERTI SI NG 0 0 67. 00	53.00	HOSPI CE GENERAL I NPATI ENT CARE					53. 00
61. 00 VOLUNTEER PROGRAM 62. 00 FUNDRAI SI NG 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 64. 00 PALLI ATI VE CARE PROGRAM 65. 00 OTHER PHYSI CI AN SERVI CES 66. 00 RESI DENTI AL CARE 67. 00 ADVERTI SI NG 0 61. 00 61. 00 62. 00 62. 00 63. 00 64. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 60. 00		NONREI MBURSABLE COST CENTERS					
62. 00 FUNDRAI SI NG 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM 0 65. 00 66. 00 RESI DENTI AL CARE 0 0 66. 00 67. 00 ADVERTI SI NG 0 0 67. 00	60.00	BEREAVEMENT PROGRAM			0	0	60.00
63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 64. 00 PALLI ATI VE CARE PROGRAM 65. 00 OTHER PHYSI CI AN SERVI CES 66. 00 RESI DENTI AL CARE 0 0 65. 00 67. 00 ADVERTI SI NG 0 0 67. 00	61.00	VOLUNTEER PROGRAM			0	0	61.00
64. 00 PALLI ATI VE CARE PROGRAM 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES 0 65. 00 66. 00 RESI DENTI AL CARE 0 0 66. 00 67. 00 ADVERTI SI NG 0 0 67. 00	62.00	FUNDRAI SI NG			0	0	62.00
65. 00 OTHER PHYSI CI AN SERVI CES 0 0 65. 00 66. 00 RESI DENTI AL CARE 0 0 66. 00 67. 00 ADVERTI SI NG 0 0 67. 00	63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	63. 00
66. 00 RESI DENTI AL CARE 0 0 66. 00 67. 00 ADVERTI SI NG 0 67. 00							
67. 00 ADVERTI SI NG 0 67. 00	65.00	OTHER PHYSICIAN SERVICES					65. 00
	66. 00	RESI DENTI AL CARE				0	66. 00
					-	_	
	68. 00	TELEHEALTH/TELEMONI TORI NG			0	0	68. 00
69. 00 THRI FT STORE 0 69. 00							
70. 00 NURSING FACILITY ROOM & BOARD 0 70. 00							l
71. 00 OTHER NONREIMBURSABLE (SPECIFY)							1
99. 00 NEGATI VE COST CENTER				2 (01 2)	-		
100. 00 TOTAL 2, 601, 987 1, 056, 120 3, 658, 107 100. 00	100.00	I TOTAL		2,601,98	1, 056, 120	3, 658, 107	1100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 14-0160 Peri od: Worksheet 0-6 From 01/01/2023 Part I Hospi ce CCN: 14-1560 12/31/2023 Date/Time Prepared: To 5/30/2024 4:39 pm Hospi ce I TOTAL EXPENSES CAP REL BLDG & CAP REL MVBLE EMPLOYEE SUBTOTAL Descriptions EQUI P **BENEFITS** FIX DEPARTMENT 1.00 2.00 0 ЗА 3.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 1.00 13, 378 2.00 CAP REL COSTS-MVBLE EQUIP 13, 378 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 344, 888 0 344, 888 3.00 ADMINISTRATIVE & GENERAL 720, 206 13, 333 733, 539 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 0 0 0 5.00 0 0 LAUNDRY & LINEN SERVICE 0 0 0 0 6.00 0 6.00 7.00 HOUSEKEEPI NG 0 0 0 0 7.00 8.00 DI ETARY 0 0 0 0 0 8.00 NURSING ADMINISTRATION 0 9.00 0 9.00 0 0 0 ROUTINE MEDICAL SUPPLIES 0 9, 727 10.00 9.727 10.00 11.00 MEDICAL RECORDS 37, 489 0 0 0 0 0 37, 489 11.00 12.00 STAFF TRANSPORTATION 46, 309 46, 309 12.00 VOLUNTEER SERVICE COORDINATION 59, 627 0 59, 627 13.00 0 13.00 0 14.00 PHARMACY 205, 246 0 205, 246 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 OTHER GENERAL SERVICE 0 16.00 242, 835 0 242, 835 16.00 PATIENT/RESIDENTIAL CARE SERVICES 0 17.00 0 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 50.00 HOSPICE ROUTINE HOME CARE 1, 953, 568 338, 985 2, 292, 553 51.00 51.00 HOSPICE INPATIENT RESPITE CARE 5, 705 52.00 23, 567 C 25 29, 297 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 1, 267 0 20 198 1, 485 53.00 NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 n n 60.00 0 0 0 0 VOLUNTEER PROGRAM 0 0 61.00 0 61.00 0 62.00 FUNDRAI SI NG 0 0 62.00 0 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 00000000 0 0 63.00 0 PALLIATIVE CARE PROGRAM 0 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 0 65.00 RESIDENTIAL CARE 0 0 66.00 0 0 66.00

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3, 658, 107 100. 00

67.00

71.00

99.00

67 00

68.00

69.00

70.00

71 00

100.00 TOTAL

ADVERTI SI NG

THRIFT STORE

99.00 NEGATIVE COST CENTER

TELEHEALTH/TELEMONI TORI NG

NURSING FACILITY ROOM & BOARD

OTHER NONREIMBURSABLE (SPECIFY)

In Lieu of Form CMS-2552-10 Health Financial Systems FHN MEMORIAL HOSPITAL COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 14-0160 Peri od: Worksheet 0-6 From 01/01/2023 Part I Hospi ce CCN: 14-1560 12/31/2023 Date/Time Prepared: 5/30/2024 4:39 pm Hospi ce I ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY Descriptions & GENERAL OPERATION & LINEN SERVICE MAI NTENANCE 4.00 6.00 7. 00 8. 00 5.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL 733, 539 4.00 5.00 PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE 0 0 0 6.00 6.00 7.00 HOUSEKEEPI NG 0 8.00 DI ETARY 0 NURSING ADMINISTRATION 9.00 0

Heal th	Financial Systems	FHN MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	_ SERVICE COSTS	Provi der Co		Peri od: From 01/01/2023	Worksheet 0-6 Part I	
			Hospi ce CCN		To 12/31/2023	Date/Time Pre	pared:
			·			5/30/2024 4: 3	9 pm
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	Hospi ce I STAFF	VOLUNTEER	
	Descriptions	ADMI NI STRATI ON	MEDI CAL	RECORDS	TRANSPORTATION	SERVI CE	
		7 DIMITITI OTTOTT OIL	SUPPLI ES	REGORDS	THURST CICTATT CIC	COORDI NATI ON	
		9. 00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6. 00 7. 00	LAUNDRY & LINEN SERVICE HOUSEKEEPING						6. 00 7. 00
8. 00	DI ETARY						8.00
9. 00	NURSING ADMINISTRATION	0					9.00
10. 00	ROUTINE MEDICAL SUPPLIES		12, 167				10.00
11. 00	MEDI CAL RECORDS		12, 107	46, 89	12		11. 00
12. 00	STAFF TRANSPORTATION	0		10,07	57, 924		12.00
13. 00	VOLUNTEER SERVICE COORDINATION	O			0	74, 583	13. 00
14.00	PHARMACY	0			o	0	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	O			0	0	15. 00
16.00	OTHER GENERAL SERVICE	0			0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE						
50. 00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50. 00
51. 00	HOSPICE ROUTINE HOME CARE	0	12, 013			73, 306	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	145			1, 234	52.00
53. 00	HOSPI CE GENERAL I NPATI ENT CARE NONREI MBURSABLE COST CENTERS	0	9		6 33	43	53. 00
60. 00	BEREAVEMENT PROGRAM	0			0	0	60.00
61. 00	VOLUNTEER PROGRAM				0	0	61. 00
62. 00	FUNDRAI SI NG				0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	o			o	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM	o			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65. 00
66.00	RESI DENTI AL CARE	0			0	0	66. 00
67.00	ADVERTI SI NG	0			0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68. 00
69. 00	THRI FT STORE	0			0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD				_	_	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	-		0	0	71.00
99. 00	NEGATIVE COST CENTER	0	10.1/7	47.00	0	74 503	99.00
100.00	TOTAL	0	12, 167	46, 89	57, 924	74, 583	1100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 14-0160 Peri od: Worksheet 0-6 From 01/01/2023 Part I Hospi ce CCN: 14-1560 12/31/2023 Date/Time Prepared: To 5/30/2024 4:39 pm Hospi ce I PHARMACY PHYSI CI AN OTHER GENERAL PATI ENT/ TOTAL Descriptions ADMI NI STRATI VE SERVI CE RESI DENTI AL SERVI CES CARE SERVICES 14. 00 16. 00 18. 00 15.00 17.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 4. 00 4.00 ADMINISTRATIVE & GENERAL 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 9.00 9.00 ROUTINE MEDICAL SUPPLIES 10.00 10.00 11.00 MEDICAL RECORDS 11.00 12.00 STAFF TRANSPORTATION 12.00 VOLUNTEER SERVICE COORDINATION 13.00 13.00 14.00 PHARMACY 256, 726 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 OTHER GENERAL SERVICE 16.00 0 303, 743 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 50.00 HOSPICE ROUTINE HOME CARE 3, 606, 995 252, 332 0 298, 544 51.00 51.00 HOSPICE INPATIENT RESPITE CARE 48, 811 4, 246 0 52.00 5, 024 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 148 175 2, 301 53.00 NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 n 60.00 VOLUNTEER PROGRAM 0 0 0 0 0 0 0 0 61.00 0 61.00 0 62.00 FUNDRAI SI NG 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 0 63.00 PALLIATIVE CARE PROGRAM 0 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 0 66.00 67 00 ADVERTI SI NG 0 0 67.00 0 TELEHEALTH/TELEMONI TORI NG 68.00 0 68.00 69.00 THRIFT STORE 0 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 0 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 0 O 71.00 0 99.00 NEGATIVE COST CENTER

0

256, 726

0

0

303, 743

0

0 99.00

3, 658, 107 100. 00

100.00 TOTAL

Health Financial Systems	FHN MEMORIAL HOSP	PLTAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS		rovider CCN: 14-0160 ospice CCN: 14-1560	From 01/01/2023	Worksheet 0-6 Part II Date/Time Prepared: 5/30/2024 4:39 pm

			nospi ce con	1. 14-1300 1	0 12/31/2023	5/30/2024 4: 3	
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG & C	CAP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
	'	FLX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET) (DEPARTMENT		(ACCUMULATED	
		(**************************************	/	(GROSS		COSTS)	
				SALARI ES)			
		1.00	2. 00	3. 00	4A	4. 00	
	GENERAL SERVICE COST CENTERS	1					
1.00	CAP REL COSTS-BLDG & FLXT	855					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		14, 334				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	11,001	13, 905			3. 00
4. 00	ADMINISTRATIVE & GENERAL	855	14, 286	13, 703	-733, 539	2, 924, 568	4. 00
5.00	PLANT OPERATION & MAINTENANCE	033	14, 200	0	-733, 337	2, 724, 300	5. 00
6.00	LAUNDRY & LINEN SERVICE		0	0	0	0	6.00
		0	0	0	0	0	
7.00	HOUSEKEEPI NG	0	U	0	0	-	7. 00
8.00	DI ETARY	0	0	0	0	0	8. 00
9.00	NURSI NG ADMI NI STRATI ON	0	0	0	0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	9, 727	1
11. 00	MEDI CAL RECORDS	0	0	0	0	37, 489	1
12. 00	STAFF TRANSPORTATION	0	0	0	0	46, 309	
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	59, 627	13. 00
14.00	PHARMACY	0	0	0	0	205, 246	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15. 00
16.00	OTHER GENERAL SERVICE	0	0	0	0	242, 835	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			13, 667	0	2, 292, 553	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	ol	27	230	0	29, 297	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	o	21	8		· ·	
	NONREI MBURSABLE COST CENTERS			-		.,	
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61. 00	VOLUNTEER PROGRAM	o	0	0	0	Ö	61.00
62. 00	FUNDRAI SI NG		0	0	0	Ö	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0	0	0	Ö	63.00
64. 00	PALLIATIVE CARE PROGRAM		0	0	0	0	64.00
65. 00	OTHER PHYSICIAN SERVICES		0	0	0	0	65.00
	A CONTRACTOR OF THE CONTRACTOR	0	0	0	0		1
66.00	RESI DENTI AL CARE	0	0	0	0	0	66.00
67. 00	ADVERTI SI NG	0	0	0	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0	0	0	0	68. 00
69. 00	THRI FT STORE	0	O	0	0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD				0		70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	
99. 00	NEGATIVE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		13, 378	344, 888		733, 539	
101.00	UNIT COST MULTIPLIER	0. 000000	0. 933305	24. 803164		0. 250820	101. 00

Heal th	Financial Systems	FHN MEMORIAL	L HOSPITAL		In Li€	eu of Form CMS-2	2552-10
	NLLOCATION - HOSPITAL-BASED HOSPICE GENERAL S STICAL BASIS	ERVICE COSTS	Provi der C Hospi ce CC		Peri od: From 01/01/2023 To 12/31/2023		pared:
					Hospi ce I		
	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	`) (IN-FACILITY DAYS)	NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE PATIENT/RESIDENTIAL CARE SERVICES LEVEL OF CARE	0 0 0 0 0 0 0 0 0	l .		0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
50. 00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51. 00 52. 00 53. 00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS	0 0	l e	•	0 0 0	0 0	51. 00 52. 00 53. 00
60. 00	BEREAVEMENT PROGRAM	0			0	0	60.00
61. 00	VOLUNTEER PROGRAM	0	ł		0	Ö	61.00
62.00	FUNDRAI SI NG	0			0	0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63. 00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES	0			0	0	65. 00

0.000000

0.000000

66. 00

68.00

69. 00

70.00

71.00

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0 67.00

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0.000000

0.000000

RESI DENTI AL CARE ADVERTI SI NG

THRI FT STORE

99.00 NEGATIVE COST CENTER

101.00 UNIT COST MULTIPLIER

TELEHEALTH/TELEMONI TORI NG

70.00 NURSING FACILITY ROOM & BOARD 71.00 OTHER NONREIMBURSABLE (SPECIFY)

100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I)

66. 00

67.00

68.00

69. 00

Health Financial Systems	S		FHN MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPI STATISTICAL BASIS	TAL-BASED HOSPICE	GENERAL SERVI	ICE COSTS	Provider CCN:	 From 01/01/2023	Worksheet 0-6 Part II Date/Time Prepared: 5/30/2024 4:39 pm

3171112	THORE BIGIO		Hospi ce CCI	N: 14-1560 T	o 12/31/2023	Date/Time Pre 5/30/2024 4:3	
					Hospi ce I		
	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MI LEAGE)	VOLUNTEER SERVI CE COORDI NATI ON (HOURS OF	PHARMACY (CHARGES)	
		(,		(===)	SERVICE)		
		10.00	11. 00	12.00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT					I	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP					I	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT					l	3. 00
4.00	ADMINISTRATIVE & GENERAL					I	4. 00
5. 00	PLANT OPERATION & MAINTENANCE					I	5. 00
6.00	LAUNDRY & LINEN SERVICE					I	6.00
7.00	HOUSEKEEPI NG					I	7. 00
8. 00 9. 00	DI ETARY					I	8.00
10.00	NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES	15, 616					9.00
11. 00	MEDICAL RECORDS	15,010	15, 616			I	11.00
12. 00	STAFF TRANSPORTATION		13,010	13, 905		I	12.00
13. 00	VOLUNTEER SERVICE COORDINATION			0	13, 905	I	13. 00
14. 00	PHARMACY			0	0	13, 905	1
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES			0	o	0	15. 00
16.00	OTHER GENERAL SERVICE			0	O	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE	15, 418				13, 667	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	186	186			230	1
53. 00	HOSPICE GENERAL INPATIENT CARE	12	12	8	8	8	53. 00
(0.00	NONREI MBURSABLE COST CENTERS	1		0	O	0	/ 0 00
60. 00 61. 00	BEREAVEMENT PROGRAM VOLUNTEER PROGRAM			0	_	_	60.00
62. 00	FUNDRAI SI NG			0	_	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0		Ö	63.00
64. 00	PALLIATIVE CARE PROGRAM			0		Ö	64.00
65. 00	OTHER PHYSI CI AN SERVI CES			0	o	Ō	65. 00
66. 00	RESI DENTI AL CARE			0	0	0	66.00
67.00	ADVERTI SI NG			0	0	0	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG			0	0	0	68. 00
69. 00	THRI FT STORE			0	0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD					I	70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71. 00
99. 00	NEGATIVE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		46, 892			256, 726	
101.00	UNIT COST MULTIPLIER	0. 779137	3. 002818	4. 165696	5. 363754	18. 462855	1101.00

Health Financial Systems	FHN MEMORIAL HO	OSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HO STATISTICAL BASIS		Provi der CCN: Hospi ce CCN:	From 01/01/2023	Worksheet 0-6 Part II Date/Time Prepared: 5/30/2024 4:39 nm

			nospi ce coi	N. 14-1300	10 12/31/2023	5/30/2024 4: 39	
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI VE		RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICE	S		
		(PATIENT DAYS)	,	(IN-FACILITY			
		(DAYS)			
		15. 00	16.00	17. 00			
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT		I	I			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMI NI STRATI VE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION						9. 00
10. 00	ROUTINE MEDICAL SUPPLIES						10. 00
11. 00	MEDI CAL RECORDS						11. 00
12. 00	STAFF TRANSPORTATION						12.00
13. 00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY						14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0					15.00
16.00	OTHER GENERAL SERVICE		13, 905				16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE	•					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0				50.00
51.00	HOSPICE ROUTINE HOME CARE	0	13, 667				51.00
	HOSPICE INPATIENT RESPITE CARE	0		1	0		52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE			1	0		53. 00
00.00	NONREI MBURSABLE COST CENTERS			1			00.00
60.00	BEREAVEMENT PROGRAM		0	ı			60. 00
61. 00	VOLUNTEER PROGRAM		0				61. 00
62. 00	FUNDRAI SI NG		0				62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS						63. 00
64. 00	PALLIATIVE CARE PROGRAM					•	64. 00
	OTHER PHYSICIAN SERVICES						65. 00
66. 00	RESIDENTIAL CARE				0	l l	66. 00
					U		
67. 00	ADVERTI SI NG						67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG			1			68. 00
69. 00	THRIFT STORE		0	1			69. 00
	NURSING FACILITY ROOM & BOARD	_	_				70. 00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0	1	0		71. 00
	NEGATIVE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I		303, 743	1	0		00. 00
101.00	UNIT COST MULTIPLIER	0. 000000	21. 844157	0.00000	00	1	01. 00

Heal th	Financial Systems	FHN MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	IONMENT OF HOSPITAL-BASED HOSPICE SHARED SER	VICE COSTS BY	Provi der CC		Peri od:	Worksheet 0-7	
LEVEL	OF CARE		Hospi ce CCN	N: 14-1560	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 4:3	
					Hospi ce I		
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, Co Part I, Col. 9 Line	Ratio		HRHC	HI RC	
		0	1. 00	2.00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS	T ,,T	0.0571		al -1	_	
1. 00 2. 00 3. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	66. 00 67. 00 68. 00	0. 257901		0 0	0	1. 00 2. 00 3. 00
4. 00 5. 00 6. 00	DRUGS CHARGED TO PATIENTS DURABLE MEDICAL EQUIP-RENTED LABORATORY	73. 00 96. 00 60. 00	0. 107790 0. 137312		0 183, 762	0	4. 00 5. 00 6. 00
7. 00 8. 00 9. 00	MEDICAL SUPPLIES CHARGED TO PATIENT OTHER OUTPATIENT SERVICE COST CENTER	71. 00 93. 00 55. 00	0. 004539		0 0	0	7. 00 8. 00 9. 00
10. 00 10. 01	RADIOLOGY-THERAPEUTIC DIABETIC EDUCATION CANCER CENTER Totals (sum of lines 1-11)	76. 00 76. 01	0. 000000 0. 343910		0 0	0	10.00
		Charges by LOC (from Provider Records)			ce Costs by LOC		
	Cost Center Descriptions		col. 2)	col . 3)	xHIRC (col. 1 x col. 4)	col. 5)	
	ANCILLARY SERVICE COST CENTERS	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00 2. 00 3. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	0	0		0 0	0	1. 00 2. 00 3. 00
4. 00 5. 00 6. 00	DRUGS CHARGED TO PATIENTS DURABLE MEDICAL EQUIP-RENTED LABORATORY	0	0	19, 80	0 0	0	4. 00 5. 00
7. 00 8. 00 9. 00	MEDICAL SUPPLIES CHARGED TO PATIENT OTHER OUTPATIENT SERVICE COST CENTER RADIOLOGY-THERAPEUTIC	0	0		0 0	0	
10. 00 10. 01	DIABETIC EDUCATION CANCER CENTER Totals (sum of lines 1-11)	0	0 0 0	19, 80	0 0 0 0 08 0	0 0 0	10. 00 10. 01

Health Financial Systems	FHN MEMORIAL HOSPITAL		In Lie	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provi de	r CCN: 14-0160	Peri od:	Worksheet 0-8

					5/30/2024 4: 3	9 pm
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7	, col . 6,			0	1.00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	10)		0		4. 00
5.00	Program cost (line 3 times line 4)	,		0		5. 00
	HOSPI CE ROUTI NE HOME CARE			<u>'</u>		
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7	, col . 7,			3, 626, 803	6.00
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				15, 418	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)				235. 23	8. 00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	e 11)	14, 38	1 366		9. 00
10.00	Program cost (line 8 times line 9)	•	3, 382, 84	86, 094		10.00
	HOSPICE INPATIENT RESPITE CARE					
11. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7	, col . 8,			48, 811	11. 00
	line 11)				·	
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				186	12. 00
13.00	Total average cost per diem (line 11 divided by line 12)				262. 42	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	e 12)	15	6 0		14. 00
15.00	Program cost (line 13 times line 14)		40, 93	3 0		15. 00
	HOSPICE GENERAL INPATIENT CARE			<u> </u>		ĺ
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7	, col . 9,			2, 301	16. 00
	line 11)					
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				12	17. 00
18.00	Total average cost per diem (line 16 divided by line 17)				191. 75	18. 00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	e 13)	1	2 0		19. 00
20.00	Program cost (line 18 times line 19)		2, 30	1 0		20.00
	TOTAL HOSPICE CARE			•		
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				3, 677, 915	21. 00
22. 00	Total unduplicated days (Wkst. S-9, col. 4, line 14)				15, 616	
	Average cost per diem (line 21 divided by line 22)				235. 52	
			'	1		

CALCULATION OF CAPITAL PAYMENT Provider CCN: 14-0160 Period: From 01/01/2023 To 12/31/2023 From 12/31/2023 F	Worksheet L Parts I-III Date/Time Prep 5/30/2024 4:39 PPS	
	PPS	
PART I - FULLY PROSPECTIVE METHOD		
PART I - FULLY PROSPECTIVE METHOD		
PAKT I - FULLY PRUSPECTIVE METHUD	1. 00	
CAPITAL FEDERAL AMOUNT		1
1.00 Capital DRG other than outlier	592, 031	1.00
1.01 Model 4 BPCI Capital DRG other than outlier	0	
2.00 Capital DRG outlier payments	1, 469	
2.01 Model 4 BPCI Capital DRG outlier payments	0	
3.00 Total inpatient days divided by number of days in the cost reporting period (see instructions)	37. 87	3. 00
4.00 Number of interns & residents (see instructions)	0.00	4. 00
5.00 Indirect medical education percentage (see instructions)	0. 00	5. 00
6.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and	0	6. 00
1.01)(see instructions) 7.00 Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line	0.00	7. 00
30) (see instructions)		
8.00 Percentage of Medicaid patient days to total days (see instructions)	0.00	
9.00 Sum of lines 7 and 8	0.00	
10.00 Allowable disproportionate share percentage (see instructions) 11.00 Disproportionate share adjustment (see instructions)	0.00	
12.00 Total prospective capital payments (see instructions)	593, 500	
12. 00 Total prospective capital payments (see Histructions)	373, 300	12.00
	1. 00	
PART II - PAYMENT UNDER REASONABLE COST		
1.00 Program inpatient routine capital cost (see instructions)	0	1.00
2.00 Program inpatient ancillary capital cost (see instructions)	0	
3.00 Total inpatient program capital cost (line 1 plus line 2)	0	
4.00 Capital cost payment factor (see instructions)	0	
5.00 Total inpatient program capital cost (line 3 x line 4)	0	5. 00
	1. 00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00 Program inpatient capital costs (see instructions)	0	
2.00 Program inpatient capital costs for extraordinary circumstances (see instructions)	0	
3.00 Net program inpatient capital costs (line 1 minus line 2)	0, 00	
4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4)	0.00	
6.00 Percentage adjustment for extraordinary circumstances (see instructions)	0. 00	
7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0.00	
8.00 Capital minimum payment level (line 5 plus line 7)	0	
9.00 Current year capital payments (from Part I, line 12, as applicable)	0	
10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	ő	
11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	
12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12. 00
13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)	ő	
14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period	ő	
(if line 12 is negative, enter the amount on this line)	1	
15.00 Current year allowable operating and capital payment (see instructions)	0	
	0 0 0	16. 00

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: 14-0160 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/30/2024 4: 42 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/30/2024 4:42 pm] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Contractor use only (3) Settled with Audit number of times reopened = 0-9. (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 FHN MEMORIAL HOSPITAL (14-0160) 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		
		1	2	SI GNATURE STATEMENT	
1	Mich	ael C Clark	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	Michael C Clark			2
3	Signatory Title	EVP AND CFO			3
4	Date	(Dated when report is electronica			4

			Title XVIII				
		Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	C	-16, 733	-65, 200	0	0	1. 00
2.00	SUBPROVIDER - IPF	C	0	0		0	2. 00
3.00	SUBPROVIDER - IRF	C	0	0		0	3. 00
5.00	SWING BED - SNF	C	0	0		0	5. 00
6.00	SWING BED - NF	C				0	6. 00
200.00	TOTAL	C	-16, 733	-65, 200	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA

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

Health Financial Systems FHN MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0160 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 4:42 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1405 WEST STEPHENSON STREET 1.00 PO Box: 1.00 2.00 City: FREEPORT State: IL Zip Code: 64032 County: STEPHENSON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal FHN MEMORIAL HOSPITAL 140160 99914 07/01/1966 3.00 Subprovider - IPF 4.00 4.00 Subprovi der - IRF 5.00 5 00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 12.00 Hospi tal -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 FHN MEMORIAL - HOSPICE 141560 99914 08/12/1993 14.00 15.00 Hospital-Based Health Clinic - RHC 15 00 16.00 Hospital-Based Health Clinic - FQHC 16, 00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 12/31/2023 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 20 00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for Υ Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22. 01 22 01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires a final UCP to be 22 02 N Ν 22 02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. Did this hospital receive a geographic reclassification from urban to 22.03 Ν Ν N 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no.

22.04

23.00

N

22.04 Did this hospital receive a geographic reclassification from urban to

rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 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.

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25

below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

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. If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

Ν

58.00

Health Financial Systems FHN MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0160 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 4: 42 pm 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion 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. Y/N IMF Direct GME IME Direct GME 1. 00 2. 00 3. 00 4.00 5. 00 61.00 Did your hospital receive FTE slots under ACA 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 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) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 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 Code Unweighted IME Unweighted Program Name 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 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 63.00

Health Financial Systems	FHN M	EMORIAL HOSP	I TAL		In Li€	eu of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	TA Pr	ovider CC		Period: From 01/01/2023 To 12/31/2023		pared:
				Unweighted	Unwei ghted	Ratio (col. 1/	
				FTEs Nonprovider Site	FTEs in Hospital	(col. 1 + col. 2))	
				1. 00	2.00	3.00	
Section 5504 of the ACA Base Yea	r FTE Residents in No	onprovi der Se	ettings				
64.00 Enter in column 1, if line 63 is in the base year period, the numl resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	ty trained re n-primary car all nonprovi d non-primary n column 3 th	sidents e der care e ratio	0. 0	Unwei ghted	Ratio (col. 3/	64. 00
				FTEs	FTEs in	(col. 3 + col.	
				Nonprovider Site	Hospi tal	4))	
	1. 00	2.00)	3. 00	4.00	5. 00	_
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0. C	Unweighted	0.000000	
				FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
				Si te 1. 00	2.00	2.00	
Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovide	Settings		2.00	3.00	
beginning on or after July 1, 20							
66.00 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 (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3 column 2)). (see ins	rovider setti ry care resic 3 the ratio c structions)	ngs. ent f	0.0			
	Program Name	Program	Code	Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
				Si te		, ,	
	1. 00	2.00)	3. 00	4.00	5. 00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.0	0.00	0. 000000	67. 00

Health Financial Systems FHN MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-0160 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 4:42 pm 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 (August 10, 2022)? 68.00 68.00 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 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.

76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 75.00 76.00 0 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 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 85.00 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 Ν 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Adjustment Permanent (Y/N) Adjustments 1.00 2.00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target Ν 0 88.00 amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments. Wkst. A Line Effective Date Approved No. Permanent Adjustment Amount Per Di scharge 1.00 2.00 3.00 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0.00 0 89.00 on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per di scharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. XI X 1 00 2 00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for N 90.00 Υ yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in 91.00 91.00 Ν N full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92.00 Ν 92.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 93.00 Ν Ν Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν 94.00 94.00 Ν applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 95.00 0.00 0.00 95.00 96.00 Ν Ν 96.00 applicable column. 97.00 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0 00 0.00

117. 00

118. 00

117.00 is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

118.00|s the mal practice insurance a claims-made or occurrence policy? Enter 1

if the policy is claim-made. Enter 2 if the policy is occurrence.

Health Financial Systems FHN MEMORIAL	HOSPI TAL		In Lie	u of Form CM	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CO	CN: 14-0160	Peri od: From 01/01/2023	Worksheet S Part I	5-2
			To 12/31/2023	Date/Time P 5/30/2024 4	
		Premi ums	Losses	Insurance	
tto orbit is a second or the s		1. 00	2.00	3.00	170 110 01
118.01 List amounts of malpractice premiums and paid losses:			0 0	210, 7	778 118. 01
			1. 00	2. 00	
118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein.			N		118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y' alifies for th	" for yes or he Outpatient		Y	119. 00 120. 00
121.00 Did this facility incur and report costs for high cost implar	ntable devices	s charged to	N		121. 00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1					122. 00
the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) pure services, e.g., legal, accounting, tax preparation, bookkeepi	ng, payroll,	and/or	Υ	N	123. 00
management/consulting services, from an unrelated organization for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from unlocated in a CBSA outside of the main hospital CBSA? In column "N" for no.	greater than unrelated orga	50% of total ani zati ons			
Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant ce	enter? Enter '	"Y" for ves	N		125. 00
and "N" for no. If yes, enter certification date(s) (mm/dd/yy	yyy) below.	,			
126.00 f this is a Medicare-certified kidney transplant program, er in column 1 and termination date, if applicable, in column 2.		ification dat	te		126. 00
127.00 If this is a Medicare-certified heart transplant program, ent		fication date	9		127. 00
in column 1 and termination date, if applicable, in column 2. 128.00 olf this is a Medicare-certified liver transplant program, ent		fication data			128. 00
in column 1 and termination date, if applicable, in column 2.		ircation date			120.00
129.00 If this is a Medicare-certified lung transplant program, enter		ication date			129. 00
in column 1 and termination date, if applicable, in column 2. 130.00 of this is a Medicare-certified pancreas transplant program,		rti fi cati on			130. 00
date in column 1 and termination date, if applicable, in colu	umn 2.				
131.00 If this is a Medicare-certified intestinal transplant program date in column 1 and termination date, if applicable, in column 1	m, enter the d	certi fi cati or	ו		131. 00
132.00 If this is a Medicare-certified islet transplant program, ent		fication date	e		132. 00
in column 1 and termination date, if applicable, in column 2.					122.00
133.00 Removed and reserved 134.00 If this is a hospital-based organ procurement organization (Cin column 1 and termination date, if applicable, in column 2.		he OPO number	-		133. 00 134. 00
All Providers 140.00 Are there any related organization or home office costs as de	efined in CMS	Pub. 15-1.	Y		140. 00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If y are claimed, enter in column 2 the home office chain number. 1.00 2.00	yes, and home (see instruct	office costs			110.00
If this facility is part of a chain organization, enter on li home office and enter the home office contractor name and con	ines 141 thro	er.	name and address	of the	141.00
141.00 Name: Contractor's Name: 142.00 Street: PO Box:		Contract	or's Number:		141. 00 142. 00
143. 00 Ci ty: State:		Zi p Code):		143. 00
				1.00	
144.00 Are provider based physicians' costs included in Worksheet A?	?			1.00 Y	144. 00
145.00 If costs for renal services are claimed on Wkst. A, line 74,	are the costs	s for	1. 00 Y	2. 00 N	145. 00
inpatient services are craimed on wist. A, Time 74, inpatient services only? Enter "Y" for yes or "N" for no in condition of no, does the dialysis facility include Medicare utilization of period? Enter "Y" for yes or "N" for no in column 2.	column 1. If o	column 1 is	r	IN IN	143.00
146.00 Has the cost allocation methodology changed from the previous Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15 yes, enter the approval date (mm/dd/yyyy) in column 2.			- N		146. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Р	rovider CC	N: 14-0160		iod: m 01/01/2023 12/31/2023		epared:
							1.00	
147.00 Was there a change in the statist	cal hasis? Enter "Y" f	or ves o	r "N" for	no			N N	147. 00
148.00Was there a change in the order of							N	148. 00
149.00 Was there a change to the simplif					for no.		N	149. 00
	, , , , , , , , , , , , , , , , , , ,		Part A	Part		Title V	Title XIX	
			1.00	2.00	1	3. 00	4.00	
Does this facility contain a prov								
or charges? Enter "Y" for yes or	'N" for no for each com	mponent f			B. (Se			
55. 00 Hospi tal			N	N		N	N	155. 0
56.00 Subprovi der - IPF			N	N		N	N	156. 0
57.00 Subprovi der - IRF 58.00 SUBPROVI DER			N	N		N	N	157. 0 158. 0
59. 00 SNF			N	N		N	N	159. 0
160.00HOME HEALTH AGENCY			N	N N		N	N N	160. 0
61. OO CMHC			IN	N N		N	N N	161. 0
OT. CO CIVILIE				14			14	101.0
							1.00	
Multicampus								
65.00 Is this hospital part of a Multica	ampus hospital that has	one or	more campu	ıses in di	fferen	t CBSAs?	N	165. 0
Enter "Y" for yes or "N" for no.	N				7: 0	1 00004	ETE (O	
	Name 0		unty . 00	State 2.00	Zip Co 3. 00		FTE/Campus 5.00	
66.00 If line 165 is yes, for each	U	ı	. 00	2.00	3.00	3 4.00		00 166. 0
campus enter the name in column							0. (JO 100. U
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)								
W 1 1 1 C 1 T 1 1 (W)	5)	· D					1.00	
Heal th Information Technology (HI						CT	Y	167. 0
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 168.00 f this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the								168. 0
reasonable cost incurred for the			usei (iiile	: 107 13	1), 6	itter the		100. 0
68.01 If this provider is a CAH and is			s provider	gualify	for a l	hardshi n	N	168. 0
exception under §413.70(a)(6)(ii)						nar dom p		1.00.0
169.00 If this provider is a meaningful), enter the	9.	99169. 0
transition factor. (see instruction	ons)							
						Begi nni ng	Endi ng 2. 00	
1.00								1
70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and endi	ng date	for the re	porting				170. 0
perrod respectivery (IIIII/dd/yyyy)								
						1. 00	2.00	
71.00 If line 167 is "Y", does this pro	vider have any days for	individ	uals enrol	led in		N N	2.00	0171.0
section 1876 Medicare cost plans					r	**		
							1	- 1
"Y" for yes and "N" for no in column 2. (∕es, ente	r the numb	er of sec	tion			

Health Financial Systems FHN MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-0160 Peri od: Worksheet S-2 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/30/2024 4:42 pm 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 1.00 N reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 2.00 Ν yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Υ 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 4 00 4 00 Α Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 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. Y/N Legal Oper. 1.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider Ν 6.00 the legal operator of the program? 7 00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N 7.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 Ν 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 Ν 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions. Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting 13.00 Ν 13.00 period? If yes, submit copy. 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 B Y/N Y/N Date Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? N N 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 17.00 Was the cost report prepared using the PS&R Report for Υ 03/28/2024 03/28/2024 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 Report data for additional claims that have been billed Ν Ν 18.00 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 Ν Ν 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

H0251 I	FINANCIAL Systems FHN MEMORIAL FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CO	CN: 14-0160	Peri od: From 01/01/2023	u of Form CMS- Worksheet S-2	
					Part II Date/Time Pre 5/30/2024 4:4	
		Descri	pti on	Y/N	Y/N	+Z piii
)	1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2. 00	3. 00	4. 00	101.01
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 (EXCEP	PT CHILDRENS H	OSPI TALS)			
	Capital Related Cost					
						22. 0
23. 00	Have changes occurred in the Medicare depreciation expense of reporting period? If yes, see instructions.	due to apprais	als made dur	ing the cost		23. 0
24. 00	Were new leases and/or amendments to existing leases entered If yes, see instructions	eporting period?		24. 0		
25. 00	Have there been new capitalized leases entered into during t instructions.	Plf yes, see		25. 0		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	f yes, see		26. 00		
7. 00			27. 00			
8. 00	Interest Expense	tered into dur	ing the cost	reporting		28. 0
9. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or be		3	, ,		29. 0
0. 00	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled matur	uctions		ŕ		30. 0
1. 00	instructions. Has debt been recalled before scheduled maturity without iss	,	,			31. 0
,,,,	instructions. Purchased Services			,, 333		
2. 00	Have changes or new agreements occurred in patient care servarrangements with suppliers of services? If yes, see instruc		d through co	ontractual		32. 0
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 appl no, see instructions.		g to competi	tive bidding? If		33. 0
	Provi der-Based Physi ci ans					
4. 00	Were services furnished at the provider facility under an ar	rrangement wit	h provider-b	ased physicians?		34.0
5. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exis	stina aareemen	te with the	nrovi der-hased		35. 0
5.00	physicians during the cost reporting period? If yes, see ins		its with the	provider-based		35.0
				Y/N	Date	
	U 066: C			1. 00	2. 00	
26 OO	Home Office Costs Were home office costs claimed on the cost report?			Y		36. 0
36. 00 37. 00	If line 36 is yes, has a home office cost statement been pre	epared by the	home office?			37. 00
	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi				12/31/2023	38. 0
39. 00	the provider? If yes, enter in column 2 the fiscal year end	of the home o	ffi ce.		,	39. 0
	see instructions. If line 36 is yes, did the provider render services to the h	•	,	Υ Υ		40. 0
0 00	instructions.			·		10.0
0. 00			00	2.	00	1
10.00		1.	00		00	
	Cost Report Preparer Contact Information		00		00	
11. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	DAVI D	00	MCCLUNG	00	41.00
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.					41. 0

Heal th	Financial Systems	FHN MEMORIAL	L HOSPITAL		In Lie	In Lieu of Form CMS-2552-10		
H0SPI 1	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT C	QUESTI ONNAI RE	Provi der		Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/30/2024 4:4	pared:	
				3. 00				
	Cost Report Preparer Contact Information							
41.00			MANAGER				41. 00	
	held by the cost report preparer in column	s 1, 2, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the cos	t report					42.00	
	preparer.							
43.00	Enter the telephone number and email addre	ss of the cost					43.00	
	report preparer in columns 1 and 2, respec	ti vel y.						

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared:

					'	0 12/31/2023	5/30/2024 4: 4:	
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		92	33, 580	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			92	33, 580	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		8	2, 920	0.00	0	8. 00
9.00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY	43. 00					0	13.00
14. 00	Total (see instructions)			100	36, 500	0.00	0	14.00
15. 00	CAH visits						0	15. 00
15. 10	REH hours and visits					0.00	0	15. 10
16. 00	SUBPROVI DER - I PF							16.00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	444 00						23. 00
24. 00	HOSPI CE	116. 00		0	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC	00.00						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		100			0	26. 25
	Total (sum of lines 14-26)			100				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF			0	0			31. 00
32. 00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
22 00	outpatient days (see instructions)							33. 00
	LTCH non-covered days LTCH site neutral days and discharges							33. 00
	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	0		o	
34.00	Tomporary Expansion Covid-19 The Acute Care	30.00		Ч	1	1	١	54.00

In Lieu of Form CMS-2552-10

Period: Worksheet S-3

From 01/01/2023 Part I

To 12/31/2023 Date/Time Prepared: 5/30/2024 4:42 pm

						5/30/2024 4: 4	2 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA	0.00	7.00	0.00	7. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	3, 888	1, 851	12, 369			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)	5, 018	0				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO I RF Subprovi der	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	C			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	2 000	1 051	12.24			6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	3, 888	1, 851	12, 369			7. 00
8. 00	INTENSIVE CARE UNIT	189	116	1, 286			8.00
9.00	CORONARY CARE UNIT	107	110	1, 200			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		364	508			13. 00
14. 00	Total (see instructions)	4, 077	2, 331	14, 163	0.00	557. 38	14.00
15. 00	CAH visits	o	0	C)		15. 00
15. 10	REH hours and visits	o	o	C)		15. 10
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE	0	0	O		23. 34	
24. 10	HOSPICE (non-distinct part)			C			24. 10
25. 00 26. 00	CMHC - CMHC RURAL HEALTH CLINIC						25. 00 26. 00
26. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	o	C	0.00	0.00	
27. 00	Total (sum of lines 14-26)	٩	٩	C	0.00	580. 72	
28. 00	Observation Bed Days		0	5, 611		300.72	28. 00
29. 00	Ambul ance Tri ps	o	ĭ	3, 011			29.00
30. 00	Employee discount days (see instruction)	Ĭ		C	,		30.00
31. 00	Employee discount days - IRF			C			31.00
32. 00	Labor & delivery days (see instructions)	ol	o	167			32. 00
32. 01	Total ancillary labor & delivery room]	٦	C			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	C			34.00

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | Propage | Prop

				10) 12/31/2023	Date/IIme Pre 5/30/2024 4:4	
		Full Time		Di sch	arges	,	
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	12.00	12.00	14.00	Pati ents	
	DADT I CTATICTICAL DATA	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and		0	920	562	2 102	1.00
1.00	8 exclude Swing Bed, Observation Bed and		U	920	302	3, 183	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			1, 104	0		2.00
3.00	HMO IPF Subprovider			, -	0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	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	0.00		000	5.0	0.400	13.00
14.00	Total (see instructions)	0. 00	0	920	562	3, 183	1
15. 00 15. 10	CAH visits						15. 00 15. 10
16. 00	REH hours and visits SUBPROVIDER - IPF						16.00
17. 00	SUBPROVIDER - IPF						17. 00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days			o			33. 00
33. 00	LTCH site neutral days and discharges			0			33. 00
	Temporary Expansi on COVID-19 PHE Acute Care						34. 00
5 50	1. Imparian and action in the Moute out o	1	l l	1			, 5 00

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 14-0160

					T	o 12/31/2023	Date/Time Pre 5/30/2024 4:4	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries (from Wkst.	Sal ari es (col . 2 ± col .	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				A-6)	3)	col. 4	ŕ	
	PART II - WAGE DATA	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	SALARI ES							
1. 00	Total salaries (see instructions)	200. 00	44, 270, 721	0	44, 270, 721	1, 085, 108. 00	40. 80	1.00
2. 00	Non-physician anesthetist Part		C	0	0	0.00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		C	0	0	0. 00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		C	0	0	0. 00	0. 00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		4, 124, 721	0	0 4, 124, 721	0. 00 22, 751. 00	1	
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		C	0	0	0.00	0. 00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	C	0	0	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved programs)		C	0	0	0.00	0.00	7. 01
8. 00	Home office and/or related organization personnel		C	0	0	0.00	0.00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	1, 328, 253	0 3 22, 667	0 1, 350, 920	0. 00 39, 357. 00	•	
10. 00	instructions) OTHER WAGES & RELATED COSTS		1, 320, 230	22,007	1, 330, 720	37, 337. 00	54. 32	10.00
11. 00	Contract labor: Direct Patient Care		3, 640, 411	0	3, 640, 411	34, 600. 00	105. 21	11. 00
12. 00	Contract labor: Top level management and other management and administrative services		C	0	0	0. 00	0. 00	12. 00
13. 00	Contract Labor: Physician-Part A - Administrative		C	0	0	0.00	0. 00	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		C	0	0	0.00	0.00	14. 00
14. 01	Home office salaries		5, 800, 092	0	5, 800, 092	138, 393. 00	41. 91	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		C	0	0	0. 00 0. 00	•	1
15.00	- Administrative		C	,	0	0.00	0.00	15.00
16. 00	Home office and Contract Physicians Part A - Teaching		C	0	0	0. 00	0. 00	16. 00
16. 01	Home office Physicians Part A - Teaching		C	0	0	0. 00	0. 00	16. 01
16. 02	Home office contract Physicians Part A - Teaching		C	0	0	0.00	0. 00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		9, 755, 957	' 0	9, 755, 957			17. 00
18. 00	instructions) Wage-related costs (other)							18. 00
19. 00	(see instructions) Excluded areas		375, 333	0	375, 333			19. 00
20. 00	Non-physician anesthetist Part A		(0	0			20.00
21. 00	Non-physician anesthetist Part B		(0	0			21. 00
22. 00	Physician Part A - Administrative		C	0	0			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		216, 963	0	0 216, 963			22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		210, 700	0 0	0			24. 00 25. 00
25. 50	approved program) Home office wage-related		1, 909, 449	0	1, 909, 449			25. 50
25. 51	(core) Related organization wage-related (core)		C	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		C	0	0			25. 52

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION FHN MEMORIAL HOSPITAL

| Period: | Worksheet S-3 | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: Provider CCN: 14-0160

					11	5 12/31/2023	Date/lime Prep 5/30/2024 4:4:	
		Wkst. A Line	Amount	Reclassi fi cati	Adjusted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			·	(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00	Employee Benefits Department	4. 00	1, 983	l .	1, 983			
27. 00	Administrative & General	5. 00	2, 436, 997	-15, 057	2, 421, 940	·		27. 00
28. 00	Administrative & General under		0	0	0	0.00	0. 00	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00		29. 00
30.00	Operation of Plant	7. 00	389, 119	0	389, 119	17, 983. 00		
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00		
32.00	Housekeepi ng	9. 00	0	0	0	0.00		32.00
33.00	Housekeeping under contract		396, 673	0	396, 673	25, 766. 00	15. 40	33. 00
	(see instructions)							
34.00	Di etary	10. 00	0	0	0	0.00		34.00
35. 00	Di etary under contract (see		566, 125	0	566, 125	29, 264. 00	19. 35	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	0	0	0	0. 00		36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00		
38. 00	Nursing Administration	13. 00	777, 584		777, 584	17, 983. 00		
39. 00	Central Services and Supply	14. 00	113, 096	0	113, 096	4, 972. 00	22. 75	39. 00
40.00	Pharmacy	15. 00	1, 380, 896	0	1, 380, 896	35, 657. 00	38. 73	40.00
41.00	Medical Records & Medical	16. 00	1, 213, 036	0	1, 213, 036	36, 961. 00	32. 82	41.00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0.00		42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

Health Financial Systems FHN MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 H05

HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part III Date/Time Prep 5/30/2024 4:42	
	·	Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		41, 108, 798	0	41, 108, 79	8 1, 117, 387. 00	36. 79	1.00
	instructions)							
2.00	Excluded area salaries (see		1, 328, 253	22, 667	1, 350, 92	39, 357. 00	34. 32	2.00
	instructions)							
3.00	Subtotal salaries (line 1		39, 780, 545	-22, 667	39, 757, 87	8 1, 078, 030. 00	36. 88	3.00
	minus line 2)							
4.00	Subtotal other wages & related		9, 440, 503	0	9, 440, 50	3 172, 993. 00	54. 57	4.00

11, 665, 406

60, 863, 787

7, 260, 452

-22, 667

-15, 057

0.00

1, 251, 023. 00

256, 595. 00

29. 34

48. 65

28. 30

5.00

6. 00

7.00

11, 665, 406

60, 886, 454

7, 275, 509

5.00

6.00

7.00

costs (see inst.)
Subtotal wage-related costs (see inst.)

Total overhead cost (see

instructions)

Total (sum of lines 3 thru 5)

Health Financial Systems	FHN MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 14-0160	Peri od: Worksheet S-3
		From 01/01/2023 Part IV
		T- 10/01/0000 D-+-/T: D

	10 12/31/2023	Date/lime Prep 5/30/2024 4:42	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	835, 616	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		l
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8.03	Health Insurance (Purchased)	5, 955, 956	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	42, 171	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	146, 266	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	230, 059	
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumulative portion)		l
	TAXES		
		3, 130, 054	
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unempl oyment I nsurance	8, 131	
20. 00	State or Federal Unemployment Taxes	0	20. 00
	OTHER	_	
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
00.00	instructions))		00.00
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	0	23. 00
24. 00		10, 348, 253	24. 00
25.00	Part B - Other than Core Related Cost OTHER WAGE RELATED COSTS (SPECIFY)		25.00
25.00	OTHER WAGE RELATED COSTS (SPECIFT)		25. 00

Health Financial Systems	FHN MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 14-0160	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Preps/30/2024 4:4:	pared:	
Cost Center Description		Contract Labor			
PART V - Contract Labor and Benefit Cost		1. 00	2. 00		

			5/30/2024 4:42	2 pm
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	7, 222, 683	12, 163, 988	1.00
2.00	Hospi tal	7, 222, 683	12, 163, 988	2.00
3.00	SUBPROVI DER - I PF			3.00
4.00	SUBPROVI DER - I RF			4.00
5.00	Subprovi der - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9. 00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospi tal -Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	RENAL DIALYSIS I	0	0	17.00
18.00	0ther	0	0	18.00

Heal th	Financial Systems		FHN MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TAL-BASED HOSPICE IDENTIFICATION	DATA		Provi der CC Hospi ce CCN		Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-9 PARTS I THROU Date/Time Pre	GH IV pared:
						11! 1	5/30/2024 4: 4:	2 pm
		Unduplicated				Hospi ce I		
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
		TI CI O XVIII	TI CI O XI X	Skilled	Nursi ng	711 0 01101	col s. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility			٥,	
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO	ST REPORTING F	PERI ODS BEGINNI	NG BEFORE OCTO	BER 1, 2015			
1.00	Hospice Continuous Home Care							1. 00
2.00	Hospice Routine Home Care							2. 00
3.00	Hospice Inpatient Respite Care							3. 00
4.00	Hospice General Inpatient Care							4. 00
5.00	Total Hospice Days							5. 00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015			
6.00	Number of patients receiving							6. 00
	hospi ce care							
7.00	Total number of unduplicated							7. 00
	Continuous Care hours billable							
	to Medicare							
8. 00	Average Length of Stay (line 5							8. 00
0 00	/ line 6)							0 00
9. 00	Unduplicated census count			L				9. 00
NOIE:	Parts I and II, columns 1 and 2	also include	the days report	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
							through 3)	
				1. 00	2. 00	3. 00	4. 00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	PERIODS BEGIN	NING ON OR AFT	ER OCTOBER 1,	2015		
10.00	Hospice Continuous Home Care			0		0	0	
11. 00	Hospice Routine Home Care			14, 381	3	66 671	15, 418	
12. 00				156		0 30		12. 00
13.00	Hospice General Inpatient Care			12		0 0		13. 00
14. 00	Total Hospice Days			14, 549		66 701	15, 616	14. 00
	PART IV - CONTRACTED STATISTICA	AL DATA FOR COS	ST REPORTING PE	1	G ON OR AFTER			
15.00	Hospice Inpatient Respite Care			0		0 0	0	15. 00
	Hospice General Inpatient Care			0		0 0	Ō	16. 00

	_	I AL HOSPITAL	N 44 04/0		u of Form CMS-2			
HOSPI	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC	JN: 14-0160	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Pre 5/30/2024 4:4	pared:		
					1. 00			
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1.00			
	Uncompensated and Indigent Care Cost-to-Charge Ratio							
1. 00	Cost to charge ratio (see instructions) Medicaid (see instructions for each line)				0. 205091	1.00		
2. 00	Net revenue from Medicaid				8, 973, 250	2.00		
3. 00	Did you receive DSH or supplemental payments from Medicai	d?			Y Y	3.00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supp		s from Medica	ni d?	N	4. 00		
5.00	If line 4 is no, then enter DSH and/or supplemental payment		4, 328, 293	5.00				
6.00	Medicaid charges		105, 156, 317	6. 00				
7.00	Medicaid cost (line 1 times line 6)		21, 566, 614					
8.00	Difference between net revenue and costs for Medicaid pro Children's Health Insurance Program (CHIP) (see instructi		8, 265, 071	8. 00				
9. 00	Net revenue from stand-alone CHIP	ons for each fin	e)		0	9.00		
10.00					Ö			
11. 00	9	0						
12.00	Difference between net revenue and costs for stand-alone		0	12. 00				
	Other state or local government indigent care program (se				0	13. 00		
13. 00								
14. 00	00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)							
15. 00		0	15. 00					
16. 00			program (see	e instructions)	0			
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)							
17. 00		0	17. 00					
18.00	Government grants, appropriations or transfers for support	•	-		0	18. 00		
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16)	(sum of lines	8, 265, 071	19. 00				
			Uni nsured	Insured	Total (col. 1			
			patients	patients	+ col . 2)			
	Uncompensated care cost (see instructions for each line)		1. 00	2. 00	3. 00			
20. 00	Charity care charges and uninsured discounts (see instruc	rtions)	2, 307, 54	1, 251, 849	3, 559, 397	20.00		
21. 00			473, 25					
	instructions)	()			, .,			
22. 00		ritten off as		0 0	0	22. 00		
23. 00	charity care Cost of charity care (see instructions)		473, 25	57 1, 251, 849	1, 725, 106	23. 00		
24. 00	Does the amount on line 20 col. 2, include charges for page 1	ationt days hoven	d a Langth of	ctov limit	1. 00 N	24. 00		
24.00	imposed on patients covered by Medicaid or other indigen		u a rength of	Stay IIIII t	IN	24.00		
25. 00			care program	n's length of	0	25. 00		
25. 01	1 3	s)			0	25. 01		
26. 00		,			8, 929, 142			
27. 00					340, 587			
27. 01	,				523, 979			
28. 00	,				8, 405, 163			
29. 00		•	ınstructions)		1, 907, 215			
	Cost of uncompensated care (line 23, col. 3, plus line 29	7)			3, 632, 321	30.00		
30.00	Total unreimbursed and uncompensated care cost (line 19 p	olus line 30)			11, 897, 392	31 00		

UJF1 1	FINANCIAL Systems FHN MEMORI FAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC	`N: 14_0160	Period:	u of Form CMS-2 Worksheet S-10		
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	.N: 14-0160	From 01/01/2023 To 12/31/2023	Parts I & II Date/Time Pre 5/30/2024 4: 4.	pared	
					1. 00		
	PART II - HOSPITAL DATA				11.00		
	Uncompensated and Indigent Care Cost-to-Charge Ratio						
00	Cost to charge ratio (see instructions)				0. 201677	1.	
	Medicaid (see instructions for each line)						
00	Net revenue from Medicaid					2.	
00	Did you receive DSH or supplemental payments from Medicai					3.	
00	If line 3 is yes, does line 2 include all DSH and/or supp			ai d'?		4.	
00	If line 4 is no, then enter DSH and/or supplemental payme	ents from Medical	a			5. 6.	
00							
00	Difference between net revenue and costs for Medicaid pro		7. 8.				
00	Children's Health Insurance Program (CHIP) (see instructi					0.	
00	Net revenue from stand-alone CHIP	ons for each fine	<i>-</i>)			9.	
0. 00	Stand-al one CHIP charges					10.	
. 00							
. 00			11. 12.				
	Other state or local government indigent care program (se)			
. 00						13.	
. 00	Charges for patients covered under state or local indiger	nt care program (Not included	in lines 6 or		14.	
	10)						
. 00	State or local indigent care program cost (line 1 times l					15.	
6. 00						16.	
	Grants, donations and total unreimbursed cost for Medicai	d, CHIP and state	e/Local indi	gent care program	ns (see		
7. 00	Instructions for each line) Private grants denations or endowment income restricted	l to funding char	i ty caro				
. 00							
	Covernment grants appropriations or transfers for suppor	9	-				
3. 00	Government grants, appropriations or transfers for supported unreimbursed cost for Medicaid. CHLP and state and	t of hospital op	erati ons	s (sum of lines		18.	
3. 00	Total unreimbursed cost for Medicaid , CHIP and state and	t of hospital op	erati ons	s (sum of lines		18.	
3. 00 9. 00		t of hospital op	erati ons	s (sum of lines	Total (col. 1	17. 18. 19.	
3. 00	Total unreimbursed cost for Medicaid , CHIP and state and	t of hospital op	erations care program Uninsured patients	Insured patients	+ col . 2)	18.	
. 00	Total unreimbursed cost for Medicaid , CHIP and state and 8, 12 and 16)	t of hospital op	erations care program Uninsured	Insured		18.	
. 00	Total unreimbursed cost for Medicaid , CHIP and state and 8, 12 and 16) Uncompensated care cost (see instructions for each line)	t of hospital op I local indigent	erations care program Uninsured patients 1.00	Insured patients 2.00	+ col . 2) 3.00	18.	
3. 00 9. 00 0. 00	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 instruc	t of hospital op I local indigent	Uni nsured patients 1.00	I nsured pati ents 2.00	+ col . 2) 3.00 599, 554	18. 19.	
3. 00 9. 00 0. 00	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 instructions for each line) Cost of patients approved for charity care and uninsured	t of hospital op I local indigent	erations care program Uninsured patients 1.00	I nsured pati ents 2.00	+ col . 2) 3.00	18. 19.	
3. 00 9. 00 0. 00 . 00	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 instructions of patients approved for charity care and uninsured instructions)	t of hospital op I local indigent tions) discounts (see	Uni nsured patients 1.00	I nsured pati ents 2.00 63 222, 191 05 222, 191	+ col . 2) 3.00 599, 554 298, 296	18. 19. 20. 21.	
3. 00 9. 00 0. 00 . 00	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 instructions) Cost of patients approved for charity care and uninsured instructions) Payments received from patients for amounts previously wr	t of hospital op I local indigent tions) discounts (see	Uni nsured patients 1.00	I nsured pati ents 2.00	+ col . 2) 3.00 599, 554	18. 19. 20. 21.	
0.00	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 instructions of patients approved for charity care and uninsured instructions) Payments received from patients for amounts previously worcharity care	t of hospital op I local indigent tions) discounts (see	Uninsured patients 1.00 377,3 76,1	I nsured pati ents 2.00 63 222, 191 0 0 0	+ col . 2) 3.00 599, 554 298, 296	18. 19. 20. 21.	
0.00	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 instructions of patients approved for charity care and uninsured instructions) Payments received from patients for amounts previously worcharity care	t of hospital op I local indigent tions) discounts (see	Uni nsured patients 1.00	I nsured pati ents 2.00 63 222, 191 0 0 0	+ col . 2) 3.00 599, 554 298, 296	18. 19. 20. 21.	
0.00	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 instructions of patients approved for charity care and uninsured instructions) Payments received from patients for amounts previously worcharity care	t of hospital op I local indigent tions) discounts (see	Uninsured patients 1.00 377,3 76,1	I nsured pati ents 2.00 63 222, 191 0 0 0	+ col . 2) 3.00 599, 554 298, 296	18. 19. 20. 21.	
0.00	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 instructions of patients approved for charity care and uninsured instructions) Payments received from patients for amounts previously worcharity care	et of hospital op I local indigent Etions) discounts (see	Uni nsured pati ents 1.00 377,3 76,1	Insured pati ents 2.00 63 222, 191 05 222, 191 0 0 05 222, 191	+ col . 2) 3.00 599, 554 298, 296 0 298, 296	18. 19. 20. 21. 22.	
0. 00 0. 00 0. 00 0. 00 0. 00	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 instructions) 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 paimposed on patients covered by Medicaid or other indigent	et of hospital op I local indigent etions) discounts (see eitten off as	Uninsured patients 1.00 377,3 76,1	Insured patients 2.00 63 222,191 05 222,191 0 0 05 222,191 f stay limit	+ col . 2) 3.00 599, 554 298, 296 0 298, 296	18. 19. 20. 21. 22.	
0. 00 0. 00 0. 00 0. 00 0. 00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Payments received from patients for amounts previously wrighted charity care (see instructions) Does the amount on line 20 col. 2, include charges for patients approved by Medicaid or other indigent of line 24 is yes, enter the charges for patient days bey	et of hospital op I local indigent etions) discounts (see eitten off as	Uninsured patients 1.00 377,3 76,1	Insured patients 2.00 63 222,191 05 222,191 0 0 05 222,191 f stay limit	+ col . 2) 3.00 599, 554 298, 296 0 298, 296	18. 19. 20. 21. 22.	
3. 00 2. 00 3. 00 3. 00 4. 00 4. 00 5. 00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) 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 patients covered by Medicaid or other indigent line 24 is yes, enter the charges for patient days bey stay limit	et of hospital op I local indigent Etions) discounts (see Fitten off as	Uninsured patients 1.00 377,3 76,1	Insured patients 2.00 63 222,191 05 222,191 0 0 05 222,191 f stay limit	+ col . 2) 3.00 599, 554 298, 296 0 298, 296 1.00 N	20. 21. 22. 23.	
33.00 3.00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) 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 bey stay limit Charges for insured patients' liability (see instructions)	et of hospital op I local indigent Etions) discounts (see Fitten off as	Uninsured patients 1.00 377,3 76,1	Insured patients 2.00 63 222,191 05 222,191 0 0 05 222,191 f stay limit	+ col . 2) 3.00 599, 554 298, 296 0 298, 296 1.00 N	20. 21. 22. 23. 24. 25.	
3. 00 3. 00 3. 00 3. 00 4. 00 4. 00 5. 00 5. 01 6. 00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Payments received from patients for amounts previously wrighter ty care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for paimposed on patients covered by Medicaid or other indigent If line 24 is yes, enter the charges for patient days bey stay limit Charges for insured patients' liability (see instructions)	et of hospital op I local indigent Etions) discounts (see Fitten off as	Uninsured patients 1.00 377,3 76,1	Insured patients 2.00 63 222,191 05 222,191 0 0 05 222,191 f stay limit	+ col. 2) 3.00 599, 554 298, 296 0 298, 296 1.00 N 0 8, 929, 142	20, 21, 22, 23, 24, 25, 26, 26, 26, 26, 27, 27, 27, 27, 27, 27, 27, 27, 27, 27	
3. 00 2. 00 3. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Payments received from patients for amounts previously write charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for pailingsed on patients covered by Medicaid or other indigent of line 24 is yes, enter the charges for patient days bey stay limit Charges for insured patients' liability (see instructions) Medicare reimbursable bad debts (see instructions)	et of hospital op I local indigent Etions) discounts (see Fitten off as	Uninsured patients 1.00 377,3 76,1	Insured patients 2.00 63 222,191 05 222,191 0 0 05 222,191 f stay limit	+ col. 2) 3.00 599, 554 298, 296 0 298, 296 1.00 N 0 8, 929, 142 340, 587	20, 21, 22, 23, 25, 26, 27, 26, 27, 27, 27, 27, 27, 27, 27, 27, 27, 27	
3. 00 3. 00 3. 00 3. 00 3. 00 4. 00 5. 00 7. 00 7. 00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Payments received from patients for amounts previously writerity 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 of line 24 is yes, enter the charges for patient days bey stay limit Charges for insured patients' liability (see instructions) Medicare reimbursable bad debts (see instructions)	et of hospital op I local indigent Etions) discounts (see Fitten off as	Uninsured patients 1.00 377,3 76,1	Insured patients 2.00 63 222,191 05 222,191 0 0 05 222,191 f stay limit	+ col. 2) 3.00 599, 554 298, 296 0 298, 296 1.00 N 0 8, 929, 142 340, 587 523, 979	20. 21. 22. 23. 24. 25. 26. 27. 27.	
3. 00 3. 00 3. 00 3. 00 4. 00 5. 01 6. 00 7. 01 3. 00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Payments received from patients for amounts previously wricharity care (see instructions) Does the amount on line 20 col. 2, include charges for patimposed on patients covered by Medicaid or other indigent of line 24 is yes, enter the charges for patient days bey stay limit Charges for insured patients' liability (see instructions) Medicare reimbursable bad debts (see instructions) Non-Medicare bad debt amount (see instructions)	et of hospital op I local indigent etions) discounts (see eitten off as etient days beyon care program? rond the indigent	Uninsured patients 1.00 377,3 76,1 d a length o care progra	Insured patients 2.00 63 222, 191 05 222, 191 0 0 05 222, 191 f stay limit m's length of	+ col. 2) 3.00 599, 554 298, 296 0 298, 296 1.00 N 0 8, 929, 142 340, 587 523, 979 8, 405, 163	20. 21. 22. 23. 24. 25. 26. 27. 27. 28.	
3. 00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) 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 patients or a patients covered by Medicaid or other indigent of the patients o	et of hospital op I local indigent I local indigent Etions) discounts (see Fitten off as Etient days beyon Care program? Fond the indigent Es)	Uninsured patients 1.00 377,3 76,1 d a length o care progra	Insured patients 2.00 63 222, 191 05 222, 191 0 0 05 222, 191 f stay limit m's length of	+ col. 2) 3.00 599, 554 298, 296 0 298, 296 1.00 N 0 8, 929, 142 340, 587 523, 979	20. 21. 22. 23. 24. 25. 26. 27. 27. 28. 29.	

Health Financial Systems	FHN MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provi der CO		eri od:	Worksheet A	
				rom 01/01/2023 o 12/31/2023		
Cook Control Doors' atting	C-1	0+4	T-+-1 (1 1	D1: £:+:	5/30/2024 4: 4	2 pm
Cost Center Description	Sal ari es	Other	+ col . 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance	
			1 (01. 2)	0113 (See A 0)	(col. 3 +-	
					col . 4)	
OSNEDAL OSDINOS COOT OSNESDO	1.00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS		0		1 200 2/0	1 200 2/0	1 00
1. 00 00100 CAP REL COSTS-BLDG & FLXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP		4, 065, 205		.,,		1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 983	11, 121, 062			11, 123, 045	4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	2, 436, 997	23, 148, 540			25, 569, 340	5. 00
7.00 OO700 OPERATION OF PLANT	389, 119	3, 138, 876	3, 527, 995	0	3, 527, 995	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	325, 845			325, 845	8. 00
9. 00 00900 HOUSEKEEPI NG	0	2, 062, 366			2, 062, 366	9. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	0	2, 175, 589	2, 175, 589			1
13. 00 O1300 NURSING ADMINISTRATION	777, 584	170, 092	·		947, 200	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	113, 096	500, 413			613, 509	14. 00
15. 00 01500 PHARMACY	1, 380, 896	5, 958, 360			2, 898, 635	
16.00 01600 MEDICAL RECORDS & LIBRARY	1, 213, 036	684, 726			1, 897, 762	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS			,			
30. 00 03000 ADULTS & PEDI ATRI CS	14, 575, 707	4, 137, 371			18, 703, 644	30.00
31. 00 03100 NTENSI VE CARE UNIT	1, 503, 911	430, 113				31.00
43. 00 O4300 NURSERY ANCI LLARY SERVICE COST CENTERS	0	0	C	0	0	43. 00
50. 00 05000 OPERATING ROOM	2, 400, 234	8, 544, 805	10, 945, 039	0	10, 945, 039	50.00
50. 01 05001 GI LAB	609, 878	562, 536			1, 172, 414	•
50. 02 05002 AMBULATORY CARE UNIT	1, 748, 297	1, 341, 170		0	3, 089, 467	50. 02
51.00 05100 RECOVERY ROOM	512, 034	20, 362	532, 396	0	532, 396	51. 00
53. 00 05300 ANESTHESI OLOGY	0	2, 104, 469			2, 104, 469	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 228, 182	5, 508, 247			8, 736, 429	54.00
60. 00 06000 LABORATORY	1, 641, 729	4, 700, 232			6, 341, 961	1
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	983, 701	363, 742 294, 573			1, 347, 443 2, 891, 898	
69. 00 06900 ELECTROCARDI OLOGY	2, 597, 325 233, 487	294, 373 294, 732			528, 219	69.00
69. 01 06901 CATH LAB	514, 812	725, 222			1, 240, 034	•
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	o o	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	4, 440, 621	4, 440, 621	73. 00
74. 00 07400 RENAL DI ALYSI S	0	261, 301				
76. 00 03950 DI ABETI C EDUCATI ON 76. 01 03480 CANCER CENTER	1, 751, 071	75, 800 10, 651, 667			,	76. 00 76. 01
OUTPATIENT SERVICE COST CENTERS	1, 731, 071	10, 031, 007	12, 402, 730	0	12, 402, 730	70.01
90. 00 09000 CLINIC	4, 996	1, 292, 134	1, 297, 130	0	1, 297, 130	90.00
91. 00 09100 EMERGENCY	4, 324, 393	5, 872, 215				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE	4 000 050	0	0 (01 007	0		113.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 328, 253 44, 270, 721	1, 273, 734 101, 805, 499			2, 601, 987 146, 050, 589	
NONREI MBURSABLE COST CENTERS	44, 270, 721	101, 603, 499	140, 076, 220	-25, 651	140, 030, 369	1110.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	O	0		0	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	Ö	0	l c	o o		192. 00
192.01 19201 JANE ADDAMS BLDG	0	0	C	0		192. 01
192. 02 19202 SENI OR PROGRAM	o	0	C	0		192. 02
192. 03 19203 NA VOLUNTEER SERVICES	O	0	0	16, 197	16, 197	
192. 04 19204 SMART STEPS	0	0	C	0		192. 04
192. 05 19205 RESPITE CARE 193. 00 19300 NONPALD WORKERS	0	0		9, 434		192. 05 193. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	44, 270, 721	101, 805, 499	146, 076, 220	0		
233.33 101/12 (30m of Elites 110 till ough 177)	11,210,121	101, 000, 477	1 10,070,220	١	1 10,070,220	1=00.00

 Health Financial
 Systems
 FHN MEMO

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 FHN MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 14-0160

				5/30/2024 4:4	
	Cost Center Description	Adjustments	Net Expenses	0, 66, 2621	1
	'		or Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	0	1, 380, 269		1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	2, 684, 936		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	11, 123, 045		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-7, 703, 731	17, 865, 609		5. 00
7.00	00700 OPERATION OF PLANT	-263	3, 527, 732		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	325, 845		8. 00
9.00	00900 HOUSEKEEPI NG	0	2, 062, 366		9. 00
10.00	01000 DI ETARY	-7, 905	1, 240, 478		10. 00
11. 00	01100 CAFETERI A	-1, 777	925, 429		11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	-39, 000	908, 676		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	613, 509		14. 00
15. 00	01500 PHARMACY	0	2, 898, 635		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-375	1, 897, 387		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDIATRICS	-5, 410, 159	13, 293, 485		30. 00
31. 00	03100 I NTENSI VE CARE UNI T	-99, 130	1, 834, 894		31. 00
43.00	04300 NURSERY	0	0		43. 00
	ANCILLARY SERVICE COST CENTERS				
50. 00	05000 OPERATING ROOM	-293, 961	10, 651, 078		50. 00
50. 01	05001 GI LAB	0	1, 172, 414		50. 01
50. 02	05002 AMBULATORY CARE UNIT	0	3, 089, 467		50. 02
51. 00	05100 RECOVERY ROOM	0	532, 396		51. 00
53. 00	05300 ANESTHESI OLOGY	-1, 929, 884	174, 585		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-3, 189, 827	5, 546, 602		54.00
60. 00	06000 LABORATORY	0	6, 341, 961		60. 00
65. 00	06500 RESPI RATORY THERAPY	-78, 240	1, 269, 203		65. 00
66.00	06600 PHYSI CAL THERAPY	-5, 335	2, 886, 563		66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	528, 219		69. 00
69. 01	06901 CATH LAB	0	1, 240, 034		69. 01
	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	4 440 (04		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	4, 440, 621		73. 00
	07400 RENAL DIALYSIS	0	261, 301		74. 00
	03950 DI ABETI C EDUCATI ON	1 712 712	75, 800		76. 00
76.01	03480 CANCER CENTER OUTPATIENT SERVICE COST CENTERS	-1, 712, 712	10, 690, 026		76. 01
90. 00	09000 CLINIC	O	1, 297, 130		90.00
91.00	09100 EMERGENCY	-4, 980, 759	5, 215, 849		91.00
	1 1	-4, 700, 737	5, 215, 649		92.00
72.00	SPECIAL PURPOSE COST CENTERS				92.00
113 00	11300 I NTEREST EXPENSE	O	0		113. 00
	11600 HOSPI CE	0	2, 601, 987		116. 00
118.00		-25, 453, 058	120, 597, 531		118. 00
110.00	NONREI MBURSABLE COST CENTERS	25, 455, 050	120, 377, 331		1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		192. 00
	19201 JANE ADDAMS BLDG	0	0		192. 01
	19202 SENI OR PROGRAM	o o	o		192. 02
	19203 NA VOLUNTEER SERVICES		16, 197		192. 03
	19204 SMART STEPS	O	0		192. 04
	19205 RESPI TE CARE	o	9, 434		192. 05
	19300 NONPAI D WORKERS	O	0		193. 00
200.00	1	-25, 453, 058	120, 623, 162		200. 00
	· · · · · · · · · · · · · · · · · · ·				

Heal th	Financial Systems		FHN MEMORIA	L HOSPITAL		In Lie	u of Form CMS	S-2552-10
RECLAS	SIFICATIONS			Provi der CC	CN: 14-0160	Peri od: From 01/01/2023	Worksheet A	-6
						To 12/31/2023	Date/Time P	repared:
						I .	5/30/2024 4	: 42 pm
	2 1 2 1	Increases	6.1	011				
	Cost Center	Li ne #	Salary	0ther				
	2. 00	3. 00	4. 00	5. 00				
	A - CHARGEABLE DRUGS							
1.00	DRUGS CHARGED TO PATIENTS		0	<u>4, 440, 621</u>				1. 00
	TOTALS		0	4, 440, 621				
	B - SHARED DIETARY EXPENSES							
1.00	CAFETERI A	11. 00	0	927, 206				1. 00
	TOTALS		0	927, 206				
	C - RESPITE CARE	-						
1.00	RESPITE CARE	192. 05	7, 610	1, 824				1.00
	TOTALS		7, 610	1, 824				
	D - NON PATIENT VOLUNTEER ADM	MI N	, , ,	, ,				
1.00	NA VOLUNTEER SERVICES	192. 03	15, 057	1, 140				1.00
	TOTALS		15, 057	1, 140				
	E - BUILDING DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 380, 269				1.00
	TOTALS			1, 380, 269				
500 00	Grand Total: Increases		22, 667	6, 751, 060				500.00
550.00	15. 4.14 . 5.44	ı	22,007	3, .01, 000				1 555. 66

Heal th Financial Systems

FHN MEMORIAL HOSPITAL

Provider CCN: 14-0160

Peri od:
From 01/01/2023
To 12/31/2023

Decreases

Decreases

Provider CCN: 4-7 Ref

						5/30/2024 4:	42 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - CHARGEABLE DRUGS						
1.00	PHARMACY	15. 00	0	4, 440, 621	(1. 00
	TOTALS		0	4, 440, 621			
	B - SHARED DIETARY EXPENSES						
1.00	DI ETARY	10. 00	0	927, 206	(1. 00
	TOTALS		0	927, 206			
	C - RESPITE CARE						
1.00	ADULTS & PEDIATRICS	30.00	7, 610	1, 824	(1. 00
	TOTALS		7, 610	1, 824			
	D - NON PATIENT VOLUNTEER ADM	II N					
1.00	ADMINISTRATIVE & GENERAL	5. 00	15, 057	1, 140	(1. 00
	TOTALS		15, 057	1, 140			
	E - BUILDING DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	1, 380, 269	(9	1. 00
	TOTALS			1, 380, 269			
500.00	Grand Total: Decreases		22, 667	6, 751, 060			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS FHN MEMORIAL HOSPITAL Provider CCN: 14-0160

					Γο 12/31/2023	Date/Time Prep 5/30/2024 4:42	
				Acqui si ti ons		373072024 4.42	<u> 2 piii</u>
		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 ASSET	T BALANCES					
1.00	Land	944, 945	0	(0	0	1.00
2.00	Land Improvements	2, 222, 791	17, 480	(17, 480	0	2.00
3.00	Buildings and Fixtures	55, 977, 981	1, 513, 552	(1, 513, 552	0	3.00
4.00	Building Improvements	0	0	(0	0	4.00
5.00	Fixed Equipment	1, 417, 175	14, 535	(14, 535	0	5.00
6.00	Movable Equipment	33, 699, 548	1, 761, 967	(1, 761, 967	0	6.00
7.00	HIT designated Assets	8, 402, 457	0	(0	0	7.00
8.00	Subtotal (sum of lines 1-7)	102, 664, 897	3, 307, 534	(3, 307, 534	0	8.00
9.00	Reconciling Items	0	0	(0	0	9. 00
10.00	Total (line 8 minus line 9)	102, 664, 897	3, 307, 534	(3, 307, 534	0	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	944, 945	0				1. 00
2.00	Land Improvements	2, 240, 271	0				2.00
3.00	Buildings and Fixtures	57, 491, 533	0				3.00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	1, 431, 710	0				5.00
6.00	Movable Equipment	35, 461, 515	0				6.00
7.00	HIT designated Assets	8, 402, 457	0				7. 00
8.00	Subtotal (sum of lines 1-7)	105, 972, 431	0				8.00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	105, 972, 431	0				10.00

Heal th	Health Financial Systems FHN MEMORIAL HOSPITAL In Lieu of Form CMS-255						2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 14-0160	Peri od:	Worksheet A-7	
					From 01/01/2023 To 12/31/2023		narod:
					10 12/31/2023	5/30/2024 4: 4:	
			SL	JMMARY OF CAP	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	•	
					instructions)		
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	4, 065, 205	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	4, 065, 205	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4, 065, 205				2. 00
3.00	Total (sum of lines 1-2)	0	4, 065, 205	1			3. 00
		•					

Health Financial Systems	FHN MEMORIA	L HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2023 To 12/31/2023		pared:
	COM	IPUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capitalized	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			(col . 1 - col 2)			
	1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS		1			
1.00 CAP REL COSTS-BLDG & FLXT	70, 510, 916		70, 510, 91			1.00
2.00 CAP REL COSTS-MVBLE EQUIP	35, 461, 515		1,,			2. 00
3.00 Total (sum of lines 1-2)	105, 972, 431		105, 972, 43			3. 00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)			
DART III DECONCILIATION OF CARLTAL COCTO	6. 00	7.00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS 1.00 CAP REL COSTS-BLDG & FIXT	CENTERS		1	0 1, 380, 269	0	1. 00
2.00 CAP REL COSTS-BLDG & FTXT				0 1, 360, 269		2.00
3.00 Total (sum of lines 1-2)				0 4, 065, 205	l .	3. 00
3.00 Total (Suil Of Titles 1-2)		SI SI	JMMARY OF CAPI		0	3.00
		5.	SWIMARCE OF CALL	IAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
		instructions)	instructions)	Capi tal -Relate	of cols. 9	
				d Costs (see	through 14)	
				instructions)		
DART III DECONOLITATION OF CARLEY COORS	11. 00	12.00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS		J			1 200 272	1 00
1.00 CAP REL COSTS-BLDG & FLXT 2.00 CAP REL COSTS-MVBLE EQULP			1	0 0	1, 380, 269	1. 00 2. 00
3.00 Total (sum of lines 1-2)		1	1	0 0	2, 684, 936 4, 065, 205	
3.00 Total (Suiii Of TitleS 1-2)	1	ا ا	'I	U _I U	4, 000, 200	3.00

COSTS-BLDG & FIXT (chapter 2) CAP REL COSTS-MVBLE EQUIP COSTS-MVBLE EQUIP (chapter 2) COSTS-MVBLE EQUIP (chapter 2) COSTS-MVBLE EQUIP (chapter 2) CAP REL COSTS-MVBLE EQUIP (chapter 2) CAP REL COSTS-MVBLE EQUIP	ed:
Cost Center Description Basis/Code (2) Amount Cost Center Line # Wist. A-7 Ref.	
1.00	
1.00	
1.00	
1.00	
2.00	. 00
COSTS-MBLE EQUIP (chapter 2) Chapter 3) Chapter 4) Chapter 4) Chapter 5) Chapter 6) Chapter 7) Chapter 7) Chapter 8) Chapter 8)	. 00
Chapter 2) Trade, quantity, and time 0 0 0 0 0 0 0 0 0	. 00
di scounts (chapter 8) Refunds and rebates of expenses (chapter 8) 0.00	. 00
Sefunds and rebates of expenses (chapter 8)	. 00
6.00 Rental of provider space by suppliers (chapter 8) 7.00 Telephone services (pay stations excluded) (chapter 21) 8.00 Television and radio service (chapter 21) 9.00 Parking lot (chapter 21) 11.00 Sale of scrap, waste, etc. (chapter 23) 12.00 Related organization A-8-1 -1, 204, 814 transactions (chapter 10) 13.00 Laundry and linen service 0 14.00 Cafeteria-employees and guests 0 16.00 Sale of medical and surgical suppliers to other than patients 0 17.00 Sale of drugs to other than patients 0 18.00 Sale of medical records and abstracts 19.00 Nursing and allied health education (tuition, fees,	. 00
7. 00 Tel ephone services (pay stations excluded) (chapter 21) 8. 00 Tel evision and radio service (chapter 21) 9. 00 Parking I of (chapter 21) 10. 00 Provider-based physician A-8-2 -17, 981, 607 adjustment 11. 00 Sale of scrap, waste, etc. (chapter 23) 12. 00 Related organization transactions (chapter 10) 13. 00 Laundry and Linen service 14. 00 Cafeteria-employees and guests 15. 00 Rental of quarters to employee and others 16. 00 Sale of medical and surgical supplies to other than patients 17. 00 Sale of drugs to other than patients 18. 00 Sale of medical records and abstracts 19. 00 Nursing and allied health education (tuition, fees,	. 00
21) Television and radio service (chapter 21) 0 0 0 0 0 8	. 00
8.00	
9.00 Parking lot (chapter 21) 10.00 Provider-based physician adjustment 11.00 Sale of scrap, waste, etc. (chapter 23) 12.00 Related organization transactions (chapter 10) 13.00 Laundry and linen service 14.00 Cafeteria-employees and guests 15.00 Rental of quarters to employee and others 16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of medical records and abstracts 18.00 Sale of medical records and abstracts 19.00 Nursing and allied health education (tuition, fees,	. 00
11.00 Sale of scrap, waste, etc. 0 0 0 11	. 00
11. 00	. 00
12.00 Related organization transactions (chapter 10) 13.00 Laundry and linen service 0.00 0.00 0.13 14.00 Cafeteria-employees and guests 0.00 0.00 0.14 15.00 Rental of quarters to employee and others 0.00 0.00 0.15 16.00 Sale of medical and surgical supplies to other than patients 0.00 0.00 0.17 17.00 Sale of drugs to other than patients 0.00 0.00 0.17 18.00 Sale of medical records and abstracts 0.00 0.00 0.18 19.00 Nursing and allied health education (tuition, fees,	. 00
13.00 Laundry and linen service 14.00 Cafeteria-employees and guests 15.00 Rental of quarters to employee and others 16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 19.00 Nursing and allied health education (tuition, fees,	. 00
14.00 Cafeteria-employees and guests 15.00 Rental of quarters to employee and others 16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 19.00 Nursing and allied health education (tuition, fees,	. 00
and others 16. 00 Sale of medical and surgical supplies to other than patients 17. 00 Sale of drugs to other than patients 18. 00 Sale of medical records and abstracts 19. 00 Nursing and allied health education (tuition, fees,	. 00
supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 19.00 Nursing and allied health education (tuition, fees,	. 00
17.00 Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 19.00 Nursing and allied health education (tuition, fees,	. 00
18.00 Sale of medical records and abstracts 19.00 Nursing and allied health education (tuition, fees,	. 00
19.00 Nursing and allied health education (tuition, fees,	. 00
	. 00
books, etc.)	
	. 00 . 00
interest, finance or penalty charges (chapter 21)	. 00
	. 00
repay Medicare overpayments	00
23. 00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65. 00 23. therapy costs in excess of limitation (chapter 14)	. 00
	. 00
limitation (chapter 14)	00
physicians' compensation	. 00
(chapter 21) 26.00 Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 0 26	. 00
COSTS-BLDG & FLXT 27. 00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 0 27.	. 00
COSTS-MVBLE EQUIP	
	. 00 . 00
30.00 Adjustment for occupational therapy costs in excess of A-8-3 0 *** Cost Center Deleted *** 67.00 30.	. 00
limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.	. 99
instructions)	
pathology costs in excess of	. 00
	. 00
Depreciation and Interest	

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

					0 12/31/2023	5/30/2024 4: 4:	
				Expense Classification on	Worksheet A	, .,	
				To/From Which the Amount is			
					•		
					T		
	Cost Center Description	· /	Amount	Cost Center	-	Wkst. A-7 Ref.	
	T=====	1.00	2. 00	3. 00	4. 00	5. 00	
33. 00	TRADE, QUANTITY AND TIME	В	-9, 233	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
00.04	DI SCOUNTS		075	MEDICAL DECORDS & LIBRARY	44.00		00.04
33. 01	SALE OF MEDICAL RECORDS &	В	-3/5	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 01
33. 02	ABSTRACTS VENDING MACHINES	В	1 777	 CAFETERI A	11 00	_	33. 02
33. 02	PHYSICIAN COLLECTIONS EXPENSES			[* ·	11. 00 5. 00	0	33. 02
		A B	·	ADMINISTRATIVE & GENERAL		0	
33. 04	DI ETARY CONSULTI NG	B A		DI ETARY ADMI NI STRATI VE & GENERAL	10.00	0	33. 04
33. 05	TELEPHONE CAPITAL COSTS	1 "			5. 00	0	33. 05
33. 06	TV CAPITAL COSTS	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
33. 07	ASSOC LOBBYING FEES	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	MEALS ON WHEELS	В	·	DIETARY	10.00	0	33. 08
33. 09	OTHER REVENUE MISC	В	·	ADMI NI STRATI VE & GENERAL	5. 00	0	33. 09
33. 10	OB MISC INCOME	В		ADULTS & PEDIATRICS	30.00	0	33. 10
33. 11	RENTAL I NCOME	В	·	ADMI NI STRATI VE & GENERAL	5. 00	0	33. 11
33. 12	RADI OLOGY MED RECORD REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 12
33. 13	PT, OT, SPORTS MED MISC INCOME	1		PHYSI CAL THERAPY	66. 00	0	33. 13
33. 14	PROVIDER TAX COST	A		ADMINISTRATIVE & GENERAL	5. 00		33. 14
33. 15	FMH OP. FINANCE MISCELLANEOUS	В	-22, 274	ADMINISTRATIVE & GENERAL	5. 00	0	33. 15
22 1/	I NCOME	D.	0	ADMINISTRATIVE & CENEDAL	F 00	_	22.1/
33. 16	FMH EMERG MGT PROG	В	0	ADMINISTRATIVE & GENERAL	5. 00	U	33. 16
22 17	MI SCELLANEOUS	В	2/2	ODERATION OF DIANT	7.00	0	22 17
33. 17	FMH MAINTENANCE MISCELLANEOUS	В	-263	OPERATION OF PLANT	7. 00	0	33. 17
50. 00	TOTAL (sum of lines 1 thru 49)		-25, 453, 058				50. 00
50.00	(Transfer to Worksheet A,		-20, 400, 008				30.00
	column 6, line 200.)						
	COLUMN 0, TITLE 200.)				1		

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Heal th	Financial Systems	FHN MEMORIA	AL HOSPITAL	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Peri od:	Worksheet A-8	B-1
OFFICE	COSTS			From 01/01/2023 To 12/31/2023		
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5. 00	ADMINISTRATIVE & GENERAL	CORPORATE ALLOCATION	12, 637, 928	13, 842, 742	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	o	4.00
5.00	TOTALS (sum of lines 1-4).			12, 637, 928	13, 842, 742	5.00
	Transfer column 6, line 5 to					

* 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.

 p	cor anno i aria, or 2, the amoun				
			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME 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	A	FREEPORT MEMORI	100.00 FREEPORT HEALTH	100.00	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-financial) specify:				

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

Worksheet A-8, column 2,

line 12.

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

Heal th	Financial Syste	ems		FHI	N MEMORIAL	HOSPI TAL			In L	ieu of Form CMS	-2552-10
STATEME	ENT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI ONS	S AND HOME	Provi der	CCN:	14-0160	Peri od:	Worksheet A-	8-1
OFFICE	COSTS								From 01/01/20: To 12/31/20:		onarod:
									10 12/31/20.	5/30/2024 4:	
	Net	Wkst. A-7 Ref.									
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REC	QUIRED AS A R	ESULT OF TE	RANSACTI ONS	WI TH	RELATED C	RGANIZATIONS O	R CLAIMED	
	HOME OFFICE CO	STS:									
1.00	-1, 204, 814	0									1.00
2.00	0	0									2.00
3.00	0	0									3.00
4.00	l o	0									4.00
5.00	-1, 204, 814										5. 00
* The	amounts on lin	es 1-4 (and sub	scripts	as appropri at	te) are tra	nsferred in	deta	ail to Wor	ksheet A, colur	nn 6, lines as	
										nome office cost	whi ch
has not	been posted to	o Worksheet A,	col umns	1 and/or 2, 1	the amount	allowable s	shoul	d be indic	ated in column	4 of this part.	
	Related Orga	ani zati on(s)								·	
	l and/an Ha	ma Offica									

Related Organization(s)
and/or Home Office

Type of Business

6.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	HEALTH CARE PARENT CO	6.	5. 00
7.00		7.	7. 00
8.00			3. 00
9.00		9.	9. 00
10.00		10.	0. 00
7. 00 8. 00 9. 00 10. 00 100. 00		100.). 00

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 14-0160

						10 12/31/2023	5/30/2024 4:4	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Component	Component		ider Component	
					· ·		Hours	
	1. 00	2.00	3.00	4. 00	5. 00	6. 00	7. 00	
1. 00	30.00	ADULTS & PEDIATRICS	2, 467, 558	2, 467, 55	8 0	0	0	1. 00
2.00	31.00	INTENSIVE CARE UNIT	99, 130	99, 130	0 0	0	0	2. 00
3.00		OPERATING ROOM	28, 461	28, 46	1 0	0	0	3. 00
4.00		NURSING ADMINISTRATION	39, 000	39, 000	0 0	0	0	4. 00
5.00		RADI OLOGY-DI AGNOSTI C	3, 189, 817	3, 189, 81		1	0	5. 00
6. 00		RESPI RATORY THERAPY	78, 240				o o	6. 00
7. 00		EMERGENCY	4, 980, 759				1	7. 00
8. 00		CANCER CENTER	1, 712, 712				1	8. 00
9. 00		ADULTS & PEDIATRICS	2, 942, 601	2, 942, 60				9. 00
10. 00		ADMINISTRATIVE & GENERAL	245, 322			-	1	10.00
11. 00		ANESTHESI OLOGY	1, 929, 884		· ·	177,000		11. 00
12. 00		OPERATING ROOM	265, 500			-	1	12. 00
13. 00		PHYSI CAL THERAPY	4, 000				1	13. 00
200.00	00.00	IIII SI GAL III LIKAI I	17, 982, 984				16	
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Provi der	Physician Cost	200.00
	WKSt. A LITTE #	I denti fi er	Li mi t		E Memberships &	Component	of Malpractice	
		rdentiffer	Limit	Li mi t	Continuing	Share of col.	Insurance	
				Limit	Education	12	Trisul ance	
	1.00	2.00	8.00	9. 00	12. 00	13. 00	14.00	
1.00		ADULTS & PEDIATRICS	0.00		0 0			1. 00
2. 00		INTENSIVE CARE UNIT	Ö		o o		•	2. 00
3.00		OPERATING ROOM	0		0 0	-		3. 00
4. 00		NURSI NG ADMI NI STRATI ON	0		0 0		1	4. 00
5. 00		RADI OLOGY-DI AGNOSTI C	0			,	1	5. 00
6. 00		RESPI RATORY THERAPY					Ί	6. 00
7. 00		EMERGENCY					Ö	7. 00
8. 00		CANCER CENTER			0 0		Ö	8. 00
9. 00		ADULTS & PEDIATRICS			0 0		1	9. 00
10. 00		ADDETS & TEDIATRICS ADMINISTRATIVE & GENERAL	1, 377	6	-		0	10.00
11. 00		ANESTHESI OLOGY	1,3//		0 0		1	11.00
12. 00		OPERATING ROOM			0 0			12.00
13. 00		PHYSICAL THERAPY			0 0		1	13. 00
200.00	66.00	PHISICAL THERAPT	1, 377		0	۷	0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE		Adjustment	0	200.00
	WKSt. A Line #	I denti fi er	Component	Limit	Di sal I owance	Adjustment		
		ruenti ii ei	Share of col.	LIIIII	Di Sai i Owalice			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1.00		ADULTS & PEDIATRICS	13.00		0 0			1. 00
2. 00		INTENSIVE CARE UNIT	Ö		0 0			2. 00
3. 00		OPERATING ROOM	0		0 0	28, 461		3. 00
4. 00		NURSI NG ADMI NI STRATI ON	0			39, 000	•	4. 00
5.00		RADI OLOGY-DI AGNOSTI C	0			3, 189, 817	•	5. 00
6. 00		RESPI RATORY THERAPY	0			78, 240		6. 00
7. 00		EMERGENCY		1		4, 980, 759	•	7. 00
8. 00		CANCER CENTER				1, 712, 712		8.00
9. 00		ADULTS & PEDIATRICS				2, 942, 601	•	9.00
9. 00 10. 00		ADULTS & PEDIATRICS ADMINISTRATIVE & GENERAL		1, 37	7 11, 623			10.00
		ADMINISTRATIVE & GENERAL ANESTHESIOLOGY		1	0 11,623			
11. 00 12. 00		OPERATING ROOM			-		•	11. 00 12. 00
		PHYSICAL THERAPY		'	0		1	12.00
13.00	00.00	PHISICAL IMEKAPI	-	1 27	7 11 / 22	4,000	1	
200.00			0	1, 37	7 11, 623	17, 981, 607	I	200. 00

Provider CCN: 14-0160 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 4:42 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1, 380, 269 1 00 1 00 00100 CAP REL COSTS-BLDG & FLXT 1, 380, 269 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2, 684, 936 2, 684, 936 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 11, 123, 045 8, 384 11, 131, 429 4.00 00500 ADMINISTRATIVE & GENERAL 299, 887 608, 999 18, 936, 532 5 00 17, 865, 609 162, 037 5 00 00700 OPERATION OF PLANT 7.00 3, 527, 732 150, 616 27, 195 97, 844 3, 803, 387 7.00 10, 091 8.00 00800 LAUNDRY & LINEN SERVICE 325, 845 335, 936 8.00 9.00 00900 HOUSEKEEPI NG 2,062,366 22, 140 o 2,084,506 9.00 C 01000 DI ETARY 10.00 1, 240, 478 49, 836 0 1, 296, 440 10 00 6, 126 11.00 01100 CAFETERI A 925, 429 42, 533 967, 962 11.00 01300 NURSING ADMINISTRATION 908, 676 1, 609 15, 509 195, 524 1, 121, 318 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 613, 509 28, 438 14.00 14.00 3.848 645, 806 11 01500 PHARMACY 15.00 15.00 2, 898, 635 10, 462 112, 599 347, 228 3, 368, 924 01600 MEDICAL RECORDS & LIBRARY 1, 897, 387 2, 976 305, 019 2, 205, 382 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 13, 293, 485 247, 293 17, 422, 589 218, 638 3, 663, 173 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 834, 894 18, 601 18, 638 378, 160 2, 250, 293 31 00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 93, 240 438, 733 50.00 10, 651, 078 603, 541 11, 786, 592 50.00 05001 GI LAB 50.01 1, 172, 414 30,078 88.980 153, 354 1, 444, 826 50.01 05002 AMBULATORY CARE UNIT 3, 089, 467 40, 415 29, 051 439, 611 3, 598, 544 50.02 50.02 51.00 05100 RECOVERY ROOM 532, 396 7, 191 8, 440 128, 751 676, 778 51.00 3, 709 53.00 05300 ANESTHESI OLOGY 174.585 62, 474 240, 768 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 5, 546, 602 75, 417 488, 689 811, 730 6, 922, 438 54.00 06000 LABORATORY 6, 341, 961 7, 038, 573 60.00 38, 198 245, 600 412, 814 60.00 65.00 06500 RESPIRATORY THERAPY 1, 269, 203 31, 829 58, 561 247, 353 1, 606, 946 65.00 06600 PHYSI CAL THERAPY 66.00 2, 886, 563 67, 266 83, 776 653, 100 3, 690, 705 66.00 666, 072 06900 ELECTROCARDI OLOGY 528, 219 7,611 71, 531 58, 711 69.00 69.00 69.01 06901 CATH LAB 1, 240, 034 2,682 151, 100 129, 450 1, 523, 266 69.01 07000 ELECTROENCEPHALOGRAPHY 70 00 70 00 0 \cap Ω 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 C 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 4, 440, 621 o 4, 440, 621 73.00 0 73.00 Ω 07400 RENAL DIALYSIS n 0 74.00 261, 301 1, 327 262, 628 74.00 76.00 03950 DIABETIC EDUCATION 75,800 1, 327 179 0 77, 306 76.00 76.01 03480 CANCER CENTER 10, 690<u>, 026</u> 35, 753 206, 862 440, 309 11, 372, 950 76.01 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1, 297, 130 12,648 10, 225 1, 256 1, 321, 259 90.00 09100 EMERGENCY 5, 215, 849 59, 056 166, 604 1, 087, 373 6, 528, 882 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 2, 601, 987 13, 378 333, 991 2, 949, 356 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 120, 597, 531 1, 376, 023 2, 684, 936 11, 125, 729 120, 587, 585 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 3, 419 3, 419 190. 00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 827 192.00 827 192. 01 19201 JANE ADDAMS BLDG 0 0 0 0 192. 01 C 192. 02 19202 SENI OR PROGRAM 0 0 192, 02 0 0 0 192. 03 19203 NA VOLUNTEER SERVICES 0 3, 786 19, 983 192. 03 16, 197 192. 04 19204 SMART STEPS 0 0 0 192. 04 11, 348 192. 05 192. 05 19205 RESPITE CARE 1, 914 0 9.434 Ω 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 200.00 0 200. 00 Cross Foot Adjustments 0 201. 00 201.00 Negative Cost Centers 11, 131, 429 TOTAL (sum lines 118 through 201) 120, 623, 162 1, 380, 269 2, 684, 936 120, 623, 162 202. 00 202.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 14-0160

				1	0 12/31/2023	5/30/2024 4: 4:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	Z
	, , , , , , , , , , , , , , , , , , ,	& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7.00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					1	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					1	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	18, 936, 532				ı	5. 00
7.00	00700 OPERATION OF PLANT	708, 282	4, 511, 669			ı	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	62, 559	49, 414	447, 909		1	8. 00
9.00	00900 HOUSEKEEPI NG	388, 185	108, 413	0	2, 581, 104	ı	9. 00
10.00	01000 DI ETARY	241, 428	244, 027	0	144, 668	1, 926, 563	10.00
11. 00	01100 CAFETERI A	180, 258	208, 269	0	123, 469	0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	208, 816	7, 878	0	4, 670	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	120, 265	18, 842	0	11, 170	0	14. 00
15.00	01500 PHARMACY	627, 375	51, 230	0	30, 371	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	410, 695	14, 575	0	8, 640	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 244, 545	1, 210, 899	164, 821	717, 863	1, 826, 318	30.00
31. 00	03100 INTENSIVE CARE UNIT	419, 059	91, 081	13, 735	53, 996	100, 245	31.00
43.00	04300 NURSERY	O	0	0	O	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 194, 946	456, 563	17, 565	270, 666	0	50.00
50. 01	05001 GI LAB	269, 061	147, 279	13, 854	87, 312	0	50. 01
50. 02	05002 AMBULATORY CARE UNIT	670, 135	197, 896	12, 810	117, 319	0	50. 02
51.00	05100 RECOVERY ROOM	126, 032	35, 211	9, 246	20, 874	0	51.00
53.00	05300 ANESTHESI OLOGY	44, 837	18, 164	0	10, 768	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 289, 124	369, 291	82, 411	218, 928	0	54.00
60.00	06000 LABORATORY	1, 310, 751	187, 042	0	110, 885	0	60.00
65.00	06500 RESPI RATORY THERAPY	299, 252	155, 857	4, 578	92, 397	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	687, 298	329, 374	13, 735	195, 264	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	124, 039	37, 268	0	22, 094	0	69. 00
69. 01	06901 CATH LAB	283, 669	13, 130	13, 735	7, 784	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	826, 950	0	0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	48, 908	6, 500	0	3, 853	0	74. 00
76.00	03950 DI ABETI C EDUCATI ON	14, 396	6, 500	0	3, 853	0	76. 00
76. 01	03480 CANCER CENTER	2, 117, 916	175, 071	16, 926	103, 788	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	246, 050	61, 931	0	36, 715	0	90.00
91. 00	09100 EMERGENCY	1, 215, 835	289, 174	84, 493	171, 432	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE					i	113. 00
116.00	11600 HOSPI CE	549, 241	0	0	0	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	18, 929, 907	4, 490, 879	447, 909	2, 568, 779	1, 926, 563	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	637	16, 741	0	9, 925	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	154	4, 049	0	2, 400		192. 00
192. 01	19201 JANE ADDAMS BLDG	0	0	0	0		192. 01
192. 02	19202 SENI OR PROGRAM	0	0	0	0		192. 02
192. 03	19203 NA VOLUNTEER SERVICES	3, 721	0	0	0	0	192. 03
192. 04	19204 SMART STEPS	0	0	0	0	0	192. 04
	19205 RESPITE CARE	2, 113	0	0	0		192. 05
	19300 NONPALD WORKERS	0	0	0	0	0	193. 00
200.00						ı	200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	18, 936, 532	4, 511, 669	447, 909	2, 581, 104	1, 926, 563	202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | Part | | P Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-0160

			То	12/31/2023	Date/Time Pre 5/30/2024 4:4	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Z piii
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 O0700 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	4 470 050					10.00
11. 00 01100 CAFETERI A	1, 479, 958	1				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	25, 285		202 224			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	7, 148	1	803, 231	4 400 (40		14.00
15. 00 01500 PHARMACY	49, 420	1	12, 290	4, 139, 610	2 (00 000	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	51, 606	0	0	0	2, 690, 898	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	414, 280	1 210 021	201 042	2 747	174 402	30.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	54, 073		201, 042 40, 077	2, 767 565	174, 493 20, 499	31.00
43. 00 04300 NURSERY	34, 0/3	1	40, 077	0	20, 499	43.00
ANCI LLARY SERVI CE COST CENTERS		y O	U		<u>U</u>	43.00
50. 00 05000 OPERATING ROOM	102, 792	l ol	29, 547	10, 915	426, 276	50.00
50. 01 05001 GI LAB	38, 712		82, 699	587	69, 647	50. 01
50. 02 05002 AMBULATORY CARE UNIT	67, 472	1	32, 907	347, 203	32, 302	50. 02
51. 00 05100 RECOVERY ROOM	26, 798		2, 000	71	14, 760	51.00
53. 00 05300 ANESTHESI OLOGY		1	31, 603	2, 236	45, 322	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	149, 240	ol ol	66, 637	995	519, 732	54.00
60. 00 06000 LABORATORY	73, 275	1	35, 984	916	302, 045	60.00
65. 00 06500 RESPIRATORY THERAPY	37, 338	1	36, 223	3, 102	59, 371	65. 00
66. 00 06600 PHYSI CAL THERAPY	103, 184	1	12, 563	28	90, 940	66. 00
69. 00 06900 ELECTROCARDI OLOGY	7, 344	. 0	481	0	48, 098	69. 00
69. 01 06901 CATH LAB	19, 230	o	352	68	77, 432	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	C	o	0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	0	0	0	48	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	0	0	1, 255, 067	289, 314	73. 00
74.00 07400 RENAL DIALYSIS	C	0	157	0	8, 368	74. 00
76.00 03950 DIABETIC EDUCATION	C	0	14	0	0	76. 00
76. 01 03480 CANCER CENTER	45, 383	0	38, 294	2, 457, 337	220, 280	76. 01
OUTPATIENT SERVICE COST CENTERS	1	ا	50.055	- aa.i		
90. 00 09000 CLI NI C	0		58, 255	5, 984	41, 001	90.00
91. 00 09100 EMERGENCY	141, 111	0	112, 430	4, 850	213, 481	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92. 00
113. 00 11300 I NTEREST EXPENSE		Ι				113. 00
116. 00 11600 HOSPI CE	65, 426		9, 676	46, 919	37, 489	1
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 479, 117	1	803, 231	4, 139, 610	2, 690, 898	
NONREI MBURSABLE COST CENTERS	1, 1, 2, 11,	1,007,707	000, 201	1, 107, 010	2, 0,0, 0,0	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	0	0	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	C	o	0	0		192. 00
192.01 19201 JANE ADDAMS BLDG	C	o	0	0	0	192. 01
192.02 19202 SENIOR PROGRAM	C	o o	0	0	0	192. 02
192.03 19203 NA VOLUNTEER SERVICES	813	o	0	О		192. 03
192.04 19204 SMART STEPS	C	0	0	0		192. 04
192. 05 19205 RESPI TE CARE	28	0	0	0		192. 05
193.00 19300 NONPALD WORKERS	C	0	0	0	0	193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	C	이	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 479, 958	1, 367, 967	803, 231	4, 139, 610	2, 690, 898	202. 00

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

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-0160 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 4:42 pm Cost Center Description Subtotal Intern & Total Residents Cost & Post Stepdown Adjustments 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 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 03000 ADULTS & PEDIATRICS 26, 589, 638 30.00 26, 589, 638 30.00 03100 INTENSIVE CARE UNIT 3, 201, 569 31.00 31 00 3, 201, 569 0 43.00 04300 NURSERY 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 15, 295, 862 15, 295, 862 50.00 50 01 05001 GL LAB 2, 153, 977 Ω 2, 153, 977 50 01 05002 AMBULATORY CARE UNIT 50.02 5,076,588 0 5, 076, 588 50.02 05100 RECOVERY ROOM 911, 770 911, 770 51.00 51.00 53.00 05300 ANESTHESI OLOGY 393, 698 393, 698 53.00 05400 RADI OLOGY-DI AGNOSTI C 9, 618, 796 9, 618, 796 54 00 54 00 60.00 06000 LABORATORY 9, 059, 471 9, 059, 471 60.00 06500 RESPIRATORY THERAPY 2, 295, 064 2, 295, 064 65.00 65.00 06600 PHYSI CAL THERAPY 5, 123, 091 5, 123, 091 66.00 66.00 06900 ELECTROCARDI OLOGY 905, 396 905, 396 69.00 69.00 69. 01 06901 CATH LAB 1, 938, 666 1, 938, 666 69.01 07000 ELECTROENCEPHALOGRAPHY 70 00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 48 0 48 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 0 0 Ω 72 00 07300 DRUGS CHARGED TO PATIENTS 6, 811, 952 6, 811, 952 73.00 73.00 07400 RENAL DIALYSIS 0 74.00 330, 414 330, 414 74.00 03950 DIABETIC EDUCATION 102,069 76.00 102.069 0 76.00 03480 CANCER CENTER 76.01 16, 547, 945 16, 547, 945 76.01 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1, 771, 195 1, 771, 195 90.00 91.00 09100 EMERGENCY C 8, 761, 688 91.00 8, 761, 688 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 3, 658, 107 3, 658, 107 116. 00 11600 HOSPI CE 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 120, 547, 004 120, 547, 004 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190 00 30, 722 30, 722 192.00 19200 PHYSICIANS' PRIVATE OFFICES 7,430 0 7, 430 192. 00 192. 01 19201 JANE ADDAMS BLDG 192. 01 0 0 192. 02 19202 SENI OR PROGRAM 192. 02 0 0 192.03 19203 NA VOLUNTEER SERVICES 24, 517 24, 517 192.03 192. 04 19204 SMART STEPS 0 192. 04 192. 05 19205 RESPITE CARE 13, 489 13, 489 192. 05 193. 00 19300 NONPALD WORKERS 0 O 193. 00 0 200.00 Cross Foot Adjustments 0 0 0 200.00

120, 623, 162

120, 623, 162

201.00

202.00

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Provider CCN: 14-0160

				То	12/31/2023	Date/Time Pre 5/30/2024 4:4	
			CAPI TAL REI	LATED COSTS		373072024 4.4.	Z pili
			57 1 17.12 1.12.	211125 00010			
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	8, 384	0	8, 384	8, 384	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	0	299, 887		461, 924	458	5. 00
7. 00	00700 OPERATION OF PLANT	0	150, 616		177, 811	74	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	10, 091	1	10, 091	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	22, 140	1	22, 140	0	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	49, 836	1	55, 962	0	10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	42, 533 1, 609	1	42, 533 17, 118	147	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	3, 848		3, 859	21	14. 00
15. 00	01500 PHARMACY	0	10, 462	1	123, 061	261	15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	2, 976		2, 976	229	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	0	247, 293	218, 638	465, 931	2, 772	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	18, 601	1	37, 239	284	31. 00
43. 00	04300 NURSERY	0	0	0	0	0	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS		02.240	420 722	531, 973	454	
50. 00 50. 01	05000	0	93, 240 30, 078		531, 973 119, 058	454 115	50. 00 50. 01
50. 01	05002 AMBULATORY CARE UNIT	0	40, 415	1	69, 466	330	1
51. 00	05100 RECOVERY ROOM	0	7, 191		15, 631	97	51.00
53. 00	05300 ANESTHESI OLOGY	0	3, 709		66, 183	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	75, 417	1	564, 106	610	1
60. 00	06000 LABORATORY	0	38, 198	1	283, 798	310	ł
65.00	06500 RESPI RATORY THERAPY	0	31, 829	1	90, 390	186	65. 00
66.00	06600 PHYSI CAL THERAPY	0	67, 266		151, 042	491	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	7, 611	71, 531	79, 142	44	69. 00
69. 01	06901 CATH LAB	0	2, 682	151, 100	153, 782	97	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	-	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	1 227	1	1 227	0	73.00
74. 00 76. 00	03950 DI ABETI C EDUCATI ON	0	1, 327 1, 327	1	1, 327 1, 506	0	74. 00 76. 00
	03480 CANCER CENTER	0	35, 753	1	242, 615	331	76. 00
70.01	OUTPATIENT SERVICE COST CENTERS		00,700	200,002	212,010	001	70.01
90.00	09000 CLI NI C	0	12, 648	10, 225	22, 873	1	90.00
91.00	09100 EMERGENCY	0	59, 056	166, 604	225, 660	817	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	SPECIAL PURPOSE COST CENTERS						
	11300 NTEREST EXPENSE	_	_				113. 00
	11600 HOSPI CE	0	0		13, 378		116. 00
118. 00	,	0	1, 376, 023	2, 684, 936	4, 060, 959	8, 380	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 419	0	3, 419	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	827		827		192. 00
	19201 JANE ADDAMS BLDG	0	027	1	0		192. 01
	19202 SENI OR PROGRAM	0	0		Ö		192. 02
	19203 NA VOLUNTEER SERVICES	l ő	Ö	Ö	ől		192. 03
	19204 SMART STEPS	0	Ö	ō	o		192. 04
	19205 RESPITE CARE	0	0	O	o		192. 05
	19300 NONPALD WORKERS	0	0	0	o		193. 00
200.00					0		200. 00
201.00			0	0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	0	1, 380, 269	2, 684, 936	4, 065, 205	8, 384	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 CMS-2552-10 | Part II | Prepared: | Part II | Pr Provider CCN: 14-0160

				1	0 12/31/2023	5/30/2024 4: 4:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	Z
	, , , , , , , , , , , , , , , , , , ,	& GENERAL	PLANT	LINEN SERVICE			
		5.00	7.00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	462, 382					5. 00
7.00	00700 OPERATION OF PLANT	17, 294	195, 179				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 528	2, 138	13, 757			8. 00
9.00	00900 HOUSEKEEPI NG	9, 478	4, 690	0	36, 308		9. 00
10.00	01000 DI ETARY	5, 895	10, 557	0	2, 035	74, 449	10.00
11. 00	01100 CAFETERI A	4, 401	9, 010	0	1, 737	0	11. 00
13.00	01300 NURSING ADMINISTRATION	5, 099	341	0	66	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	2, 936	815	0	157	0	14.00
15. 00	01500 PHARMACY	15, 318	2, 216	0	427	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	10, 028	631	0	122	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	79, 230	52, 385		10, 097	70, 575	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	10, 232	3, 940	422	760	3, 874	31. 00
43.00	04300 NURSERY	0	0	0	0	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	53, 594	19, 751	1	3, 807	0	50.00
50. 01	05001 GI LAB	6, 570	6, 371	426	1, 228	0	50. 01
50. 02	05002 AMBULATORY CARE UNIT	16, 363	8, 561	393	1, 650	0	50. 02
51. 00	05100 RECOVERY ROOM	3, 077	1, 523	1	294	0	51. 00
53. 00	05300 ANESTHESI OLOGY	1, 095	786		151	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	31, 476	15, 976		3, 080	0	54. 00
60. 00	06000 LABORATORY	32, 004	8, 092		1, 560	0	60.00
65. 00	06500 RESPI RATORY THERAPY	7, 307	6, 743	1	1, 300	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	16, 782	14, 249	1	2, 747	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	3, 029	1, 612	1	311	0	69. 00
69. 01	06901 CATH LAB	6, 926	568	1	109	0	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	20, 192	0	0	0	0	73. 00
74. 00	07400 RENAL DI ALYSI S	1, 194	281	0	54	0	74.00
76. 00	03950 DI ABETI C EDUCATI ON	352	281	1	54	0	76. 00
76. 01	03480 CANCER CENTER	51, 713	7, 574	520	1, 460	0	76. 01
	OUTPATIENT SERVICE COST CENTERS		0 (70		Ea /		
90.00	09000 CLINIC	6, 008	2, 679	1	516	0	90.00
91.00	09100 EMERGENCY	29, 687	12, 510	2, 595	2, 412	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE						113. 00
	11600 HOSPI CE	13, 411	0	0	0	0	116. 00
118.00	+ I	462, 219	194, 280	_	36, 134	74, 449	•
110.00	NONREI MBURSABLE COST CENTERS	402, 219	174, 200	13,737	30, 134	74,447	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	16	724	0	140	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	4	175	1			192. 00
	19201 JANE ADDAMS BLDG	0	179		0		192. 01
	19202 SENI OR PROGRAM	l o	0	0	0		192. 02
	19203 NA VOLUNTEER SERVICES	91	0	0	0		192. 03
	19204 SMART STEPS	0	0	0	0		192. 04
	19205 RESPITE CARE	52	0	ا م	o o		192. 05
	19300 NONPALD WORKERS	0	0	ا م	o o		193. 00
200.00			O		Ĭ	· ·	200.00
201.00		0	0	0	0	0	201. 00
202. 00		462, 382	195, 179	13, 757	36, 308	74, 449	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 CMS-2552-10 | Part II | Prepared: | Part II | Pr

				10	12/31/2023	5/30/2024 4: 4	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	·		ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
	T	11. 00	13. 00	14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS		1				
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
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	F7 (04					10.00
11. 00	01100 CAFETERI A	57, 681	1				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	985		0.047			13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	279	1	8, 067	140 000		14.00
15.00	01500 PHARMACY	1, 926	1	123	143, 332	45.007	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	2, 011	0	0	0	15, 997	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1/ 14	21 012	2 010	0/	1 000	20.00
30.00	03000 ADULTS & PEDI ATRI CS	16, 147		2, 019	96	1, 029	1
31. 00	03100 I NTENSI VE CARE UNI T	2, 107		403	20	121	31.00
43. 00	04300 NURSERY	C) 0	0	0	0	43. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS	4.007		207	270	2 F14	FO 00
50.00	05000 OPERATING ROOM 05001 GI LAB	4,006	1	297	378	2, 514	50.00
50. 01 50. 02	05001 GT LAB 05002 AMBULATORY CARE UNIT	1, 509	1	831	20 12, 022	411 191	50. 01 50. 02
51. 00	05100 RECOVERY ROOM	2, 630	1	330 20	12, 022	87	51.00
53. 00	05300 ANESTHESI OLOGY	1, 044		317	77	267	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 817		669		3, 193	54. 00
60.00	06000 LABORATORY	2, 856		361	34 32	1, 781	60.00
65. 00	06500 RESPIRATORY THERAPY	1, 455		364	107	350	1
66. 00	06600 PHYSI CAL THERAPY	4, 022	1	126	107	536	66.00
69. 00	06900 ELECTROCARDI OLOGY	286	1	120		284	69.00
69. 01	06901 CATH LAB	749	1	3	2	457	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	/47		4	2	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0	0	0	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS			0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS			0	43, 457	1, 706	1
74. 00	07400 RENAL DIALYSIS			2	43, 437	49	74.00
76. 00	03950 DI ABETI C EDUCATI ON		_	0	0	0	76. 00
76. 00	03480 CANCER CENTER	1, 769		385	85, 084	1, 299	1
70.01	OUTPATIENT SERVICE COST CENTERS	1,707	<u> </u>	000	00,001	1,277	70.01
90.00	09000 CLI NI C	C	o	585	207	242	90. 00
91. 00	09100 EMERGENCY	5, 500	1	1, 129	168	1, 259	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	-,		.,		., ==.	92. 00
	SPECIAL PURPOSE COST CENTERS	l	'		,		
113.00	11300 NTEREST EXPENSE						113. 00
	11600 HOSPI CE	2, 550	ol ol	97	1, 625	221	116. 00
118.00	1	57, 648		8, 067	143, 332	15, 997	118. 00
	NONREI MBURSABLE COST CENTERS			•			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	0	0	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	C	ol	0	0	0	192. 00
192. 01	19201 JANE ADDAMS BLDG	C	o	0	0	0	192. 01
192. 02	19202 SENIOR PROGRAM	C	o	0	0	0	192. 02
192.03	19203 NA VOLUNTEER SERVICES	32	el ol	0	0	0	192. 03
192. 04	19204 SMART STEPS	C		0	o	0	192. 04
192.05	19205 RESPITE CARE	1	0	0	o	0	192. 05
	19300 NONPALD WORKERS	[C	ol ol	0	0	0	193. 00
200.00							200. 00
201.00		(o o	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	57, 681	23, 756	8, 067	143, 332	15, 997	202. 00

FHN MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2023	Part II
To 12/31/2023	Date/Time Prepared:
5/30/2024 4:42 pm	Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-0160

					0 12/31/2023	5/30/2024 4: 42 pm
	Cost Center Description	Subtotal	Intern &	Total		
	'		Residents Cost			
			& Post			
			Stepdown			
			Adjustments			
		24. 00	25. 00	26.00		
GE	ENERAL SERVICE COST CENTERS					
1.00 00	0100 CAP REL COSTS-BLDG & FIXT					1. 00
2.00 00	0200 CAP REL COSTS-MVBLE EQUIP				1	2. 00
4.00 00	0400 EMPLOYEE BENEFITS DEPARTMENT				1	4. 00
5.00 00	0500 ADMINISTRATIVE & GENERAL				1	5. 00
7.00 00	0700 OPERATION OF PLANT				1	7. 00
8.00 00	0800 LAUNDRY & LINEN SERVICE				1	8. 00
9.00 00	0900 HOUSEKEEPI NG				1	9. 00
10.00 0	1000 DI ETARY				1	10. 00
11. 00 0	1100 CAFETERI A				1	11. 00
13. 00 0	1300 NURSING ADMINISTRATION				1	13. 00
	1400 CENTRAL SERVICES & SUPPLY				1	14. 00
	1500 PHARMACY				1	15. 00
	1600 MEDICAL RECORDS & LIBRARY				1	16. 00
	NPATIENT ROUTINE SERVICE COST CENTERS					
	3000 ADULTS & PEDIATRICS	726, 356	0	726, 356		30.00
	3100 I NTENSI VE CARE UNI T	62, 145	o	62, 145		31.00
	4300 NURSERY	02, 143	Ö	02, 143		43.00
_	NCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>	<u> </u>		43.00
	5000 OPERATING ROOM	617, 313	ol	617, 313		50.00
	5001 GI LAB	136, 539	0	136, 539		50. 00
	5001 GI LAB 5002 AMBULATORY CARE UNIT	111, 936	0	111, 936		50. 02
	5100 RECOVERY ROOM	22, 059	0	22, 059		51. 00
	5300 ANESTHESI OLOGY		0	68, 876		53.00
	5400 RADI OLOGY-DI AGNOSTI C	68, 876	0	·		54.00
		627, 492	O O	627, 492		· ·
1	6000 LABORATORY	330, 794	O O	330, 794		60.00
	6500 RESPI RATORY THERAPY	108, 343	0	108, 343		65. 00
	6600 PHYSI CAL THERAPY	190, 418	U	190, 418		66. 00
	6900 ELECTROCARDI OLOGY	84, 713	0	84, 713		69. 00
	6901 CATH LAB	163, 116	0	163, 116		69. 01
	7000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71. 00
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72. 00
	7300 DRUGS CHARGED TO PATIENTS	65, 355	0	65, 355		73. 00
	7400 RENAL DI ALYSI S	2, 907	0	2, 907		74. 00
	3950 DIABETIC EDUCATION	2, 193	0	2, 193		76. 00
	3480 CANCER CENTER	392, 750	0	392, 750		76. 01
	UTPATIENT SERVICE COST CENTERS					
	9000 CLI NI C	33, 111	0	33, 111		90. 00
	9100 EMERGENCY	281, 737	0	281, 737	1	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART		0		ı	92. 00
	PECIAL PURPOSE COST CENTERS					
	1300 INTEREST EXPENSE				1	113. 00
116. 00 1	1600 HOSPI CE	31, 533	0	31, 533	1	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	4, 059, 686	0	4, 059, 686	<u> </u>	118. 00
NO	ONREI MBURSABLE COST CENTERS					
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 299	0	4, 299		190. 00
192. 00 19	9200 PHYSICIANS' PRIVATE OFFICES	1, 040	0	1, 040	1	192. 00
	9201 JANE ADDAMS BLDG	0	0	0	Ì	192. 01
192. 02 19	9202 SENIOR PROGRAM	0	0	0	İ	192. 02
192. 03 19	9203 NA VOLUNTEER SERVICES	126	o	126	İ	192. 03
192. 04 19	9204 SMART STEPS	o	0	0	Ì	192. 04
192. 05 19	9205 RESPITE CARE	54	0	54	Ì	192. 05
193.00 19	9300 NONPALD WORKERS	o	0	0	Ì	193. 00
200.00	Cross Foot Adjustments	o	0	0		200. 00
201.00	Negative Cost Centers	o	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	4, 065, 205	0	4, 065, 205	Ì	202. 00
	, ,		-1			1

					rom 01/01/2023 o 12/31/2023	Date/Time Pre	
		CAPITAL RE	LATED COSTS			5/30/2024 4: 4	2 pm
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation		
		(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS DEPARTMENT		& GENERAL (ACCUM. COST)	
				(GROSS SALARI ES)			
	OFNEDAL CEDIUSE COCT OFNEDO	1.00	2.00	4.00	5A	5. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT	308, 842					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2, 684, 931				2. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	1, 876 67, 101	1	1 , ==== , . ==		101, 686, 630	4. 00 5. 00
7.00	00700 OPERATION OF PLANT	33, 701	27, 195	389, 119	0	3, 803, 387	7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	2, 258 4, 954		· -		335, 936 2, 084, 506	1
10.00	01000 DI ETARY	11, 151	6, 126	0	0	1, 296, 440	10.00
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	9, 517 360	1	ľ	_	967, 962 1, 121, 318	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	861	11	113, 096	0	645, 806	14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	2, 341	l .			3, 368, 924 2, 205, 382	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	55, 333 4, 162	1			17, 422, 589 2, 250, 293	1
43. 00	04300 NURSERY	0	1				1
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	20, 863	438, 732	2, 400, 234	0	11, 786, 592	50.00
50. 01	05001 GI LAB	6, 730	88, 980	609, 878	0	1, 444, 826	50. 01
50. 02 51. 00	05002 AMBULATORY CARE UNIT 05100 RECOVERY ROOM	9, 043 1, 609	•			3, 598, 544 676, 778	1
53.00	05300 ANESTHESI OLOGY	830				240, 768	
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	16, 875 8, 547	•			6, 922, 438 7, 038, 573	1
65. 00	06500 RESPIRATORY THERAPY	7, 122	•			1, 606, 946	1
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	15, 051	1			3, 690, 705	1
69. 00 69. 01	06901 CATH LAB	1, 703 600	1			666, 072 1, 523, 266	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	·	_	0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 MPL. DEV. CHARGED TO PATIENTS		0	0	_	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	_	4, 440, 621	1
74. 00 76. 00	07400 RENAL DIALYSIS 03950 DIABETIC EDUCATION	297 297	1	· -		262, 628 77, 306	1
76. 01	03480 CANCER CENTER	8, 000	1	1, 751, 071	0	11, 372, 950	
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	2, 830	10, 225	4, 996	0	1, 321, 259	90.00
91. 00	09100 EMERGENCY	13, 214	1			6, 528, 882	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92. 00
	11300 I NTEREST EXPENSE	_			_		113. 00
116. 00 118. 00	0111600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	307, 892					
	NONREI MBURSABLE COST CENTERS						
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS' PRIVATE OFFICES	765 185	 				190. 00 192. 00
192. 01	1 19201 JANE ADDAMS BLDG	0	1	0	0	0	192. 01
	2 19202 SENIOR PROGRAM 3 19203 NA VOLUNTEER SERVICES	0	0	0 15, 057			192. 02 192. 03
192. 04	1 19204 SMART STEPS	0	Ö	0	0	0	192. 04
	5 19205 RESPITE CARE D 19300 NONPALD WORKERS	0	0	7, 610	0		192. 05 193. 00
200.00	Cross Foot Adjustments					9	200. 00
201. 00 202. 00		1, 380, 269	2, 684, 936	11, 131, 429		18, 936, 532	201.00
	Part I)						
203. 00 204. 00		4. 469175	1. 000002	0. 251451 8, 384		0. 186224 462, 382	1
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part			0. 000189		0. 004547	205. 00
206.00	NAHE adjustment amount to be allocated						206. 00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						I

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-0160 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 4:42 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE (SQUARE FEET) (MEALS SERVED) PLANT (FTE'S) (SQUARE FEET) (POUNDS OF LAUNDRY) 7.00 9.00 10.00 11.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 206, 164 7.00 00800 LAUNDRY & LINEN SERVICE 2, 258 8.00 507, 072 8.00 00900 HOUSEKEEPI NG 9.00 4, 954 198, 952 9.00 10.00 01000 DI ETARY 11, 151 11, 151 61, 845 10.00 11.00 01100 CAFETERI A 9,517 9, 517 52, 796 C 11.00 01300 NURSING ADMINISTRATION 13.00 360 902 13.00 360 C 0 14.00 01400 CENTRAL SERVICES & SUPPLY 861 C 861 0 255 14.00 15.00 01500 PHARMACY 2, 341 2, 341 1,763 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 1.841 16.00 666 666 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 55, 333 186, 592 55, 333 58, 627 14, 779 30.00 03100 INTENSIVE CARE UNIT 31.00 4, 162 15, 549 4, 162 3, 218 1, 929 31.00 04300 NURSERY 43 00 Ω 43 00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 20, 863 19, 885 20, 863 0 3, 667 50.00 0 50.01 05001 GI LAB 6,730 15, 684 6,730 1, 381 50.01 05002 AMBULATORY CARE UNIT 9, 043 2, 407 14, 502 9,043 50 02 50 02 0 51.00 05100 RECOVERY ROOM 1,609 10, 467 1,609 956 51.00 53.00 05300 ANESTHESI OLOGY 830 830 0 0 0 0 0 0 0 0 0 53.00 0 54 00 05400 RADI OLOGY-DI AGNOSTI C 16.875 93, 296 16 875 5 324 54 00 06000 LABORATORY 60.00 8,547 8,547 2, 614 60.00 06500 RESPIRATORY THERAPY 7, 122 5, 183 7, 122 1, 332 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 15,051 15, 549 15,051 3, 681 66.00 06900 ELECTROCARDI OLOGY 1, 703 69 00 1, 703 69 00 262 69.01 06901 CATH LAB 600 15, 549 600 686 69.01 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 C 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 0 0 Ω 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 C 0 0 73.00 07400 RENAL DIALYSIS 0 74.00 297 297 74.00 76.00 03950 DIABETIC EDUCATION 297 297 0 0 76, 00 03480 CANCER CENTER 19<u>, 162</u> 1, 619 76.01 8.000 8,000 0 76.01 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 2,830 2,830 0 90.00 09100 EMERGENCY 5, 034 91.00 91.00 13, 214 95, 654 13, 214 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 2, 334 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 507, 072 118.00 205, 214 198,002 61,845 52, 766 118. 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 765 765 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192. 00 185 0 185 192. 01 19201 JANE ADDAMS BLDG 0 0 192. 01 0 C 192. 02 19202 SENI OR PROGRAM 0 0 0 0 0 192. 02 0 192. 03 19203 NA VOLUNTEER SERVICES 29 192, 03 0 0 192.04 19204 SMART STEPS C 0 0 0 192. 04 192. 05 19205 RESPITE CARE 0 C 0 0 192.05 193. 00 19300 NONPALD WORKERS 0 193.00 0 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 201. 00 1, 479, 958 202. 00 202.00 Cost to be allocated (per Wkst. B, 4, 511, 669 447, 909 2, 581, 104 1, 926, 563 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 21. 883884 0.883324 12. 973501 31. 151475 28. 031631 203. 00 204.00 Cost to be allocated (per Wkst. B, 195, 179 13, 757 36, 308 74.449 57, 681 204. 00 Part II) Unit cost multiplier (Wkst. B, Part 0.182496 1. 092526 205. 00 205.00 0.946717 0.027130 1.203800 II) 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)

						5/30/2024 4: 42 pm
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
		(DI DECT)	SUPPLY	REQUIS.)	LI BRARY	
		(DI RECT)	(COSTED		(GROSS CHAR	
		12.00	REQUIS.)	15.00	GES)	
CENE	AL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	
	CAP REL COSTS-BLDG & FIXT					1.00
	CAP REL COSTS-BEDG & TTXT					2.00
	EMPLOYEE BENEFITS DEPARTMENT					4.00
	ADMINISTRATIVE & GENERAL					5.00
	OPERATION OF PLANT					7. 00
	LAUNDRY & LINEN SERVICE					8.00
	HOUSEKEEPING					9. 00
	DI ETARY					10.00
	CAFETERI A					11.00
13.00 01300	NURSING ADMINISTRATION	347, 565				13.00
14. 00 01400	CENTRAL SERVICES & SUPPLY	o	2, 384, 638			14.00
15. 00 01500	PHARMACY	0	36, 486	13, 968, 930		15. 00
	MEDICAL RECORDS & LIBRARY	0	0	0	587, 773, 439	16. 00
	IENT ROUTINE SERVICE COST CENTERS					
	ADULTS & PEDIATRICS	307, 435	596, 856		38, 115, 597	
	INTENSIVE CARE UNIT	40, 130	118, 982		4, 477, 751	
	NURSERY	0	0	0	0	43. 00
	LARY SERVICE COST CENTERS		07.700	0, 000	00 111 051	50.00
	OPERATING ROOM	0	87, 720		93, 114, 054	
	GI LAB AMBULATORY CARE UNIT	0	245, 518		15, 213, 403	
	RECOVERY ROOM	0	97, 694 5, 937		7, 056, 007	
	ANESTHESI OLOGY	0	93, 824		3, 224, 155 9, 899, 973	
	RADI OLOGY-DI AGNOSTI C	0	197, 831		113, 512, 153	1
	LABORATORY		106, 830		65, 977, 425	
	RESPI RATORY THERAPY	Ö	107, 539		12, 968, 864	
	PHYSI CAL THERAPY	ol	37, 297		19, 864, 540	
	ELECTROCARDI OLOGY	o	1, 428		10, 506, 338	
	CATH LAB	o	1, 045		16, 913, 993	
70.00 07000	ELECTROENCEPHALOGRAPHY	o	0	0	0	70.00
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	0	10, 574	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
	DRUGS CHARGED TO PATIENTS	0	0	4, 235, 169	63, 196, 622	
	RENAL DIALYSIS	0	466		1, 827, 864	74.00
	DI ABETI C EDUCATI ON	0	41	0	0	
76. 01 03480	CANCER CENTER	0	113, 688	8, 292, 167	48, 117, 137	76. 01
	TIENT SERVICE COST CENTERS		170 047	20.104	0.057.005	00.00
	CLINIC EMERGENCY	0	172, 947 333, 784		8, 956, 095 46, 631, 922	
	OBSERVATION BEDS (NON-DISTINCT PART	٩	333, 704	10, 303	40, 031, 722	92. 00
	AL PURPOSE COST CENTERS					72.00
	I NTEREST EXPENSE					113. 00
116. 00 11600		o	28, 725	158, 326	8, 188, 972	
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	347, 565	2, 384, 638		587, 773, 439	
NONRE	IMBURSABLE COST CENTERS					
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190. 00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192. 00
	JANE ADDAMS BLDG	0	0	0	0	
	SENI OR PROGRAM	0	0	0	0	
	NA VOLUNTEER SERVICES	0	0	0	0	
	SMART STEPS	0	0	0	0	
	RESPITE CARE	0	0	0	0	
	NONPAI D WORKERS	0	0	0	0	193. 00
200.00	Cross Foot Adjustments					200.00
201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	1 267 067	803, 231	4, 139, 610	2, 690, 898	201. 00 202. 00
202.00	Part I)	1, 367, 967	003, 231	4, 139, 010	2, 090, 090	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	3. 935859	0. 336836	0. 296344	0. 004578	203. 00
204. 00	Cost to be allocated (per Wkst. B,	23, 756	8, 067		15, 997	
2011.00	Part II)	20,700	0,007	1.10,002	.0, ,,,] [20.1.00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 068350	0. 003383	0. 010261	0. 000027	205. 00
	[11)					
206. 00	NAHE adjustment amount to be allocated					206. 00
	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,					207. 00
	Parts III and IV)					i I

Heal th	Financial Systems	FHN MEMORIA	HOSPI TAI		In lie	u of Form CMS-2	2552_10
COMPUTATION OF RATIO OF COSTS TO CHARGES		THI WEWORTA	Provider Co		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I	
			Title	XVIII	Hospi tal	PPS	
				Costs			
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		26)	0.00	0.00	4.00	5.00	
	I	1. 00	2.00	3. 00	4. 00	5. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
		26, 589, 638		26, 589, 63	3 0	26, 589, 638	30. 00
31.00	03100 INTENSIVE CARE UNIT	3, 201, 569		3, 201, 56	9 0	3, 201, 569	31. 00
43.00	04300 NURSERY	0			0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	15, 295, 862		15, 295, 86	2 0	15, 295, 862	50.00
50. 01	05001 GI LAB	2, 153, 977		2, 153, 97	7 0	2, 153, 977	50. 01
50.02	05002 AMBULATORY CARE UNIT	5, 076, 588		5, 076, 58	0	5, 076, 588	50. 02
51.00	05100 RECOVERY ROOM	911, 770		911, 770	o	911, 770	51.00
	11	1	I		_1		l

393, 698

9, 618, 796

9, 059, 471

2, 295, 064

5, 123, 091

1, 938, 666

6, 811, 952

16, 547, 945

1, 771, 195

8, 761, 688

8, 297, 827

3, 658, 107

8, 297, 827

128, 844, 831

120, 547, 004

330, 414

102, 069

905, 396

0

48

0

393, 698

9, 618, 796

9, 059, 471

2, 295, 064

5, 123, 091

1, 938, 666

6, 811, 952

16, 547, 945

1, 771, 195

8, 761, 688

8, 297, 827

3, 658, 107

8, 297, 827

128, 844, 831

120, 547, 004

0

330, 414

102, 069

905, 396

0

48

393, 698

9, 618, 796

9, 059, 471

2, 295, 064

5, 123, 091

1, 938, 666

6, 811, 952

16, 547, 945

1, 771, 195

8, 761, 688

8, 297, 827

3, 658, 107 116. 00 128, 844, 831 200. 00

8, 297, 827 201. 00

120, 547, 004 202. 00

330, 414

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69.00

69 01

70.00

71.00

72.00

73. 00 74. 00

76.00

76.01

90.00

91.00

92.00

200.00

201.00

202.00

05300 ANESTHESI OLOGY

06000 LABORATORY

06901 CATH LAB

05400 RADI OLOGY-DI AGNOSTI C

06500 RESPIRATORY THERAPY

07000 ELECTROENCEPHALOGRAPHY

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

SPECIAL PURPOSE COST CENTERS

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

07200 IMPL. DEV. CHARGED TO PATIENTS

06600 PHYSI CAL THERAPY

07400 RENAL DIALYSIS

03480 CANCER CENTER

09000 CLI NI C

116. 00 11600 HOSPI CE

09100 EMERGENCY

113.00 11300 I NTEREST EXPENSE

03950 DIABETIC EDUCATION

06900 ELECTROCARDI OLOGY

Health Financial Systems	FHN MEMORIAL HOSPITAL	In Lieu of Form CMS-2552	2-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-0160	Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepare 5/30/2024 4:42 pm	

					10 12/31/2023	5/30/2024 4:4	
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	28, 060, 992		28, 060, 99			30. 00
	03100 INTENSIVE CARE UNIT	4, 477, 751		4, 477, 75	1		31. 00
43.00	04300 NURSERY	0			O		43. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	23, 279, 416	69, 834, 638			0. 000000	
50. 01	05001 GI LAB	2, 060, 627	13, 152, 776			0. 000000	
50. 02	05002 AMBULATORY CARE UNIT	10, 749	7, 045, 258			0. 000000	
51. 00	05100 RECOVERY ROOM	838, 857	2, 385, 298			0. 000000	
53.00	05300 ANESTHESI OLOGY	2, 293, 463	7, 606, 510			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	20, 506, 238	93, 005, 915			0. 000000	
60.00	06000 LABORATORY	15, 693, 541	50, 283, 884			0. 000000	
65.00	06500 RESPI RATORY THERAPY	9, 016, 054	3, 952, 810			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	3, 324, 892	16, 539, 648			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	3, 333, 318	7, 173, 020			0. 000000	
	06901 CATH LAB	7, 702, 016	9, 211, 977	16, 913, 99		0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0. 000000	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 194	2, 380	10, 57		0. 000000	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0. 000000	0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	26, 903, 070	36, 293, 552			0. 000000	
	07400 RENAL DI ALYSI S	1, 686, 080	141, 784			0. 000000	
	03950 DI ABETI C EDUCATION	0	0		0. 000000	0. 000000	
76. 01	03480 CANCER CENTER	9, 592	48, 107, 545	48, 117, 13	0. 343910	0. 000000	76. 01
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	50, 644	8, 905, 451			0. 000000	
91. 00	09100 EMERGENCY	8, 678, 963	37, 952, 959			0. 000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 400, 478	7, 654, 127	10, 054, 60	0. 825276	0. 000000	92. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
	11600 H0SPI CE	0	8, 188, 972	8, 188, 97	2		116. 00
200.00		160, 334, 935	427, 438, 504	587, 773, 43	9		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	160, 334, 935	427, 438, 504	587, 773, 43	9		202. 00

Health Financial Systems	FHN MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0160	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Preps/30/2024 4:4:	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Innatient				

43. 00					10 12/31/2023	5/30/2024 4: 4:	
Ratio 11.00				Title XVIII	Hospi tal	PPS	
11.00		Cost Center Description	PPS Inpatient				
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 30.00 ADULTS & PEDI ATRI CS 31.00 31.00 O3000 ADULTS & PEDI ATRI CS 31.00 O3000 O1000							
30. 00 31. 00 31. 00 43. 00 43. 00 43. 00 ANCI LLARY SERVI CE COST CENTERS 50. 00 50. 01 50. 01 50. 01 50. 01 50. 01 50. 01 50. 00 50. 01 50. 00 50. 01 50. 00			11. 00				
31. 00							
43. 00							
ANCI LLARY SERVI CE COST CENTERS 50. 00							31. 00
50. 00 05000 0PERATING ROOM 0. 164270 50. 01 05001 GI LAB 50. 00 0. 141584	43.00						43. 00
50. 01 05001 GI LAB 0. 141584 50. 01							
			1				
50. 02 05002 AMBULATORY CARE UNIT 0. 719470 50. 02			1				
			0. 719470				
	51.00		0. 282793				51. 00
53. 00 05300 ANESTHESI OLOGY	53.00	05300 ANESTHESI OLOGY	0. 039768				53. 00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0. 084738 54. 00	54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 084738				54. 00
60. 00 06000 LABORATORY 0. 137312 60. 00	60.00	06000 LABORATORY	0. 137312				60.00
65. 00 06500 RESPI RATORY THERAPY 0. 176967 65. 00	65.00	06500 RESPI RATORY THERAPY	0. 176967				65. 00
66. 00 06600 PHYSI CAL THERAPY 0. 257901 66. 00	66.00	06600 PHYSI CAL THERAPY	0. 257901				66. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 086176 69. 00	69.00	06900 ELECTROCARDI OLOGY	0. 086176				69. 00
69. 01 06901 CATH LAB 0. 114619 69. 01	69. 01	06901 CATH LAB	0. 114619				69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 70. 00	70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 004539 71. 00	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 004539				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 107790 73. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	0. 107790				73. 00
74. 00 07400 RENAL DI ALYSI S 0. 180765 74. 00	74.00	07400 RENAL DIALYSIS	0. 180765				74. 00
76. 00 03950 DI ABETI C EDUCATI ON 0. 000000 76. 00	76.00	03950 DIABETIC EDUCATION	0. 000000				76. 00
76. 01 03480 CANCER CENTER 0. 343910 76. 01	76. 01	03480 CANCER CENTER	0. 343910				76. 01
OUTPATIENT SERVICE COST CENTERS		OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C 0. 197764 90. 00	90.00	09000 CLI NI C	0. 197764				90. 00
91. 00 09100 EMERGENCY 0. 187890 91. 00	91.00	09100 EMERGENCY	0. 187890				91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0. 825276 92. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 825276				92. 00
SPECIAL PURPOSE COST CENTERS		SPECIAL PURPOSE COST CENTERS					
113. 00 11300 NTEREST EXPENSE 113. 00	113.00	11300 I NTEREST EXPENSE					113. 00
116. 00 11600 HOSPI CE 116. 00	116.00	11600 H0SPI CE					116. 00
200.00 Subtotal (see instructions) 200.00	200.00	Subtotal (see instructions)					200. 00
201.00 Less Observation Beds 201.00	201.00	Less Observation Beds					201. 00
202. 00 Total (see instructions) 202. 00	202.00	Total (see instructions)					202. 00

	5.00.050000.00				6.5. 0110	
Health Financial Systems	FHN MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	<u> 2552-10</u>
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CO	CN: 14-0160	Peri od:	Worksheet C	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre	pared:
					5/30/2024 4:4	2 pm
		Ti tl	e XIX	Hospi tal	Cost	
		·		Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
·	(from Wkst. B,			Di sal I owance		
	Part I, col.	.,				
	26)					
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					

		1111	C XIX	nospi tai	0031	_
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	26, 589, 638		26, 589, 638	0	26, 589, 638	30.00
31.00 03100 INTENSIVE CARE UNIT	3, 201, 569		3, 201, 569	0	3, 201, 569	31. 00
43. 00 04300 NURSERY	0		0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	15, 295, 862		15, 295, 862	0	15, 295, 862	50.00
50. 01 05001 GI LAB	2, 153, 977		2, 153, 977	0	2, 153, 977	50. 01
50. 02 05002 AMBULATORY CARE UNIT	5, 076, 588		5, 076, 588	0	5, 076, 588	50. 02
51.00 05100 RECOVERY ROOM	911, 770		911, 770	0	911, 770	51.00
53. 00 05300 ANESTHESI OLOGY	393, 698		393, 698	0	393, 698	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 618, 796		9, 618, 796	0	9, 618, 796	54.00
60. 00 06000 LABORATORY	9, 059, 471		9, 059, 471	0	9, 059, 471	60.00
65. 00 06500 RESPIRATORY THERAPY	2, 295, 064	0	2, 295, 064	0	2, 295, 064	65.00
66. 00 06600 PHYSI CAL THERAPY	5, 123, 091	0	5, 123, 091	0	5, 123, 091	66. 00
69. 00 06900 ELECTROCARDI OLOGY	905, 396		905, 396	0	905, 396	69. 00
69. 01 06901 CATH LAB	1, 938, 666		1, 938, 666	0	1, 938, 666	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	48		48	0	48	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 811, 952		6, 811, 952	0	6, 811, 952	73. 00
74. 00 07400 RENAL DIALYSIS	330, 414		330, 414	0	330, 414	74.00
76. 00 03950 DI ABETI C EDUCATI ON	102, 069		102, 069	0	102, 069	76. 00
76. 01 03480 CANCER CENTER	16, 547, 945		16, 547, 945	0	16, 547, 945	
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	1, 771, 195		1, 771, 195	0	1, 771, 195	90.00
91. 00 09100 EMERGENCY	8, 761, 688		8, 761, 688		8, 761, 688	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	8, 297, 827		8, 297, 827		8, 297, 827	
SPECIAL PURPOSE COST CENTERS	-,,				5/2:1/52	1
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	3, 658, 107		3, 658, 107		3, 658, 107	
200.00 Subtotal (see instructions)	128, 844, 831		128, 844, 831		128, 844, 831	
201.00 Less Observation Beds	8, 297, 827		8, 297, 827		8, 297, 827	
202.00 Total (see instructions)	120, 547, 004	l .	1			
	.23,3.7,001		1 .20,01.,001	۱	.20,0,001	1-32. 00

Health Financial Systems	FHN MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-0160	Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

Title XIX						0 12/31/2023	Date/lime Pre 5/30/2024 4:4	
Cost Center Description	-			Ti tl	e XIX	Hospi tal		<u> </u>
INPATI ENT ROUTI NE SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.00				Charges	<u> </u>	'		
INPATIENT ROUTI NE SERVICE COST CENTERS		Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
IMPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.		· ·		·	+ col. 7)	Ratio	Inpati ent	
INPATIENT ROUTI NE SERVICE COST CENTERS 28,060,992 28,060,992 30.00 30.00 30.00 30.00 ADULTS & PEDI ATRICS 28,060,992 31.00 30.00 31.00 INTENSIVE CARE UNIT 4,477,751 4,477,751 4,477,751 31.00 31.00 31.00 INTENSIVE CARE UNIT 4,477,751 4,477,751 4,477,751 4.477,751 31.00 31.0					· ·		Rati o	
30.00			6. 00	7. 00	8. 00	9. 00	10.00	
31.00 03100 INTENSI VE CARE UNIT	IN	IPATIENT ROUTINE SERVICE COST CENTERS						
43.00	30. 00 03	3000 ADULTS & PEDI ATRI CS	28, 060, 992		28, 060, 992	2		30. 00
ANCILLARY SERVICE COST CENTERS SerVICE COST CENTERS Subtotal (see instructions) 160, 334, 935 427, 438, 504 587, 773, 439 SerVICE COST CONTERS Subtotal (see instructions) 160, 334, 935 427, 438, 504 587, 773, 439 SerVICE COST CENTERS Subtotal (see instructions) 160, 334, 935 427, 438, 504 587, 773, 439 SerVICE COST CONTERS Subtotal (see instructions) 160, 334, 935 427, 438, 504 587, 773, 439 SerVICE COST CENTERS Subtotal (see instructions) 201, 000, 000, 000, 000, 000, 000, 000,	31.00 03	3100 INTENSIVE CARE UNIT	4, 477, 751		4, 477, 75°			31.00
50.00			0		(43.00
50. 01 05.001 05.001 05.001 05.001 05.001 05.002 0	AN	ICI LLARY SERVI CE COST CENTERS						
50. 02 05002 AMBULATORY CARE UNIT 10, 749 7, 045, 258 7, 056, 007 0.719470 0.000000 50. 02 51. 00 05100 RECOVERY ROOM 838, 857 2, 385, 298 3, 224, 155 0.282793 0.000000 51. 00 53. 00 05300 ANESTHESI OLOGY 2, 293, 463 7, 606, 510 9, 899, 973 0.039768 0.000000 53. 00 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 20, 506, 238 93, 005, 915 113, 512, 153 0.084738 0.000000 54. 00 60. 00 06000 LABORATORY 15, 693, 541 50, 283, 884 65, 977, 425 0.137312 0.000000 65. 00 65000 RESPIRATORY THERAPY 9, 016, 054 3, 952, 810 12, 948, 864 0.176967 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 3, 324, 892 16, 539, 648 19, 864, 540 0.257901 0.000000 66. 00 66. 00 06900 ELECTROCARDI OLOGY 3, 333, 318 7, 173, 020 10, 506, 338 0.086176 0.000000 69. 01 06910 CATH LAB 7, 702, 016 9, 211, 977 16, 913, 993 0.114619 0.000000 69. 01 70. 00				69, 834, 638	93, 114, 054	0. 164270		
51. 00			2, 060, 627	13, 152, 776	15, 213, 403	0. 141584		
53. 00 05300 ANESTHESI OLOGY 2, 293, 463 7, 606, 510 9, 899, 973 0. 039768 0. 000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 20, 506, 238 93, 005, 915 113, 512, 153 0. 084738 0. 000000 54. 00 60. 00 06000 LABRATORY 15, 693, 541 50, 288, 884 65, 977, 425 0. 137312 0. 000000 65. 00 65. 00 06500 RESPI RATORY THERAPY 9, 016, 054 3, 952, 810 12, 968, 864 0. 176967 0. 000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 3, 324, 892 16, 539, 648 19, 864, 540 0. 257901 0. 000000 66. 00 69. 01 06901 CATH LAB 7, 702, 016 9, 211, 977 16, 913, 993 0. 114619 0. 000000 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0. 000000 0. 000000 0. 000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 8, 194 2, 380 10, 574 0. 004539 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0. 000000 0. 000000 72. 00 74. 00 07400 RENAL DI ALYSIS 1, 686, 080 141, 784 1, 827, 864 0. 180765 0. 000000 76. 01 75. 00 03480 CANCER CENTER 9, 592 48, 107, 545 48, 117, 137 0. 343910 0. 000000 76. 01 75. 00 09000 CLI NI C 50, 644 8, 905, 451 8, 956, 095 0. 197764 0. 000000 76. 01 75. 00 09000 CLI NI C 50, 644 8, 905, 451 8, 956, 095 0. 197764 0. 000000 76. 01 75. 00 09000 CLI NI C 50, 644 8, 905, 451 8, 956, 095 0. 197764 0. 000000 76. 01 75. 00 09000 CLI NI C 50, 644 8, 905, 451 8, 956, 095 0. 197764 0. 000000 76. 01 75. 00 09000 CLI NI C 50, 644 8, 905, 451 8, 956, 095 0. 197764 0. 000000 76. 01 75. 00 09000 CLI NI C 50, 644 8, 905, 451 8, 956, 095 0. 197764 0. 000000 0.			10, 749	7, 045, 258	7, 056, 00			
54. 00 05400 RADI OLOGY-DI AGNOSTI C 20, 506, 238 93, 005, 915 113, 512, 153 0.084738 0.000000 54. 00 60. 00 06000 LABORATORY 15, 693, 541 50, 283, 884 65, 977, 425 0.137312 0.000000 60. 00 60. 00 06500 RESPI RATORY THERAPY 9, 016, 054 3, 952, 810 12, 968, 864 0.176967 0.000000 65. 00 60. 00 06600 PHYSI CAL THERAPY 3, 324, 892 16, 539, 648 19, 864, 540 0.257901 0.000000 66. 00 69. 00 06900 ELECTROCARDI OLOGY 3, 333, 318 7, 173, 020 10, 506, 338 0.086176 0.000000 69. 00 69. 01 06901 CATH LAB 7, 702, 016 9, 211, 977 16, 913, 993 0.114619 0.000000 69. 00 71. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0.000000 0.000000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 8, 194 2, 380 10, 574 0.004539 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0.000000 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 26, 903, 070 36, 293, 552 63, 196, 622 0.107790 0.000000 73. 00 74. 00 07400 REMAL DI ALYSI S 1, 686, 080 141, 784 1, 827, 864 0.180765 0.000000 74. 00 76. 01 03480 CANCER CENTER 9, 592 48, 107, 545 48, 117, 137 0.343910 0.000000 76. 00 79. 00 09000 CLI NI C 50, 644 8, 905, 451 8, 956, 095 0.197764 0.000000 90. 00 791. 00 09200 DSERVATI ON BEDS (NON-DI STI NCT PART 2, 400, 478 7, 654, 127 10, 054, 605 0.825276 0.000000 91. 00 792. 00 09500 DSERVATI ON BEDS (NON-DI STI NCT PART 2, 400, 478 7, 654, 127 10, 054, 605 0.825276 0.000000 92. 00 791. 00 00 DSERVATI ON BEDS (NON-DI STI NCT PART 2, 400, 478 7, 654, 127 10, 054, 605 0.825276 0.000000 92. 00 792. 00 00 DSERVATI ON BEDS (NON-DI STI NCT PART 2, 400, 478 7, 654, 127 10, 054, 605 0.825276 0.000000 92. 00 792. 00 00 00 00 00 00 00 00								
60. 00 06000 LABORATORY 15, 693, 541 50, 283, 884 65, 977, 425 0. 137312 0. 000000 60. 00 65. 00 06500 RESPI RATORY THERAPY 9, 016, 054 3, 952, 810 12, 968, 864 0. 176967 0. 000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 3, 324, 892 16, 539, 648 19, 864, 540 0. 257901 0. 000000 66. 00 69. 01 06901 CATH LAB 7, 702, 016 9, 211, 977 16, 913, 993 0. 114619 0. 000000 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0. 000000 0. 000000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 8, 194 2, 380 10, 574 0. 004539 0. 000000 72. 00 73. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 0. 000000 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 26, 903, 070 36, 293, 552 63, 196, 622 0. 107790 0. 000000 73. 00 74. 00 07400 RENAL DI ALYSI S 1, 686, 080 141, 784 1, 827, 864 0. 180765 0. 000000 74. 00 76. 01 03480 CANCER CENTER 9, 592 48, 107, 545 48, 117, 137 0. 343910 0. 000000 76. 01 79. 00 09000 CLI NI C 50, 644 8, 905, 451 8, 956, 095 0. 197764 0. 000000 90. 00 79. 00 09000 DSERVATI ON BEDS (NON-DISTINCT PART 2, 400, 478 7, 654, 127 10, 054, 605 0. 825276 0. 000000 92. 00 79. 00 00000 DISTENSE 1300 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000			2, 293, 463					
65.00 06500 RESPIRATORY THERAPY 9, 016, 054 3, 952, 810 12, 968, 864 0. 176967 0. 000000 65.00 66.00 06600 PHYSI CAL THERAPY 3, 324, 892 16, 539, 648 19, 864, 540 0. 257901 0. 000000 66.00 69.00 06900 ELECTROCARDI OLOGY 3, 333, 318 7, 173, 020 10, 506, 338 0. 086176 0. 000000 69.00 70.00 06901 CATH LAB 7, 702, 016 9, 211, 977 16, 913, 993 0. 114619 0. 000000 69.00 71.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0. 000000 0. 000000 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 8, 194 2, 380 10, 574 0. 004539 0. 000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0. 000000 0. 000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 26, 903, 070 36, 293, 552 63, 196, 622 0. 107790 0. 000000 73.00 74.00 07400 RENAL DI ALYSI S 1, 686, 080 141, 784 1, 827, 864 0. 180765 0. 000000 74.00 76.01 03480 CANCER CENTER 9, 592 48, 107, 545 48, 117, 137 0. 343910 0. 000000 76.00 79.00 09000 CLI NI C 50, 644 8, 905, 451 8, 956, 095 0. 197764 0. 000000 76.00 79.00 09100 EMERGENCY 8, 678, 963 37, 952, 959 46, 631, 922 0. 187890 0. 000000 92.00 79.00 09200 OBSERVATION BEDS (NON-DI STI NCT PART 2, 400, 478 7, 654, 127 10, 054, 605 0. 825276 0. 000000 92.00 79.00 09100 EMERGEN COST CENTERS 0 8, 188, 972 8, 188, 972 8, 188, 972 113.00 79.00 00000 000000 0000000 0000000 000000			20, 506, 238	93, 005, 915	113, 512, 15		0.000000	
66. 00 06600 PHYSICAL THERAPY 3, 324, 892 16, 539, 648 19, 864, 540 0. 257901 0. 000000 66. 00 69. 00 6900 ELECTROCARDI OLOGY 3, 333, 318 7, 173, 020 10, 506, 338 0. 086176 0. 000000 69. 00 69. 01 06901 CATH LAB 7, 702, 016 9, 211, 977 16, 913, 993 0. 114619 0. 000000 69. 01 0. 000000 0. 000000 0. 000000 0. 000000			15, 693, 541	50, 283, 884	65, 977, 42!			
69. 00			9, 016, 054	3, 952, 810	12, 968, 864			
69. 01 06901 CATH LAB 7, 702, 016 9, 211, 977 16, 913, 993 0. 114619 0. 000000 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0. 000000 0. 000000 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 8, 194 2, 380 10, 574 0. 004539 0. 000000 71. 00 72. 00 1MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0. 000000 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 26, 903, 070 36, 293, 552 63, 196, 622 0. 107790 0. 000000 74. 00			3, 324, 892	16, 539, 648	19, 864, 540	0. 257901		
70. 00			3, 333, 318					
71. 00			7, 702, 016	9, 211, 977	16, 913, 993			
72. 00			0	0	(0.000000	70. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 26, 903, 070 36, 293, 552 63, 196, 622 0. 107790 0. 000000 73. 00 74. 00 07400 RENAL DI ALYSI S 1, 686, 080 141, 784 1, 827, 864 0. 180765 0. 000000 74. 00 03950 DI ABETI C EDUCATI ON 0 0 0 0. 000000 0. 000000 76. 00 03480 CANCER CENTER 9, 592 48, 107, 545 48, 117, 137 0. 343910 0. 000000 76. 01 000000 000000 0. 000000 0. 000000 000000	71. 00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 194	2, 380	10, 57	0. 004539	0.000000	71.00
74. 00			0	0				
76. 00			26, 903, 070	36, 293, 552	63, 196, 622			
76. 01 03480 CANCER CENTER 9, 592 48, 107, 545 48, 117, 137 0. 343910 0. 000000 76. 01 000000 00000 00000 00000 00000 00000 0000			1, 686, 080	141, 784	1, 827, 86	0. 180765	0.000000	74. 00
90. 00			0	0	(
90. 00			9, 592	48, 107, 545	48, 117, 13	0. 343910	0. 000000	76. 01
91. 00								
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 2,400,478 7,654,127 10,054,605 0.825276 0.000000 92.00			50, 644					
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11600	91.00 09	P100 EMERGENCY	8, 678, 963	37, 952, 959	46, 631, 922	0. 187890	0.000000	91.00
113. 00	92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART	2, 400, 478	7, 654, 127	10, 054, 60	0. 825276	0. 000000	92. 00
116. 00	SP	PECIAL PURPOSE COST CENTERS						
200.00 Subtotal (see instructions) 160,334,935 427,438,504 587,773,439 200.00 201.00 Less Observation Beds 200.00	113. 00 11	300 I NTEREST EXPENSE						113. 00
201.00 Less Observation Beds 201.00	116. 00 11	600 HOSPI CE	0	8, 188, 972	8, 188, 972	2		116. 00
	200. 00	Subtotal (see instructions)	160, 334, 935	427, 438, 504	587, 773, 439)		200.00
202.00 Total (see instructions) 160.334.935 427.438.504 587.773.439 202.00	201.00	Less Observation Beds						
202. 00 Total (See That det only) 100,001,700 127, 100,001 007,770, 107	202.00	Total (see instructions)	160, 334, 935	427, 438, 504	587, 773, 439)		202. 00

Heal th	Financial Systems	FHN MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0160	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/30/2024 4:4	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30. 00
31.00	03100 INTENSIVE CARE UNIT					31.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000				50.00
50. 01	05001 GI LAB	0. 000000				50. 01
50.02	05002 AMBULATORY CARE UNIT	0. 000000				50. 02
	05100 RECOVERY ROOM	0. 000000				51.00
53.00	05300 ANESTHESI OLOGY	0. 000000				53. 00
54 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00

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0.000000

0. 000000

60.00

65.00

66.00

69.00

69.01

70.00

71.00

72.00

73.00

74.00

76.00

76.01

90. 00 91. 00

92.00

113.00

116. 00

200.00

201.00

202. 00

60. 00 | 06000 | LABORATORY

06500 RESPIRATORY THERAPY

06600 PHYSI CAL THERAPY

70. 00 07000 ELECTROENCEPHALOGRAPHY

07400 RENAL DIALYSIS

03480 CANCER CENTER

09000 CLI NI C

113. 00 11300 INTEREST EXPENSE

91. 00 09100 EMERGENCY

116. 00 11600 HOSPI CE

03950 DIABETIC EDUCATION

07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS

09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

SPECIAL PURPOSE COST CENTERS

69. 00 06900 ELECTROCARDI OLOGY

06901 CATH LAB

65.00

66.00

69. 01

71.00

72. 00 73. 00

74.00

76.00

76. 01

90.00

92.00

200.00

201.00

202.00

Health Financial Systems	FHN MEMORIA	L HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023		narod:
				10 12/31/2023	5/30/2024 4: 4:	pareu. 2 pm
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	726, 356	0	726, 35	6 17, 980	40. 40	30. 00
31.00 INTENSIVE CARE UNIT	62, 145		62, 14	5 1, 286	48. 32	31. 00
43. 00 NURSERY	0			0 508	0.00	43.00
200.00 Total (lines 30 through 199)	788, 501		788, 50	1 19, 774		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days					
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	3, 888		•		ļ	30. 00
31.00 INTENSIVE CARE UNIT	189	9, 132	2		ļ	31. 00
43. 00 NURSERY	0	0)		ļ	43. 00
200.00 Total (lines 30 through 199)	4, 077	166, 207	1			200. 00

Health Financial Cystems	FUN MEMORIA	HOCDITAL		المانا	u of Form CMC (DEE2 10
Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	FHN MEMORIAI L COSTS	Provi der CO		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre 5/30/2024 4:4	pared:
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
ANOLLI ADV. CEDVI OF COCT. CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	/17 010	02 114 054	0.00//3	(572 250	42 574	
50.00 05000 OPERATI NG ROOM 50.01 05001 GLAB	617, 313				43, 574	1
	136, 539				6, 778 57	50. 01 50. 02
50. 02 05002 AMBULATORY CARE UNIT 51. 00 05100 RECOVERY ROOM	111, 936					50.02
53. 00 05300 ANESTHESI OLOGY	22, 059 68, 876				1, 317 3, 797	53.00
54. 00 05400 RADI OLOGY 54. 00 05400 RADI OLOGY 54. 00 05400 RADI OLOGY 54. 00 05400 RADI OLOGY 55. 00 05300 ANESTHEST OLOGY 56. 00 05300 ANESTHEST OLOGY 57. 00 05300 ANESTHEST OLOGY 58. 00 05300 ANESTHEST OLOGY 59. 00 05400 RADI OLOGY 59. 00 05400 RADI OLOGY 59. 00 05400 RADI OLOGY 59. 00 05400 RADI OLOGY 59. 00 05400 RADI OLOGY 59. 00 05400 RADI OLOGY 59. 00 05400 RADI OLOGY 59. 00 05400 RADI OLOGY 59. 00 05400 RADI OLOGY 59. 00 05400	627, 492		l .			54.00
60. 00 06000 LABORATORY	330, 794		l .		23, 102	60.00
65. 00 06500 RESPI RATORY THERAPY	108, 343				23, 102	65.00
66. 00 06600 PHYSI CAL THERAPY	190, 418				10, 426	
69. 00 06900 ELECTROCARDI OLOGY	84, 713				9, 738	1
69. 01 06901 CATH LAB	163, 116				19, 641	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	103, 110	10, 913, 993			19,041	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		10, 574			0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		10, 374	•		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	65, 355	·			7, 535	
74. 00 07400 RENAL DI ALYSI S	2, 907				959	
76. 00 03950 DI ABETI C EDUCATI ON	2, 193				0	76.00
76. 01 03480 CANCER CENTER	392, 750	l .			78	
OUTPATIENT SERVICE COST CENTERS	372, 730	1 40, 117, 137	0.00010	7, 372	70	70.01
90. 00 09000 CLINIC	33, 111	8, 956, 095	0.00369	7 37, 310	138	90.00
91. 00 09100 EMERGENCY	281, 737		l .			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	226, 672		l .		17, 114	
200.00 Total (Lines 50 through 199)	3, 466, 324		•	37, 606, 170		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			1		,	

Health Financial Systems	FHN MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST			Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 4:4	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•	<u> </u>		
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	ol	0		0 0	0	31. 00
43. 00 04300 NURSERY	0	0		0	0	43.00
200.00 Total (lines 30 through 199)		0		0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	,-			
		minus col. 4)				
	4, 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1			1		
30. 00 03000 ADULTS & PEDIATRICS	0	0	17, 98	0.00	3, 888	30.00
31. 00 03100 NTENSI VE CARE UNI T		0	1, 28			
43. 00 04300 NURSERY		0	50			1
200.00 Total (lines 30 through 199)		0	•			200.00
Cost Center Description	I npati ent		17,77	'	1,077	200.00
oost odifter beschiptron	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9, 00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 NTENSI VE CARE UNI T						31.00
43. 00 04300 NURSERY						43.00
I I						
200.00 Total (lines 30 through 199)	١					200. 00

Health Financial S	Systems		FHN MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTI ONMENT OF THROUGH COSTS	I NPATI ENT/OUTPATI ENT AF	NCILLARY SE	RVICE OTHER PASS	S Provider CO		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 5/30/2024 4:4	
				Title	: XVIII	Hospi tal	PPS	
Cost	Center Description		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health	

					5/30/2024 4: 4:	2 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0	(0	0	50. 00
50. 01 05001 GI LAB	0	0	(0	0	50. 01
50. 02 05002 AMBULATORY CARE UNIT	0	0	(0	0	50. 02
51.00 05100 RECOVERY ROOM	0	0	(0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0	0	(0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
60. 00 06000 LABORATORY	0	0	(0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
69. 01 06901 CATH_LAB	0	0	(0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
74.00 07400 RENAL DI ALYSI S	0	0	(0	0	74. 00
76. 00 03950 DI ABETI C EDUCATI ON	0	0	(0	0	76. 00
76. 01 03480 CANCER CENTER	0	0	(0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	(0	0	90. 00
91. 00 09100 EMERGENCY	0	0	(o	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		(0	92. 00
200.00 Total (lines 50 through 199)	0	0	(o o	0	200. 00

Health Financial Systems	FHN MEMORIAL	ΗΟςρι ΤΔΙ		In lie	eu of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SETTHROUGH COSTS				Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV	pared:
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCI LLARY SERVI CE COST CENTERS	_					
50.00 05000 OPERATING ROOM	0	0)	0 93, 114, 054		
50. 01 05001 GI LAB	0	0)	0 15, 213, 403		50. 01
50. 02 05002 AMBULATORY CARE UNIT	0	0)	0 7, 056, 007		
51. 00 05100 RECOVERY ROOM	0	0)	0 3, 224, 155		
53. 00 05300 ANESTHESI OLOGY	0	0)	0 9, 899, 973		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0 113, 512, 153		
60. 00 06000 LABORATORY	0	0)	0 65, 977, 425		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 12, 968, 864		
66. 00 06600 PHYSI CAL THERAPY	0	0)	0 19, 864, 540		
69. 00 06900 ELECTROCARDI OLOGY	0	0)	0 10, 506, 338		
69. 01 06901 CATH LAB	0	0)	0 16, 913, 993		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0)	0	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0 10, 574		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0 63, 196, 622		
74. 00 07400 RENAL DI ALYSI S	0	0)	0 1, 827, 864		
76. 00 03950 DI ABETI C EDUCATI ON	0	0)	0	0.000000	
76. 01 03480 CANCER CENTER	0	0)	0 48, 117, 137	0.000000	76. 01
OUTPAȚI ENT SERVI CE COST CENTERS						
90. 00 09000 CLI NI C	0	0	•	0 8, 956, 095		
91. 00 09100 EMERGENCY	0	0)	0 46, 631, 922		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0)	0 10, 054, 605		
200.00 Total (lines 50 through 199)	0	0)	0 547, 045, 724		200. 00

Health Financial Systems	FHN MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERTHROUGH COSTS	RVICE OTHER PASS	Provi der CO		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 5/30/2024 4:4	pared:
		Title	XVIII	Hospi tal	PPS	
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		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	6, 572, 259		14, 918, 629	0	
50. 01 05001 GI LAB	0. 000000	755, 232		2, 722, 582	0	50. 01
50. 02 05002 AMBULATORY CARE UNIT	0. 000000	3, 583		3, 157, 340	0	50. 02
51.00 05100 RECOVERY ROOM	0. 000000	192, 494		0 422, 073	0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	545, 726		1, 595, 326	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	6, 387, 248		16, 546, 937	0	54.00
60. 00 06000 LABORATORY	0. 000000	4, 607, 590		3, 459, 998	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	2, 777, 117		598, 335	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0.000000	1, 087, 601		1, 274, 827	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	1, 207, 689		2, 191, 602	0	69.00
69. 01 06901 CATH LAB	0. 000000	2, 036, 605		2, 701, 127	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	7, 287, 671		8, 765, 047	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000	603, 280		18, 983	0	74. 00
76.00 03950 DIABETIC EDUCATION	0. 000000	0		0	0	76. 00
76. 01 03480 CANCER CENTER	0. 000000	9, 592		15, 357, 632	0	76. 01
OUTPATIENT SERVICE COST CENTERS		·	<u>'</u>			
90. 00 09000 CLI NI C	0. 000000	37, 310		3, 777, 231	0	90.00
91. 00 09100 EMERGENCY	0. 000000	2, 736, 036		0 4, 585, 354	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	759, 137		1, 474, 146		92. 00
200.00 Total (lines 50 through 199)		37, 606, 170		83, 567, 169		200. 00
			•	•	-	•

Health Financial Systems	FHN MEMORIAL HO	OSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0160	Peri od:	Worksheet D

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	<u> </u>	Peri od: From 01/01/2023 To 12/31/2023		pared:
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
	1.00	0.00	(see inst.)	(see inst.)		
ANOLILIABLY OFFICE OFFICE	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0.4/4070	14 040 (00			0.450.700	
50. 00 05000 OPERATING ROOM	0. 164270			0	2, 450, 683	
50. 01 05001 GLAB	0. 141584			0	385, 474	
50. 02 05002 AMBULATORY CARE UNIT	0. 719470			3, 463	2, 271, 611	
51. 00 05100 RECOVERY ROOM	0. 282793			0	119, 359	
53. 00 05300 ANESTHESI OLOGY	0. 039768			0	63, 443	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 084738			0 610	1, 402, 154	•
60. 00 06000 LABORATORY	0. 137312			0	475, 099	•
65. 00 06500 RESPI RATORY THERAPY	0. 176967	1		0	105, 886	
66. 00 06600 PHYSI CAL THERAPY	0. 257901			0	328, 779	
69. 00 06900 ELECTROCARDI OLOGY	0. 086176			0	188, 863	
69. 01 06901 CATH LAB	0. 114619		(0	309, 600	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000		(0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 004539		(0	0	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000		(0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 107790			15, 960	944, 784	
74. 00 07400 RENAL DI ALYSI S	0. 180765		(0	3, 431	
76. 00 03950 DI ABETI C EDUCATI ON	0. 000000		(0	0	70.00
76. 01 03480 CANCER CENTER	0. 343910	15, 357, 632		19, 573	5, 281, 643	76. 01
OUTPATIENT SERVICE COST CENTERS			T			
90. 00 09000 CLI NI C	0. 197764			384	747, 000	
91. 00 09100 EMERGENCY	0. 187890			0	861, 542	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 825276			0	1, 216, 577	
200.00 Subtotal (see instructions)		83, 567, 169	(39, 990	17, 155, 928	
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges 202.00 Net Charges (line 200 - line 201)		83, 567, 169		39, 990	17, 155, 928	202. 00

Health Financial Systems	FHN MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH S	ERVICES AND VACCINE COST Provider CCI	From 01/01/2023	Worksheet D Part V Date/Time Prepared: 5/30/2024 4:42 pm
	Title	XVIII Hospi tal	PPS
	Costs		

					10 12/31/2023	5/30/2024 4:4	
			Titl∈	XVIII	Hospi tal	PPS	
		Cos	its				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)	-			
	ANOLILIADY OFFICE OFFICE	6.00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	Ü				50.00
	05001 GI LAB	0	0				50. 01
	05002 AMBULATORY CARE UNIT	0	2, 492				50. 02
	05100 RECOVERY ROOM	0	Ü				51.00
	05300 ANESTHESI OLOGY	0	0	1			53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	52				54.00
	06000 LABORATORY	0	0	1			60. 00
	06500 RESPI RATORY THERAPY	0	0	1			65. 00
	06600 PHYSI CAL THERAPY	0	0	1			66. 00
	06900 ELECTROCARDI OLOGY	0	0	1			69. 00
	06901 CATH LAB	0	0	1			69. 01
	07000 ELECTROENCEPHALOGRAPHY	0	0	1			70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1			71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1			72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 720	1			73. 00
	07400 RENAL DIALYSIS	0	0	1			74. 00
	03950 DI ABETI C EDUCATI ON	0	(704	1			76. 00
	03480 CANCER CENTER	0	6, 731				76. 01
	OUTPATIENT SERVICE COST CENTERS		7.				
	09000 CLI NI C	0	76	1			90.00
	09100 EMERGENCY	0	Ü				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	11 071	'[92. 00
200.00	Subtotal (see instructions)	0	11, 071				200. 00
201. 00	Less PBP Clinic Lab. Services-Program	0					201. 00
202.00	Only Charges (Line 200 Line 201)		11 071	-			202.00
202.00	Net Charges (line 200 - line 201)	ا ا	11, 071	[202. 00

Health Financial Systems	FHN MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-0160	Peri od: From 01/01/2023	Worksheet D-1	
			Date/Time Pre 5/30/2024 4:4	
	Title XVIII	Hospi tal	PPS	

		Title XVIII	Hospi tal	5/30/2024 4: 4: PPS	2 pm
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
1. 00 2. 00 3. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bed and observation bed days	ped and newborn days)	vate room days,	17, 980 17, 980 0	1. 00 2. 00 3. 00
4. 00 5. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room reporting period		31 of the cost	12, 369 0	4. 00 5. 00
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December :	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	m days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	0 1 0		3, 888	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	tions)		0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nter O on this line)	,	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	3 .	,	0	12.00
13. 00 14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter O on this line	e)	0	13. 00 14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	all (excluding swing-bed to	lays)	0	15. 00 16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	<u> </u>		0. 00	
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				
19. 00	reporting period				19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services reporting period		ne cost	0.00	
21. 00 22. 00	Total general inpatient routine service cost (see instructions $Swing$ -bed cost applicable to SNF type services through $December 5 \times Iine 17$)		ng period (line	26, 589, 638 0	21. 00 22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		0 26, 589, 638	26. 00 27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	26, 589, 638	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			4 470 05	20.00
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 478. 85	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	-		5, 749, 769	39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		0 5, 749, 769	40. 00 41. 00
			·		

	Financial Systems NTION OF INPATIENT OPERATING COST		Provi der (CN: 14 0160	Peri od:	TW 1 1 1 D 4	
			Trovider (JCN. 14-0100	From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre 5/30/2024 4:4	pared:
	Cost Center Description	Total Inpatient Cost	Total			PPS Program Cost (col. 3 x col.	
		1.00	2. 00	col. 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0		0 0.1			42. 00
	Intensive Care Type Inpatient Hospital Units				1		
44. 00 45. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	3, 201, 569	1, 28	6 2, 489.	56 189	470, 527	43. 00 44. 00 45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	Line 200)			1. 00 5, 594, 489	48. 00
	Program inpatient cellular therapy acquisiti			III, line 10,	column 1)	0,071,107	48. 01
	Total Program inpatient costs (sum of lines					11, 814, 785	49. 00
	PASS THROUGH COST ADJUSTMENTS					4// 007	
	Pass through costs applicable to Program inp III)	atient routine	services (fro	m Wkst. D, sur	m of Parts I and	166, 207	50.00
	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D, s	sum of Parts II	219, 294	51.00
1	and IV)						
	Total Program excludable cost (sum of lines		طع عمد المعادات	uoi oi on onco+l	notiot and	385, 501	1
	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		rated, non-pri	ysician anesti	ietist, and	11, 429, 284	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
	Program di scharges					0	
	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	1
	Adjustment amount per discharge (contractor	use only)				0.00	1
	Target amount (line 54 x sum of lines 55, 55					0.00	1
	Difference between adjusted inpatient operat			line 56 minus	line 53)	0	57. 00
	Bonus payment (see instructions)					0	
	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)		the cost rep	orting period	endi ng 1996,	0.00	59. 00
	Expected costs (lesser of line 53 ÷ line 54,		m prior year	cost report, (updated by the	0.00	60.00
61. 00	market basket) Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les	e 53 ÷ line 54	is less than	the lowest of	lines 55 plus	0	
	53) are less than expected costs (lines 54 x enter zero. (see instructions)					o	42.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ictions)			0	
I	PROGRAM INPATIENT ROUTINE SWING BED COST	•	,				
	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64. 00
	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	period (See	0	65. 00
	instructions)(title XVIII only)						
	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	I only); for	0	66.00
	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	eporting period	0	67. 00
	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after [ecember 31 of	the cost reno	orting period	0	68. 00
	(line 13 x line 20)			·	g por rod		
=	Total title V or XIX swing-bed NF inpatient PART III – SKILLED NURSING FACILITY, OTHER N					0	69. 00
	Skilled nursing facility/other nursing facil)		70.00
	Adjusted general inpatient routine service c						71.00
1	Program routine service cost (line 9 x line						72. 00
1	Medically necessary private room cost applic		•	,			73.00
	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II column		74. 00 75. 00
	26, line 45)	. 521.110 501 11 00	. 35515 (11011		, GOI umil		. 5. 55
1	Per diem capital-related costs (line 75 ÷ li	. *					76. 00
1	Program capital -related costs (line 9 x line	•					77.00
4	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	•	rovi der recor	ds)			78. 00 79. 00
4	Total Program routine service costs for comp				nus line 79)		80.00
81. 00	Inpatient routine service cost per diem limi	tati on					81.00
1	Inpatient routine service cost limitation (I		•				82.00
1	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		15)				83.00
	Program inpatient anciliary services (see in Utilization review – physician compensation		ons)				85.00
	Total Program inpatient operating costs (sum					<u> </u>	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					1_
-	Lotal observation had days (see instructions	:)				5, 611	87. 00
87. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			1, 478. 85	88. 00

Health Financial Systems FHN MEMORIAL HOSPITAL In Lieu of Form					u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC	Provider CCN: 14-0160		Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 4: 4:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	726, 356	26, 589, 638	0. 02731	7 8, 297, 827	226, 672	90.00
91.00 Nursing Program cost	0	26, 589, 638	0.00000	0 8, 297, 827	0	91.00
92.00 Allied health cost	0	26, 589, 638	0.00000	0 8, 297, 827	0	92.00
93.00 All other Medical Education	0	26, 589, 638	0.00000	0 8, 297, 827	0	93. 00

Health Financial Systems FHN MEMORIA		au 4 a4 a		u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 14-0160	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Pre 5/30/2024 4:4	pared:
	Title	e XVIII	Hospi tal	PPS	_ p
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	ŭ .	Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					4
30. 00 03000 ADULTS & PEDI ATRI CS			7, 003, 761		30.00
31. 00 03100 INTENSIVE CARE UNIT			975, 519		31.00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM		0.1(40	70 / 572 250	1 070 (25	
50.00 05000 0PERATING ROOM 50.01 05001 GI LAB		0. 16427 0. 14158			
50. 01 05001 GT LAB 50. 02 05002 AMBULATORY CARE UNIT		0. 14158			
51. 00 05100 RECOVERY ROOM		0. 7194		54, 436	
53. 00 05300 ANESTHESI OLOGY		0. 03976			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 08473			
60. 00 06000 LABORATORY		0. 1373			
65. 00 06500 RESPI RATORY THERAPY		0. 17696		491, 458	
66. 00 06600 PHYSI CAL THERAPY		0. 25790		280, 493	
59. 00 06900 ELECTROCARDI OLOGY		0. 08617	76 1, 207, 689	104, 074	69.00
69. 01 06901 CATH LAB		0. 1146		233, 434	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000	00	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 00453	39 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000	00	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 10779		785, 538	73.00
74.00 07400 RENAL DI ALYSI S		0. 18076		109, 052	
76.00 03950 DIABETIC EDUCATION		0.00000		0	
76. 01 03480 CANCER CENTER		0. 34391	9, 592	3, 299	76. 01
OUTPATIENT SERVICE COST CENTERS		1			4
90. 00 09000 CLI NI C		0. 19776			90.00
91. 00 09100 EMERGENCY		0. 18789			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 82527		626, 498	
Total (sum of lines 50 through 94 and 96 through 98)	(1: (4)		37, 606, 170	5, 594, 489	
201.00 Less PBP Clinic Laboratory Services-Program only char	rges (line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)		1	37, 606, 170		202. 00

	Title XVIII Hospital	5/30/2024 4: 4: PPS	2 pm
	DADT A LABATIENT HOODITAL CERVILOGO INDER LODG	1. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5, 727, 858	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2, 134, 825	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1. 04
2.00	Outlier payments for discharges. (see instructions)		2. 00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2. 01 2. 02
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	64, 442	2. 02
2. 04	Outlier payments for discharges occurring on or after October 1 (see instructions)	28, 907	2. 04
3.00	Managed Care Simulated Payments	0	3. 00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	84. 63	4. 00
F 00	Indirect Medical Education Adjustment	0.00	5. 00
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)	0.00	5.00
5. 01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5. 01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for	0.00	6. 00
. 2.	new programs in accordance with 42 CFR 413.79(e)	0.00	()(
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0. 00	6. 26
7. 00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the	0.00	7. 01
7 00	cost report straddles July 1, 2011 then see instructions.	0.00	7 00
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b)	0. 00	7. 02
	and 87 FR 49075 (August 10, 2022) (see instructions)		
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for	0.00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,		
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost	0.00	8. 01
0.01	report straddles July 1, 2011, see instructions.	0.00	0.01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital	0.00	8. 02
	under § 5506 of ACA. (see instructions)		
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0. 00	8. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or	0. 00	9. 00
10. 00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10. 00
11. 00	FTE count for residents in dental and podiatric programs.		11. 00
12. 00	Current year allowable FTE (see instructions)		12. 00
13. 00	Total allowable FTE count for the prior year.		13. 00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,	0. 00	14. 00
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.	0.00	15. 00
16. 00	Adjustment for residents in initial years of the program (see instructions)		16. 00
17. 00	Adjustment for residents displaced by program or hospital closure		17. 00
18. 00	Adjusted rolling average FTE count		18. 00
19. 00 20. 00	Current year resident to bed ratio (line 18 divided by line 4).	0. 000000 0. 000000	
21.00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)	0. 000000	
22. 00	IME payment adjustment (see instructions)	0.000000	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)	0	22. 01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA	0.00	
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 $(f)(1)(iv)(C)$.	0. 00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)	0.00	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see	0.00	
	instructions)		
26. 00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26. 00
27. 00 28. 00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)	0.000000	27. 00 28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)	Ö	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)	0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29. 01
20.00	Disproportionate Share Adjustment	4 75	20.00
30. 00 31. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days (see instructions)	4. 75 16. 27	30. 00 31. 00
32. 00	Sum of lines 30 and 31	21. 02	32. 00
33.00	Allowable disproportionate share percentage (see instructions)	6. 56	33. 00
34. 00	Disproportionate share adjustment (see instructions)	128, 948	34. 00

LCULATION OF RE	*	Provider CCN: 14-0160	Peri od:	Worksheet E	
			From 01/01/2023		
	Uncompensated Care Payment Adjustment Uncompensated Care Payment Adjustment Uncompensated Care Payment Adjustment Uncompensated Care amount (see instructions) Total uncompensated care amount (see instructions) Total uncompensated care amount (see instructions) Total uncompensated care amount (see instructions) Total uncompensated care amount (see instructions) Total uncompensated care amount (see instructions) Total uncompensated care amount (see instructions) Total uncompensated care amount (see instructions) Total uncompensated care amount (see instructions) Total uncompensated care amount (see instructions) Total uncompensated care amount (see instructions) Total uncompensated (see instructions) Total uncompensated (see instructions) Total uncompensated (see instructions) Total uncompensated (see instructions) Total uncompensated (see instructions) Total uncompensated (see instructions) Total uncompensated (see instructions) Total uncompensated (see instructions) Total uncompensated (see instructions) Total uncompensated (see instructions) Total uncompensated (see instructions) Total uncompensated (see instructions) Total uncompensated (see instructions) Total uncompensated (see instructions) Total uncompensated (see instructions) Total uncompensated (see instructions) Total uncompensate (see instructions) Total uncompensated (see instructions) Total uncompensated (see instructions) Total uncompensated (see instructions) Total uncompensate (see instructions) Total uncompensate (see instructions) Total uncompensate (see instructions) Total uncompensate (see instructions) Total uncompensate (see instructions) Total uncompensate (see instructions) Total uncompensate (see instructions) Total uncompensate (see instructions) Total uncompensate (see instructions) Total uncompensate (see instructions) Total uncompensate (see instructions) Total uncompensate (see instructions) Total uncompensate (see instructions) Total uncompensate (see instructions) Total uncompensate	PPS	z piii		
,				On/After 10/1	
				2. 00	
-					
1	•				
					1
	9 11	•			1
1		,			35. 36.
					30.
		grany areenarges (Tribes to time			40.
1	9 ,		0		41.
			0		41.
.00 Divide lin	e 41 by line 40 (if less than 10%, you do n	ot qualify for adjustment)	0.00		42.
1			0		43.
	/erage length of stay to one week (line 43	divided by line 41 divided by 7	0.000000		44.
	akly cost for dialysis treatments (see inst	ructions)	0.00		45.
, ,			0.00		46.
1	1 3 .		8, 738, 501		47.
,		d MDH, small rural hospitals		l .	48.
		<u>.</u>			
				Amount	
.00 Total paym	ent for innationt operating costs (see inst	ructions)		1. 00 8, 905, 419	49.
1 2	1 9 1	•	<i>i</i>)	593, 500	1
, ,				0	
				0	52.
. 00 Nursi ng an	d Allied Health Managed Care payment			0	53.
.00 Special ad	d-on payments for new technologies			28, 576	54.
1	. 3			0	
		, line 69)		0	
				0	
	,	•	through 2E)	0 0	
4			tili ougii 33).	0	
,		5, 11. 1V, cor. 11 1111e 200)		9, 527, 495	
,	9 ,			14, 699	1
.00 Total amou	nt payable for program beneficiaries (line	59 minus line 60)		9, 512, 796	61.
. 00 Deductible	s billed to program beneficiaries			1, 104, 868	62.
	1 3			83, 123	1
	,			244, 207	1
		'ann i natmusti an-\		158, 735	1
				197, 561	
			See instructions)	8, 483, 540 0	
	•	• •	•	0	1
	,		/	0	1
	· · · · · · · · · · · · · · · · · · ·	Demonstration) adjustment (see	e instructions)	0	
			,	0	
				0	1
				0	
					70.
1				87	
. 91 HSP bonus	•	ı ons)		-2, 582	
00 0 11 1	THE I RESCRIPT AMOUNT (SEE ENSTRUCTIONS)			0	
1	· · · · · · · · · · · · · · · · · · ·			4 440	70
. 93 HVBP payme	nt adjustment amount (see instructions)			4, 410 -119, 852	

Health Financial Systems	FHN MEMORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der (CCN: 14-0160	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Pre 5/30/2024 4:4	
	Ti tl	e XVIII	Hospi tal	PPS	
		FFY	(yyyy)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal			2024	581, 876	70. 96

				10 12/31/2023	5/30/2024 4: 4:	
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	n column 0	:	2024	581, 876	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or aft		:	2023	159, 651	70. 97
70. 98	Low Volume Payment-3	10/1/		0	0	70. 98
	HAC adjustment amount (see instructions)			-	Ō	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	59 & 70)			9, 107, 130	71.00
71. 01	Sequestration adjustment (see instructions)	,			182, 143	1
	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs					71. 03
72.00	Interim payments				8, 941, 720	72. 00
72. 01	Interim payments-PARHM					72. 01
73.00	Tentative settlement (for contractor use only)				0	73. 00
73. 01	Tentative settlement-PARHM (for contractor use only)					73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02 73)	2, 72, and			-16, 733	74. 00
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75.00	Protested amounts (nonallowable cost report items) in accordan	nce with			367, 036	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	of 2.03			0	90.00
	plus 2.04 (see instructions)					
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92. 00	Operating outlier reconciliation adjustment amount (see instru				0	92.00
	Capital outlier reconciliation adjustment amount (see instruct				0	93.00
94. 00	The rate used to calculate the time value of money (see instru	uctions)			0.00	1
95. 00	Time value of money for operating expenses (see instructions)				0	
96.00	Time value of money for capital related expenses (see instruct	(I ons)		Dust +- 10/1	0 /45+ 10 /1	96. 00
					On/After 10/1	
	HSP Bonus Payment Amount			1. 00	2. 00	
100 00	HSP bonus amount (see instructions)			124, 846	42, 072	100 00
100.00	HVBP Adjustment for HSP Bonus Payment			124, 040	42,072	100.00
101 00	HVBP adjustment factor (see instructions)			1. 0000000000	1. 0020655127	101 00
	HVBP adjustment amount for HSP bonus payment (see instructions	3)		0		102. 00
.02.00	HRR Adjustment for HSP Bonus Payment	-,			<u> </u>	1.02.00
103.00	HRR adjustment factor (see instructions)			0. 9807	0. 9959	103. 00
	HRR adjustment amount for HSP bonus payment (see instructions))		-2, 410		104.00
	Rural Community Hospital Demonstration Project (§410A Demonstr		stment			
200.00	Is this the first year of the current 5-year demonstration per					200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					
	Cost Reimbursement					
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	9 49)				201. 00
	Medicare discharges (see instructions)					202. 00
203. 00	Case-mix adjustment factor (see instructions)					203. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year	of the currer	nt 5-year demonst	tration	
	peri od)					
204.00	Medicare target amount					204. 00
	1					205.00
	Case-mix adjusted target amount (line 203 times line 204)					
	Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
206. 00	Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement					206. 00
206. 00 207. 00	Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr	,				206. 00 207. 00
206. 00 207. 00 208. 00	Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	,				206. 00 207. 00 208. 00
206. 00 207. 00 208. 00 209. 00	Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions payment to Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	,				206. 00 207. 00 208. 00 209. 00
206. 00 207. 00 208. 00 209. 00 210. 00	Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	,				206. 00 207. 00 208. 00 209. 00 210. 00
206. 00 207. 00 208. 00 209. 00 210. 00	Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	,				206. 00 207. 00 208. 00 209. 00
206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	line 59)				206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2	line 59)				206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00	Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2 Low-volume adjustment (see instructions)	line 59)	hursement)			206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00
206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00	Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2	line 59)	bursement)			206. 00 207. 00 208. 00 209. 00 210. 00 211. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2023 | Part A Exhibit 4 | To 12/31/2023 | Date/Time Prepared: | 5/30/2024 4:42 pm Provider CCN: 14-0160

						0 12/31/2023	5/30/2024 4: 4	
		W/C F D+ A	A		XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1.00	0	0	(0	1. 00
	payments			_				
1. 01	DRG amounts other than outlier payments for discharges	1. 01	5, 727, 858	0	5, 727, 858	3	5, 727, 858	1. 01
	occurring prior to October 1							
1.02	DRG amounts other than outlier	1. 02	2, 134, 825	0		2, 134, 825	2, 134, 825	1. 02
	payments for discharges							
	occurring on or after October							
1. 03	DRG for Federal specific	1. 03	0	0	()	0	1. 03
	operating payment for Model 4			J	Ì			
	BPCI occurring prior to							
1 04	October 1	1. 04		0				1 04
1. 04	DRG for Federal specific operating payment for Model 4	1.04	0	U		0	0	1. 04
	BPCI occurring on or after							
	October 1							
2.00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for	2. 02	0	0		0	0	2. 01
	discharges for Model 4 BPCI							
2.02	Outlier payments for	2. 03	64, 442	0	64, 442	2	64, 442	2. 02
	discharges occurring prior to October 1 (see instructions)							
2. 03	Outlier payments for	2. 04	28, 907	0		28, 907	28, 907	2. 03
	discharges occurring on or						•	
	after October 1 (see							
3. 00	instructions) Operating outlier	2. 01		0	(0	0	3.00
3.00	reconciliation	2.01		J		,		3.00
4.00	Managed care simulated	3. 00	0	0	(0	0	4. 00
	payments	L						_
5. 00	Indirect Medical Education Adju Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
0.00	A, line 21 (see instructions)	21.00	0.00000	0.000000	0.00000	0.00000		0.00
6.00	IME payment adjustment (see	22. 00	0	0	(0	0	6. 00
6. 01	instructions) IME payment adjustment for	22. 01		0	(0	0	6. 01
0.01	managed care (see	22.01		J		,		0.01
	instructions)							
7.00	Indirect Medical Education Adjustment factor	ustment for the		otion 422 of t 0.000000		0.000000		7 00
7. 00	(see instructions)	27.00	0. 000000	0.000000	0. 000000	0. 000000		7. 00
8.00	IME adjustment (see	28. 00	0	0	(0	0	8. 00
	instructions)							
8. 01	IME payment adjustment add on for managed care (see	28. 01	0	0	(0	0	8. 01
	instructions)							
9.00	Total IME payment (sum of	29. 00	0	0	(0	0	9. 00
	lines 6 and 8)							
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	(0	0	9. 01
	8. 01)							
	Di sproporti onate Share Adjustm							
10. 00	Allowable disproportionate	33.00	0. 0656	0. 0656	0. 0656	0. 0656		10.00
	share percentage (see instructions)							
11. 00	Di sproporti onate share	34.00	128, 948	0	93, 937	35, 011	128, 948	11. 00
	adjustment (see instructions)			_				
11. 01	Uncompensated care payments	36.00	653, 521	0	506, 867	146, 654	653, 521	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	rcentage of ESF	RD beneficiary of	di scharges 0		0	0	12. 00
. 2. 00	(see instructions)	.5. 55		J				.2. 55
13.00	Subtotal (see instructions)	47. 00	8, 738, 501	0	6, 393, 104		8, 738, 501	1
14. 00	Hospital specific payments	48. 00	8, 961, 058	0	6, 561, 448	2, 399, 610	8, 961, 058	14.00
	(completed by SCH and MDH, small rural hospitals only.)							
	(see instructions)							
15. 00	Total payment for inpatient	49. 00	8, 905, 419	0	6, 519, 362	2, 386, 057	8, 905, 419	15. 00
	operating costs (see							
16. 00	instructions) Payment for inpatient program	50. 00	593, 500	0	428, 243	165, 257	593, 500	16 00
	capital (from Wkst. L, Pt. I,	55.00	375, 550	J	120, 240	100, 207	75, 300	
	if applicable)							

						o 12/31/2023	Date/Time Pre 5/30/2024 4:4	pared:
				Title	XVIII	Hospi tal	PPS	2 piii
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3. 00	4. 00	5. 00	
17. 00	Special add-on payments for new technologies	54. 00	28, 576	0	28, 576	0	28, 576	17. 00
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from manufacturers for replaced	68. 00	0	0	C	0	0	17. 02
18. 00	devices for applicable MS-DRGs Capital outlier reconciliation	93. 00	0	0	С	0	0	18. 00
	adjustment amount (see instructions)							
19. 00	SUBTOTAL	W (C	(1)	0	6, 976, 181	2, 551, 314	9, 527, 495	19.00
		W/S L, line	(Amounts from L)					
	I	0	1. 00	2. 00	3.00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1.00	592, 031	0	120,		592, 031	1
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0	0	
21. 00	Capital DRG outlier payments	2. 00	1, 469	0	1, 469	0	1, 469	1
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	C	O	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.0000	0. 0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0	C	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0.0000	0. 0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0	С	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	593, 500	0	428, 243	165, 257	593, 500	26. 00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
	1	0	1.00	2. 00	3. 00	4. 00	5. 00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 083409 581, 876		581, 876	27. 00 28. 00
29. 00	(transfer amount to Wkst. E,	70. 97				159, 651	159, 651	29. 00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Provider CCN: 14-0160 Peri od: Worksheet E From 01/01/2023 Part A Exhibit 5 Date/Time Prepared: 12/31/2023 5/30/2024 4:42 pm Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 5, 727, 858 5, 727, 858 5, 727, 858 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 2, 134, 825 2. 134. 825 2, 134, 825 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 C 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 O 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 64 442 64 442 64 442 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 28, 907 28, 907 28, 907 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 C 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.0656 0.0656 0.0656 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 128.948 93. 937 35.011 128.948 11.00 instructions) 11.01 Uncompensated care payments 36 00 653, 521 524, 782 196, 521 721, 303 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 2, 395, 264 13 00 8, 738, 501 6, 343, 237 8, 738, 501 Subtotal (see instructions) 13 00 14.00 Hospital specific payments (completed by SCH 48.00 8, 961, 058 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 8, 905, 419 6, 510, 155 2, 395, 264 8, 905, 419 15.00 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50 00 593, 500 428, 243 165, 257 593, 500 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 28, 576 28, 576 28, 576 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 0 replaced devices for applicable MS-DRGs

93.00

6, 966, 974

2, 560, 521

0 18.00

9, 527, 495 19. 00

18.00

19.00

SUBTOTAL

Capital outlier reconciliation adjustment

amount (see instructions)

Heal th	Financial Systems	FHN MEMORIA	L HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5		F	Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 4:4	pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1.00	592, 031	426, 774	165, 257	592, 031	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	(0	0	20. 01
21.00	Capital DRG outlier payments	2.00	1, 469	1, 469	0	1, 469	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0.0000	0.0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	(0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0. 0000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	0	(0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	593, 500	428, 243	165, 257	593, 500	26. 00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3. 00	4. 00	
27. 00							27. 00
28.00	Low volume adjustment prior to October 1	70. 96	581, 876	581, 876	b	581, 876	28. 00
29. 00	Low volume adjustment on or after October 1	70. 97	159, 651		159, 651	159, 651	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	4, 410	(4, 410	4, 410	30. 00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	87		87	87	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-119, 852	-111, 099	-8, 753	-119, 852	31.00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	-2, 582	-2, 410	-172	-2, 582	31. 01

0

70. 99

(Amt. to Wkst. E, Pt. A) 4.00

0 32.00

100.00

3. 00

0

2.00

0

1.00

Ν

instructions)

32.00 HAC Reduction Program adjustment (see

instructions)

100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

Health Financial Systems	FHN MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-0160	From 01/01/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 4:42 pm
	T1 11 30 (11)		200

		Title XVIII	Hospi tal	5/30/2024 4: 4: PPS	2 pm
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructi	ons)		11, 071 17, 155, 928	1. 00 2. 00
3. 00	OPPS or REH payments	0113)		12, 308, 201	3. 00
4. 00	Outlier payment (see instructions)			137, 453	4. 00
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instruct	ions)		0 0. 822	4. 01 5. 00
6. 00	Line 2 times line 5	10115)		14, 102, 173	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			88. 25	7. 00
8.00	Transitional corridor payment (see instructions)	araduata madical aduar	ation costs from	0	8.00
9. 00	Ancillary service other pass through costs including REH direct Wkst. D, Pt. IV, col. 13, line 200	graduate medicar educa	ation costs from	U	9. 00
10.00	Organ acqui si ti ons			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			11, 071	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12.00	Ancillary service charges			39, 990	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			39, 990	14. 00
15. 00	Aggregate amount actually collected from patients liable for pa	yment for services on a	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for	payment for services or		0	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)			0. 000000	17 00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			39, 990	17. 00 18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds lir	ne 11) (see	28, 919	19. 00
00.00	instructions)		10) (00.00
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	IT line II exceeds IIr	ne 18) (see	0	20. 00
21. 00	Lesser of cost or charges (see instructions)			11, 071	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instru Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ctions)		0 12, 445, 654	23. 00 24. 00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			12, 445, 054	24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line	•		2, 169, 093	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plinstructions)	us the sum of lines 22	and 23] (see	10, 287, 632	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
28. 50	REH facility payment amount (see instructions)			_	28. 50
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27, 28, 28.50 and 29)			0 10, 287, 632	29. 00 30. 00
31. 00	Primary payer payments			98	31.00
32.00	Subtotal (line 30 minus line 31)			10, 287, 534	32. 00
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE Composite rate ESRD (from Wkst. I-5, line 11)	S)		0	33. 00
33. 00 34. 00	Allowable bad debts (see instructions)			279, 772	
35. 00	Adjusted reimbursable bad debts (see instructions)			181, 852	
36. 00		ctions)		217, 634	
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			10, 469, 386 0	37. 00 38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replace	d devices (see instruct	tions)	0	39. 97 39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	(300 1113 ti dot		0	39. 99
40.00	Subtotal (see instructions)			10, 469, 386	•
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			209, 388 0	40. 01 40. 02
40. 02	Sequestration adjustment-PARHM pass-throughs			O	40. 02
41. 00	Interim payments			10, 325, 198	
41. 01	Interim payments-PARHM				41. 01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42. 00 42. 01
43. 00	Balance due provider/program (see instructions)			-65, 200	43. 00
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2, o	chapter 1,	226, 970	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90. 00
91.00	1			0	91.00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92. 00 93. 00
	1 va. as or moriey (300 riistractions)			0	, , , , , , ,

Health Financial Systems	FHN MEMORIAL HO	OSPI TAL	In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0160	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	pared:
				5/30/2024 4:4	2 pm
		Title XVIII	Hospi tal	PPS	
				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

Provider CCN: 14-0160

					5/30/2024 4: 42	2 pm
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		8, 993, 82	3	10, 381, 537	1. 00
2.00	Interim payments payable on individual bills, either			O	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
0.04	Program to Provider					0.04
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				-	0	3. 02
3.03				O	0	3. 03
3. 04				0	0 0	3. 04
3. 05	Provider to Program			J	0	3. 05
3. 50	ADJUSTMENTS TO PROGRAM	09/07/2023	52, 10	3 09/07/2023	56, 339	3. 50
3. 51	ADJUSTIMENTS TO FROGRAM	04/01/2023	· ·	0 0 9 7 0 7 7 2 0 2 3	0	3. 51
3. 52				0		3. 52
3. 53				0		3. 53
3. 54				o o	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		-52, 10	~	-56, 339	3. 99
0. 77	3. 50-3. 98)		02, 10		00,007	0. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		8, 941, 72	O	10, 325, 198	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)					
E 04	Program to Provider					E 04
5. 01	TENTATI VE TO PROVI DER			O	0 0	5. 01 5. 02
5. 02 5. 03				0	0	5. 02
5.03	Provider to Program		'	J	0	5. 03
5. 50	TENTATI VE TO PROGRAM			o	0	5. 50
5. 51	TENTATI VE TO TROOKAW			0	l ől	5. 51
5. 52				Ö	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER			O	0	6. 01
6.02	SETTLEMENT TO PROGRAM		16, 73	3	65, 200	6. 02
7.00	Total Medicare program liability (see instructions)		8, 924, 98	7	10, 259, 998	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractors)	1. 00	2. 00	0.00
8. 00	Name of Contractor					8. 00

Health Financial Systems FHN MEMORIAL HOSPITAL In Lieu					2552-10			
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0160	Peri od: From 01/01/2023	Worksheet E-1	I			
	To 12/31/2023 D							
		Title XVIII	Hospi tal	PPS				
				1. 00				
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS							
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1.00			
	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14							
2.00 Medicare days (see instructions)								
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00			
4.00	Total inpatient days (see instructions)				4. 00			
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00			
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I				6. 00			
7. 00	CAH only - The reasonable cost incurred for the purchase of c	ertified 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			
10. 00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)							
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH							
	Initial/interim HIT payment adjustment (see instructions)				30. 00			
	Other Adjustment (specify)				31. 00 32. 00			
32. 00	32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)							

Health Financial Systems FHN MEMORIAL HOSPITAL In Lieu				u of Form CMS-2	552-10
OUTLI E	Worksheet E-5				
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	nstructions)	0	1.00		
2.00 Capital outlier from Wkst. L, Pt. I, line 2					2.00
3.00 Operating outlier reconciliation adjustment amount (see instructions)					3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)					4.00
5.00 The rate used to calculate the time value of money (see instructions)					5.00
6.00		0	6.00		
6.00 Time value of money for operating expenses (see instructions) 7.00 Time value of money for capital related expenses (see instructions)					7.00

FHN MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

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

Provider CCN: 14-0160

| Period: | Worksheet G | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/30/2024 4:42 pm |

oni y)			'	0 12/01/2020	5/30/2024 4: 4	2 pm
		General Fund	Speci fi c	Endowment Fund		
			Purpose Fund			
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	32, 809, 933	0	0	0	1. 00
2.00	Temporary investments	8, 770, 624	0	0	0	2. 00
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts receivable	22, 323, 420	0	0	0	4.00
5.00	Other recei vable	2, 540, 996	1	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	•
7. 00	Inventory	0	0	0	0	•
8.00	Prepaid expenses	1	0	0	0	
9. 00	Other current assets	5, 780, 576	l ő	0	0	9. 00
10. 00	Due from other funds	3, 700, 370	0	o	0	1
11. 00		72 225 540	_	1	0	11. 00
11.00	Total current assets (sum of lines 1-10) FIXED ASSETS	72, 225, 549	1 0	U	U	11.00
12 00				٥	0	12.00
12.00	Land	0			0	•
13.00	Land improvements	0	_	· ·	0	
14.00	Accumulated depreciation	0	0	0	0	
15. 00	Bui I di ngs	18, 738, 646	0	0	0	15. 00
16. 00	Accumulated depreciation	0	0	0	0	16. 00
17. 00	Leasehold improvements	0	0	0	0	17. 00
18. 00	Accumul ated depreciation	0	0	0	0	18. 00
19. 00	Fi xed equi pment	0	0	0	0	19. 00
20.00	Accumul ated depreciation	0	0	0	0	20. 00
21.00	Automobiles and trucks	0	0	0	0	21. 00
22.00	Accumul ated depreciation	0	0	0	0	22. 00
23.00	Major movable equipment	0	0	0	0	23. 00
24.00	Accumul ated depreciation	0	0	O	0	24. 00
25.00	Mi nor equi pment depreci able	0	0	0	0	25. 00
26.00	Accumulated depreciation	l o	0	o	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	1	o o	o	0	•
30.00	Total fixed assets (sum of lines 12-29)	18, 738, 646	_	· ·		
30.00	OTHER ASSETS	10, 730, 040	1 0	<u> </u>	0	30.00
31. 00	Investments	7, 300, 051	0	0	0	31. 00
32. 00	Deposits on Leases	7, 300, 031	0	0	0	32.00
33. 00	Due from owners/officers			0	0	1
		2 4/0 212		0		1
34. 00	Other assets	3, 460, 312	1	U	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	10, 760, 363	1	0	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	101, 724, 558	0	0	0	36. 00
	CURRENT LI ABI LI TI ES	500 700				
37. 00	Accounts payable	503, 788	1		0	•
38. 00	Salaries, wages, and fees payable	5, 471, 774	0	0	0	
39. 00	Payroll taxes payable	0	0	0	0	•
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	Accel erated payments	0	1			42. 00
43.00	Due to other funds	0	0	0	0	43. 00
44.00	Other current liabilities	19, 200, 249	0	0	0	44. 00
45.00	Total current liabilities (sum of lines 37 thru 44)	25, 175, 811	0	0	0	45. 00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	0	0	0	0	47. 00
48.00	Unsecured Loans	l o	0	o	0	48. 00
49.00	Other long term liabilities	5, 948, 952	0	0	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	5, 948, 952	1	1		
51.00	Total liabilities (sum of lines 45 and 50)	31, 124, 763	1			1
01.00	CAPITAL ACCOUNTS	01, 121, 100	·	<u> </u>	U	01.00
52. 00	General fund balance	70, 599, 795				52.00
53. 00	Specific purpose fund	10, 377, 173	l o			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				_	56.00
57. 00	Plant fund balance - invested in plant				0	•
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
FO 00	replacement, and expansion	70 500 555	_	_	_	F0 00
59. 00	Total fund balances (sum of lines 52 thru 58)	70, 599, 795	1	0	0	•
60. 00	Total liabilities and fund balances (sum of lines 51 and	101, 724, 558	0	이	0	60. 00
	[59]	I	I			l

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES FHN MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Period: Worksheet G-1
From 01/01/2023 Provider CCN: 14-0160

					To	12/31/2023	Date/Time Pre 5/30/2024 4:4	pared: 2 pm
		General	Fund	Speci al	Pu	rpose Fund	Endowment Fund	
		1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		76, 806, 462			0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		22, 376, 160 99, 182, 622			0		2. 00 3. 00
4. 00	PRIOR PERIOD ADJ	-673, 338	77, 102, 022		0	O	О	4. 00
5.00		0			0		0	5. 00
6.00		0			0		0	6.00
7. 00 8. 00					0		0	7. 00 8. 00
9. 00		o			0		Ö	9. 00
10.00	Total additions (sum of line 4-9)		-673, 338			0	l	10. 00
11.00	Subtotal (line 3 plus line 10)	07.045.400	98, 509, 284			0	l	11.00
12. 00 13. 00	TRANSFER TO AFFILIATE	27, 945, 489			0		0	12. 00 13. 00
14. 00		0			0		Ö	14. 00
15. 00		0			0		0	15. 00
16.00		0			0		0	16.00
17. 00 18. 00	Total deductions (sum of lines 12-17)	٥	27, 945, 489		U	0	0	17. 00 18. 00
19. 00	Fund balance at end of period per balance		70, 563, 795			0	l .	19. 00
	sheet (line 11 minus line 18)		DI I					
		Endowment Fund	PI ant	Funa				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)				0			2. 00 3. 00
4. 00	PRIOR PERIOD ADJ		0		Ŭ			4. 00
5.00			0					5. 00
6. 00 7. 00			0					6. 00 7. 00
8. 00			0					8. 00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) TRANSFER TO AFFILIATE	0	0		0			11. 00 12. 00
13. 00	TRANSFER TO AFFILIATE		0					13. 00
14. 00			O					14. 00
15.00			0					15. 00
16. 00 17. 00			0					16. 00 17. 00
18. 00	Total deductions (sum of lines 12-17)	0	U		0			18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	o			0			19. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-0160

			0 12/31/2023	5/30/2024 4:4	
	Cost Center Description	I npati ent	Outpati ent	Total	
	'	1.00	2. 00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	49, 987, 163	3	49, 987, 163	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF			0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	49, 987, 163	3	49, 987, 163	
	Intensive Care Type Inpatient Hospital Services	11/101/101		,,	
11. 00	INTENSIVE CARE UNIT	4, 743, 010)	4, 743, 010	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	4, 743, 010		4, 743, 010	16. 00
10.00	11-15)	1, 710, 010	1	1, 7 10, 010	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	54, 730, 173		54, 730, 173	17. 00
18. 00	Ancillary services	121, 306, 919		510, 596, 787	18. 00
19. 00	Outpati ent servi ces	11, 634, 040		75, 004, 114	19.00
20. 00	RURAL HEALTH CLINIC	11,001,010	1	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		´l	0	21. 00
22. 00	HOME HEALTH AGENCY		ĺ	O	22. 00
23. 00	AMBULANCE SERVI CES				23. 00
24. 00	CMHC				24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE		8, 188, 972	8, 188, 972	26.00
27. 00	OTHER (SPECIFY)		0, 100, 772	0, 100, 772	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	187, 671, 132	460, 848, 914	648, 520, 046	28. 00
20.00	G-3, line 1)	107, 071, 132	400, 040, 714	040, 320, 040	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		146, 076, 220		29. 00
30.00	ADD (SPECIFY)				30.00
31. 00	(SI EOTT I)				31. 00
32. 00					32.00
33. 00		1	ó		33. 00
34. 00					34. 00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)	`	ĺ		36.00
37. 00	DEDUCT (SPECIFY)		J		37. 00
38. 00	DEDUCT (SPECITI)		1		38.00
39. 00			1		39. 00
40. 00					40. 00
41. 00					41.00
42.00	Total deductions (sum of lines 37-41)		<u></u>		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	or	146, 076, 220		42.00
43.00	to Wkst. G-3, line 4)	C.	140, 070, 220		43.00
	TO HIGH, U.O. TITIC 4)	į.	1		I

	Financial Systems FHN MEMORIAL MENT OF REVENUES AND EXPENSES	Provider CCN: 14-0160	Period:	u of Form CMS-2 Worksheet G-3	
SIAIL	IENT OF REVENUES AND EXTENSES	Trovider cent. 14 0100	From 01/01/2023		
			To 12/31/2023	Date/Time Pre 5/30/2024 4:4	
	· · · · · · · · · · · · · · · · · · ·			37 307 2024 4. 4.	Z DIII
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li			648, 520, 046	
2.00	Less contractual allowances and discounts on patients' accou	nts		493, 623, 729	
3.00	Net patient revenues (line 1 minus line 2)			154, 896, 317	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		146, 076, 220	4. 00
5. 00	Net income from service to patients (line 3 minus line 4)			8, 820, 097	5. 00
/ 00	OTHER I NCOME			// 25/	/ 00
6.00	Contributions, donations, bequests, etc			66, 254	6.00
7. 00 8. 00	Income from investments Revenues from telephone and other miscellaneous communicatio	n corvi coc		1, 770, 941 0	7. 00 8. 00
9.00	Revenue from television and radio service	II sel vi ces		0	9.00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11.00
12. 00	Parking Lot receipts			0	12.00
13. 00				0	13. 00
14. 00	1 · · · · · · · · · · · · · · · · · · ·			0	14. 00
15. 00	Revenue from rental of living quarters			0	15. 00
16. 00	9 .	than patients		0	16. 00
17. 00		•		0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23.00				0	23. 00
24. 00				191, 465	
24. 01	MEDICALD ASSESSMENT REV			10, 399, 946	
24. 02				6, 000	
24. 03				18, 514	
24. 04	NET ASSETS RELEASED			1, 102, 943	•
	COVI D-19 PHE Funding			12.554.043	24. 50
	Total other income (sum of lines 6-24)			13, 556, 063	
26. 00 27. 00				22, 376, 160	26. 00 27. 00
	Total other expenses (sum of line 27 and subscripts)			0	28.00
	Net income (or loss) for the period (line 26 minus line 28)			22, 376, 160	
27.00	The tricome (or 1033) for the period (trie 20 illinus fille 20)		ı	22, 370, 100	27.00

			·			5/30/2024 4: 4	2 pm
		SALARI ES	OTHER	SUBTOTAL (col. 1 plus col. 2)	Hospi ce I RECLASSI FI - CATI ONS	SUBTOTAL	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	CAP REL COSTS-BLDG & FIXT*		0		0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	10, 897		0	10, 897	3. 00
4.00	ADMINISTRATIVE & GENERAL*	0	105, 539		0	105, 539	4. 00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5. 00
6. 00 7. 00	LAUNDRY & LINEN SERVICE* HOUSEKEEPING*		0	0	0	0	6. 00 7. 00
8. 00	DI ETARY*		0	0	0	0	8. 00
9. 00	NURSING ADMINISTRATION*		0		0	0	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES*		51		0	51	10. 00
11. 00	MEDI CAL RECORDS*		0	0	0	0	11. 00
12. 00	STAFF TRANSPORTATION*	0	46, 309	_	0	46, 309	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION*	59, 627	0	59, 627	o	59, 627	13. 00
14. 00	PHARMACY*	0	158, 327		Ö	158, 327	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15. 00
16.00	OTHER GENERAL SERVICE*	242, 835	0	242, 835	O	242, 835	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00	INPATIENT CARE-CONTRACTED**		0		0	0	25. 00
26. 00	PHYSI CI AN SERVI CES**	0	0	0	0	0	26. 00
27. 00	NURSE PRACTITIONER**	126, 974	00/ /55	126, 974	0	126, 974	27. 00
28. 00	REGI STERED NURSE**	642, 624	906, 655		0	1, 549, 279	28. 00
29. 00 30. 00	LPN/LVN**	110, 489	0	110, 489	U	110, 489	29. 00
31. 00	PHYSI CAL THERAPY** OCCUPATI ONAL THERAPY**		0		0	0	30. 00 31. 00
32. 00	SPEECH/LANGUAGE PATHOLOGY**		0		0	0	32. 00
33. 00	MEDICAL SOCIAL SERVICES**	145, 704	0	145, 704	0	145, 704	33. 00
34. 00	SPIRITUAL COUNSELING**	0	Ö	0	o	0	34.00
35. 00	DI ETARY COUNSELI NG**	0	0	o o	o	0	35. 00
36. 00	COUNSELING - OTHER**	0	0	0	o	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0	0	0	0	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	28, 656	28, 656	0	28, 656	38. 00
39.00	PATI ENT TRANSPORTATION**	0	17, 300	17, 300	0	17, 300	39. 00
40.00	I MAGI NG SERVI CES**	0	0	0	0	0	40. 00
41. 00	LABS & DI AGNOSTI CS**	0	0	0	0	0	41. 00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0	0	0	0	42. 00
42. 50	DRUGS CHARGED TO PATI ENTS**	0	0	0	0	0	42. 50
43. 00	OUTPATIENT SERVICES**	0	0	0	0	0	43. 00
44.00	PALLIATIVE RADIATION THERAPY**	0	Ü	0	0	0	44.00
45. 00 46. 00	PALLIATIVE CHEMOTHERAPY**		0	0	O O	0	45. 00
40.00	OTHER PATIENT CARE SERVICES (SPECIFY)** NONREIMBURSABLE COST CENTERS	J O		<u> </u>	U _I	0	46. 00
60. 00	BEREAVEMENT PROGRAM *	l	0	0	ol	0	60.00
61. 00	VOLUNTEER PROGRAM *	i o	Ö	o o	o	0	61. 00
62. 00	FUNDRAI SI NG*	0	0	o o	o	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	o	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	o	0	0	o	0	1
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	o	0	65. 00
66.00	RESI DENTI AL CARE*	0	0	0	O	0	66. 00
	ADVERTI SI NG*	0	0	0	0	0	
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	0	0	0	0	
69. 00	THRI FT STORE*	0	0	0	0	0	
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*	1 220 252	1 272 724	0 2 401 007	0	0 2 401 007	71.00
100.00	TOTAL	1, 328, 253	1, 273, 734	2, 601, 987	0	2, 601, 987	100.00

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate. ** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

### ADJUSTMENTS TOTAL (cal. 5 100 6.00 7.00						Hospi ce I	
CAP REL COSTS -BLOG R FLXT"			ADJUSTMENTS				
GENERAL SERVICE COST CENTERS			4.00		-		
1.00 CAP REL COSTS-BLOCK FIXT* 0 0 2.00 3.00 3.00 4.00 3.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 3.00 4.00 4.00 3.00 4.00		CENEDAL SERVICE COST CENTERS	6.00	7.00			
2.00 CAP REL COSTS-AWELE EQUIP* 0 10, 897 3.00 4.00 ADMINISTRATIVE & GENERAL* 0 105, 539 4.00 4.00 ADMINISTRATIVE & GENERAL* 0 105, 539 4.00 5.00 PLANT OPERATION & MAINTENANCE* 0 0 0 0 6.00 6.00 LAUNDRY & LIKEN SERVICE* 0 0 0 0 0 6.00 6.00 LAUNDRY & LIKEN SERVICE* 0 0 0 0 0 6.00 6.00 URSING SERVICES* 0 0 0 0 0 6.00 6.00 URSING ADMINISTRATION* 0 0 0 0 6.00 6.00 URSING ADMINISTRATION* 0 0 0 0 1.10.00 6.00 URSING ADMINISTRATION* 0 15, 399 12.00 6.00 URSING ADMINISTRATION* 0 15, 397 1.10.00 6.10 OPHARMACY* 1 1.00	1 00		O	0			1 00
SMPLOYCE BENEFITS DEPARTMENT* 0 10,897 3.00					•		
DIANT OPERATION & MAINTERMANCE*	3.00	EMPLOYEE BENEFITS DEPARTMENT*	o	10, 897			3. 00
ALMINERY & LINEN SERVICE*	4.00	ADMINISTRATIVE & GENERAL*	o	105, 539			4. 00
7.00 HOUSEKEEPING* 0 0 0 0 8.00 9.00 NURSING ADMINISTRATION* 0 0 0 0 9.00 NURSING ADMINISTRATION* 0 0 0 9.00 NURSING ADMINISTRATION* 0 0 0 11.00 MEDICAL RECORDS* 0 0 0 11.00 MEDICAL RECORDS* 0 0 0 11.00 MEDICAL RECORDS* 0 0 0 13.00 VOLUNTEER SERVICE COORDINATION* 0 46,309 112,00 13.00 VOLUNTEER SERVICE COORDINATION* 0 59,627 13.00 15.00 PHYSICIAN ARMINISTRATIVE SERVICES* 0 0 0 15.00 PHYSICIAN ARMINISTRATIVE SERVICES* 0 0 0 16.00 OTHER GENERAL SERVICE COST CENTERS 16.00 17.00 DIRECT PARTIENT CARE SERVICE COST CENTERS 17.00 18.00 DIRECT PARTIENT CARE SERVICE COST CENTERS 0 0 25.00 DIRECT PARTIENT CARE SERVICE COST CENTERS 0 0 27.00 MIRSS PRACTITIONER* 0 126,974 27,000 28.00 PHYSICIAN SERVICE* 0 0 15,49,279 27,000 29.00 PHYSICIAN SERVICES* 0 0 15,49,279 27,000 29.00 PHYSICIAN SERVICES* 0 0 15,49,279 27,000 29.00 PHYSICIAN SERVICES* 0 0 0 0 0 20.00 PHYSICIAN SERVICES* 0 0 0 0 0 20.00 OURSELING* 0 0 0 0 0 0 20.00 PHYSICIAN SERVICES* 0 0 0 0 0 0 20.00 PHYSICIAN SERVICES* 0 0 0 0 0 0 20.00 PHYSICIAN SERVICES* 0 0 0 0 0 0 20.00 PHYSICIAN SERVICES* 0 0 0 0 0 0 20.00 PHYSICIAN SERVICES* 0 0 0 0 0 0 20.00 PHYSICIAN SERVICES* 0 0 0 0 0 0 0 20.00 PHYSICIAN SERVICES* 0 0 0 0 0 0 0 20.00 PHYSICIAN SERVICES* 0 0 0 0 0 0 0 20.00 PHYSICIAN SERVICES* 0 0 0 0 0 0 0 20.00 PHYSICIAN SERVICES* 0 0 0 0 0 0 0 20.00 PHYSICIAN SERVICES* 0 0 0 0 0 0 0 20.00 PHYSICIAN SERVICES* 0 0 0 0 0 0 0 0 20.00 PHYSICIAN SERVICES* 0 0 0 0 0 0 0 0 20.00 PHYSICIAN SERVICES* 0 0 0 0 0 0 0 0 0 20.00 PHYSICIAN SERVICES* 0 0 0 0 0 0 0 0 0	5.00	PLANT OPERATION & MAINTENANCE*	o	0			5. 00
8.00 O ETARY*	6.00	LAUNDRY & LINEN SERVICE*	0	0			6. 00
9.00 0.00 0.00 0.00 0.00 0.00 1.00 0.00 1.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.			0	0			
10.00 ROUTINE MEDICAL SUPPLIES* 0 51 11.00			_	ū			
11.00 MEDICAL RECORDS* 0 0 0 11.00 13.00 13.00 13.00 13.00 00.00 13.00 00.00 00.00 13.00 00.00 13.00 00.00 13.00 00.00 13.00 00.00 158,327 13.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 17.			· ·				1
12.00 STAFF TRANSPORTATION* 0 46.309 12.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 15.00 14.00 15.00				51			•
13.00 VOLUNTEER SERVICE COORDINATION* 0 59,627 14.00				0			•
14.00 PHARMACY* 0 158,327 14.00 15.00 16.00 17.00							
15.00 PHYSICIAN ADMINISTRATIVE SERVICES* 0 0 0 0 0 16.00 0 0 0 0 0 0 0 0 0							•
16. 00 OTHER GENERAL SERVICE* 0 242,835 16. 00 17. 00				130, 327			•
17. 00 PATI ENT_RESIDENTI AL_CARE_SERVICES				242 835			•
DIRECT PATIENT CARE SERVICE COST CENTERS 0			Ĭ	242, 033			
25. 00 INPATIENT CARE-CONTRACTED** 0 0 0 26. 00	17.00						17.00
27. 00	25. 00		0	0			25. 00
28 00 REGISTERED NURSE** 0 1,549,279 29.00			o	0			
28. 00 REGISTERE NURSE** 0 1,549,279 29. 00 29. 00 LPM/LVN** 0 110,489 29. 00 30. 00 PM/SICAL THERAPY** 0 0 0 30. 00 31. 00 OCCUPATI ONAL THERAPY** 0 0 0 31. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY** 0 0 0 32. 00 33. 00 MEDICAL SOCIAL SERVICES** 0 145,704 33. 00 35. 00 DI ETARY COUNSELING** 0 0 0 34. 00 35. 00 DI ETARY COUNSELING** 0 0 0 34. 00 37. 00 DI STARY COUNSELING** 0 0 0 34. 00 37. 00 DI STARY COUNSELING** 0 0 0 34. 00 37. 00 DI STARY COUNSELING** 0 0 0 34. 00 38. 00 DI WASELING THERAPY** 0 0 0 0 36. 00 39. 00 DI THER** 0 0 0 0 36. 00 39. 00 DI THER THE THE THE THE THE THE THE THE THE THE	27.00	NURSE PRACTITIONER**	o	126, 974			27. 00
30 00 Note Company	28.00	REGI STERED NURSE**	o				28. 00
31.00 OCCUPATIONAL THERAPY** 0	29. 00		0	110, 489			29. 00
32.00 SPEECH/LANGUAGE PATHOLOGY** 0 0 0 33.00 33.00 MEDI CAL SCRI AL SERVI CES** 0 145,704 33.00 34.00 SPIRI TUAL COUNSELI NG** 0 0 0 34.00 35.00 DIETARY COUNSELI NG** 0 0 0 36.00 36.00 COUNSELI NG** 0 0 0 36.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES** 0 0 0 37.00 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 28,656 38.00 39.00 PATI LENT TRANSPORTATI LON** 0 17,300 39.00 40.00 LMGS NG SERVI CES** 0 0 0 0 40.00 41.00 LABS & DIAGNOSTI CS** 0 0 0 42.50 42.00 MEDI CAL SUPPLIES-NON-ROUTI NE** 0 0 0 42.50 42.00 MEDI CAL SUPPLIES-NON-ROUTI NE** 0 0 0 43.00 44.00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 44.00 45.00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 44.00 46.00 DANGEL MBURSABLE COST CENTERS 0 0 0 60.00 60.00 FOR SERVI CES SERV			0	0			
33. 00 MEDI CAL SOCI AL SERVI CES** 0 145, 704 33. 00 34. 00 SPIR ITUAL COUNSELING** 0 0 0 35. 00 35. 00 DIETARY COUNSELING** 0 0 0 0 35. 00 36. 00 COUNSELING - OTHER** 0 0 0 0 37. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES** 0 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON** 0 17, 300 38. 00 40. 00 IMAGIN OS ERVI CES** 0 0 0 0 39. 00 41. 00 IMAGIN OS ERVI CES** 0 0 0 0 40. 00 41. 00 IMAGIN OS ERVI CES** 0 0 0 0 40. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 0 0 0 42. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 0 0 0 42. 00 44. 00 OTHER PATI ENT SERVI CES** 0 0 0 0 42. 00 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 42. 00 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY)** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0			
34.00 SPIRITUAL COUNSELING** 0 0 0 0 35.00 35.00 DIETARY COUNSELING** 0 0 0 0 0 36.00 COUNSELING - OTHER** 0 0 0 0 37.00 HOSPICE AIDE & HOMEMAKER SERVICES** 0 0 0 37.00 HOSPICE AIDE & HOMEMAKER SERVICES** 0 0 0 37.00 HOSPICE AIDE & HOMEMAKER SERVICES** 0 0 0 37.00 DAIRBLE MEDICAL FOUL PMENT/OXYGEN** 0 0 28,656 38,00 39.00 PATIENT TRANSPORTATION** 0 17,300 39.00 40.00 IMAGING SERVICES** 0 0 0 0 41.00 LABS & DIAGNOSTICS** 0 0 0 0 42.00 MEDICAL SUPPLIES-NON-ROUTINE** 0 0 0 42.00 MEDICAL SUPPLIES-NON-ROUTINE** 0 0 0 43.00 OUTPATIENT SERVICES** 0 0 0 44.00 PALLIATIVE RADIATION THERAPY** 0 0 0 45.00 DALLIATIVE RADIATION THERAPY** 0 0 0 46.00 DALLIATIVE CHEMOTHERAPY** 0 0 0 46.00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 0 60.00 ERERAVEMENT PROGRAM * 0 0 0 61.00 FUNDRAISING* 0 0 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS* 0 0 64.00 PALLIATIVE CARE PROGRAM * 0 0 0 65.00 OTHER PHYSICIAN SERVICES* 0 0 0 66.00 RESIDENTIAL CARE * 0 0 0 66.00 RESIDENTIAL CARE * 0 0 0 66.00 RESIDENTIAL CARE * 0 0 0 67.00 ADVERTISING* 0 0 68.00 TELEHEALTH/TELEMONITORING* 0 0 69.00 THRIFT STORE* 0 0 70.00 NURSING FACILITY ROOM & BOARD* 0 70.00 OTHER NONREI MBURSABLE (SPECIFY)* 0 0 70.00 OTHER NONREI MBURSABLE				0			
35. 00 DI ETARY COUNSELING** 0 0 0 36. 00 COUNSELING** 0 0 0 0 0 0 0 0 36. 00 COUNSELING* 0 THER** 0 0 0 0 0 36. 00 37. 00 40SPI CE AI DE & HOMEMAKER SERVI CES** 0 0 0 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 17, 300 39. 00 PATI ENT TRANSPORTATI ON** 0 17, 300 39. 00 1 MAGI NG SERVI CES** 0 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS** 0 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS** 0 0 0 0 42. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 0 0 0 42. 50 DRUGS CHARGED TO PATI ENTS** 0 0 0 0 42. 50 DRUGS CHARGED TO PATI ENTS** 0 0 0 0 42. 50 DRUGS CHARGED TO PATI ENTS** 0 0 0 0 42. 50 DRUGS CHARGED TO PATI ENTS** 0 0 0 0 42. 50 DRUGS CHARGED TO PATI ENTS** 0 0 0 0 42. 50 DRUGS CHARGED TO PATI ENTS** 0 0 0 0 42. 50 DRUGS CHARGED TO PATI ENTS** 0 0 0 0 44. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 44. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 45. 00 0 0 46. 00 THER PATI ENT CARE SERVI CES (SPECI FY)** 0 0 0 0 66. 00 67. 00 6				145, 704			
36. 00 COUNSELING - OTHER** 0 0 0 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES** 0 0 0 37. 00 0 38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN** 0 28, 656 38. 00 39. 00 PATIENT TRANSPORTATION** 0 17, 300 39. 00 40. 00 1 MAGI NG SERVICES** 0 0 0 0 40. 00 40.				0			
37. 00 HOSPICE AIDE & HOMEMAKER SERVICES** 0 0 0 0 0 38. 00 0 0 0 0 38. 00 0 0 0 0 38. 00 0 0 0 0 39. 00 39. 00 39. 00 40. 00 1MAGI NG SERVI CES** 0 0 0 0 0 0 0 0 0			_	0			
38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 28, 656 38. 00 39. 00 PATI ENT TRANSPORTATION** 0 17, 300 39. 00 40. 00				0			
39. 00 PATI ENT TRANSPORTATION** 0 17, 300 39. 00 40. 00 IMAGI NG SERVI CES** 0 0 0 41. 00 LABS & DI AGNOSTICS** 0 0 0 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 0 0 42. 50 DRUGS CHARGED TO PATI ENTS** 0 0 0 0 42. 50 DRUGS CHARGED TO PATI ENTS** 0 0 0 0 43. 00 OUTPATI ENT SERVI CES** 0 0 0 0 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) ** 0 0 0 61. 00 VOLUNTEER PROGRAM * 0 0 0 61. 00 VOLUNTEER PROGRAM * 0 0 0 62. 00 FUNDRAI SI NG* 0 0 0 63. 00 HOSPI CES-PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 66. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 67. 00 ADVERTI SI NG* 0 0 0 0 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 69. 00 THIRI FT STORE* 0 0 0 0 71. 00 ONNESI MBURSABLE (SPECI FY)** 0 0 0 71. 00 OTHER NONNEI MBURSABLE (SPECI FY)*				28 656			
40. 00							
41. 00					1		
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 0 0 0 42. 50 0 42. 50 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							1
43. 00				0			•
44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 45. 00 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 45. 00 46. 00 OTHER PATIENT CARE SERVI CES (SPECI FY) ** 0 0 0 0 60. 00 NONREI MBURSABLE COST CENTERS 60. 00 BEREAVEMENT PROGRAM * 0 0 0 61. 00 62. 00 FUNDRAI SI NG* 0 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 64. 00 64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 65. 00 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 66. 00 66. 00 RESI DENTI AL CARE* 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 66. 00 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 69. 00 69. 00 THRI FT STORE* 0 0 0 0 69. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD* 0 0 0 THER NONREI MBURSABLE (SPECI FY) * 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	42.50	DRUGS CHARGED TO PATIENTS**	o	0			42. 50
45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	43.00	OUTPATIENT SERVICES**	o	0			43.00
46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	44. 00	PALLIATIVE RADIATION THERAPY**	0	0			44. 00
NONREIMBURSABLE COST CENTERS O		III			1		•
60. 00 BEREAVEMENT PROGRAM * 0 0 0 61. 00 62. 00 61. 00 VOLUNTEER PROGRAM * 0 0 0 0 61. 00 62. 00 FUNDRAI SI NG* 0 0 0 0 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 65. 00 66. 00 RESI DENTI AL CARE* 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 69. 00 THRI FT STORE* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	46. 00	, ,	0	0			46. 00
61. 00 VOLUNTEER PROGRAM * 0 0 0 0 62. 00 63. 00 FUNDRAI SI NG* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
62. 00 FUNDRAI SI NG* 0 0 0 63. 00 64. 00 65. 00 64. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					1		1
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65. 00 OTHER PHYSICIAN SERVICES* 0 0 0 66. 00 66. 00 66. 00 67. 00 ADVERTISING* 0 0 0 67. 00 68. 00 67. 00 0 68. 00 67. 00 0 68. 00 0 69. 00 0 68. 00 0 69. 00 0 69. 00 0 69. 00 0 69. 00 0 0 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			· ·	-	ł		
66. 00 RESI DENTI AL CARE* 0 0 0 67. 00 ADVERTI SI NG* 0 0 0 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 68. 00 THRI FT STORE* 0 0 0 0 69. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					ŧ .		1
67. 00 ADVERTI SI NG* 0 0 0 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 68. 00 69. 00 THRI FT STORE* 0 0 0 0 0 69. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD* 0 0 0 0 0 71. 00 OTHER NONREI MBURSABLE (SPECI FY)* 0 0 0 0 0 0 0 0 0 0 0					•		
68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 68. 00 69. 00 THRI FT STORE* 0 0 0 70. 00 NURSI NG FACILITY ROOM & BOARD* 0 0 0 71. 00 OTHER NONREI MBURSABLE (SPECI FY)* 0 0 0 71. 00 0 0 0 71. 00 0 0 71. 00 0 0 71. 00 0 0 71. 00 0 0 71. 00 0 0 71. 00 0 0 71. 00 0 0 71. 00 0 71. 00 0 0 71. 00 0 71.							
69. 00 THRIFT STORE* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			- 1	ū			1
70. 00 NURSING FACILITY ROOM & BOARD* 0 0 71. 00 OTHER NONREIMBURSABLE (SPECIFY)* 0 0 0 71. 00				-	ł		
71. 00 OTHER NONREI MBURSABLE (SPECI FY)* 0 0 71. 00							
			o	0			
	100.00		0	2, 601, 987			 100.00

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate. ** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Hospi ce CCN: 14-0100

Peri od: Worksheet 0-2 From 01/01/2023 To 12/31/2023 Date/Ti me Prepared:

5/30/2024 4:42 pm Hospi ce I SUBTOTAL (col SALARI ES OTHER RECLASSI FI -SUBTOTAL 1 + col. CATI ONS 2) 1.00 2.00 5. 00 3 00 4 00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 25.00 PHYSICIAN SERVICES 0 26.00 26.00 NURSE PRACTITIONER 125, 380 125, 380 27.00 125, 380 27.00 Ω 0 28.00 REGISTERED NURSE 634, 557 895, 274 1, 529, 831 1, 529, 831 28.00 29.00 LPN/LVN 109, 102 109, 102 109, 102 29.00 30.00 PHYSI CAL THERAPY 0 30.00 0 0 OCCUPATIONAL THERAPY 0 31.00 0 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 32.00 33.00 MEDICAL SOCIAL SERVICES 143, 875 0 143, 875 143, 875 33.00 34.00 SPIRITUAL COUNSELING 0 0 0 0 34.00 35.00 DIETARY COUNSELING 0 0 0 0 35.00 36.00 COUNSELING - OTHER 0 0 0 36.00 0 HOSPICE AIDE & HOMEMAKER SERVICES 37.00 37.00 0 0 28, 297 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 28. 297 28, 297 38.00 39. 00 PATIENT TRANSPORTATION 0 0 0 0 0 0 0 17, 083 17,083 17, 083 39.00 40.00 I MAGING SERVICES 40.00 41.00 LABS & DIAGNOSTICS 0 0 0 41.00 MEDICAL SUPPLIES-NON-ROUTINE 0 42.00 C 0 42.00 42.50 DRUGS CHARGED TO PATIENTS 42.50 OUTPATIENT SERVICES 0 43.00 0 0 43.00 PALLIATIVE RADIATION THERAPY 44.00 C 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY C 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 46.00 1, 012, 914 100.00 TOTAL * 940, 654 1, 953, 568 1, 953, 568 100. 00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	INPATIENT CARE-CONTRACTED			25. 00
26.00	PHYSI CI AN SERVI CES	0	0	26. 00
27. 00	NURSE PRACTITIONER	0	125, 380	27. 00
28. 00	REGI STERED NURSE	0	1, 529, 831	28. 00
29. 00	LPN/LVN	0	109, 102	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	143, 875	33. 00
34.00	SPIRITUAL COUNSELING	0	o	34.00
35.00	DI ETARY COUNSELING	0	o	35. 00
36.00	COUNSELING - OTHER	0	o	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	o	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	28, 297	38. 00
39.00	PATIENT TRANSPORTATION	0	17, 083	39.00
40.00	I MAGING SERVICES	0	o	40.00
41.00	LABS & DIAGNOSTICS	0	o	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	o	42. 00
42. 50	DRUGS CHARGED TO PATIENTS	0	o	42. 50
43.00	OUTPATIENT SERVICES	0	ol	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	o	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	o	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	o	46.00
100.00	TOTAL *	0	1, 953, 568	100. 00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATTENT RESPITE CARE

Hospi ce CCN: 14-1560

Peri od: Worksheet 0-3 From 01/01/2023 To 12/31/2023 Date/Ti me Prepared:

5/30/2024 4:42 pm Hospi ce I SUBTOTAL (col SALARI ES OTHER RECLASSI FI -SUBTOTAL 1 + col. CATI ONS 2) 1.00 2.00 5. 00 3 00 4.00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 0 25.00 0 PHYSICIAN SERVICES 26.00 0 0 26.00 NURSE PRACTITIONER 1, 513 1, 513 27.00 1.513 27.00 o 28.00 REGISTERED NURSE 7,655 10,800 18, 455 18, 455 28.00 0 29.00 LPN/LVN 1, 316 1, 316 1, 316 29.00 30.00 PHYSI CAL THERAPY 0 30.00 0 0 0 OCCUPATIONAL THERAPY 0 31.00 0 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 32.00 33.00 MEDICAL SOCIAL SERVICES 1,736 0 1,736 1,736 33.00 SPIRITUAL COUNSELING 34.00 0 0 34.00 0 0 35.00 DIETARY COUNSELING 0 0 0 0 35.00 36.00 COUNSELING - OTHER 0 0 0 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 0 0 0 0 0 0 0 0 0 37.00 0 37.00 0 0 341 DURABLE MEDICAL EQUIPMENT/OXYGEN 38.00 38.00 341 341 39.00 PATIENT TRANSPORTATION 206 206 206 39.00 40.00 I MAGING SERVICES 40.00 0 LABS & DIAGNOSTICS 41.00 0 0 41.00 0 MEDICAL SUPPLIES-NON-ROUTINE 0 42.00 C 0 42.00 42.50 DRUGS CHARGED TO PATIENTS 0 42.50 OUTPATIENT SERVICES 0 0 43.00 0 43.00 PALLIATIVE RADIATION THERAPY 44.00 C 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY C 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 46.00 100.00 TOTAL * 12, 220 11, 347 23, 567 100. 00 23, 567

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		AD ILICTATIVE	TOTAL (L E	
		ADJUSTMENTS	TOTAL (col. 5	
		6. 00	± col. 6)	
- Ir	DIRECT PATIENT CARE SERVICE COST CENTERS	6.00	7.00	
-				25. 00
	INPATIENT CARE-CONTRACTED	0	0	
	PHYSI CI AN SERVI CES	0	4 540	26. 00
	NURSE PRACTITIONER	0	1, 513	27. 00
	REGI STERED NURSE	0	18, 455	28. 00
	LPN/LVN	0	1, 316	29. 00
	PHYSI CAL THERAPY	0	0	30.00
	OCCUPATI ONAL THERAPY	0	0	31. 00
32. 00	SPEECH/LANGUAGE PATHOLOGY	0	0	32. 00
33. 00	MEDICAL SOCIAL SERVICES	0	1, 736	33. 00
34. 00	SPIRITUAL COUNSELING	0	0	34.00
35. 00	DI ETARY COUNSELING	0	o	35. 00
36. 00	COUNSELING - OTHER	0	o	36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES	0	ol	37. 00
	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	341	38. 00
39. 00	PATI ENT TRANSPORTATION	0	206	39.00
40. 00	I MAGI NG SERVI CES	0	o	40.00
	LABS & DIAGNOSTICS	0	0	41.00
1	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
	DRUGS CHARGED TO PATIENTS	0	o	42. 50
	OUTPATIENT SERVICES			43.00
	PALLIATIVE RADIATION THERAPY			44. 00
	PALLIATIVE CHEMOTHERAPY			45. 00
	OTHER PATIENT CARE SERVICES (SPECIFY)			46. 00
	TOTAL *		23, 567	100.00
100.00	TOTAL		25,507	1100.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/30/2024 4:42 pm

INPATIENT CARE Hospi ce CCN: 14-1560

					Hospi ce I				
	·	SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL			
				1 + col . 2)	CATI ONS				
		1.00	2.00	3. 00	4. 00	5. 00			
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25.00	I NPATIENT CARE-CONTRACTED		0	0	0	0	25. 00		
26. 00	PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00		
27. 00	NURSE PRACTITIONER	81	0	81	0	81	27. 00		
28. 00	REGI STERED NURSE	412	581	993	0	993	28. 00		
29. 00	LPN/LVN	71	0	71	0	71	29. 00		
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30. 00		
31. 00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31. 00		
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00		
33.00	MEDICAL SOCIAL SERVICES	93	0	93	0	93	33. 00		
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34. 00		
35.00	DI ETARY COUNSELI NG	0	0	0	0	0	35. 00		
36.00	COUNSELING - OTHER	0	0	0	0	0	36. 00		
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37. 00		
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	18	18	0	18	38. 00		
39.00	PATI ENT TRANSPORTATION	0	11	11	0	11	39. 00		
40.00	I MAGI NG SERVI CES	0	0	0	0	0	40. 00		
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41. 00		
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42. 00		
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42. 50		
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43. 00		
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44. 00		
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45. 00		
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46. 00		
100.00	TOTAL *	657	610	1, 267	0	1, 267	100.00		
* Tran	* Transfer the amount in column 7 to Wkst 0-5 column 1 line 53								

Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5		
		7.D3 03 TMENTO	± col. 6)		
		6. 00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	I NPATI ENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSI CI AN SERVI CES	0	0		26.00
27.00	NURSE PRACTITIONER	0	81		27.00
28.00	REGI STERED NURSE	0	993		28. 00
29. 00	LPN/LVN	0	71		29. 00
30.00	PHYSI CAL THERAPY	0	0		30.00
31.00	OCCUPATI ONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	93		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DI ETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	18		38. 00
39. 00	PATI ENT TRANSPORTATION	0	11		39. 00
40.00	I MAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0		42. 50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0		45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	1, 267	1	100. 00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

Heal th	Financial Systems FHN MEMORIAL F	HOSPI TAL		In Li∈	eu of Form CMS-2	2552-10
	ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provi der C	CN: 14-0160	Peri od:	Worksheet 0-5	
EXPENS	SES FOR ALLOCATION	Hospi ce CC	N: 14-1560	From 01/01/2023 To 12/31/2023		
				Hospi ce I		
	Descriptions		HOSPICE DIREC	T GENERAL	TOTAL EXPENSES	
			EXPENSES (se	e SERVI CE	(sum of cols.	
			instructions		1 + 2)	
				WKST B PART I		
				(see		
			1 00	instructions)		
	CENEDAL CEDVICE COST CENTEDS		1.00	2. 00	3. 00	
1. 00	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT			0 0	0	1.00
2. 00	CAP REL COSTS-DEDG & FIXT			0 13, 378		2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT		10, 89			3.00
4. 00	ADMINISTRATIVE & GENERAL		105, 53	· ·		4.00
5.00	PLANT OPERATION & MAINTENANCE		103, 30	0 014,007		5. 00
6. 00	LAUNDRY & LINEN SERVICE			0 0	_	6.00
7. 00	HOUSEKEEPI NG			0 0	0	7.00
8. 00	DI ETARY			0 0		8.00
9. 00	NURSI NG ADMINI STRATI ON			0 0		9. 00
10. 00	ROUTINE MEDICAL SUPPLIES			9, 676		10. 00
11. 00	MEDI CAL RECORDS		1	0 37, 489		11. 00
12. 00	STAFF TRANSPORTATION		46, 30		46, 309	12.00
13. 00	VOLUNTEER SERVICE COORDINATION		59, 62		59, 627	13. 00
14.00	PHARMACY		158, 32			14. 00
15.00	PHYSI CI AN ADMINISTRATIVE SERVICES			0	0	15. 00
16.00	OTHER GENERAL SERVICE		242, 83	55 0	242, 835	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0	0	17. 00
	LEVEL OF CARE					
50.00	HOSPI CE CONTI NUOUS HOME CARE			0	0	50. 00
51. 00	HOSPI CE ROUTI NE HOME CARE		1, 953, 56		1, 953, 568	•
52. 00	HOSPICE INPATIENT RESPITE CARE		23, 56		23, 567	52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE		1, 26	07	1, 267	53. 00
	NONREI MBURSABLE COST CENTERS				1	
60.00	BEREAVEMENT PROGRAM			0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	61.00
62. 00 63. 00	FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	62. 00 63. 00
64. 00	PALLIATIVE CARE PROGRAM			0	0	64.00
65. 00	OTHER PHYSI CI AN SERVI CES			0	0	65.00
66. 00	RESI DENTI AL CARE			0	0	66.00
67. 00	ADVERTI SI NG			0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG			0	0	68.00
69. 00	THRI FT STORE			0	0	69.00
70. 00	NURSING FACILITY ROOM & BOARD			0	0	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)			0	Ö	71. 00
99. 00	NEGATIVE COST CENTER			Ö	l o	99. 00
100.00			2, 601, 98	1, 056, 120		
			•	•		

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 14-0160 Peri od: Worksheet 0-6 From 01/01/2023 Part I Hospi ce CCN: 14-1560 12/31/2023 Date/Time Prepared: To 5/30/2024 4:42 pm Hospi ce I TOTAL EXPENSES CAP REL BLDG & CAP REL MVBLE EMPLOYEE SUBTOTAL Descriptions EQUI P **BENEFITS** FIX DEPARTMENT 1.00 2.00 0 3.00 3A GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 1.00 13, 378 2.00 CAP REL COSTS-MVBLE EQUIP 13, 378 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 344, 888 0 344, 888 3.00 ADMINISTRATIVE & GENERAL 720, 206 13, 333 733, 539 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 0 0 0 5.00 0 0 LAUNDRY & LINEN SERVICE 0 0 0 0 6.00 0 6.00 7.00 HOUSEKEEPI NG 0 0 0 0 7.00 8.00 DI ETARY 0 0 0 0 0 8.00 NURSING ADMINISTRATION 0 9.00 0 9.00 0 0 0 ROUTINE MEDICAL SUPPLIES 0 9, 727 10.00 9.727 10.00 11.00 MEDICAL RECORDS 37, 489 0 0 0 0 0 37, 489 11.00 12.00 STAFF TRANSPORTATION 46, 309 46, 309 12.00 VOLUNTEER SERVICE COORDINATION 59, 627 0 59, 627 13.00 0 13.00 0 14.00 PHARMACY 205, 246 0 205, 246 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 OTHER GENERAL SERVICE 0 16.00 242, 835 0 242, 835 16.00 PATIENT/RESIDENTIAL CARE SERVICES 0 17.00 0 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 50.00 HOSPICE ROUTINE HOME CARE 1, 953, 568 338, 985 2, 292, 553 51.00 51.00 HOSPICE INPATIENT RESPITE CARE 5, 705 52.00 23, 567 C 25 29, 297 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 1, 267 0 20 198 1, 485 53.00 NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 n n 60.00 0 0 0 0 VOLUNTEER PROGRAM 0 0 61.00 0 61.00 0 62.00 FUNDRAI SI NG 0 0 62.00 0 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 00000000 0 0 63.00 PALLIATIVE CARE PROGRAM 0 0 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 0 65.00 RESIDENTIAL CARE 0 0 66.00 0 0 66.00 67 00 ADVERTI SI NG 0 0 0 67.00 TELEHEALTH/TELEMONI TORI NG 0 0 68.00 0 68.00 69.00 THRIFT STORE 0 0 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 0 70.00

0

3, 658, 107

Ω

0

0

0

13, 378

0

344, 888

71.00

99.00

0

3, 658, 107 100. 00

OTHER NONREIMBURSABLE (SPECIFY)

99.00 NEGATIVE COST CENTER

71 00

100.00 TOTAL

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 14-0160 Peri od: Worksheet 0-6 From 01/01/2023 Part I Hospi ce CCN: 14-1560 12/31/2023 Date/Time Prepared: 5/30/2024 4:42 pm Hospi ce I ADMI NI STRATI VE PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY Descriptions & GENERAL OPERATION & LINEN SERVICE MAI NTENANCE 4.00 6.00 7. 00 8. 00 5.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 ADMINISTRATIVE & GENERAL 733, 539 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 0 0 0 6.00 6.00 7.00 HOUSEKEEPI NG 0 7.00 8.00 DI ETARY 0 0 0 0 0 0 0 0 8.00 NURSING ADMINISTRATION 9.00 9.00 0 ROUTINE MEDICAL SUPPLIES 0 10.00 2.440 10.00 11.00 MEDICAL RECORDS 9, 403 11.00 12.00 STAFF TRANSPORTATION 11, 615 12.00 14, 956 VOLUNTEER SERVICE COORDINATION 13.00 0 13.00 14.00 PHARMACY 51, 480 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 OTHER GENERAL SERVICE 0 16.00 60, 908 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 0 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 50.00 HOSPICE ROUTINE HOME CARE 575, 017 51.00 51.00 HOSPICE INPATIENT RESPITE CARE 52.00 7, 348 C 0 0 0 52.00 0 53.00 HOSPICE GENERAL INPATIENT CARE 372 0 0 0 53.00 NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 n 60 00 0 0 0 0 0 0 0 0 VOLUNTEER PROGRAM 0000000 0 61.00 61.00 62.00 FUNDRAI SI NG 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 63.00 PALLIATIVE CARE PROGRAM 0 64.00 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 66.00 67 00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 0 68.00 68.00 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 0 0 0 71.00 0 Ω 99.00 NEGATIVE COST CENTER 0 0 0 0 0 99.00 100.00 TOTAL 733, 539 0 100.00

Heal th	Financial Systems	FHN MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	_ SERVICE COSTS	Provi der CO		Peri od:	Worksheet 0-6	
			Hospi ce CCN		From 01/01/2023 To 12/31/2023	Part I Date/Time Pre	pared:
						5/30/2024 4:4	2 pm
		AUUDOLAIO	BOUTI NE	11501.041	Hospi ce I	\(\(\)	
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL RECORDS	STAFF	VOLUNTEER SERVI CE	
		ADMI NI STRATI ON	MEDI CAL SUPPLI ES	RECORDS	TRANSPORTATI ON	COORDI NATI ON	
		9. 00	10.00	11. 00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS	1					
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7. 00	HOUSEKEEPI NG						7. 00
8. 00	DI ETARY	_					8. 00
9.00	NURSI NG ADMI NI STRATI ON	0	40 4/7				9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	12, 167	47.00			10.00
11.00	MEDI CAL RECORDS	0		46, 89			11.00
12. 00 13. 00	STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION	0			57, 924	74, 583	12. 00 13. 00
14. 00	PHARMACY	0			0	74, 565	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES				0	0	15.00
16. 00	OTHER GENERAL SERVICE				0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES					ŭ	17. 00
	LEVEL OF CARE				,		
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	o	12, 013	46, 29	7 56, 933	73, 306	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	145	55		1, 234	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	0	9	3	6 33	43	53. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62. 00 63. 00	FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	62. 00 63. 00
64. 00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65. 00	OTHER PHYSICIAN SERVICES				0	0	65.00
66. 00	RESI DENTI AL CARE				0	0	66. 00
67. 00	ADVERTI SI NG				0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	o			0	0	68. 00
69. 00	THRI FT STORE	o			0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD						70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	o			0	0	71. 00
99. 00	NEGATI VE COST CENTER	0	0		0 0	0	99. 00
100.00	TOTAL	0	12, 167	46, 89	2 57, 924	74, 583	100. 00

Heal th	Financial Systems	FHN MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provi der CO	CN: 14-0160	Peri od:	Worksheet 0-6	<u> </u>
					From 01/01/2023	Part I	
			Hospi ce CCN	N: 14-1560	To 12/31/2023	Date/Time Pre	
			·			5/30/2024 4: 4	2 pm
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL	PATI ENT/	TOTAL	
			ADMI NI STRATI VE	SERVI CE	RESI DENTI AL		
			SERVI CES		CARE SERVICES		
		14.00	15. 00	16.00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
	LAUNDRY & LINEN SERVICE						1
6.00							6.00
7.00	HOUSEKEEPI NG						7. 00
8. 00	DIETARY						8. 00
9.00	NURSING ADMINISTRATION						9. 00
10. 00	ROUTINE MEDICAL SUPPLIES						10. 00
11. 00	MEDI CAL RECORDS						11. 00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13. 00
14.00	PHARMACY	256, 726					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15. 00
16.00	OTHER GENERAL SERVICE	o		303, 74	3		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
.,. 00	LEVEL OF CARE						1 55
50.00		0	0		ol	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE	252, 332	0	298, 54	-	3, 606, 995	
52. 00		4, 246	0	5, 02		48, 811	1
53. 00	·	148	0	17		2, 301	1
55.00	NONREI MBURSABLE COST CENTERS	140	U	17	<u>ی</u> ا	2, 301	33.00
(0.00							(0.00
60.00	BEREAVEMENT PROGRAM	0			0	0	
61. 00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAI SI NG	0			0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	
64. 00	PALLIATIVE CARE PROGRAM	0			0	0	1
65. 00	OTHER PHYSICIAN SERVICES	0			0	0	65. 00
66. 00	RESI DENTI AL CARE	0	0		0 0	0	66. 00
67.00	ADVERTI SI NG	0			0	0	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	0			o l	0	68. 00
69. 00	THRI FT STORE	O			ol	0	69. 00
70. 00	1					0	1
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		o	0	71. 00
	NEGATIVE COST CENTER		0		0 0	0	1
	TOTAL	256, 726	0		-	3, 658, 107	
	-1	200,720	o _l	1 000,71	-ı ºı	3, 333, 107	1.30.00

Health Financial Systems	FHN MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL STATISTICAL BASIS	_ SERVICE COSTS	Provider CCN: Hospice CCN:	From 01/01/2023	Worksheet 0-6 Part II Date/Time Prepared: 5/30/2024 4:42 pm

						5/30/2024 4: 4	2 pm
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG &	CAP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
		FLX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET)	(DOLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
		`	`	(GROSS		COSTS)	
				SALARI ES)		ĺ	
		1.00	2. 00	3.00	4A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT	855					1.00
2. 00	CAP REL COSTS-MVBLE EQUIP		14, 334				2. 00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	0	, 55 .	13, 905			3.00
4. 00	ADMI NI STRATI VE & GENERAL	855	14, 286	10, 700		2, 924, 568	4.00
5. 00	PLANT OPERATION & MAINTENANCE	0	11, 200	Ĭ	, , , , , , ,	0	5. 00
6. 00	LAUNDRY & LINEN SERVICE		0	,		Ö	6.00
7. 00	HOUSEKEEPI NG		0			0	7. 00
8. 00	DI ETARY		0			0	8.00
			0			0	
9.00	NURSI NG ADMI NI STRATI ON	0	U			_	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0			9, 727	1
11.00	MEDI CAL RECORDS	0	0		0	37, 489	1
12.00	STAFF TRANSPORTATION	0	0		0	46, 309	
13. 00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	59, 627	1
14. 00	PHARMACY	0	0	C	0	205, 246	1
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15. 00
16. 00	OTHER GENERAL SERVICE	0	0	0	0	242, 835	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			C	_	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			13, 667	0	2, 292, 553	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	27	230	0	29, 297	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	0	21	8	0	1, 485	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	C	0	0	60.00
61. 00	VOLUNTEER PROGRAM	o	o	l c	0	0	61.00
62.00	FUNDRAI SI NG	o	o	l c	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	o	0	d	0	0	63. 00
64.00	PALLIATIVE CARE PROGRAM	0	o	d	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	o	o		0	0	65.00
66. 00	RESI DENTI AL CARE	0	0	d	0	0	66.00
67. 00	ADVERTI SI NG	0	0	i o	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0	ĺ	0	Ö	68. 00
69. 00	THRIFT STORE		0	١	0	0	69.00
70. 00	NURSING FACILITY ROOM & BOARD		Ĭ	Ĭ			70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)		O	_		0	
99. 00	NEGATIVE COST CENTER	١	o l	١			99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		13, 378	344, 888		733, 539	
	UNIT COST MULTIPLIER	0. 000000	0. 933305			0. 250820	
101.00	UNIT COST WULTIFLIER	0.000000	0. 733303	24.003104	1	0.250620	1101.00

	Financial Systems	FHN MEMORIAL				eu of Form CMS-2	
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE STICAL BASIS	RVICE COSTS	Provi der CC Hospi ce CCI		Peri od: From 01/01/2023 To 12/31/2023		pared:
					Hospi ce I	37 307 2024 4. 4	Σ μιι
	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPI NO (SQUARE FEET		NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	•				•	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE PATIENT/RESIDENTIAL CARE SERVICES	0 0 0 0 0 0 0 0	0		0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
50. 00 51. 00 52. 00 53. 00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE	0	0		0 0		50. 00 51. 00 52. 00 53. 00
	NONREI MBURSABLE COST CENTERS		-				
60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00	VOLUNTEER PROGRAM FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM OTHER PHYSICIAN SERVICES	0 0 0 0 0 0 0	0		0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00

0.000000

0.000000

70.00

71.00

99.00

0 100.00 0. 000000 101. 00

0

0.000000

0.000000

70. 00 NURSING FACILITY ROOM & BOARD 71. 00 OTHER NONREIMBURSABLE (SPECIFY)

100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I)
101.00 UNIT COST MULTIPLIER

99.00 NEGATIVE COST CENTER

Health Financial Systems	FHN MEMORIAL	_ HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE STATISTICAL BASIS	ERVICE COSTS	Provi der CC	CN: 14-0160	Peri od: From 01/01/2023	Worksheet 0-6	
STATISTICAL BASIS		Hospi ce CCN	l: 14-1560	To 12/31/2023		
				Hospi ce I		
Coot Contan Decemintions	DOUTLNE	MEDICAL	CTAFF	VOLUNTEED	DLIADMACV	

			Hospi ce CCI	N: 14-1560 T	o 12/31/2023	Date/Time Prep 5/30/2024 4:4:	
					Hospi ce I		
	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MI LEAGE)	VOLUNTEER SERVI CE COORDI NATI ON (HOURS OF	PHARMACY (CHARGES)	
					SERVICE)		
		10.00	11. 00	12.00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE					ļ	5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPING						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION					ļ	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	15, 616				l	10.00
11.00	MEDI CAL RECORDS		15, 616	,		l	11. 00
12.00	STAFF TRANSPORTATION			13, 905		ļ	12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	13, 905	ļ	13. 00
14.00	PHARMACY			0	0	13, 905	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15. 00
16.00	OTHER GENERAL SERVICE			0	0	0	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					ļ	17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	15, 418	15, 418	13, 667	13, 667	13, 667	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	186	186		230	230	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	12	12	8	8	8	53. 00
	NONREI MBURSABLE COST CENTERS						
60.00				0	0	0	60.00
61. 00	VOLUNTEER PROGRAM			0	0	0	61. 00
62.00	FUNDRAI SI NG			0	0	0	62. 00
63.00				0	0	0	63. 00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64. 00
65.00				0	0	0	65. 00
66.00				0	0	0	66. 00
67. 00				0	0	0	67. 00
68. 00				0	-	0	68. 00
69. 00				0	0	0	69. 00
70. 00							70. 00
71. 00	` ′			0	0	0	71. 00
99. 00		1					99. 00
	O COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		46, 892			256, 726	
101.0	O UNIT COST MULTIPLIER	0. 779137	3. 002818	4. 165696	5. 363754	18. 462855	1101.00

Health Financial Systems	FHN MEMORIAL H	OSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE (STATISTICAL BASIS	GENERAL SERVICE COSTS	Provider CCN: Hospice CCN:	Peri od: From 01/01/2023 To 12/31/2023	Worksheet 0-6 Part II Date/Time Prepared: 5/30/2024 4:42 pm

			Hospi ce CC	N: 14-1560	To 12	2/31/2023	Date/Time 5/30/2024	
					Hosp	oi ce I	37 307 2024	4. 42 piii
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/				
	'	ADMI NI STRATI VE	SERVI CE	RESI DENTI AL	_			
		SERVI CES	(SPECI FY	CARE SERVICE	S			
		(PATIENT DAYS)		(IN-FACILIT				
		,		DAYS)				
		15. 00	16. 00	17. 00				
_	GENERAL SERVICE COST CENTERS			•	<u>"</u>			
1.00	CAP REL COSTS-BLDG & FLXT							1. 00
2.00	CAP REL COSTS-MVBLE EQUIP							2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMINISTRATIVE & GENERAL							4.00
5.00	PLANT OPERATION & MAINTENANCE							5. 00
6.00	LAUNDRY & LINEN SERVICE							6, 00
7. 00	HOUSEKEEPI NG							7. 00
8.00	DI ETARY							8. 00
9. 00	NURSING ADMINISTRATION	•						9. 00
10.00	ROUTINE MEDICAL SUPPLIES							10.00
11. 00	MEDICAL RECORDS							11. 00
12. 00	STAFF TRANSPORTATION							12.00
13. 00								13. 00
	VOLUNTEER SERVICE COORDINATION							
14. 00	PHARMACY							14.00
15. 00	PHYSI CI AN ADMINISTRATI VE SERVI CES	0						15. 00
16. 00	OTHER GENERAL SERVICE		13, 905		_			16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0			17. 00
	LEVEL OF CARE	_	1					
50. 00	HOSPI CE CONTI NUOUS HOME CARE	0	_	1				50.00
51. 00	HOSPICE ROUTINE HOME CARE	0						51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	0		1	0			52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	0	8	8	0			53. 00
	NONREI MBURSABLE COST CENTERS							
60. 00	BEREAVEMENT PROGRAM		0	1				60.00
61. 00	VOLUNTEER PROGRAM		0)				61. 00
62.00	FUNDRAI SI NG		0)				62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0)				63. 00
64.00	PALLIATIVE CARE PROGRAM		0)				64. 00
65.00	OTHER PHYSICIAN SERVICES		0					65. 00
66.00	RESI DENTI AL CARE	0	0		0			66. 00
67.00	ADVERTI SI NG		0					67. 00
68.00	TELEHEALTH/TELEMONI TORI NG							68. 00
69.00	THRI FT STORE			ol .				69. 00
70. 00	NURSING FACILITY ROOM & BOARD							70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0			71. 00
	NEGATIVE COST CENTER				_			99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part)	303, 743		0			100.00
	UNIT COST MULTIPLIER	0. 000000		•	no			101.00
101.00	John Cook Modelli Elek	0.00000	21.014107	3. 5000	~~			1.01.00

Heal th	Financial Systems	FHN MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY			Provi der CC		Peri od:	Worksheet 0-7	
LEVEL	LEVEL OF CARE				From 01/01/2023 To 12/31/2023	B Date/Time Prepare 5/30/2024 4:42 pm	
					Hospi ce I		
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, Co Part I, Col. 9 Line	Ratio		HRHC	HI RC	
		0	1. 00	2. 00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS	1 ,,1	0 0571		al -1	_	
1. 00 2. 00 3. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	66. 00 67. 00 68. 00	0. 257901		0 0	0	1. 00 2. 00 3. 00
4. 00 5. 00 6. 00	DRUGS CHARGED TO PATIENTS DURABLE MEDICAL EQUIP-RENTED LABORATORY	73. 00 96. 00 60. 00	0. 107790 0. 137312		0 183, 762	0	4. 00 5. 00 6. 00
7. 00 8. 00 9. 00	MEDICAL SUPPLIES CHARGED TO PATIENT OTHER OUTPATIENT SERVICE COST CENTER	71. 00 93. 00 55. 00	0. 004539		0 0	0	7. 00 8. 00 9. 00
10. 00 10. 01	RADIOLOGY-THERAPEUTIC DIABETIC EDUCATION CANCER CENTER Totals (sum of lines 1-11)	76. 00 76. 01	0. 000000 0. 343910		0 0	0	10. 00 10. 01 11. 00
		Charges by LOC (from Provider Records)			ce Costs by LOC		
	Cost Center Descriptions		col. 2)	col. 3)	xHIRC (col. 1 x col. 4)	col. 5)	
	ANCILLARY SERVICE COST CENTERS	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00 2. 00 3. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	0	0		0 0	0	1. 00 2. 00 3. 00
4. 00 5. 00 6. 00	DRUGS CHARGED TO PATIENTS DURABLE MEDICAL EQUIP-RENTED LABORATORY	0	0	19, 80	0 0	0	4. 00 5. 00 6. 00
7. 00 8. 00 9. 00	MEDICAL SUPPLIES CHARGED TO PATIENT OTHER OUTPATIENT SERVICE COST CENTER RADIOLOGY-THERAPEUTIC	0	0		0 0	0	7. 00 8. 00 9. 00
10. 00 10. 01	DI ABETIC EDUCATION CANCER CENTER Totals (sum of lines 1-11)	0	0 0 0	19, 80	0 0 0 0 08 0	0 0 0	10. 00 10. 01

Health Financial Systems	FHN MEMORIAL H	OSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST		Provider CCN: 14-0160	Peri od:	Worksheet 0-8

COLLATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0160 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/2023 | Period: From 01/01/20

					5/30/2024 4: 42	2 pm
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7,	col . 6,			0	1.00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2. 00
3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	10)		0		4. 00
5.00	Program cost (line 3 times line 4)			0		5. 00
	HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7,	col . 7,			3, 626, 803	6.00
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				15, 418	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)				235. 23	8. 00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	e 11)	14, 38°	366		9. 00
10.00	Program cost (line 8 times line 9)		3, 382, 843	86, 094		10.00
	HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7,	col . 8,			48, 811	11. 00
	line 11)					
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				186	12.00
13.00	Total average cost per diem (line 11 divided by line 12)				262. 42	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	e 12)	150	5 0		14.00
15.00	Program cost (line 13 times line 14)		40, 938	0		15. 00
	HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7,	col . 9,			2, 301	16.00
	line 11)					
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				12	17. 00
18.00	Total average cost per diem (line 16 divided by line 17)				191. 75	18. 00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	e 13)	1:	2 0		19.00
20.00	0 Program cost (line 18 times line 19) 2,301			1 0		20.00
	TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				3, 677, 915	21. 00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)				15, 616	22. 00
23.00	Average cost per diem (line 21 divided by line 22)				235. 52	23. 00
			'	•	. '	

Heal th	Financial Systems FHN	MEMORIAL HOSPITAL	Inlia	u of Form CMS-2	2552_10
CALCULATION OF CAPITAL PAYMENT		Provi der CCN: 14-0160	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Pre 5/30/2024 4:4:	pared:
		Title XVIII	Hospi tal	PPS	
				1 00	
	DART I FILLY PROSPECTIVE METHOD			1. 00	
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			592, 031	1.00
1. 00	Model 4 BPCI Capital DRG other than outlier		0 0	1. 00	
2.00	Capital DRG outlier payments			1, 469	2. 00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in	the cost reporting period (see inst	ructions)	37.87	3. 00
4.00	Number of interns & residents (see instructions)			0.00	4.00
5.00	Indirect medical education percentage (see instruc-	ti ons)		0.00	5. 00
6.00	Indirect medical education adjustment (multiply line 1.01) (see instructions)	ne 5 by the sum of lines 1 and 1.01	, columns 1 and	0	6. 00
7. 00	Percentage of SSI recipient patient days to Medical 30) (see instructions)	re Part A patient days (Worksheet E	, part A line	0.00	7. 00
8.00	Percentage of Medicaid patient days to total days	(see instructions)		0.00	8. 00
9. 00	Sum of lines 7 and 8	(0.00	9. 00
10.00	Allowable disproportionate share percentage (see in	nstructions)		0.00	10. 00
11.00	Disproportionate share adjustment (see instructions	s)		0	11. 00
12.00	Total prospective capital payments (see instruction	ns)		593, 500	12.00
	DADT III DAVIGENT INDER DEADONARIE COOT			1. 00	
1 00	PART II - PAYMENT UNDER REASONABLE COST	-+:>		0	1 00
1. 00 2. 00	Program inpatient routine capital cost (see instructions and inpatient ancillary capital cost (see instructions)			0	1. 00 2. 00
3. 00					3. 00
4. 00					4. 00
5. 00	Total inpatient program capital cost (line 3 x line		0	5. 00	
	DART LLL COMPUTATION OF EVOEDTION DAVMENTS			1. 00	
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)		1	0	1. 00
2. 00				0	2.00
3.00	Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2)				3.00
4. 00	Applicable exception percentage (see instructions)				4. 00
5. 00	Capital cost for comparison to payments (line 3 x line 4)				5. 00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)				6. 00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)				7. 00
8.00					8. 00
9.00	Current year capital payments (from Part I, line 12, as applicable)				9. 00
10.00					10. 00
11. 00	O Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)				11. 00
12.00	Net comparison of capital minimum payment level to	0	12. 00		
13.00					13. 00
14. 00	O Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)				
15. 00	Current year allowable operating and capital paymen	0	15. 00		
16. 00	00 Current year operating and capital costs (see instructions)				16. 00
17. 00	Current year exception offset amount (see instructi	i ons)		0	17. 00