PART II - CERTIFICATION

(4) Reopened(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 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 the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSP & HEALTH CARE CTR (150115) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 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.

Officer or Administrator of Provider(s)

Title

			Title	XVIII			
	Cost Center Description	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	97, 071	47, 494	17, 285	0	1. 00
2.00	Subprovi der - I PF	0	6, 867	0		0	2. 00
3.00	Subprovi der - I RF	0	-11, 378	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	5, 648	4		0	7. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		4, 460		0	10.00
10.01	RURAL HEALTH CLINIC II	0		10, 350		0	10. 01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200.00	Total	0	98, 208	62, 308	17, 285	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDI CARE.

Provi der CCN: 150115

Peri od:

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA From 07/01/2014 Part I Date/Time Prepared: 06/30/2015 11/23/2015 9:52 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 800 WEST 9TH STREET 1.00 PO Box: 1.00 State: IN Zi p Code: 47546 2.00 City: JASPER County: DUBOIS 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal MEMORIAL HOSP & HEALTH 150115 99915 07/01/1966 Ν Р 0 3.00 1 CARE CTR Р 4.00 Subprovider - IPF MEMORIAL HOSP & HCC 15S115 99915 07/01/1985 0 4 Ν 4.00 (PSYCH) 5.00 Subprovider - IRF MEMORIAL HOSP & HCC 15T115 99915 5 07/01/2005 Ν Ρ 0 5.00 (REHAB) 6.00 Subprovider - (Other) 6 00 Swing Beds - SNF 7.00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF MEMORIAL HOSP & HEALTH 155305 99915 08/04/1987 Ν Р 0 9.00 CARE CTR 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA MEMORIAL HOSP & HEALTH 99915 08/28/1991 12.00 157222 Ν Ρ Ν CARE CTR Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 15.00 Hospital-Based Health Clinic - RHC FRENCH LICK FAMILY 158507 99915 06/19/2009 Ν 0 N 15.00 MEDI CI NE Hospital-Based Health Clinic - RHC LOOGOOTEE FAMILY 158508 15.01 99915 12/14/2009 0 15.01 MEDICINE 16 00 Hospital-Based Health Clinic - FQHC 16, 00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From To: 1.00 2.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2014 06/30/2015 20.00 Type of Control (see instructions) 21.00 21 00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for disproportionate Υ N 22.00 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 §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this cost reporting γ γ 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes 22.02 Ν Ν 22.02 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 rural as a result Ν 22.03 N of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 23.00 Ν 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 enter "Y" for yes or used in the prior cost reporting period? In column 2 "N" for no In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d el i gi bl e Medicai d Medi cai d paid days days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3. 00 4 00 5 00 6 00 24.00 If this provider is an IPPS hospital, enter the 652 246 0 1,673 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

PITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der	CCN: 150115	Period: From 07/0 To 06/3	01/2014 80/2015	Part I Date/T	ieet S-2 ime Pre '2015 9:	pare
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	id (ys Me	Other di cai d days	
	1.00	2. 00	3. 00	4. 00	5. 00		6. 00	
00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	(D 15	0	Urban/F	Rural S	Date o	f Genar	25
				1.			00	
 Enter your standard geographic classification (not we cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban or 	rural. nge) status "2" for n	s at the end rural. If ap	d of the cos		2			26
enter the effective date of the geographic reclassifi 00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0			35
				Begi n			i ng: 00	
00 Enter applicable beginning and ending dates of SCH st		script line	36 for numb					36
of periods in excess of one and enter subsequent date on the lifthis is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	the number	·		5	0			37
00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38
				1.	/N 00		/N 00	-
OD Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage rec CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes)? Enter i uirements	n column 1 in accordar	"Y" for yes nce with 42	me N	1		N	39
00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	n adjustmer oer 1. Ente	nt? Enter "\ er "Y" for y	" for yes o	- I			Y	40
					1. 00	XVI I I		
Prospective Payment System (PPS)-Capital ODoes this facility qualify and receive Capital paymen	nt for disc	proporti onat	te share in a	accordance	N	l N	N	45
with 42 CFR Section §412.320? (see instructions) 00 Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst	ption for	extraordi na	ary circumsta	ances	N	N	N	46
Pt. III. On Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment		,			N N	N N	N N	47
Teaching Hospitals O Is this a hospital involved in training residents in	approved (GME programs	s? Enter "Y	' for yes	N		T	56
or "N" for no. Of If line 56 is yes, is this the first cost reporting programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y"	yes or "Neth of this '", complet	N" for no ir cost report te Worksheet	n column 1. ting period?	If column Enter "Y				57
"N", complete Wkst. D, Parts III & IV and D-2, Pt. II 00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	oursement 1 complete V	for physicia Vkst. D-5.		s as				58
00 Are costs claimed on line 100 of Worksheet A? If yes 00 Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"	costs for	a program t	that meets t		N N			60
	Y/N	IME	Direct GMI	E IN	ИE	Di red	ct GME	
	1.00	2. 00	3. 00	4.	00	5.	00	
00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0. 00		0. 00	
01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0	. 00				6
instructions)								

HOSPII	AL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA			F		Worksheet S-2 Part I Date/Time Pre 11/23/2015 9:	pared:
			Y/N	IME	Direct GME	IME	Direct GME	
			1. 00	2. 00	3. 00	4. 00	5. 00	
	Enter the base line FTE count for and/or general surgery residents, determining compliance with the 7 instructions)	which is used for 5% test. (see		0.00	0.00			61. 03
61. 04	Enter the number of unweighted pr surgery allopathic and/or osteopa current cost reporting period. (se	thic FTEs in the		0.00	0.00			61. 04
	Enter the difference between the and/or general surgery FTEs and t primary care and/or general surge 61.04 minus line 61.03). (see ins	baseline primary he current year's ry FTE counts (line tructions)		0.00				61. 05
61. 06	Enter the amount of ACA §5503 awa used for cap relief and/or FTEs t care or general surgery. (see ins	hat are nonprimary		0.00				61. 06
			Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1. 00	2. 00	3. 00	4.00	
61. 10	Of the FTEs in line 61.05, specific special ty, if any, and the number for each new program. (see instrucolumn 1, the program name, enter program code, enter in column 3, unweighted count and enter in col FTE unweighted count.	of FTE residents ections) Enter in in column 2, the the IME FTE				0.00	0.00	61. 10
61. 20	Of the FTEs in line 61.05, specific program specialty, if any, and the residents for each expanded progrinstructions) Enter in column 1, enter in column 2, the program column 2, the IME FTE unweighted count 4, direct GME FTE unweighted cour	e number of FTE am. (see the program name, de, enter in column nd enter in column				0.00	0.00	61. 20
							1.00	
	ACA Provisions Affecting the Heal	th Resources and Ser	vi ces	Administration	(HRSA)		1.00	
62. 00	Enter the number of FTE residents your hospital received HRSA PCRE	that your hospital	trai ne			od for which	0.00	62. 00
62. 01	Enter the number of FTE residents during in this cost reporting per Teaching Hospitals that Claim Res	iod of HRSA THC prog	ıram. (:	<u>see instruction</u>		your hospital	0.00	62. 01
63. 00	.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)						N	63. 00
					Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	To the second se				1. 00	2.00	3.00	
(4.00	Section 5504 of the ACA Base Year period that begins on or after Ju	lly 1, 2009 and befor	e June	30, 2010.				44.00
64. 00	Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	er of unweighted nor ations occurring in number of unweighted r hospital. Enter ir + column 2)). (see	i-prima all non l non-p n column instru	ry care nprovider rimary care n 3 the ratio ctions)	0. 00			64. 00
		Program Name	Pr	ogram 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	

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150115 Peri od: Worksheet S-2 From 07/01/2014 Part I Date/Time Prepared: 06/30/2015 11/23/2015 9:52 am Unwei ghted Unwei ghted Program Name Program Code Ratio (col. 3/ (col. 3 + col FTEs FTEs in Hospi tal 4)) Nonprovi der Si te 1.00 2.00 3.00 4.00 5.00 0. 00 0. 00 0.000000 65.00 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) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most O Ν N 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Health Financial Systems MEMORIAL HOSP & H	IEALTH CARE CTF	?	In Li	eu of Form CMS-	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	CCN: 150115	Peri od: From 07/01/201 To 06/30/201		epared:		
				1.00	+		
Long Term Care Hospital PPS							
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part c "Y" for yes and "N" for no. TEFRA Providers			ng period? Enter	N N	80. 00 81. 00		
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		-		N	85. 00 86. 00		
87.00 Is this hospital a "subclause (II)" LTCH classified under se for yes or "N" for no.	ection 1886(d)	(1)(B)(iv)(II)? Enter "Y"	N	87. 00		
, , , , , , , , , , , , , , , , , , ,			V 1. 00	XI X 2. 00			
Title V and XIX Services			1.00	2.00			
90.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	al services? E	nter "Y" for	N	Y	90. 00		
91.00 Is this hospital reimbursed for title V and/or XIX through t full or in part? Enter "Y" for yes or "N" for no in the appl			N	N	91. 00		
92.00 Are title XIX NF patients occupying title XVIII SNF beds (duinstructions) Enter "Y" for yes or "N" for no in the applications	ual certificat			N	92. 00		
93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.	N	93. 00					
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	N	94. 00					
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			O. 0	0. 00 N	95. 00 96. 00		
	applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. O.00 Rural Providers						
105.00 Does this hospital qualify as a critical access hospital (CF 106.00 of this facility qualifies as a CAH, has it elected the all-	*	had of navmor	N N		105. 00		
for outpatient services? (see instructions) 107.00 of this facility qualifies as a CAH, is it eligible for cost		107. 00					
training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.							
108.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.				_	108. 00		
	Physi cal 1.00	0ccupationa 2.00	Speech 3.00	Respiratory 4.00	+		
109.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1. 00	2.00	0.00	1.00	109. 00		
				1.00	+		
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (4	410A Demo)for	N	110. 00		
			1.	00 2.00 3.00			
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider	If column 2 nt for long te	is "E", enter rm care (incl	rin column udes	0	115. 00		
Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insuruo.			r "N" for \	1 1	116. 00 117. 00		
118.00 s the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1	if the policy	yis 1		118. 00		
		Premi ums	Losses	Insurance			
		1. 00	2.00	3.00			
118.01 List amounts of malpractice premiums and paid losses:		1, 146, 1	166	0	0 118. 01		

148.00 Was there a change in the order of allocation? Enter "Y" fol	r yes or "N" fo	or no.		N	148.00
149.00 Was there a change to the simplified cost finding method? En	nter "Y" for ye	es or "N" for n	0.	N	149. 00
	Part A	Part B	Title V	Title XIX	
	1.00	2.00	3. 00	4. 00	
Does this facility contain a provider that qualifies for an	exemption from	n the applicati	on of the lowe	r of costs	
or charges? Enter "Y" for yes or "N" for no for each compon	ent for Part A	and Part B. (S	See 42 CFR §413	. 13)	1
155. 00 Hospi tal	N	N	N	N	155. 00
156. 00 Subprovi der - I PF	N	N	N	N	156. 00
157. 00 Subprovi der - I RF	N	N	N	N	157. 00
158. 00 SUBPROVI DER					158. 00
159. 00 SNF	N	N	N	N	159. 00
160.00 HOME HEALTH AGENCY	N	N	N	N	160. 00
161. 00 CMHC		N	N	N	161. 00

Health Financial Systems	MEMORIAL HOS	SP & HEALTI	I CARE CTR			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150115 Period: From 07/01/2014 To 06/30/2015								epared:
							1 00	_
Multicampus							1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that ha	as one or	more campu	ses in di	ifferent	CBSAs?	N	165. 00
	Name	Co	unty	State	Zip Co	de CBSA	FTE/Campus	
	0	1	. 00	2. 00	3.00	4. 00	5.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.0	0 166. 00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								1/7 00
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							Y	167. 00 0168. 00
reasonable cost incurred for the HIT assets (see instructions)								9100.00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168. 01
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0. 7	5169. 00	
Begi nni ng							Endi ng	
1.00								
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 07/01/2014 period respectively (mm/dd/yyyy)							09/30/2014	170. 00
474 001 01 477 1 11/11						07/	1.00	174 00
171.00 f line 167 is "Y", does this prov Medicare cost plans reported on Wk (see instructions)							N	171. 00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150115 Peri od: Worksheet S-2 From 07/01/2014 Part II Date/Time Prepared: 06/30/2015 11/23/2015 9:52 am Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν 21 00 Ν provider's records? If yes, see instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 22.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit 27.00 сору Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting 28.00 period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If 33.00 33.00 no, see instructions. Provi der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? 34.00 If yes, see instructions. Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36, 00 Were home office costs claimed on the cost report? 36, 00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of 38.00 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 39.00 see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position BOB BRANDFNBURG 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report BKD, LLP 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost (317) 383-3787 BBRANDENBURG@BKD. COM 43.00 report preparer in columns 1 and 2, respectively.

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150115 Peri od: Worksheet S-2 From 07/01/2014 To 06/30/2015 Part II Date/Time Prepared: 11/23/2015 9:52 am Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 09/28/2015 16.00 Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R 17.00 Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position PARTNER 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 43.00 report preparer in columns 1 and 2, respectively.

Health Financial Systems MEMORIAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Component Worksheet A Line Number 1.00 Feet 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospic ed also) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 1.00
Component Worksheet A No. of Beds Bed Days Available A
No. of Beds Bed Days Available Ava
Line Number
1.00
1.00
Hospice days) (see instructions for col. 2 For the portion of LDP room available beds)
For the portion of LDP room available beds 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 3.00 4.00 HM0 IPF Subprovider 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 6.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 1.
2.00
3.00
4.00 HMO IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 43.00 14.00 Total (see instructions) 15.00 CAH visits 15.00 SUBPROVIDER - IPF 40.00 SUBPROVIDER - IRF 41.00 SUBPROVIDER 19.00 SUBPROVIDER 19.00 SUBPROVIDER 19.00 SUBPROVIDER 19.00 SUBPROVIDER 19.00 SUBPROVIDER 19.00 NURSING FACILITY 44.00 20 7, 300 21.00 OTHER LONG TERM CARE
5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 43.00 15.00 CAH visits 16.00 SUBPROVIDER - IRF 40.00 SUBPROVIDER 19.00 SUBPROVIDER 19.00 SUBPROVIDER 19.00 SUBPROVIDER 20.00 NURSING FACILITY 44.00 Total (see instructions) 20.00 NURSING FACILITY 44.00 Total (SUBPROVIDER 20.00 NURSING FACILITY 44.00 Total CONTROL TO TOTAL C
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 143.00 15.00 CAH visits 10.00 SUBPROVIDER - IPF 19.00 SUBPROVIDER 19.00 SUBPROVIDER 19.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 44.00 CO.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE
7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 143.00 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 21.00 OTHER LONG TERM CARE 22.00 OTHER LONG TERM CARE 24.00 OTHER LONG TERM CARE 25.00 O.00 O 0 8.00 26.00 9, 490 0.00 O 0 8.00 9, 490 0.00 O 0 0 8.00 9, 490 0.00 O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
Beds (see instructions)
8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 43.00 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 40.00 TO SUBPROVIDER - IRF 19.00 SUBPROVIDER TRF 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 44.00 20 7, 300 21.00 OTHER LONG TERM CARE
9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGI CAL INTENSIVE CARE UNIT 11.00
10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 43.00 14.00 Total (see instructions) 15.00 CAH visits 10.00 15.00 SUBPROVIDER - IPF 40.00 19 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 20.00 21.00 OTHER LONG TERM CARE
11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 12. 00 13. 00 14. 00 15. 00 15. 00 15. 00 16. 00 17. 00 18. 00 18. 00 18. 00 19. 00
12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 43.00 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 40.00 19 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE
13. 00 NURSERY 43. 00 111 40,515 0. 00 0 13. 00 14. 00 15. 00 15. 00 15. 00 15. 00 15. 00 16. 00 17. 00 SUBPROVI DER - I RF 41. 00 8 2,920 0 17. 00 18. 00 SUBPROVI DER 18. 00 18. 00 19.
14. 00 Total (see instructions) 111 40,515 0.00 0 14. 00 15. 00 CAH visits 0 15. 00 16. 00 SUBPROVI DER - I PF 40. 00 19 6,935 0 16. 00 17. 00 SUBPROVI DER - I RF 41. 00 8 2,920 0 17. 00 18. 00 SUBPROVI DER 18 18 18 18 18 19. 00 SKI LLED NURSI NG FACI LI TY 44. 00 20 7,300 0 19. 00 20. 00 NURSI NG FACI LI TY 20. 00 21. 00 OTHER LONG TERM CARE 21. 00
15. 00 CAH visits 0 15. 00 16. 00 SUBPROVIDER - IPF 40. 00 19 6, 935 0 16. 00 17. 00 SUBPROVIDER - IRF 41. 00 8 2, 920 0 17. 00 18. 00 SUBPROVIDER 18. 00 19. 00 SKILLED NURSING FACILITY 44. 00 20 7, 300 0 19. 00 20. 00 NURSING FACILITY 20. 00 21. 00 OTHER LONG TERM CARE
16. 00 SUBPROVI DER - I PF 40. 00 19 6, 935 0 16. 00 17. 00 SUBPROVI DER - I RF 41. 00 8 2, 920 0 17. 00 18. 00 SUBPROVI DER 18. 00 19. 00 SKI LLED NURSI NG FACI LI TY 44. 00 20 7, 300 0 19. 00 20. 00 NURSI NG FACI LI TY 20. 00 21. 00 OTHER LONG TERM CARE 21. 00
17. 00 SUBPROVIDER - IRF
18. 00 SUBPROVI DER
19.00 SKILLED NURSING FACILITY 44.00 20 7,300 0 19.00 20.00 NURSING FACILITY 20.00 21.00 OTHER LONG TERM CARE 21.00
20.00 NURSING FACILITY 20.00 21.00 OTHER LONG TERM CARE 21.00
21. 00 OTHER LONG TERM CARE 21. 00
22. 00 HOME HEALTH AGENCY 101. 00 0 22. 00
23.00 AMBULATORY SURGICAL CENTER (D. P.)
24.00 HOSPICE 116.00 0 0 24.00
24. 10 HOSPICE (non-distinct part) 30.00 24.10
25. 00 CMHC - CMHC 25. 00
26. 00 RURAL HEALTH CLINIC 88. 00 0 26. 00
26. 01 RURAL HEALTH CLINIC II 88. 01 0 26. 01
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 0 26. 25
27.00 Total (sum of lines 14-26) 158 27.00
28.00 Observation Bed Days 0 28.00
29. 00 Ambul ance Trips
30.00 Employee discount days (see instruction)
31.00 Employee discount days - IRF
32.00 Labor & delivery days (see instructions) 0 0 32.00
32.01 Total ancillary labor & delivery room 32.01
outpatient days (see instructions)
33.00 LTCH non-covered days 33.00 LTCH non-covered days
, , , , , , , , , , , , , , , , , , , ,

Health Financial Systems MEMORIAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150115

| Peri od: | Worksheet S-3 | From 07/01/2014 | Part | To 06/30/2015 | Date/Time Prepared: | 11/23/2015 9: 52 am

		_				11/23/2015 9:	52 am
		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	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	5, 151	393	10, 877	7. 00	10.00	1. 00
1.00	8 exclude Swing Bed, Observation Bed and	0, 101	3,3	10,011			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	365	1, 764				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	o	15				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7.00	Total Adults and Peds. (exclude observation	5, 151	393	10, 877			7. 00
	beds) (see instructions)			•			
8.00	INTENSIVE CARE UNIT	2, 812	163	4, 298			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		77	2, 021			13. 00
14.00	Total (see instructions)	7, 963	633	17, 196	0.00	1, 145. 46	14. 00
15.00	CAH visits	0	O	0		·	15. 00
16.00	SUBPROVI DER - I PF	2, 232	643	3, 760	0.00	34. 61	16. 00
17.00	SUBPROVI DER - I RF	1, 011	15	1, 335	0.00	11. 24	17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY	4, 073	47	4, 985	0.00	25. 25	19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22.00	HOME HEALTH AGENCY	9, 842	1, 801	15, 545	0.00	23. 02	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0	0	0	0.00	0.00	24. 00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	1, 350	0	3, 528		3. 61	26. 00
26. 01	RURAL HEALTH CLINIC II	2, 094	0	6, 597	0.00	6. 26	26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	1, 249. 45	27. 00
28.00	Observation Bed Days		429	2, 215			28. 00
29.00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			0			30. 00
31.00	Employee discount days - IRF			0			31. 00
32.00	Labor & delivery days (see instructions)	0	181	377			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33. 00
		·	·		·		

Heal th Fi nancial SystemsMEMORIAL HORDITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 150115

| Peri od: | Worksheet S-3 | From 07/01/2014 | Part I | To 06/30/2015 | Date/Time Prepared:

Full Time Equivalents Title V Title XVIII Title XIX Total All Patients Nonpaid Workers Workers Title V Title XVIII Title XIX Total All Patients Nonpaid Workers Title V Title XVIII Title XIX Total All Patients Title V Title XVIII Title XIX Total All Patients Title V Title XVIII Title XVIII Title XIX Total All Patients Title V Title XVIII Title XVIII Title XIX Total All Patients Title XIX Total All Patients Title XIX Total All I Title XIX
Nonpaid Workers Title V Title XVIII Title XIX Total All Patients
Workers Workers Patients
1.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00
8 exclude Swing Bed, Observation Bed and Hospi ce days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00
For the portion of LDP room available beds 2.00
3.00
4.00 HMO IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 18.00 SUBPROVIDER 18.00 SUBPROVIDER 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 19.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 20.00 22.00 22.00
5.00 Hospi tal Adults & Peds. Swing Bed SNF 6.00 Hospi tal Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 11.00 SURGI CAL INTENSIVE CARE UNIT 12.00 OTHER SPECI AL CARE (SPECI FY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVI DER - IPF 17.00 SUBPROVI DER - IRF 18.00 SUBPROVI DER 19.00 SKILLED NURSI NG FACI LITY 20.00 NURSING FACI LITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 20.00 20.00 TOTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 10.00 Total (see instructions) 10.00 SUBPROVIDER - IPF 10.00 SUBPROVIDER - IRF 10.00 SUBPROVIDER 10.00 SUBPROVIDER 10.00 SUBPROVIDER 10.00 SUBPROVIDER 10.00 SUBPROVIDER 10.00 SUBPROVIDER 11.50 ON
7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 10.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 11.00 Total (see instructions) 10.00 CAH visits 10.00 SUBPROVIDER - IPF 10.00 OSUBPROVIDER - IRF 10.00 OSUBPROVIDER - IRF 10.00 OSUBPROVIDER ON OSUBPROVIDER 11.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 12.00 OTHER LONG TERM CARE
B. 00
9. 00 CORONARY CARE UNIT 9. 00 10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 13. 00 NURSERY 14. 00 Total (see instructions) 0. 00 0 2, 444 785 5, 941 14. 00 15. 00 CAH visits 15. 00 16. 00 SUBPROVIDER - IPF 0. 00 0 269 100 565 16. 00 17. 00 SUBPROVIDER - IRF 0. 00 0 83 1 115 17. 00 18. 00 18. 00 19. 00 SKILLED NURSING FACILITY 0. 00 20. 00 NURSING FACILITY 0. 00 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 0. 00 0. 0
10. 00 BURN INTENSIVE CARE UNIT 10. 00 11. 00 11. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 15. 00 16. 00 SUBPROVI DER - I PF 0. 00 0 269 100 565 16. 00 17. 00 SUBPROVI DER - I RF 0. 00 0 0 0 0 0 0 0 0
11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 13. 00 14. 00 Total (see instructions) 0. 00 0 2, 444 785 5, 941 14. 00 15. 00 CAH visits 15. 00 16. 00 SUBPROVI DER - IPF 0. 00 0 269 100 565 16. 00 17. 00 18. 00 SUBPROVI DER 1FF 0. 00 0 83 1 115 17. 00 18. 00 19. 00 SKILLED NURSING FACILITY 0. 00 20. 00 NURSING FACILITY 0. 00 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 0. 00 22. 00 0. 0
12. 00 OTHER SPECIAL CARE (SPECIFY) 12. 00 13. 00 14. 00 Total (see instructions) 0. 00 0 2, 444 785 5, 941 14. 00 15. 00 CAH visits 15. 00 16. 00 SUBPROVI DER - I PF 0. 00 0 269 100 565 16. 00 17. 00 SUBPROVI DER - I RF 0. 00 0 83 1 115 17. 00 18. 00 19. 00 SKILLED NURSING FACILITY 0. 00 20. 00 NURSING FACILITY 20. 00 20. 00 NURSING FACILITY 20. 00 21. 00 OTHER LONG TERM CARE 21. 00 22. 00 HOME HEALTH AGENCY 0. 00 22. 00
13. 00 NURSERY 13. 00 14. 00 Total (see instructions) 0. 00 0 2, 444 785 5, 941 14. 00 15. 00 16. 00 SUBPROVI DER - I PF 0. 00 0 269 100 565 16. 00 17. 00 SUBPROVI DER - I RF 0. 00 0 83 1 115 17. 00 18. 00 18. 00 19. 00 SKI LLED NURSI NG FACI LI TY 0. 00 20. 00 NURSI NG FACI LI TY 20. 00 NURSI NG FACI LI TY 20. 00 0 THER LONG TERM CARE 21. 00 22. 00 HOME HEALTH AGENCY 0. 00 22. 00 22. 00 23. 00 24.444 785 5, 941 14. 00 15. 00 15. 00 15. 00 15. 00 15. 00 16. 00 17. 00 18. 00 18. 00 18. 00 18. 00 19. 00
14. 00 Total (see instructions) 0. 00 0 2, 444 785 5, 941 14. 00 15. 00 16. 00 SUBPROVI DER - I PF 0. 00 0 269 100 565 16. 00 17. 00 SUBPROVI DER - I RF 0. 00 0 83 1 115 17. 00 18. 00 18. 00 19. 00 SKI LLED NURSI NG FACI LI TY 0. 00 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 0. 00 22. 00 0.
15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 25. 00 CAH visits 26. 00 O CO CAH visits 26. 00 CO CO CAH visits 26. 00 CO CAH visits 27. 00 CO CAH visits 27. 00 CO CAH visits 27. 00 CO CAH visits 28. 00 CO CAH visits 28. 00 CO
16. 00 SUBPROVI DER - I PF 0. 00 0 269 100 565 16. 00 17. 00 SUBPROVI DER - I RF 0. 00 0 83 1 115 17. 00 18. 00 19. 00 1
17. 00 SUBPROVI DER - I RF 0. 00 0 83 1 115 17. 00 18. 00 19. 00 19. 00 20. 00 NURSI NG FACILITY 0. 00 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 0. 00
18. 00 SUBPROVI DER 18. 00 19. 00 19. 00 19. 00 20. 00 NURSI NG FACILITY 20. 00 21. 00 OTHER LONG TERM CARE 21. 00 22. 00 HOME HEALTH AGENCY 0. 00 22. 00 22. 00 22. 00 23. 00 24. 00 24. 00 25. 00
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20. 00 NURSING FACILITY 20. 00 21. 00 OTHER LONG TERM CARE 21. 00 22. 00 HOME HEALTH AGENCY 0. 00 22. 00
21. 00 OTHER LONG TERM CARE 21. 00 22. 00 HOME HEALTH AGENCY 0. 00 22. 00
22. 00 HOME HEALTH AGENCY 0. 00 22. 00
23 OO AMBULI ATORY SURGICAL CENTER (D.P.)
25. 00 Number 1 on 1 o
24. 00 HOSPI CE 0. 00 24. 00
24. 10 HOSPICE (non-distinct part) 24. 10
25. 00 CMHC - CMHC 25. 00
26. 00 RURAL HEALTH CLINIC 0. 00 26. 00
26. 01 RURAL HEALTH CLINIC II 0. 00 26. 01
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26. 25
27.00 Total (sum of lines 14-26) 0.00 27.00
28.00 Observation Bed Days 28.00
29. 00 Ambul ance Tri ps
30.00 Employee discount days (see instruction) 30.00
31.00 Employee discount days - IRF
32.00 Labor & delivery days (see instructions) 32.00
32.01 Total ancillary labor & delivery room 32.01
outpatient days (see instructions)
33. 00 LTCH non-covered days

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 150115

					T	06/30/2015	Date/Time Pre 11/23/2015 9:	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries (from	Sal ari es (col . 2 ± col .	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				Worksheet A-6)	3)	col. 4	Coi . 5)	
		1.00	2. 00	3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA							-
1. 00	SALARIES Total salaries (see	200. 00	85, 520, 301	0	85, 520, 301	2, 598, 926. 00	32. 91	1.00
	instructions)							
2.00	Non-physician anesthetist Part		0	0	0	0. 00	0.00	2. 00
3.00	A Non-physician anesthetist Part		2, 547, 580	0	2, 547, 580	24, 513. 00	103. 93	3.00
	В							
4. 00	Physician-Part A - Administrative		205, 584	0	205, 584	800.00	256. 98	4. 00
4. 01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4. 01
5.00	Physician-Part B		6, 716, 276		6, 716, 276			
6. 00 7. 00	Non-physician-Part B Interns & residents (in an	21. 00	492, 924	0	492, 924	16, 366. 00 0. 00		
7.00	approved program)	21.00	0	٥		0.00	0.00	7.00
7. 01	Contracted interns and		0	0	0	0.00	0.00	7. 01
	residents (in an approved programs)							
8.00	Home office personnel		0	0	0	0.00	0.00	8. 00
9.00	SNF	44. 00	1, 212, 605				1	1
10. 00	Excluded area salaries (see instructions)		30, 545, 220	179, 603	30, 724, 823	778, 534. 00	39. 46	10.00
	OTHER WAGES & RELATED COSTS							1
11. 00	Contract Labor: Direct Patient Care		0	0	0	0. 00	0.00	11. 00
12. 00	Contract Labor: Top Level		0	0	0	0.00	0.00	12. 00
	management and other							
	management and administrative services							
13. 00	Contract Labor: Physician-Part		119, 418	o	119, 418	1, 091. 00	109. 46	13. 00
14.00	A - Administrative		0			0.00		14.00
14. 00	Home office salaries & wage-related costs		0	0	0	0. 00	0.00	14. 00
15. 00	Home office: Physician Part A		0	0	0	0.00	0.00	15. 00
16. 00	- Administrative Home office and Contract		0	0	0	0. 00	0.00	16. 00
	Physicians Part A - Teaching							
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		10, 606, 918	0	10, 606, 918			17. 00
	instructions)		10,000,710		10,000,710			
18. 00	Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00	Excluded areas		5, 165, 799	0	5, 165, 799			19. 00
20. 00	Non-physician anesthetist Part		0	0	0			20.00
21. 00	Non-physician anesthetist Part		152, 372	0	152, 372			21.00
	В			_	_			
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
23. 00	Physician Part B		192, 745		192, 745			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		37, 008 0		37, 008 0			24. 00 25. 00
	approved program)							
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	1, 706, 884	-842, 778	864, 106	15, 752. 00	54. 86	26. 00
27. 00	Administrative & General	5. 00	7, 643, 942					
28. 00	Administrative & General under		104, 450	0	104, 450	536. 00	194. 87	28. 00
29. 00	contract (see inst.) Maintenance & Repairs	6. 00	1, 554, 748	19, 476	1, 574, 224	68, 221. 00	23. 08	29. 00
30. 00	Operation of Plant	7. 00	0	0	0	0.00		
31. 00	Laundry & Linen Service	8. 00	214, 693				•	1
32. 00 33. 00	Housekeeping under contract	9. 00	953, 574 0		968, 292 0	80, 622. 00 0. 00	1	1
	(see instructions)		· ·					
34.00	Di etary	10. 00	1, 024, 910	-683, 966	340, 944		1	1
35. 00	Di etary under contract (see instructions)		0	"	0	0. 00	0.00	35. 00
36. 00	Cafeteri a	11. 00	0	702, 997	702, 997			
37. 00 38. 00	Maintenance of Personnel Nursing Administration	12. 00 13. 00	0 885, 239	0 8, 584	0 893, 823	0. 00 28, 041. 00		37. 00 38. 00
38.00	Central Services and Supply	13.00	885, 239 225, 402			28, 041. 00 15, 819. 00		
40. 00	1 ,	15. 00	1, 782, 308				1	40.00

Health Financial Systems	MEI	MORIAL HOSP &	HEALTH CARE CTF	?	In Lie	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
					From 07/01/2014		
					To 06/30/2015		
						11/23/2015 9:	<u>52 am</u>
	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	
41.00 Medical Records & Medical	16. 00	1, 028, 596	16, 057	1, 044, 65	3 53, 773. 00	19. 43	41.00
Records Library							
42.00 Social Service	17. 00	0	0		0.00	0.00	42.00
43.00 Other General Service	18. 00	0	0		0.00	0.00	43. 00

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 150115 Peri od: Worksheet S-3 From 07/01/2014 To 06/30/2015 Part III Date/Time Prepared: 11/23/2015 9:52 am 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 . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 75, 867, 971 75, 867, 971 2, 521, 959. 00 30. 08 1.00 instructions) 2.00 31, 757, 825 194, 451 31, 952, 276 831, 053. 00 38. 45 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 44, 110, 146 -194, 451 43, 915, 695 1, 690, 906. 00 25.97 3.00 minus line 2) 4.00 Subtotal other wages & related 119, 418 119, 418 1, 091. 00 109.46 4.00 costs (see inst.) Subtotal wage-related costs 5.00 10, 606, 918 Ω 10, 606, 918 0.00 24. 15 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 54, 836, 482 -194, 451 54, 642, 031 1, 691, 997. 00 32 29 7.00 Total overhead cost (see 17, 124, 746 -458, 208 16, 666, 538 699, 180. 00 23.84 7.00

instructions)

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lieu	of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150115	Peri od:	Worksheet S-3

1103111	AL WAGE RELATED COSTS	Trovider	CON. 130113	From 07/01/2014 To 06/30/2015	Part IV Date/Time Pre 11/23/2015 9:	
		•			Amount	
					Reported	
					1. 00	
	PART IV - WAGE RELATED COSTS					
	Part A - Core List					
	RETI REMENT COST					
1.00	401K Employer Contributions				1, 367, 570	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution				0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)				-327, 679	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)				8, 951, 286	8. 00
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)				69, 879	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)				221, 671	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)				0	14. 00
15.00	'Workers' Compensation Insurance				353, 072	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraord	di nary acc	rual require	d by FASB 106.	0	16. 00
	Non cumulative portion)					
	TAXES					
	FICA-Employers Portion Only				5, 207, 311	
18. 00	Medicare Taxes - Employers Portion Only				0	
19. 00	Unemployment Insurance				52, 641	
20.00	State or Federal Unemployment Taxes				0	20. 00
	OTHER					
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Repo	orted on I	ines 1 throu	gh 4 above. (see	0	21. 00
	instructions))					
22. 00	Day Care Cost and Allowances				0	22. 00
	Tuition Reimbursement				259, 091	
24. 00	Total Wage Related cost (Sum of lines 1 -23)				16, 154, 842	24. 00
0= 6-	Part B - Other than Core Related Cost					
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)				0	25. 00

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 150115	Period: Worksheet S-3

		Ϊ	o 06/30/2015	Date/Time Pre 11/23/2015 9:	
	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		0	0	1. 00
2.00	Hospi tal		0	0	2. 00
3.00	Subprovi der - IPF		0	0	3. 00
4.00	Subprovi der - I RF		0	0	4. 00
5.00	Subprovi der - (Other)		0	0	5. 00
6. 00	Swing Beds - SNF		0	0	6. 00
7. 00	Swing Beds - NF		0	0	7. 00
8. 00	Hospi tal -Based SNF		0	0	8. 00
9. 00	Hospi tal -Based NF				9. 00
10. 00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA		0	0	11. 00
12. 00	Separately Certified ASC				12.00
13. 00	Hospi tal -Based Hospi ce		0	0	13. 00
14. 00	Hospital-Based Health Clinic RHC		0	0	14.00
	Hospital-Based Health Clinic RHC 1		0	0	14. 01
	Hospital-Based Health Clinic FQHC		0	0	15. 00
16. 00	Hospi tal -Based-CMHC				16. 00
17. 00	Renal Dialysis		0	0	17. 00
18. 00	Other		0	0	18. 00

Heal th	Financial Systems ME	MORIAL HOSP &	HEALTH CARE CT	2	In lie	eu of Form CMS-2	2552-10
	HEALTH AGENCY STATISTICAL DATA	LIMORETALE FIGURE		CCN: 150115	Peri od:	Worksheet S-4	
			Componen ⁻		From 07/01/2014 To 06/30/2015	Date/Time Pre	pared:
					Home Health	11/23/2015 9: PPS	52 am
					Agency I		
					1.	00	-
0. 00	County		1				0. 00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1. 00 2. 00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00			•		1. 00 2. 00
2.00	Torrador Fourier Constitution (Coop Triber do triber)	0.00	100.00		oloyees (Full Ti		2.00
		Enter the numb	er of hours in I work week	Staff	Contract	Total	
	HOME HEALTH ACENOV NUMBER OF ENDLOYEES	(0	1.00	2. 00	3.00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		0. 00	0.0	0.00	0.00	3. 00
4.00	Director(s) and Assistant Director(s)			1.0	0.00	1.00	4. 00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			4. 7 10. 2		l .	1
7.00	Nursi ng Supervi sor			0. 1	6 0.00	0. 16	7. 00
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			1.7		l .	1
10.00	Occupational Therapy Service			0.8	0.00	0. 81	10.00
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0.0		l .	
13. 00	Speech Pathology Supervisor			0.0	0.00	0.00	13. 00
14. 00 15. 00	Medical Social Service Medical Social Service Supervisor			0.0			14. 00 15. 00
16. 00	Home Heal th Ai de			0.0			1
17. 00 18. 00	Home Health Aide Supervisor Other (specify)			0.0			1
16.00	HOME HEALTH AGENCY CBSA CODES			0.0	0.00	0.00	18.00
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost				2		19. 00
	reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			99915			20. 00
	contains the first code).						
20. 01		Full E	pi sodes	50031			20. 01
		Wi thout	With Outliers	LUPA Epi sodes	,	Total (cols.	
		0utliers 1.00	2.00	3.00	Epi sodes 4. 00	1-4) 5. 00	
	PPS ACTIVITY DATA						
21. 00 22. 00	Skilled Nursing Visits Skilled Nursing Visit Charges	4, 039 696, 475		1			1
23. 00	Physical Therapy Visits	2, 080	43	1	3 69	2, 205	23. 00
24. 00 25. 00	Physical Therapy Visit Charges Occupational Therapy Visits	413, 972 641			0 13, 800 3 41		
26. 00	Occupational Therapy Visit Charges	127, 972	l .	•			
27. 00 28. 00	Speech Pathology Visits Speech Pathology Visit Charges	4, 600			0 2 0 400	25 5, 000	
29. 00	Medical Social Service Visits	4,000		l .	0 0		29. 00
30.00	Medical Social Service Visit Charges	1, 778			0 4 76		
31. 00 32. 00	Home Health Aide Visits Home Health Aide Visit Charges	150, 681					1
33. 00	Total visits (sum of lines 21, 23, 25, 27,	8, 561	735	22	2 324	9, 842	33. 00
34. 00	29, and 31) Other Charges	0	c		0 0	0	34. 00
35. 00	Total Charges (sum of lines 22, 24, 26, 28,	1, 393, 700	116, 695	32, 51	4 51, 375	1, 594, 284	35. 00
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	448		5	9 20	527	36. 00
	outlier)				1		
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	52, 334	15 5, 272		1, 027	16 59, 661	38.00

0

0 68.00

BA1

68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	P & HEALTH CARE CT Provi der	CCN: 150115	Peri od:	eu of Form CMS- Worksheet S-7	
			From 07/01/2014		
			To 06/30/2015	Date/Time Pre 11/23/2015 9:	
	Group	SNF Days	Swing Bed SNF		<u> </u>
	'		Days	col . 2 + 3)	
	1.00	2. 00	3. 00	4. 00	
69. 00	PE2		0 0	0	69.00
70. 00	PE1		0 0	0	70.00
71. 00	PD2		0 0	0	71.00
72. 00	PD1		0 0	0	72.00
73. 00	PC2		0 0	0	73.00
74. 00	PC1		4	4	74.00
75. 00	PB2		0 0	0	75. 00
76. 00	PB1		6	6	76.00
77. 00	PA2		0 0	o o	77.00
78. 00	PA1		8	8	78.00
199. 00	AAA		0 0	ol o	199. 00
200. 00 TOTAL		4, 0	73 C	4, 073	200. 00
	<u>'</u>		CBSA at	CBSA on/after	
			Beginning of	October 1 of	
			Cost Reporting	the Cost	
			Peri od	Reporting	
				Period (if	
				applicable)	
			1 00		
			1. 00	2.00	
SNF SERVI CES					
201.00 Enter in column 1 the SNF CBSA code or 5 character non			99915	99915	201. 00
201.00 Enter in column 1 the SNF CBSA code or 5 character non in effect at the beginning of the cost reporting perio	d. Enter in column	2, the code			201. 00
201.00 Enter in column 1 the SNF CBSA code or 5 character non	d. Enter in column	2, the code ble).	99915	99915	201. 00
201.00 Enter in column 1 the SNF CBSA code or 5 character non in effect at the beginning of the cost reporting perio	d. Enter in column	2, the code		99915 Associ ated	201. 00
201.00 Enter in column 1 the SNF CBSA code or 5 character non in effect at the beginning of the cost reporting perio	d. Enter in column	2, the code ble).	99915	99915 Associated with Direct	201. 00
201.00 Enter in column 1 the SNF CBSA code or 5 character non in effect at the beginning of the cost reporting perio	d. Enter in column	2, the code ble).	99915	99915 Associated with Direct Patient Care	201. 00
201.00 Enter in column 1 the SNF CBSA code or 5 character non in effect at the beginning of the cost reporting perio	d. Enter in column	2, the code ble).	99915	99915 Associated with Direct Patient Care and Related	201. 00
201.00 Enter in column 1 the SNF CBSA code or 5 character non in effect at the beginning of the cost reporting perio	d. Enter in column	2, the code of e). Expenses	99915 Percentage	99915 Associated with Direct Patient Care and Related Expenses?	201. 00
201.00 Enter in column 1 the SNF CBSA code or 5 character non in effect at the beginning of the cost reporting perio in effect on or after October 1 of the cost reporting	d. Enter in column period (if applical	2, the code ol e). Expenses	99915 Percentage 2.00	99915 Associ ated with Direct Patient Care and Rel ated Expenses? 3.00	201. 00
201.00 Enter in column 1 the SNF CBSA code or 5 character non in effect at the beginning of the cost reporting perio in effect on or after October 1 of the cost reporting A notice published in the Federal Register Volume 68, 1	d. Enter in column period (if applical No. 149 August 4, 2	2, the code of e). Expenses 1.00 2003 provi ded	99915 Percentage 2.00 for an increase	Associated with Direct Patient Care and Related Expenses? 3.00 in the RUG	201. 00
201.00 Enter in column 1 the SNF CBSA code or 5 character non in effect at the beginning of the cost reporting perio in effect on or after October 1 of the cost reporting A notice published in the Federal Register Volume 68, payments beginning 10/01/2003. Congress expected this	d. Enter in column period (if applical No. 149 August 4, 2 Increase to be used	2, the code of e). Expenses 1.00 2003 provided for direct	99915 Percentage 2.00 for an increase patient care and	99915 Associated with Direct Patient Care and Related Expenses? 3.00 in the RUG related	201. 00
A notice published in the Federal Register Volume 68, payments beginning 10/01/2003. Congress expected this expenses. For lines 202 through 207: Enter in column 1	d. Enter in column period (if applical No. 149 August 4, : Increase to be used the amount of the	2, the code of e). Expenses 1.00 2003 provi ded d for di rect expense for	99915 Percentage 2.00 for an increase patient care and each category. E	99915 Associated with Direct Patient Care and Related Expenses? 3.00 in the RUG related nter in	201.00
A notice published in the Federal Register Volume 68, payments beginning 10/01/2003. Congress expected this expenses. For lines 202 through 207: Enter in column 1 column 2 the percentage of total expenses for each cate	d. Enter in column period (if applical No. 149 August 4, 2) Increase to be used the amount of the egory to total SNF	2, the code of e). Expenses 1.00 2003 provided of for direct expense for revenue from	99915 Percentage 2.00 for an increase and each category. E Worksheet G-2,	99915 Associated with Direct Patient Care and Related Expenses? 3.00 in the RUG related nter in Part I,	201.00
A notice published in the Federal Register Volume 68, payments beginning 10/01/2003. Congress expected this expenses. For lines 202 through 207: Enter in column 1 column 3. In column 3, enter "Y" for yes or "N"	d. Enter in column period (if applical No. 149 August 4, 2) increase to be used the amount of the egory to total SNF' for no if the specific columns in the specific columns.	2, the code ole). Expenses 1.00 2003 provided of or direct expense for revenue from ending reflected of the code of the cod	99915 Percentage 2.00 for an increase and each category. E Worksheet G-2,	99915 Associated with Direct Patient Care and Related Expenses? 3.00 in the RUG related nter in Part I,	201.00
A notice published in the Federal Register Volume 68, payments beginning 10/01/2003. Congress expected this expenses. For lines 202 through 207: Enter in column 1 column 2 the percentage of total expenses for each cat line 7, column 3. In column 3, enter "Y" for yes or "N" with direct patient care and related expenses for each	d. Enter in column period (if applical No. 149 August 4, 2) increase to be used the amount of the egory to total SNF' for no if the specific columns in the specific columns.	2, the code ole). Expenses 1.00 2003 provided of or direct expense for revenue from ending reflected of the code of the cod	99915 Percentage 2.00 for an increase patient care and each category. E Worksheet G-2, ts increases ass	Associated with Direct Patient Care and Related Expenses? 3.00 in the RUG related nter in Part I, ociated	
A notice published in the Federal Register Volume 68, payments beginning 10/01/2003. Congress expected this expenses. For lines 202 through 207: Enter in column 1 column 2 the percentage of total expenses for each catiline 7, column 3. In column 3, enter "Y" for yes or "N" with direct patient care and related expenses for each 202.	d. Enter in column period (if applical No. 149 August 4, 2) increase to be used the amount of the egory to total SNF' for no if the specific columns in the specific columns.	2, the code ole). Expenses 1.00 2003 provided of or direct expense for revenue from ending reflected of the code of the cod	99915 Percentage 2.00 for an increase patient care and each category. E Worksheet G-2, ts increases ass 0 0.00	99915 Associated with Direct Patient Care and Related Expenses? 3.00 in the RUG related nter in Part I, ociated	202. 00
A notice published in the Federal Register Volume 68, payments beginning 10/01/2003. Congress expected this expenses. For lines 202 through 207: Enter in column 1 column 2 the percentage of total expenses for each catiline 7, column 3. In column 3, enter "Y" for yes or "N" with direct patient care and related expenses for each 202.00 Staffing 203.00 Recruitment	d. Enter in column period (if applical No. 149 August 4, 2) increase to be used the amount of the egory to total SNF' for no if the specific columns in the specific columns.	2, the code ole). Expenses 1.00 2003 provided of or direct expense for revenue from ending reflected of the code of the cod	99915 Percentage 2.00 for an increase patient care and each category. E Worksheet G-2, ts increases ass 0 0.00 0 0.00	99915 Associated with Direct Patient Care and Related Expenses? 3.00 in the RUG related nter in Part I, ociated	202. 00
A notice published in the Federal Register Volume 68, payments beginning 10/01/2003. Congress expected this expenses. For lines 202 through 207: Enter in column 1 column 2 the percentage of total expenses for each catelline 7, column 3. In column 3, enter "Y" for yes or "N" with direct patient care and related expenses for each 202.00 Staffing 203.00 Recruitment	d. Enter in column period (if applical No. 149 August 4, 2) increase to be used the amount of the egory to total SNF' for no if the specific columns in the specific columns.	2, the code ole). Expenses 1.00 2003 provided of or direct expense for revenue from ending reflected of the code of the cod	99915 Percentage 2.00 for an increase patient care and each category. E Worksheet G-2, ts increases ass 0 0.00 0 0.00 0 0.00	99915 Associated with Direct Patient Care and Related Expenses? 3.00 in the RUG related nter in Part I, ociated	202. 00 203. 00 204. 00
A notice published in the Federal Register Volume 68, payments beginning 10/01/2003. Congress expected this expenses. For lines 202 through 207: Enter in column 1 column 2 the percentage of total expenses for each catiline 7, column 3. In column 3, enter "Y" for yes or "N" with direct patient care and related expenses for each 202.00 Staffing	d. Enter in column period (if applical No. 149 August 4, 2) increase to be used the amount of the egory to total SNF' for no if the specific columns in the specific columns.	2, the code ole). Expenses 1.00 2003 provided of or direct expense for revenue from ending reflected of the code of the cod	99915 Percentage 2.00 for an increase patient care and each category. E Worksheet G-2, ts increases ass 0 0.00 0 0.00	99915 Associated with Direct Patient Care and Related Expenses? 3.00 in the RUG related nter in Part I, ociated	201. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 206. 00

USTII	n Financial Systems ME TAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	MORIAL HOSP & HEA IED HEALTH CENTER		CCN: 150115	Peri od:	Worksheet S-		552-
TATI S	STICAL DATA		Component	CCN: 158507	From 07/01/2014 To 06/30/2015		-ep	
					Rural Health Clinic (RHC) I	Cost		
					1.	00		
	Clinic Address and Identification							
00	Street				522 SOUTH MAPL		_	1.
				ty	State	ZIP Code	_	
	0' 1 0 1 7 1 0 1 0 1	EDI		00	2. 00	3.00	+	
.00	City, State, ZIP Code, County	JFRE	ENCH LICK		IN	47432	+	2.
						1. 00		
00	FQHCs ONLY: Designation - Enter "R" for rural	or "U" for urbar	n				0	3.
					Grant Award	Date	4	
					1. 00	2. 00	4	
00	Source of Federal Funds	A - + \						
. 00 . 00	Community Health Center (Section 330(d), PHS				0	1		4.
00	Migrant Health Center (Section 329(d), PHS Ad Health Services for the Homeless (Section 340					,		5. 6.
00	Appal achi an Regional Commission	(u), IIIO ACL))		7.
00	Look-Alikes				l o			8.
00	OTHER (SPECIFY)				0	,		9.
					1. 00	2. 00		
). 00	Does this facility operate as other than an Ino in column 1. If yes, indicate number of or subscripts of line 11 the type of other operations.	ther operations in	n column 2.(Enter in	N		0	10.
	subscripts of trile in the type of other opera	Sunday			onday	Tuesday		
		from	to	from	to	from		
		1.00	2. 00	3. 00	4. 00	5. 00		
	Facility hours of operations (1)							
1. 00	Clinic			08: 00	17: 00	07: 00	_	11.
					1. 00	2.00	+	
2. 00	Have you received an approval for an exception	on to the producti	ivity standa	rd?	1. 00 N	2.00	+	12.
3. 00	1 3	d in CMS Pub. 100-	-04, chapter	9, section	N			13.
	number of providers included in this report.			ers and				
	number of providers included in this report. numbers below.				der name	CCN number		
				Provi	der name 1.00	CCN number		
1. 00				Provi				14.
4. 00	numbers below.	List the names of	f all provid	Provi	1. 00 XI X	2.00 Total Visits	_	14.
	numbers below. Provider name, CCN number	List the names of	f all provid	Provi	1. 00	2. 00	5	
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	Y/N 1.00	f all provid	Provi	1. 00 XI X	2.00 Total Visits	5	14.
	Provider name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	Y/N 1.00	f all provid	XVIII 3.00	1. 00 XI X	2.00 Total Visits	5	
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	Y/N 1.00	f all provid	Provi	1. 00 XI X	2.00 Total Visits	5	
5. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	Y/N 1.00	f all provid	XVIII 3.00	1. 00 XI X	2.00 Total Visits	5	15.
5. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00	V 2.00 Cou	XVIII 3.00	1. 00 XI X 4. 00	2.00 Total Visits	5	15.
5. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00	V 2.00 Cou 4. ANGE Wedne	XVIII 3.00 nty 00 esday to	1.00 XIX 4.00 Thur	2.00 Total Visits 5.00	5	
5.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00 ORA Tuesday	V 2.00 Cou	XVIII 3.00 nty 00 esday	1. 00 XI X 4. 00	2.00 Total Visits 5.00	5	15.

					u of Form CMS-2	2552-10	
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	FIED HEALTH CEN	ITER	Provi der	CCN: 150115	Peri od:	Worksheet S-8	
STATISTICAL DATA		,	Component	CCN: 158507	From 07/01/2014 To 06/30/2015	Date/Time Pre 11/23/2015 9:	
					Rural Health	Cost	
					Clinic (RHC) I		
	Fri	i day		Sa	turday		
	from		to	from	to		
	11. 00	1	2. 00	13. 00	14.00		
Facility hours of operations (1)							
11. 00 Clinic	06: 00	15: 00					11. 00

	Financial Systems MEI FAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	MORIAL HOSP & H IED HEALTH CENT		CCN: 150115	Peri od:	worksheet S-8	
	STICAL DATA			t CCN: 158508	From 07/01/2014		epare
					Rural Health Clinic (RHC) II	Cost	_
					1.	00	
	Clinic Address and Identification						1
. 00	Street		0		105 COOPER STR		1.
		-		i ty . 00	State 2.00	ZIP Code 3. 00	
2. 00	City, State, ZIP Code, County		_OOGOOTEE	. 00		47553	2.
		ļ-					
						1. 00	
. 00	FQHCs ONLY: Designation - Enter "R" for rural	or "U" for urb	oan				3.
					Grant Award	Date	
	Course of Foderal Funda				1. 00	2. 00	
. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)			0		4.
. 00	Migrant Health Center (Section 329(d), PHS Ac				0		5.
. 00	Health Services for the Homeless (Section 340				0		6.
. 00	Appalachian Regional Commission				0		7.
. 00	Look-Alikes				0		8.
. 00	OTHER (SPECIFY)				0		9.
		501100 5	. "\" 6		1.00	2.00	
0. 00	Does this facility operate as other than an Fino in column 1. If yes, indicate number of of subscripts of line 11 the type of other operations.	her operations	in column 2.	(Enter in	N		10.
	Subscripts of Title 11 the type of other opera	Sund			londay	Tuesday	
		from	to	from	to	from	
		1.00	2. 00	3.00	4. 00	5. 00	
	Facility hours of operations (1)					1	
1. 00	Clinic			08: 00	18: 00	08: 00	11.
					1. 00	2. 00	
2. 00	Have you received an approval for an exception	on to the produc	ctivity stand	ard?	1. 00 N	2.00	12.
3. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	lin CMS Pub. 10 umn 1. If yes, e	00-04, chapte enter in colu	r 9, section mn 2 the	N	C	13.
	numbers below.			Provi	der name	CCN number	
					1. 00	2.00	
4. 00	Provider name, CCN number						14.
		Y/N	V	XVIII	XIX	Total Visits	
	To the second se	1. 00	2. 00	3. 00	4. 00	5. 00	
5. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and						15.
	4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						
	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the		Co	untv			
	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.			unty . 00			
. 00	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	-	4	unty . 00			2.
2. 00	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	- N Tuesday	4 MARTIN		Thur	rsday	2.
2. 00	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Tuesday to	4 MARTIN Wedr from	nesday to	from	to	2.
2. 00	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Tuesday	4 MARTIN Wedr	. 00 nesday			2.

					u of Form CMS-	2552-10	
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIT	FIED HEALTH CEN	ITER	Provi der	CCN: 150115	Peri od:	Worksheet S-8	
STATISTICAL DATA			Component	t CCN: 158508	From 07/01/2014 To 06/30/2015	Date/Time Pre 11/23/2015 9:	
					Rural Health	Cost	
					Clinic (RHC) II		
	Fr	i day		Sa	turday		
	from		to	from	to		
	11. 00		12. 00	13. 00	14. 00		
Facility hours of operations (1)							
11. 00 Cl i ni c	08: 00	12: 00)				11. 00

MEMORIAL HOSP & HEALTH CARE CTR		FI L L C L L L L L L L L L L L L L L L L	L CARE OTO			C.E. OHC	2550 40
Uncompensated and indigent care cost computation							
Discompensated and Indigent care cost computation 1.00	HOSPI I	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150115		worksneet 5-1	U
Incompensated and Indigent care cost computation 1.00						Date/Time Pre	pared:
Discompensated and indigent care cost computation 0.00							
Discompensated and indigent care cost computation 0.00							
1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0.340114 1.00 Medicaid (See instructions for each line) 3.00 Medicaid cost (line 1 times line 6) 5.00 Medicaid cost (line 1 times line 6) 3.50 Medicaid cost (line 1 times line 6) 3.50 3.50 Medicaid cost (line 1 times line 6) 3.50 Medicaid cost (line 1 times line 6) 3.50 Medicaid cost (line 1 times line 6) 3.50 3.00 Medicaid cost (line 1 times line 6) 3.50 3.00 Medicaid cost (line 1 times line 6) 3.50 3.00 Medicaid cost (line 1 times line 6) 3.50 3.00						1. 00	
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3.00 3.00						7 005 044	
4.00						7, 285, 966	
1.00		' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		6 M!!!	10		
Medicaid charges				rrom medical	1?		
Modicaid cost ((line 1 times line 6) 15,179,535 7.00			wedi cai d				
8.00 Starte Children's Heal th Insurance Program (SCHIP) (see instructions for each line) 9.00 Net revenue From stand-alone SCHIP 0 11.00 11.00 12.00 12.00 13.10 14.00 10.00 13.10 14.00 10.00							
State Children's Heal th Insurance Program (SCHIP) (see instructions for each line) 9.00			ino 7 minu	us sum of Liv	oc 2 and 5: if		
State Children's Health Insurance Program (SCHIP) (see instructions for each line) 0 0,00 10 00 Stand-alone SCHIP charges 11 00 Stand-alone SCHIP cost (line 1 times line 10) 11 00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero) 12 00 Other state or local government indigent care program (see instructions for each line) 13 00 Net revenue from state or local indigent care program (see instructions for each line) 15 00 Stand-alone SCHIP cost (line 1 times line 10) 16 00 Net revenue from state or local indigent care program (see instructions for each line) 17 00 Net revenue from state or local indigent care program (see instructions for each line) 18 00 Net revenue from state or local indigent care program (see instructions for each line) 19 00 Net revenue from state or local indigent care program (see instructions for each line) 19 00 Net revenue from state or local indigent care program (see instructions for each line) 19 00 Net revenue from state or local indigent care program (see instructions for each line) 19 00 Net revenue from state or local indigent care program (see instructions for each line) 19 00 Net revenue from state or local indigent care program (see instructions for each line) 19 00 Net revenue from state or local indigent care program (see instructions for each line) 19 00 Net revenue from state or local indigent care program (see instructions for each line) 19 00 Net revenue from state or local indigent care program (see instructions) 10 10 10 10 10 10 10 10 10 10 10 10 10 1	0.00		1116 / IIII110	us sum or iii	ies z and s, i i	7,073,307	0.00
9, 00 Net revenue from stand-alone SGHIP 0 0 0 0 0 0 0 0 0			ons for ea	ach Line)			
10.00 Stand-al one SCHIP charges 0 10.00 Stand-al one SCHIP charges 0 11.00 11	9.00	• , , ,	0.10 1 01 00	2011 111110)		0	9.00
11.00 Stand-al one SCHIP cost (line 1 times line 10) 12.00 Difference between net revenue and costs for stand-al one SCHIP (line 11 minus line 9; if < zero then enter zero) 0 Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 10) 17.00 State or local indigent care program cost (line 1 times line 14) 18.01 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13: if < zero then enter zero) 19.00 Covernment grants, appropriations or each line) 19.00 Total unreimbursed cost for Medicald , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16) 19.00 Total initial obligation of patients approved for charity care (at full 2, 200 3, 00 2, 00 3, 00 2, 00 2, 00 Total initial obligation of patients approved for charity care (at full 2, 200 3, 00 2, 00 3, 00 2, 00 2, 00 2, 00 3, 00 2, 00 2, 00 2, 00 3, 00 2, 00 2, 00 2, 00 2, 00 3, 00 2, 00							
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17. 00 Private grants, donations, or endowment income restricted to funding charity care 0 17. 00 18. 00 Government grants, appropriations or transfers for support of hospital operations 0 18. 00 18. 00 19. 00 Total unreimbursed cost for Medicaid SCHIP and state and local indigent care programs (sum of lines 7,893,569 19. 00							
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20. 00 Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility cost of initial obligation of patients approved for charity care (line 1 1, 170, 768 0 1, 170, 768 21. 00 1, 170, 768 21. 00 22. 00 Partial payment by patients approved for charity care 0 0 0 0 22. 00 23. 00 Cost of charity care (line 21 minus line 22) 1, 170, 768 0 1, 170, 768 23. 00 24. 00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25. 00 If line 24 is "yes," charges for patient days beyond an indigent care program? 25. 00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25. 00 26. 00 Total bad debt expense for the entire hospital complex (see instructions) 9, 099, 199 26. 00 27. 00 Medicare bad debts for the entire hospital complex (see instructions) 276, 491 27. 00 29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 8, 822, 708 28. 00 29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 3, 211, 589 29. 00 30. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 4, 382, 357 30. 00				Uni nsured	Insured	Total (col. 1	
20.00 Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility 21.00 Cost of initial obligation of patients approved for charity care (line 1 times line 20) 22.00 Partial payment by patients approved for charity care 23.00 Cost of charity care (line 21 minus line 22) 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25.00 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 2 minus line 27) 29.00 Cost of uncompensated care (line 23 column 3 plus line 29) 3, 216, 273 0 3, 216, 273 0 1, 170, 768 1, 170, 768 0 0 0 1, 170, 768 21.00 1, 170, 768 22.00 1, 170, 768 23.00 1, 170, 768 24.00 25.00 26.00 27.00 Medicare bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 3, 216, 273 4, 382, 357 30.00				pati ents	pati ents	+ col . 2)	
charges excluding non-reimbursable cost centers) for the entire facility 21.00 Cost of initial obligation of patients approved for charity care (line 1 1, 170, 768 0 1, 170, 768 21.00 times line 20) 22.00 Partial payment by patients approved for charity care 0 0 0 22.00 23.00 Cost of charity care (line 21 minus line 22) 1, 170, 768 0 1, 170, 768 23.00 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25.00 Total bad debt expense for the entire hospital complex (see instructions) 9,099,199 26.00 27.00 Medicare bad debts for the entire hospital complex (see instructions) 276,491 27.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 2 minus line 27) 8,822,708 28.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4,382,357 30.00							
21.00 Cost of initial obligation of patients approved for charity care (line 1 1, 170, 768 0 1, 170, 768 21.00 times line 20) 22.00 Partial payment by patients approved for charity care 0 0 0 0 22.00 23.00 Cost of charity care (line 21 minus line 22) 1, 170, 768 0 1, 170, 768 23.00 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25.00 Total bad debt expense for the entire hospital complex (see instructions) 9, 099, 199 26.00 27.00 Medicare bad debts for the entire hospital complex (see instructions) 276, 491 27.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 8, 822, 708 28.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 3, 211, 589 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4, 382, 357 30.00	20.00			3, 216, 2	73 0	3, 216, 273	20. 00
times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 Total bad debt expense for the entire hospital complex (see instructions) Medicare bad debts for the entire hospital complex (see instructions) Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) Source of the entire hospital complex (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4,382,357 30.00	04.00			4 470 7		4 470 7/0	04.00
22.00 Partial payment by patients approved for charity care 0 0 0 1,170,768 23.00 Cost of charity care (line 21 minus line 22) 1,170,768 0 1,170,768 23.00 1,00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25.00 Total bad debt expense for the entire hospital complex (see instructions) 9,099,199 26.00 27.00 Medicare bad debts for the entire hospital complex (see instructions) 276,491 27.00 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 8,822,708 28.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 3,211,589 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4,382,357 30.00	21.00		(line 1	1, 170, 70	0	1, 170, 768	21.00
23.00 Cost of charity care (line 21 minus line 22) 1, 170, 768 1, 170, 768 23.00 1.00 24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 3, 211, 589 3, 200 4, 382, 357 30.00	22.00					0	22.00
24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 0 25.00 Total bad debt expense for the entire hospital complex (see instructions) 9,099,199 26.00 27.00 Medicare bad debts for the entire hospital complex (see instructions) 276,491 27.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 8,822,708 28.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 3,211,589 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4,382,357 30.00				1 170 7	-		
24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 24.00 25.00 9,099,199 26.00 8,822,708 8,822,708 8,822,708 8,221,708 9,090,199 9,099,	23.00	cost of charity care (fille 21 illinus fille 22)		1, 170, 70	0	1, 170, 700	23.00
imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 25.00 9,099,199 26.00 27.00 8,822,798 8,227,798 8,207,798 8,207,099 8,321,1,589 9,000 4,382,357 30.00						1.00	
25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 25.00 9,099,199 26.00 276,491 27.00 8,822,708 8,822,708 3,211,589 29.00 4,382,357 30.00	24.00			nd a Length o	of stay limit		24. 00
26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 9,099,199 26.00 276,491 27.00 8,822,708 28.00 3,211,589 29.00 4,382,357 30.00							
27. 00 Medicare bad debts for the entire hospital complex (see instructions) 28. 00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 27. 00 8, 822, 708 3, 211, 589 29. 00 4, 382, 357 30. 00				ogram's Leng	th of stay limit		
28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 8,822,708 28.00 3,211,589 29.00 4,382,357 30.00							
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 3,211,589 29.00 4,382,357 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4,382,357 30.00			,	>			
30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4,382,357 30.00		, ,		,	0.0)		
		· ·	nse (line	1 times line	28)		
31.00 Total unrelimbursed and uncompensated care cost (line 19 plus line 30) 12,275,926 31.00			- 20)				
	31.00	Trotal unifermoursed and uncompensated care cost (Tine 19 plus IIn	ie 30)			12, 275, 926	31.00

Heal th	Financial Systems ME	MORIAL HOSP & HE	ALTH CARE CTR	₹	In Lie	u of Form CMS-	2552-10
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Period: From 07/01/2014 To 06/30/2015	Worksheet A Date/Time Pre 11/23/2015 9:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		7, 925, 919	7, 925, 91	9 0	7, 925, 919	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		8, 535, 826	8, 535, 82	6 0	8, 535, 826	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 706, 884	16, 646, 986	18, 353, 87	0 -842, 778	17, 511, 092	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	7, 643, 942	15, 328, 081	22, 972, 02	3 282, 167	23, 254, 190	5. 00
6.00	00600 MAINTENANCE & REPAIRS	1, 554, 748	5, 867, 023	7, 421, 77	1 19, 476	7, 441, 247	6.00
8.00	00800 LAUNDRY & LINEN SERVICE	214, 693	109, 867	324, 56		328, 676	
9.00	00900 HOUSEKEEPI NG	953, 574	269, 360		· ·		1
10.00	01000 DI ETARY	1, 024, 910	708, 241	1, 733, 15		537, 817	
11.00	01100 CAFETERI A	0	0		0 1, 188, 787	1, 188, 787	
13.00	01300 NURSI NG ADMI NI STRATI ON	885, 239	137, 949			1, 031, 144	1
14.00	01400 CENTRAL SERVICES & SUPPLY	225, 402	231, 200	456, 60		281, 757	1
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 782, 308 1, 028, 596	10, 086, 670 152, 246			11, 885, 358 1, 196, 899	1
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1,028,390	152, 240	1, 160, 64	2 10,037	1, 170, 077	10.00
30. 00	03000 ADULTS & PEDI ATRI CS	5, 896, 987	595, 495	6, 492, 48	2 -2, 174, 482	4, 318, 000	30.00
31. 00	03100 I NTENSI VE CARE UNI T	2, 405, 619	270, 114			2, 674, 126	
40.00	04000 SUBPROVI DER - I PF	2, 097, 192	89, 485	2, 186, 67		2, 200, 631	40.00
41.00	04100 SUBPROVI DER - I RF	608, 333	157, 537	765, 87	0 2, 591	768, 461	41.00
43.00	04300 NURSERY	o	0		0 686, 605	686, 605	43.00
44.00	04400 SKILLED NURSING FACILITY	1, 212, 605	59, 874	1, 272, 47	9 9, 192	1, 281, 671	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	4, 404, 753	9, 582, 925	13, 987, 67		11, 315, 702	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 1, 258, 776	1, 258, 776	
53. 00	05300 ANESTHESI OLOGY	3, 272, 339	717, 705		·	3, 765, 855	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 851, 131	827, 287	4, 678, 41			
56. 00	05600 RADI OI SOTOPE	212, 740	586, 212	798, 95		796, 974	1
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	2, 277, 129	3, 917, 782			6, 221, 022	1
66. 00	06600 PHYSI CAL THERAPY	980, 828 1, 892, 139	345, 486 346, 081	1, 326, 31 2, 238, 22		1, 130, 486 2, 207, 675	1
69. 00	06900 ELECTROCARDI OLOGY	2, 072, 012	3, 065, 940			2, 482, 942	1
69. 01	06901 PULMONARY	2,072,012	0,000,740		0 2,033,010	2, 402, 742	1
69. 02	06902 CARDI OPULMONARY	92, 958	7, 848		-	97, 784	1
69. 03	06903 SLEEP LAB	183, 532	47, 545			223, 004	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	, ,	0 0	0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	7, 155, 970	7, 155, 97	0 -2, 541, 434	4, 614, 536	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0		0 9, 317, 329	9, 317, 329	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0 0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	239, 168	109, 413	· ·		349, 597	
88. 01	08801 RURAL HEALTH CLINIC II 08900 FEDERALLY QUALIFIED HEALTH CENTER	434, 020	58, 421 0	492, 44	1 1, 538 0 0		1
	09000 CLINIC	243, 278	821, 487	1, 064, 76	-	0 1, 030, 890	
90. 00	09001 I MED	353, 035	123, 139			478, 463	
	09002 ONCOLOGY	1, 242, 795	1, 019, 457			2, 248, 266	
90. 03	09003 OUTPATIENT CENTER	214, 531	81, 403			298, 178	
91.00		6, 473, 186	845, 711				1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	1, 668, 468	173, 576	1, 842, 04	4 -7, 169	1, 834, 875	
	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0	0	
101.00	10100 HOME HEALTH AGENCY	1, 231, 881	268, 847	1, 500, 72	8 -16, 437	1, 484, 291	101. 00
444 00	SPECIAL PURPOSE COST CENTERS		ام				111 00
116.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	0 60, 580, 955	0 97, 274, 108		0 3 -76, 092		116.00
110.00	NONREI MBURSABLE COST CENTERS	00, 360, 933	91, 214, 100	137, 633, 06	3 -70,092	157, 778, 971]110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0		0 0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	21, 794, 551	5, 616, 983				
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	698, 238	10, 937	709, 17		711, 525	1
	07950 LODGE	72	143				194. 00
	07952 MEMORIAL HOSPITAL FOUNDATION	130, 726	3, 677				
194. 03	07953 MKT/PHY SERVICES	1, 591, 068	1, 743, 266	3, 334, 33	4 35, 325	3, 369, 659	194. 03
	07954 COMMUNITY EDUCATION	373, 227	153, 916			531, 980	
	07955 VOLUNTEER	155, 480	7, 998				
	07956 MAB	0	0		0 0		194. 06
	07958 PUBLIC RELATIONS	195, 984	567, 792	763, 77			
	07959 UNUSED SPACE	0 0 001	105 270 000	100 000 10	0		194. 09
200.00	TOTAL (SUM OF LINES 118-199)	85, 520, 301	105, 378, 820	190, 899, 12	1 0	190, 899, 121	₁ 200.00

Heal th	Financial Systems	MEMORIAL HOSP & I	HEALTH CARE CTR	2	In Lie	u of Form CMS-255	52-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE			CCN: 150115	Peri od:	Worksheet A	
					From 07/01/2014 To 06/30/2015	Date/Time Prepar	red:
					10 00/ 00/ 2010	11/23/2015 9: 52	am_
	Cost Center Description	Adjustments	Net Expenses				
		(See A-8) 6.00	For Allocation 7.00				
	GENERAL SERVICE COST CENTERS	0.00	7.00	l			
1.00	00100 CAP REL COSTS-BLDG & FIXT	-2, 194, 799	5, 731, 120				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	32, 529	8, 568, 355				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 493, 653		•			4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	-586, 412		•			5.00
6. 00 8. 00	00600 MAINTENANCE & REPAIRS 00800 LAUNDRY & LINEN SERVICE	-79, 528 0					6. 00 8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10. 00	01000 DI ETARY	-31, 022	., ,				0. 00
11. 00	01100 CAFETERI A	-568, 413				11	1.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-3, 196	1, 027, 948				3. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0					4. 00
15.00	01500 PHARMACY	-214, 810		1			5.00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	-58, 815	1, 138, 084				6. 00
30. 00	03000 ADULTS & PEDI ATRI CS	0	4, 318, 000			30	80. 00
31. 00	03100 NTENSI VE CARE UNI T	Ö		1			1. 00
40. 00	04000 SUBPROVI DER – I PF	-521, 574					0.00
41.00	04100 SUBPROVI DER - I RF	-59, 750				41	1. 00
43.00	04300 NURSERY	0				43	3.00
44. 00	04400 SKILLED NURSING FACILITY	0	1, 281, 671			44	4. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	2 200 070	0.007.700	I			
50.00	05000 OPERATING ROOM	-2, 388, 979		1			0.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	-3, 414, 392	.,,	1			52. 00 53. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	-1, 208, 453					4. 00
56. 00	05600 RADI OLOGI - DI AGNOSTI C	-1, 200, 433	796, 974				6. 00
60. 00	06000 LABORATORY	-150, 000					0.00
65.00	06500 RESPIRATORY THERAPY	-2, 286					5. 00
66.00	06600 PHYSI CAL THERAPY	-5, 062		•			6. 00
69. 00	06900 ELECTROCARDI OLOGY	-402, 265	2, 080, 677			69	9. 00
69. 01	06901 PULMONARY	0	_				9. 01
69. 02	06902 CARDI OPULMONARY	-7, 470					9. 02
69. 03	06903 SLEEP LAB	-4, 106					9. 03
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0 4, 614, 536				0. 00 1. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS			•			2. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	Ö		1			3. 00
74. 00	07400 RENAL DI ALYSI S	0					4. 00
	OUTPATIENT SERVICE COST CENTERS			<u>'</u>			
88. 00	08800 RURAL HEALTH CLINIC	-3, 829	345, 768				8. 00
88. 01	08801 RURAL HEALTH CLINIC II	-19, 850					88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				9. 00
90.00	09000 CLINIC	-321, 308	1			l	0.00
	09001 I MED	-191, 458 -1, 256					0. 01 0. 02
90. 02	09003 OUTPATIENT CENTER	-1,230		•			0. 02
91. 00	09100 EMERGENCY	-4, 097, 186					1. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,077,100	0,102,770				2. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	-17, 295	1, 817, 580			95	5. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0					6. 00
101.00	10100 HOME HEALTH AGENCY	0	1, 484, 291			101	1. 00
11/ 0/	SPECIAL PURPOSE COST CENTERS			I		11.	
116.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	-18, 014, 638					6. 00
118.00	NONREI MBURSABLE COST CENTERS	- 18, 014, 038	139, 764, 333			116	8. 00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190	0.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	Ö					2. 00
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		•			2. 01
194.00	07950 LODGE	0	215			194	4. 00
	07952 MEMORIAL HOSPITAL FOUNDATION	0	139, 389				4. 02
	07953 MKT/PHY SERVICES	0		1			4. 03
	07954 COMMUNITY EDUCATION	0		1			4. 04
	07955 VOLUNTEER	0		1			4. 05
	07956 MAB 07958 PUBLIC RELATIONS	0					94. 06 94. 08
	0/07959 UNUSED SPACE	0	770, 800				74. 08 94. 09
200.00	l l	-18, 014, 638	172, 884, 483				0.00
		1, 1, 1, 1, 200	, , , , , , , , , , , , , , , , , , , ,			1-00	

Health Financial Systems RECLASSIFICATIONS MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10 Provider CCN: 150115 Peri od: Worksheet A-6 From 07/01/2014 To 06/30/2015 Date/Time Prepared:

					To	
		Increases			1172072010 7	102 4111
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3.00	4. 00	5. 00		
	B - LABOR AND DELIVERY					
1. 00	DELIVERY ROOM & LABOR ROOM	52.00	1, 091, 371	167, 405		1. 00
2.00	NURSERY	43.00	59 <u>5, 2</u> 93	9 <u>1, 3</u> 12		2. 00
	0		1, 686, 664	258, 717		
1 00	C - CAFETERIA	11 00	702 007	40E 700		1 00
1. 00	CAFETERI A	11.00	70 <u>2, 9</u> 97 702, 997	48 <u>5, 7</u> 90 485, 790		1. 00
	D - IMPLANTABLE DEVICES		702, 997	485, 790		
1.00	I MPL. DEV. CHARGED TO	72.00	0	9, 317, 329		1.00
1.00	PATIENTS	72.00		7, 317, 327		1.00
	0		$ _{0}$	9, 317, 329		
	E - BILLABLE SUPPLES			., ,		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	6, 775, 895		1.00
	PATI ENTS					
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4. 00		0.00	0	0		4. 00
5. 00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10. 00	+	0.00	0	0		10.00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	0		12. 00
13. 00		0.00	o	0		13. 00
14. 00		0.00	Ö	0		14. 00
15. 00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
17.00		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	0	0		19. 00
20. 00		0.00	0	0		20. 00
21. 00		0.00	0	0		21. 00
22. 00		0.00	0	0		22. 00
23. 00		0. 00 0. 00	0	0		23. 00
24. 00		0.00	0	6, 775, 895		24. 00
	F - GAINSHARE RECLASS		<u> </u>	0, 113, 073		
1.00	ADMINISTRATIVE & GENERAL	5.00	282, 179	0		1.00
2.00	MAINTENANCE & REPAIRS	6.00	19, 476	0		2. 00
3.00	LAUNDRY & LINEN SERVICE	8.00	4, 116	0		3. 00
4.00	HOUSEKEEPI NG	9. 00	14, 718	0		4. 00
5.00	DI ETARY	10.00	19, 031	0		5. 00
6.00	NURSING ADMINISTRATION	13. 00	8, 584	0		6. 00
7. 00	CENTRAL SERVICES & SUPPLY	14.00	4, 029	0		7. 00
8.00	PHARMACY	15.00	16, 380	0		8. 00
9.00	MEDICAL RECORDS & LIBRARY	16.00	16, 057	0		9. 00
10.00	ADULTS & PEDIATRICS	30.00	59, 679	0		10.00
11. 00 12. 00	INTENSIVE CARE UNIT SUBPROVIDER - IPF	31. 00 40. 00	22, 024 17, 368	0		11. 00 12. 00
13. 00	SUBPROVIDER - IRF	41. 00	4, 953	0		13. 00
14. 00	SKILLED NURSING FACILITY	44.00	14, 848	0		14. 00
15. 00	OPERATING ROOM	50.00	33, 880	0		15. 00
16. 00	ANESTHESI OLOGY	53.00	964	0		16. 00
17.00	RADI OLOGY-DI AGNOSTI C	54.00	24, 608	0		17. 00
18.00	RADI OI SOTOPE	56.00	1, 374	0		18. 00
19.00	LABORATORY	60.00	26, 111	0		19. 00
20. 00	RESPIRATORY THERAPY	65.00	10, 657	0		20. 00
21. 00	PHYSI CAL THERAPY	66.00	20, 451	0		21. 00
22. 00	ELECTROCARDI OLOGY	69.00	16, 830	0		22. 00
23. 00	CARDI OPULMONARY	69. 02	530	0		23. 00
24. 00	SLEEP LAB	69. 03	1, 939	0		24. 00
25. 00	RURAL HEALTH CLINIC	88.00	1, 016	0		25. 00
26. 00 27. 00	RURAL HEALTH CLINIC II	88. 01 90. 00	1, 538 2, 547	0		26. 00 27. 00
28. 00	I MED	90.00	2, 547 2, 289	0		28. 00
29. 00	ONCOLOGY	90.01	2, 269 11, 917	0		29. 00
30. 00	OUTPATIENT CENTER	90. 03	2, 244	n		30.00
31. 00	EMERGENCY	91.00	23, 159	0		31. 00
32. 00	AMBULANCE SERVICES	95.00	21, 424	o O		32. 00
33. 00	HOME HEALTH AGENCY	101.00	13, 190	0		33. 00
34.00	PHYSICIANS' PRIVATE OFFICES	192.00	66, 716	0		34. 00
				·		

Health Financial Systems RECLASSIFICATIONS

MEMORIAL HOSP & HEALTH CARE CTR

In Lieu of Form CMS-2552-10

Peri od: Worksheet A-o From 07/01/2014 To 06/30/2015 Date/Time Prepared: 11/23/2015 9:52 am Provider CCN: 150115

					11/23/2015 9. 52
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5. 00	
35.00	PSYCHI ATRI C/PSYCHOLOGI CAL	192. 01	2, 350	0	3
	SERVI CES				
36.00	MEMORIAL HOSPITAL FOUNDATION	194. 02	4, 986	0	3
37.00	MKT/PHY SERVICES	194. 03	35, 325	0	3
38.00	COMMUNITY EDUCATION	194. 04	4, 837	0	3
39.00	VOLUNTEER	194. 05	1, 430	0	3
40.00	PUBLIC RELATIONS	194. 08	7, 024	0	
	0 — — — — —	- $ +$	842, 778	_	
500.00	Grand Total: Increases		3, 232, 439	16, 837, 731	50

Health Financial Systems RECLASSIFICATIONS MEMORIAL HOSP & HEALTH CARE CTR
Provider CCN: 150115 In Lieu of Form CMS-2552-10 Peri od: From 07/01/2014 To 06/30/2015 Date/Time Prepared:

						11/23/2015	
	Cost Conton	Decreases	Calassi	Othon	Wko+ A 7 Dof		
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	B - LABOR AND DELIVERY	7.00	0.00	7. 00	10.00		
1.00	ADULTS & PEDIATRICS	30.00	1, 686, 664	258, 717	0		1. 00
2.00	<u> </u>	0.00	0				2. 00
	O CAFETERIA		1, 686, 664	258, 717	<u>'</u>		
1. 00	C - CAFETERI A DI ETARY	10.00	702, 997	485, 790	0		1.00
1.00	0		702, 997	485, 790			1.00
	D - IMPLANTABLE DEVICES						
1. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	9, 317, 329	0		1. 00
	PATI ENTS	+		9, 317, 329	<u> </u>		
	E - BILLABLE SUPPLES		<u> </u>	7, 317, 327	<u> </u>		
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12			1.00
2.00	DI ETARY	10.00	0	25, 578			2. 00
3.00	NURSING ADMINISTRATION	13.00	0	628			3. 00
4. 00 5. 00	CENTRAL SERVICES & SUPPLY ADULTS & PEDIATRICS	14. 00 30. 00	0	178, 874 288, 780			4. 00 5. 00
6. 00	INTENSIVE CARE UNIT	31.00	o	23, 631			6. 00
7.00	SUBPROVI DER - I PF	40.00	0	3, 414			7. 00
8.00	SUBPROVI DER - I RF	41. 00	0	2, 362			8. 00
9. 00 10. 00	SKILLED NURSING FACILITY OPERATING ROOM	44. 00 50. 00	0	5, 656 2, 705, 856			9. 00 10. 00
11. 00	ANESTHESI OLOGY	53.00	0	2, 705, 856			11. 00
12. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	110, 716			12. 00
13. 00	RADI OI SOTOPE	56.00	o	3, 352			13. 00
14.00	RESPIRATORY THERAPY	65.00	0	206, 485			14. 00
15. 00 16. 00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66. 00 69. 00	0	50, 996 2, 671, 840			15. 00 16. 00
17. 00	CARDI OPULMONARY	69. 02	o	3, 552			17. 00
18. 00	SLEEP LAB	69. 03	0	10, 012			18. 00
19. 00	CLINIC	90.00	0	36, 422			19. 00
20. 00 21. 00	ONCOLOGY EMERGENCY	90. 02 91. 00	0	25, 903			20. 00 21. 00
22. 00	AMBULANCE SERVICES	95.00	0	91, 877 28, 593			22.00
23. 00	HOME HEALTH AGENCY	101.00	Ö	29, 627			23. 00
24.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4 <u>6, 5</u> 76			24. 00
	O CALNCHARE RECLASS		0	6, 775, 895	5		
1. 00	F - GAINSHARE RECLASS EMPLOYEE BENEFITS DEPARTMENT	4.00	842, 778	C	0		1. 00
2. 00	EWI EGTEL BENEFIT IS BELAKTIMENT	0.00	042,770	C			2. 00
3.00		0.00	0	C			3. 00
4.00		0.00	0	C			4. 00
5. 00 6. 00		0.00	0	C			5. 00 6. 00
7. 00		0.00	0	O			7. 00
8.00		0.00	0	C			8. 00
9.00		0.00	0	O			9. 00
10. 00 11. 00		0. 00 0. 00	0	C	-		10. 00 11. 00
12. 00		0.00	0	C			12.00
13. 00		0.00	O	Ö			13. 00
14. 00		0.00	0	C			14. 00
15.00		0. 00 0. 00	0	0			15. 00
16. 00 17. 00		0.00	0	C			16. 00 17. 00
18. 00		0.00	o	C			18. 00
19. 00		0.00	0	C			19. 00
20.00		0.00	0	C			20. 00
21. 00 22. 00		0. 00 0. 00	0	C			21. 00 22. 00
23. 00		0.00	0	C			23. 00
24. 00		0.00	O	C			24. 00
25.00		0.00	0	C	o		25. 00
26. 00		0.00	0	0			26. 00
27. 00 28. 00		0. 00 0. 00	0	C			27. 00 28. 00
29. 00		0.00	0	C			29. 00
30. 00		0.00	o	C			30.00
31. 00		0.00	0	C			31.00
32.00		0.00	0	C			32.00
33. 00 34. 00		0. 00 0. 00	0	0			33. 00 34. 00
35. 00		0.00	0	C			35. 00
36. 00		0.00	0	C			36. 00

Health Financial Systems RECLASSIFICATIONS

MEMORIAL HOSP & HEALTH CARE CTR

In Lieu of Form CMS-2552-10

Period: Worksheet A-o From 07/01/2014 To 06/30/2015 Date/Time Prepared: 11/23/2015 9:52 am Provider CCN: 150115

						117 207 2010 7	. 02 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
37.00		0.00	0	C)		37. 00
38.00		0.00	0	C)		38. 00
39.00		0.00	0	C)		39. 00
40.00		0.00	0	C)		40. 00
	0		842, 778)		
500.00	Grand Total: Decreases		3, 232, 439	16, 837, 731			500.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 150115 Peri od: Worksheet A-7 From 07/01/2014 Part I Date/Time Prepared: 06/30/2015 11/23/2015 9:52 am Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5.00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 6, 145, 421 1, 440, 527 1, 440, 527 0 1.00 0 2.00 Land Improvements 0 2.00 0 3.00 Buildings and Fixtures 109, 955, 416 3.00 0 23.444 Building Improvements 0 4.00 0 0 4.00 5.00 Fixed Equipment 0 5.00 88, 581, 413 0 6.00 Movable Equipment 7, 083, 874 7, 083, 874 0 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 204, 682, 250 8, 524, 401 8, 524, 401 23, 444 8.00 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) 204, 682, 250 8, 524, 401 23, 444 10.00 0 8, 524, 401 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 7, 585, 948 1.00 2.00 Land Improvements 0 2.00 3.00 Buildings and Fixtures 109, 931, 972 0 3.00 0 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 6.00 95, 665, 287 0 6.00 7.00 HIT designated Assets 0 7.00 Subtotal (sum of lines 1-7) 8.00 213, 183, 207 0 8.00 9.00 Reconciling Items 9.00

213, 183, 207

10.00 Total (line 8 minus line 9)

Health Financial Systems ME	MORIAL HOSP & F	HEALTH CARE CTF	3	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 07/01/2014	Worksheet A-7 Part II	
				o 06/30/2015		pared:
					11/23/2015 9:	52 am_
		Sl	JMMARY OF CAPI	ΓAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
				instructions)	instructions)	
	9. 00	10.00	11. 00	12.00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	3, 900, 164	1, 114, 278	2, 728, 746	182, 731	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	8, 535, 826	0	(0	0	2.00
3.00 Total (sum of lines 1-2)	12, 435, 990	1, 114, 278	2, 728, 746	182, 731	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				

0 0 0

7, 925, 919 8, 535, 826 16, 461, 745

1. 00 2. 00 3. 00

1. 00 2. 00

3.00 Total (sum of lines 1-2)

Heal th	Financial Systems ME	MORIAL HOSP & F	HEALTH CARE CTE	2	In Lie	u of Form CMS-2	2552-10		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 07/01/2014				
					To 06/30/2015	Date/Time Pre 11/23/2015 9:			
		COMF	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	02 4		
				I					
	Cost Center Description	Gross Assets	Capitalized	Gross Assets for Ratio		Insurance			
			Leases	(col. 1 - col	instructions)				
				2)	•				
		1.00	2.00	3.00	4. 00	5. 00			
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS							
1.00	CAP REL COSTS-BLDG & FLXT	117, 517, 920	0	117, 517, 92	0. 551253	0	1. 00		
2.00	CAP REL COSTS-MVBLE EQUIP	95, 665, 287	0	95, 665, 28	7 0. 448747	0	2. 00		
3.00	Total (sum of lines 1-2)	213, 183, 207	0	213, 183, 20	7 1. 000000	0	3. 00		
		ALLOCAT	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL			
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease			
	5551 5511151 B5551 F11 611		Capi tal -Relate		50p. 00. a t. 0	20000			
			d Costs	through 7)					
		6. 00	7. 00	8.00	9. 00	10.00			
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS							
1.00	CAP REL COSTS-BLDG & FLXT	0	0)	0 3, 810, 679	1, 113, 918	1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	0)	0 8, 568, 355	0	2. 00		
3.00	Total (sum of lines 1-2)	0	0		0 12, 379, 034	1, 113, 918	3. 00		
			Sl	JMMARY OF CAPI	TAL				
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum			
			instructions)	instructions)	Capi tal -Rel ate	of cols. 9			
					d Costs (see	through 14)			
			instructions)						
		11. 00	12.00	13.00	14. 00	15. 00			
	DART III - RECONCILIATION OF CARLTAL COSTS CENTERS								

623, 792 0 623, 792

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

CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)

182, 731

182, 731

0 0 0

5, 731, 120 8, 568, 355 14, 299, 475

1.00

2. 00

0 0 0

1.00

2.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10 Provider CCN: 150115 Peri od: Worksheet A-8 From 07/01/2014 To 06/30/2015 Date/Time Prepared:

					0 06/30/2015	Date/lime Prep 11/23/2015 9:	
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00 1. 00	5. 00 0	1. 00
1.00	COSTS-BLDG & FIXT (chapter 2)		0	NEE SOSTS BEBS & TTXT	1.00	Ĭ	1. 00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
3.00	(chapter 2)		Ü		0.00		3.00
4.00	Trade, quantity, and time		0		0.00	0	4. 00
Г 00	di scounts (chapter 8)		0		0.00		F 00
5. 00	Refunds and rebates of expenses (chapter 8)		Ü		0. 00	0	5. 00
6.00	Rental of provider space by		0		0.00	o	6. 00
	suppliers (chapter 8)	_				_	
7. 00	Telephone services (pay stations excluded) (chapter	A	-10, 791	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
	21)						
8.00	Television and radio service		0		0.00	0	8. 00
0.00	(chapter 21)				0.00		0.00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-10, 640, 651		0. 00	0	9. 00 10. 00
10.00	adjustment	A-0-2	- 10, 040, 031				10.00
11. 00	Sale of scrap, waste, etc.	В	-13, 745	ADMINISTRATIVE & GENERAL	5. 00	0	11.00
10.00	(chapter 23)	A 0 1	1 170 170				10.00
12. 00	Related organization transactions (chapter 10)	A-8-1	-1, 470, 670			0	12. 00
13. 00	Laundry and linen service		0		0.00	o	13.00
14. 00	Cafeteria-employees and guests		-568, 413	CAFETERI A	11.00		14. 00
15. 00	Rental of quarters to employee and others	1	0		0. 00	0	15. 00
16. 00	Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than						
47.00	patients		044 040	DUA DMA OV	45.00		47.00
17. 00	Sale of drugs to other than patients	В	-214, 810	PHARMACY	15. 00	0	17. 00
18. 00	Sale of medical records and	В	-58, 815	MEDICAL RECORDS & LIBRARY	16. 00	o	18.00
40.00	abstracts						40.00
19. 00	Nursing school (tuition, fees, books, etc.)		0		0. 00	0	19. 00
20. 00	Vending machines	В	-406	ADMINISTRATIVE & GENERAL	5. 00	О	20. 00
21. 00	Income from imposition of		0		0.00	0	21. 00
	interest, finance or penalty						
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
22.00	overpayments and borrowings to	,	· ·		0.00		22.00
	repay Medicare overpayments		_				
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
	therapy costs in excess of						
25. 00	limitation (chapter 14) Utilization review -		0	 *** Cost Center Deleted ***	114. 00		25. 00
20.00	physicians' compensation		· ·				20.00
0, 00	(chapter 21)			0.5 551 00070 5150 0 5177			0, 00
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	o	27. 00
	COSTS-MVBLE EQUIP						
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	 *** Cost Center Deleted ***	0. 00 67. 00	1	29. 00 30. 00
55.00	therapy costs in excess of		0		37.30		55. 50
05	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech	A-8-3	0	 *** Cost Center Deleted ***	68. 00		31. 00
	pathology costs in excess of		· ·				
22.00	limitation (chapter 14)		_		2 22	_	22.00
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0. 00	0	32. 00
33. 00	TELEPHONE DEPRECIATION	A	-89, 485	CAP REL COSTS-BLDG & FIXT	1. 00		33.00
33. 01	CRNA	Α	-908, 684	OPERATING ROOM	50. 00	o	33. 01

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10 Provi der CCN: 150115 Peri od: Worksheet A-8 From 07/01/2014 To 06/30/2015 Date/Time Prepared:

Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted To/From Which the Amount						06/30/2015	11/23/2015 9:	oared: 52 am
To/From Which the Amount is to be Adjusted To/From Which Expended To/From Which the Amount is to be Adjusted To/From Which Expended To/F					Expense Classification on	Worksheet A	1172372013 7.	32 am
Cost Center Description								
1.00 2.00 3.00 4.00 5.00					To the file file file of the f	to be haj usteu		
1.00 2.00 3.00 4.00 5.00								
1.00 2.00 3.00 4.00 5.00								
1.00 2.00 3.00 4.00 5.00								
33 02 MI SCELLANEOUS REVENUE B		Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
33 03 ADVERTISING - BENEFITS A -23,087 EMPLOYEE BENEFITS DEPARTMENT 4,00 0 33,03		·	1.00	2.00	3.00	4. 00	5. 00	
33. 04 MAINTENANCE B -30, 297 MAINTENANCE & REPAIRS 6, 00 0 33, 04	33. 02	MI SCELLANEOUS REVENUE	В	-41, 043	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 05 ADVERTISING - FRENCH LICK A -3, 136/RURAL HEALTH CLINIC 88. 00 0 33. 05	33.03	ADVERTISING - BENEFITS	A	-23, 087	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 03
33.06 ADVERTISING - LOOCOOTEE A	33.04	MAI NTENANCE	В	-30, 297	MAINTENANCE & REPAIRS	6. 00	0	33. 04
33. 07 ADVERTISING - AMBULANCE A -4,300 AMBULANCE SERVICES 95.00 0 33.07	33.05	ADVERTISING - FRENCH LICK	A	-3, 136	RURAL HEALTH CLINIC	88. 00	0	33. 05
33 .08 ADVERTISING - CARING HANDS A -766 SUBPROVIDER - IPF 40,00 0 33.08 33 .09 DI ETARY SUPPLEMENTS B -27,100 DI ETARY 10,00 0 33.09 33 .10 CLINICAL ENGINEERING B -888MAINTENANCE & REPAIRS 6,00 0 33.10 33 .11 MI SCELLANEOUS - DI ETARY B -3,922 DI ETARY 10,00 0 33.11 33 .12 ADVERTISING - HOME CARE A -371 RESPIRATORY THERAPY 65.00 0 33.13 33 .13 MI SCELLANEOUS - FINANCE B -90,773 ADMINISTRATIVE & GENERAL 5.00 0 33.13 33 .14 MI SCELLANEOUS - MBULLANCE B -90,773 ADMINISTRATIVE & GENERAL 5.00 0 33.14 33 .15 ACCOUNTS PAYABLE DISCOUNT B -39,900 ADMINISTRATIVE & GENERAL 5.00 0 33.15 33 .16 MI SCELLANEOUS - SLEEP LAB B -3,700 SLEEP LAB 69.03 0 33.16 33 .17 BUIL LIN GRENTAL INCOME B -3,700 SLEEP LAB 69.03 0 33.17 33 .18 MI SCELLANEOUS - CLINCAL B -3,196 NURSING ADMINISTRATION 13.00 0 33.18 33 .19 MI SCELLANEOUS - FERNCH LICK B -693 RURAL HEALTH CLINIC 88.00 0 33.19 33 .20 MI SCELLANEOUS - LORGOOTEE B -18,823 RURAL HEALTH CLINIC 1 88.01 0 33.20 33 .21 MI SCELLANEOUS - CARDIAC REHAB B -3,156 AURINISTRATIVE & GENERAL 5.00 0 33.22 33 .22 MI SCELLANEOUS - VASCULAR B -3,156 AURINISTRATIVE & GENERAL 5.00 0 33.22 33 .22 MI SCELLANEOUS - VASCULAR B -3,156 AURINISTRATIVE & GENERAL 5.00 0 33.22 33 .22 MI SCELLANEOUS - VASCULAR B -3,156 AURINISTRATIVE & GENERAL 5.00 0 33.22 33 .23 MI SCELLANEOUS - VASCULAR B -3,156 AURINISTRATIVE & GENERAL 5.00 0 33.22 33 .25 MI SCELLANEOUS - VASCULAR B -3,156 AURINISTRATIVE & GENERAL 5.00 0 33.22 33 .25 MI SCELLANEOUS - VASCULAR B -3,156 AURINISTRATIVE & GENERAL 5.00 0 33.22 33 .25 MI SCELLANEOUS - VASCULAR B -3,156 AURINISTRATIVE & GENERAL 5.00 0 33.22 33 .27 AHA & IHA LOBBYING DUES A -1,638,896 AURINISTRATIVE & GENERAL 5.00 0 33.25 33 .27 AHA &	33.06	ADVERTISING - LOOGOOTEE	A	-1, 027	RURAL HEALTH CLINIC II	88. 01	0	33. 06
33. 09 DI ETARY SUPPLEMENTS B	33.07	ADVERTISING - AMBULANCE	A	-4, 300	AMBULANCE SERVICES	95.00	0	33. 07
33. 10 CLINICAL ENGINEERING B -888 ALINTENANCE & REPAIRS 6. 00 0 33. 10 33. 11 MI SCELLANEOUS - DIETARY B -3, 922 DIETARY 10. 00 0 33. 11 33. 12 AUDVERTISING - HOME CARE A -97, 773 ADMINISTRATI VE & GENERAL 5. 00 0 33. 12 33. 13 MI SCELLANEOUS - FINANCE B -90, 773 ADMINISTRATI VE & GENERAL 5. 00 0 33. 13 33. 14 MI SCELLANEOUS - AMBULANCE B -12, 995 AMBULANCE SERVI CES 95. 00 0 33. 14 33. 15 ACCOUNTS PAYBALE DI SCOUNT B -39, 9000 MINISTRATI VE & GENERAL 5. 00 0 33. 15 33. 16 MI SCELLANEOUS - SLEEP LAB B -3, 700 SLEEP LAB 69. 03 0 33. 16 33. 17 BUILDI NG RENTAL I NCOME B -360 CAP REL COSTS-BLDG & FIXT 1. 00 10 33. 17 33. 18 MI SCELLANEOUS - LOOGOOTEE B -18, 823 RURAL HEALTH CLINIC 88. 00 0 33. 19 33. 20 MI SCELLANEOUS - LOOGOOTEE B -18, 823 RURAL HEALTH CLINIC 88. 01 0 33. 20 33. 21 MI SCELLANEOUS - VASCULAR B -7, 470 CAPROLOPHUMONARY 69, 02 0 33. 21 33. 22 MI SCELLANEOUS - VASCULAR B -3, 150 ELECTROCARDI OLOGY 69, 00 0 33. 22 33. 25 MI SC. PROC. CENTER B -2, 000 MINISTRATI VE & GENERAL 5. 00 0 33. 22 33. 25 MI SC. PROC. CENTER B -2, 000 MINISTRATI VE & GENERAL 5. 00 0 33. 25 33. 27 AHA & 1HA LOBBYI NG DUES A -1, 638 SUBPROVI DER FIXT 1. 00 11 33. 28 33. 30 START-UP COST OFFSET A 32, 529 CAP REL COSTS-BLDG & FIXT 1. 00 11 33. 28 33. 37 ADVERTISING - AUDILOGY A -48, 343 MINISTRATIVE & GENERAL 5. 00 0 33. 35 33. 38 ADVERTISING - SLEEP CENTER A -48, 343 MINISTRATIVE & GENERAL 5. 00 0 33. 35 33. 37 ADVERTISING - ONCOLOGY A -1, 256 ONCOLOGY 90. 02 0 33. 36 33. 37 ADVERTISING - ONCOLOGY A -1, 256 ONCOLOGY 90. 02 0 33. 37 TOTAL (sum of lines 1 thru 49) TOTAL (sum	33.08	ADVERTISING - CARING HANDS	A	-766	SUBPROVIDER - IPF	40.00	0	33. 08
33. 11 MI SCELLANEOUS - DIETARY B -3, 922 DIETARY 10.00 0 33. 11 33. 12 ADVERTISING - HOME CARE A -371 RESPIRATORY THERAPY 65. 00 0 33. 12 33. 13 MI SCELLANEOUS - FINANCE B -90, 773 ADMINISTRATIVE & GENERAL 5. 00 0 33. 13 33. 13 MI SCELLANEOUS - AMBULANCE B -12, 995 AMBULANCE SERVICES 95. 00 0 33. 14 33. 15 ACCOUNTS PAYABLE DISCOUNT B -39, 900 ADMINISTRATIVE & GENERAL 5. 00 0 33. 15 33. 16 MI SCELLANEOUS - SLEEP LAB B -3, 700 SLEEP LAB 69, 03 0 33. 16 33. 17 BUILDING RENTAL INCOME B -360 CAP REL COSTS-BLDG & FIXT 1. 00 10 33. 17 33. 18 MI SCELLANEOUS - CLINCAL B -33, 196 NURSING ADMINISTRATION 13. 00 0 33. 18 33. 19 MI SCELLANEOUS - FRENCH LICK B -693 RURAL HEALTH CLINIC 1 88. 00 0 33. 19 MI SCELLANEOUS - CARDIA CREHAB B -18, 823 RURAL HEALTH CLINIC 1 88. 01 0 33. 20 MI SCELLANEOUS - CARDIA CREHAB B -7, 470 CARDI OPULMONARY 69. 02 0 33. 21 MI SCELLANEOUS - VASCULAR B -7, 470 CARDI OPULMONARY 69. 02 0 33. 22 MI SCELLANEOUS - VASCULAR B -7, 470 CARDI OPULMONARY 69. 02 0 33. 22 MI SCELLANEOUS - VASCULAR B -7, 150 ELECTROCARDI OLOGY 69. 00 0 33. 22 MI SCELLANEOUS - VASCULAR B -7, 150 ELECTROCARDI OLOGY 69. 00 0 33. 22 MI SCELLANEOUS - VASCULAR B -7, 150 ELECTROCARDI OLOGY 53. 00 0 33. 22 MI SCELLANEOUS - VASCULAR B -7, 150 ELECTROCARDI OLOGY 53. 00 0 33. 22 MI SCELLANEOUS - VASCULAR B -7, 150 ELECTROCARDI OLOGY 53. 00 0 33. 22 MI SCELLANEOUS - VASCULAR B -7, 150 ELECTROCARDI OLOGY 53. 00 0 33. 22 MI SCELLANEOUS - VASCULAR B -7, 150 ELECTROCARDI OLOGY 53. 00 0 33. 22 MI SCELLANEOUS - VASCULAR B -7, 150 ELECTROCARDI OLOGY 53. 00 0 33. 22 MI SCELLANEOUS - VASCULAR B -7, 150 ELECTROCARDI OLOGY 53. 00 0 33. 22 MI SCELLANEOUS - VASCULAR B -7, 150 ELECTROCARDI OLOGY 53. 00 0 33. 22 MI SCELLANEOUS - VASCULAR B -7, 150 ELECTROCARDI OLOGY 53. 00 0 33. 22 MI SCELLANEOUS - VASCULAR B -7, 150 ELECTROCARDI OLOGY 53. 00 0 33. 22 MI SCELLANEOUS - VASCULAR B -7, 150 ELECTROCARDI OLOGY 53. 00 0 33. 22 MI SCELLANEOUS - VASCULAR B -7, 150 ELECTROCARDI OLOGY 53. 00 0 0 33. 22 MI SCELLANEOUS - VASCULAR B -7, 150 ELECTROCARDI OLOGY 53. 0	33. 09	DI ETARY SUPPLEMENTS	В	-27, 100	DI ETARY	10.00	0	33. 09
33. 12 ADVERTISING - HOME CARE A -371 RESPIRATORY THERAPY 65. 00 0 33. 12	33. 10	CLINICAL ENGINEERING	В	-888	MAINTENANCE & REPAIRS	6. 00	0	33. 10
33. 13 MI SCELLANEOUS - FINANCE B -90, 773 ADMI NI STRATI VE & GENERAL 5.00 0 33. 13 33. 14 MI SCELLANEOUS - AMBULANCE B -12, 995 AMBULANCE SERVI CES 95.00 0 33. 14 33. 15 ACCOUNTS PAYABLE DI SCOUNT B -3, 700 ADMI NI STRATI VE & GENERAL 5.00 0 33. 15 33. 16 MI SCELLANEOUS - SLEEP LAB B -3, 700 SLEEP LAB 69.03 0 33. 16 33. 17 BUI LDI NG RENTAL I NCOME B -360 CAP REL COSTS-BLDG & FI XT 1.00 10 33. 17 33. 18 MI SCELLANEOUS - CLI NCAL B -360 CAP REL COSTS-BLDG & FI XT 1.00 10 33. 18 33. 19 MI SCELLANEOUS - FRENCH LI CK B -693 RURAL HEALTH CLI NI C 11 88.00 0 33. 18 33. 20 MI SCELLANEOUS - LOOGOOTEE B -18, 823 RURAL HEALTH CLI NI C 11 88.01 0 33. 20 33. 21 MI SCELLANEOUS - CARDI AC REHAB B -7, 470 CARDI OPULMONARY 69.02 0 33. 21 33. 22 MI SCELLANEOUS - VASCULAR B -7, 470 CARDI OPULMONARY 69.02 0 33. 22 33. 25 MI SC. PROC. CENTER B -16, 38, 896 ANESTHESI OLOGY 53.00 0 33. 24 33. 25 MI SC. PROC. CENTER B -2, 080 ADMI NI STRATI VE & GENERAL 5.00 0 33. 25 33. 28 NI TERREST B -2, 104, 94 CAP REL COSTS-BLDG & FIXT 1.00 11 33. 28 33. 29 START-UP COST OFFSET A 32, 529 CAP REL COSTS-MVBLE EQUI P 2.00 9 33. 29 33. 30 START-UP COST OFFSET A -40, 68 SUBPROVI DER - IPF 40.00 0 33. 35 33. 36 ADVERTISI NG - AUDIO LOGY A -1, 256 ONCOLOGY 90.02 0 33. 37 33. 37 ADVERTISI NG - ONCOLOGY A -1, 256 ONCOLOGY 90.02 0 33. 37 50.00 TOTAL (sum of lines 1 thru 49) -18, 014, 638 -	33. 11	MI SCELLANEOUS - DI ETARY	В	-3, 922	DI ETARY	10.00	0	33. 11
33. 14 MI SCELLANEOUS - AMBULANCE B	33. 12	ADVERTISING - HOME CARE	A	-371	RESPI RATORY THERAPY	65. 00	0	33. 12
33. 15 ACCOUNTS PAYABLE DISCOUNT B -39, 900 ADMINISTRATIVE & GENERAL 5. 00 0 33. 15 33. 16 MI SCELLANEOUS - SLEEP LAB B -3, 700 SLEEP LAB 69. 03 0 33. 16 33. 17 BUILDING RENTAL INCOME B -360 CAP REL COSTS-BLDG & FIXT 1. 00 10 33. 17 33. 18 MI SCELLANEOUS - CLI NCAL B -3, 196 NURSI NG ADMINISTRATION 13. 00 0 33. 18 33. 19 MI SCELLANEOUS - FRENCH LICK B -693 RURAL HEALTH CLINIC 88. 00 0 33. 19 33. 20 MI SCELLANEOUS - LOGGOTEE B -18, 823 RURAL HEALTH CLINIC II 88. 01 0 33. 20 33. 21 MI SCELLANEOUS - CARDI AC REHAB B -7, 470 CARDI OPULMONARY 69. 02 0 33. 21 33. 22 MI SCELLANEOUS - VASCULAR B -3, 150 ELECTROCARDI OLOGY 69. 00 0 33. 22 33. 24 CRNA EXPENSE A -1, 638, 896 ANESTHESI OLOGY 53. 00 0 33. 25 33. 25 MI SC. PROC. CENTER B -2, 080 ADMINISTRATI VE & GENERAL 5. 00 0 33. 25 33. 28 INTEREST B -2, 104, 954 CAP REL COSTS-BLDG & FIXT 1. 00 11 33. 28 33. 29 START-UP COST OFFSET A 32, 529 CAP REL COSTS-MVBLE EQUIP 2. 00 9 33. 29 33. 30 START-UP COST OFFSET A -48, 343 MAINTENANCE & REPAIRS 6. 00 0 33. 33 33. 33 ADVERTI SING - SLEEP CENTER A -406 SLEEP LAB 69. 03 0 33. 36 33. 37 ADVERTI SING - SLEEP CENTER A -406 SLEEP LAB 69. 03 0 33. 37 50. 00 TOTAL (sum of lines 1 thru 49) -18, 014, 638	33. 13	MI SCELLANEOUS - FI NANCE	В	-90, 773	ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
33. 16 33. 17 33. 18 33. 17 33. 18 33. 17 33. 18 33. 18 33. 17 33. 18 34 35. 18 36 37 38 38 38 39 39 39 39 39 39 39 39 39 39 39 39 39	33. 14	MI SCELLANEOUS - AMBULANCE	В	-12, 995	AMBULANCE SERVICES	95. 00	0	33. 14
33. 16 33. 17 33. 18 33. 17 33. 18 33. 17 33. 18 33. 17 33. 18 33. 18 33. 17 33. 18 34 35. 18 35. 18 35. 18 35. 18 35. 18 35. 18 35. 18 35. 18 35. 18 35. 18 35. 18 35. 18 35. 18 35. 18 35. 18 35. 18 35. 18 36. 18 37. 18 38 38 38 38 39 39 39 39 39 39 39 39 39 39 39 39 39	33. 15	ACCOUNTS PAYABLE DISCOUNT	В	-39, 900	ADMINISTRATIVE & GENERAL	5. 00	0	33. 15
33. 18 MI SCELLANEOUS - CLINCAL 33. 19 MI SCELLANEOUS - FRENCH LICK 33. 19 MI SCELLANEOUS - LOOGOOTEE 33. 20 MI SCELLANEOUS - LOOGOOTEE 33. 21 MI SCELLANEOUS - CARDI AC REHAB 33. 22 MI SCELLANEOUS - CARDI AC REHAB 33. 22 MI SCELLANEOUS - CARDI AC REHAB 34. 25 MI SCELLANEOUS - CARDI AC REHAB 35. 26 MI SCELLANEOUS - CARDI AC REHAB 36 MI SCELLANEOUS - CARDI AC REHAB 37. 150 ELECTROCARDI OLOGY 38. 21 MI SCELLANEOUS - VASCULAR 38. 01	33. 16	MI SCELLANEOUS - SLEEP LAB	В			69. 03	0	33. 16
33. 19	33. 17	BUILDING RENTAL INCOME	В	-360	CAP REL COSTS-BLDG & FIXT	1. 00	10	33. 17
33. 20 MI SCELLANEOUS - LOOGOOTEE B -18, 823 RURAL HEALTH CLINIC II 88. 01 0 33. 20 33. 21 MI SCELLANEOUS - CARDI AC REHAB B -7, 470 CARDI OPULMONARY 69. 02 0 33. 21 33. 22 MI SCELLANEOUS - VASCULAR B -3, 150 ELECTROCARDI OLOGY 69. 00 0 33. 22 33. 24 CRNA EXPENSE A -1, 638, 896 ANESTHESI OLOGY 53. 00 0 33. 24 33. 25 MI SC. PROC. CENTER B -2, 080 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 25 33. 27 AHA & IHA LOBBYING DUES A -8, 073 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 25 33. 29 START-UP COST OFFSET B -2, 104, 954 CAP REL COSTS-BLDG & FIXT 1. 00 11 33. 28 33. 29 START-UP COST OFFSET A 32, 529 CAP REL COSTS-MVBLE EQUI P 2. 00 9 33. 29 33. 30 START-UP COST OFFSET A 51, 698 SUBPROVI DER - I PF 40. 00 0 33. 30 33. 33 CABLE TV EXPENSE A -48, 343 MAI NTENANCE & REPAIRS 6. 00 0 33. 35 ADVERTI SI NG - AUDI OLOGY A -1, 390 PHYSI CAL THERAPY 66. 00 0 33. 36 33. 37 ADVERTI SI NG - ONCOLOGY A -1, 256 ONCOLOGY 90. 02 0 33. 37 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 50. 00 0 33. 37 50. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33. 18	MI SCELLANEOUS - CLINCAL	В	-3, 196	NURSING ADMINISTRATION	13. 00	0	33. 18
33. 21 MI SCELLANEOUS - CARDI AC REHAB B -7, 470 CARDI OPULMONARY 69. 02 0 33. 21 33. 22 MI SCELLANEOUS - VASCULAR B -3, 150 ELECTROCARDI OLOGY 69. 00 0 33. 22 33. 24 CRNA EXPENSE A -1, 638, 896 ANESTHESI OLOGY 53. 00 0 33. 24 33. 25 MI SC. PROC. CENTER B -2, 080 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 25 33. 27 AHA & IHA LOBBYI NG DUES A -8, 073 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 27 33. 28 INTEREST B -2, 104, 954 CAP REL COSTS-BLDG & FI XT 1. 00 111 33. 28 33. 29 START-UP COST OFFSET A 32, 529 CAP REL COSTS-MYBLE EQUI P 2. 00 9 33. 29 33. 30 START-UP COST OFFSET A 51, 698 SUBPROVI DER - I PF 40. 00 0 33. 30 33. 33 CABLE TV EXPENSE A -48, 343 MAI NTENANCE & REPAI RS 6. 00 0 33. 33 33. 35 ADVERTI SI NG - AUDI OLOGY A -1, 390 PHYSI CAL THERAPY 66. 00 0 33. 35 33. 37 ADVERTI SI NG - SLEEP CENTER A -406 SLEEP LAB 69. 03 0 33. 37 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 50. 00)	33. 19	MISCELLANEOUS - FRENCH LICK	В	-693	RURAL HEALTH CLINIC	88. 00	0	33. 19
33. 22 MI SCELLANEOUS - VASCULAR B -3, 150 ELECTROCARDI OLOGY 53. 00 0 33. 22 33. 24 CRNA EXPENSE A -1, 638, 896 ANESTHESI OLOGY 53. 00 0 33. 24 33. 25 MI SC. PROC. CENTER B -2, 080 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 25 33. 27 AHA & IHA LOBBYI NG DUES A -8, 073 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 27 33. 28 INTEREST B -2, 104, 954 CAP REL COSTS-BLDG & FIXT 1. 00 11 33. 29 33. 29 START-UP COST OFFSET A 32, 529 CAP REL COSTS-BUDG & FIXT 1. 00 9 33. 29 33. 30 START-UP COST OFFSET A 51, 698 SUBPROVI DER - I PF 40. 00 0 33. 30 33. 33 CABLE TV EXPENSE A -48, 343 MAI NTENANCE & REPAI RS 6. 00 0 33. 33 33. 35 ADVERTI SI NG - AUDI OLOGY A -1, 390 PHYSI CAL THERAPY 66. 00 0 33. 35 33. 36 ADVERTI SI NG - SLEEP CENTER A -406 SLEEP LAB 69. 03 0 33. 36 33. 37 ADVERTI SI NG - ONCOLOGY A -1, 256 ONCOLOGY 90. 02 0 33. 37 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 50. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33. 20	MI SCELLANEOUS - LOOGOOTEE	В	-18, 823	RURAL HEALTH CLINIC II	88. 01	0	33. 20
33. 24 CRNA EXPENSE A -1, 638, 896 ANESTHESI OLOGY 53. 00 0 33. 24 33. 25 MI SC. PROC. CENTER B -2, 080 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 25 33. 27 AHA & I HA LOBBYI NG DUES A -8, 073 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 27 33. 28 INTEREST B -2, 104, 954 CAP REL COSTS-BLDG & FI XT 1. 00 11 33. 29 START-UP COST OFFSET A 32, 529 CAP REL COSTS-MVBLE EQUI P 2. 00 9 33. 29 33. 30 START-UP COST OFFSET A 51, 698 SUBPROVI DER - I PF 40. 00 0 33. 30 33. 33 CABLE TV EXPENSE A -48, 343 MAI NTENANCE & REPAI RS 6. 00 0 33. 33 33. 35 ADVERTI SI NG - AUDI OLOGY A -1, 390 PHYSI CAL THERAPY 66. 00 0 33. 35 33. 36 ADVERTI SI NG - SLEEP CENTER A -406 SLEEP LAB 69. 03 0 33. 36 33. 37 ADVERTI SI NG - ONCOLOGY A -1, 256 ONCOLOGY 90. 02 0 33. 37 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 50. 00 00 00 00 00 00 00 00 00 00 00 00 0	33. 21	MI SCELLANEOUS - CARDI AC REHAB	В	-7, 470	CARDI OPULMONARY	69. 02	0	33. 21
33. 25 MI SC. PROC. CENTER 33. 27 AHA & I HA LOBBYI NG DUES A -8, 073 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 25 AHA & I HA LOBBYI NG DUES A -8, 073 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 27 ADMI NI STRATI VE & GENERAL 6. 00 0 0 33. 29 ADMI NI STRATI VI NI STATI VI N	33. 22	MI SCELLANEOUS - VASCULAR	В	-3, 150	ELECTROCARDI OLOGY	69. 00	0	33. 22
33. 27 AHA & IHA LOBBYING DUES A -8,073 ADMINISTRATIVE & GENERAL 5.00 0 33. 27 33. 28 INTEREST B -2,104,954 CAP REL COSTS-BLDG & FIXT 1.00 11 33. 28 33. 29 START-UP COST OFFSET A 32,529 CAP REL COSTS-MVBLE EQUIP 2.00 9 33. 29 33. 30 START-UP COST OFFSET A 51,698 SUBPROVIDER - IPF 40.00 0 33. 30 33. 33 CABLE TV EXPENSE A -48,343 MAINTENANCE & REPAIRS 6.00 0 33. 33 33. 35 ADVERTISING - AUDIOLOGY A -1,390 PHYSICAL THERAPY 66.00 0 33. 35 33. 37 ADVERTISING - SLEEP CENTER A -406 SLEEP LAB 69.03 0 33. 36 33. 37 ADVERTISING - ONCOLOGY A -1,256 ONCOLOGY 90.02 0 33. 37 50.00 TOTAL (sum of lines 1 thru 49) -18,014,638 50.00 (Transfer to Worksheet A,	33. 24	CRNA EXPENSE	A	-1, 638, 896	ANESTHESI OLOGY	53.00	0	33. 24
33. 28 INTEREST B -2, 104, 954 CAP REL COSTS-BLDG & FIXT 1.00 11 33. 28 33. 29 START-UP COST OFFSET A 32, 529 CAP REL COSTS-MVBLE EQUIP 2.00 9 33. 29 33. 30 START-UP COST OFFSET A 51, 698 SUBPROVI DER - IPF 40. 00 0 33. 30 CABLE TV EXPENSE A -48, 343 MAINTENANCE & REPAIRS 6.00 0 33. 33 33. 35 ADVERTISING - AUDIOLOGY A -1, 390 PHYSICAL THERAPY 66. 00 0 33. 35 33. 36 ADVERTISING - SLEEP CENTER A -406 SLEEP LAB 69. 03 0 33. 36 33. 37 ADVERTISING - ONCOLOGY A -1, 256 ONCOLOGY 90. 02 0 33. 37 50. 00 (Transfer to Worksheet A, 50. 00	33. 25	MISC. PROC. CENTER	В	-2, 080	ADMINISTRATIVE & GENERAL	5. 00	0	33. 25
33. 29 START-UP COST OFFSET A 32, 529 CAP REL COSTS-MVBLE EQUIP 2. 00 9 33. 29 51, 698 SUBPROVIDER - IPF 40. 00 0 33. 30 33. 33 CABLE TV EXPENSE A -48, 343 MAINTENANCE & REPAIRS 6. 00 0 33. 33 ADVERTISING - AUDIOLOGY A -1, 390 PHYSICAL THERAPY 66. 00 0 33. 35 ADVERTISING - SLEEP CENTER A -406 SLEEP LAB 69. 03 0 33. 36 ADVERTISING - ONCOLOGY A -1, 256 ONCOLOGY 90. 02 0 33. 37 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 50. 00 00 00 00 00 00 00 00 00 00 00 00 0	33. 27	AHA & IHA LOBBYING DUES	A	-8, 073	ADMINISTRATIVE & GENERAL	5. 00	0	33. 27
33. 30 START-UP COST OFFSET A 51, 698 SUBPROVIDER - IPF 40. 00 0 33. 30 33. 33 CABLE TV EXPENSE A -48, 343 MAINTENANCE & REPAIRS 6. 00 0 33. 33 33. 35 ADVERTISING - AUDIOLOGY A -1, 390 PHYSICAL THERAPY 66. 00 0 33. 35 33. 36 ADVERTISING - SLEEP CENTER A -406 SLEEP LAB 69. 03 0 33. 36 33. 37 ADVERTISING - ONCOLOGY A -1, 256 ONCOLOGY 90. 02 0 33. 37 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 51, 698 SUBPROVIDER - IPF 40. 00 0 33. 30 40. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33. 28	INTEREST	В	-2, 104, 954	CAP REL COSTS-BLDG & FIXT	1. 00	11	33. 28
33. 33 CABLE TV EXPENSE A -48, 343 MAINTENANCE & REPAIRS 6. 00 0 33. 33 33. 35 ADVERTISING - AUDIOLOGY A -1, 390 PHYSICAL THERAPY 66. 00 0 33. 35 33. 36 ADVERTISING - SLEEP CENTER A -406 SLEEP LAB 69. 03 0 33. 36 33. 37 ADVERTISING - ONCOLOGY A -1, 256 ONCOLOGY 90. 02 0 33. 37 50. 00 (Transfer to Worksheet A, 50. 00	33. 29	START-UP COST OFFSET	A	32, 529	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 29
33. 35 ADVERTISING - AUDIOLOGY A -1, 390 PHYSICAL THERAPY 66. 00 0 33. 35 33. 36 ADVERTISING - SLEEP CENTER A -406 SLEEP LAB 69. 03 0 33. 36 33. 37 ADVERTISING - ONCOLOGY A -1, 256 ONCOLOGY 90. 02 0 33. 37 50. 00 (Transfer to Worksheet A, 50. 00	33. 30	START-UP COST OFFSET	A	51, 698	SUBPROVIDER - IPF	40.00	0	33. 30
33. 36 ADVERTISING - SLEEP CENTER A -406 SLEEP LAB 69. 03 0 33. 36 33. 37 ADVERTISING - ONCOLOGY A -1, 256 ONCOLOGY 90. 02 0 33. 37 50. 00 (Transfer to Worksheet A, 50. 00	33. 33	CABLE TV EXPENSE	A	-48, 343	MAINTENANCE & REPAIRS	6. 00	0	33. 33
33. 37 ADVERTISING - ONCOLOGY A -1, 256 ONCOLOGY 90. 02 0 33. 37 50. 00 (Transfer to Worksheet A, 50. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33. 35	ADVERTISING - AUDIOLOGY	Α	-1, 390	PHYSI CAL THERAPY	66.00	0	33. 35
50.00 TOTAL (sum of lines 1 thru 49) -18,014,638 50.00 (Transfer to Worksheet A,	33. 36	ADVERTISING - SLEEP CENTER	A	-406	SLEEP LAB	69. 03	0	33. 36
(Transfer to Worksheet A,	33. 37	ADVERTISING - ONCOLOGY	A	-1, 256	ONCOLOGY	90. 02	0	33. 37
	50.00	TOTAL (sum of lines 1 thru 49)		-18, 014, 638				50.00
column 6, line 200.)		(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.

					117 207 2010 7.	OZ GIII
	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 OR	GANIZATIONS OR	CLAI MED	Ì
	HOME OFFICE COSTS:					İ
1.00	50. 00	OPERATING ROOM	AMBULATORY SURGERY CENTER	3, 565, 013	5, 035, 683	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).			3, 565, 013	5, 035, 683	5.00
	Transfer column 6, line 5 to					Ì
	Worksheet A-8, column 2,					Ì
	line 12.					

* 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, tho 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	С	MHHCC	O. OO MEM HOS OP SURG	40. 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:
- 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.

Heal th	Health Financial Systems				MEMOR	RLAL HOSE	% HEALT	H CARE CT	ΓR			In Li	eu of Form C	MS-2552-10
STATEME OFFICE	NT OF COSTS OF	SERVI (CES FROM	RELATED	ORGANI ZATI	IONS AND	HOME	Provi der	CCN:	150115	Peri o	d: 07/01/2014	Worksheet	A-8-1
												06/30/2015		
	Net	Wkst.	A-7 Ref.											
	Adjustments													
	(col. 4 minus													
	col. 5)*													
	6. 00	7	. 00											
	A. COSTS INCUR	RED AND) ADJUSTI	MENTS RE	QUI RED AS	A RESULT	OF TRANS	SACTIONS V	NITH F	RELATED (ORGANI Z	ATIONS OR	CLAI MED	
	HOME OFFICE CO	STS:												
1.00	-1, 470, 670		0											1.00
2.00	0		0											2.00
3.00	0		0											3.00
4.00	0		0											4.00
5.00	-1, 470, 670													5. 00
* The	amounts on line	es 1-4	(and sub	scripts	as appropr	riate) ar	e transf	erred in	detai	I to Wor	ksheet	A. column	6. lines as	 S
	i ate. Posi ti ve													
	been posted to										_			
	Related Orga	ani zati	on(s)										'	
	and/or Ho													

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

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

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

6. 00	SURGERY CENTER	6. 00
7.00		7.00
8.00		8.00
9.00		9.00
8. 00 9. 00 10. 00		10.00
100.00		100.00

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

Type of Business

- 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: 150115

						10 06/30/2015	11/23/2015 9:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	0 <u>2</u> diii
		I denti fi er	Remuneration	Component	Component	1102 711104111	ider Component	
							Hours	
	1. 00	2.00	3.00	4. 00	5. 00	6. 00	7. 00	
1. 00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	1, 470, 566	1, 470, 566	5 0		0	1. 00
2.00		ADMINISTRATIVE & GENERAL	379, 601	379, 60°		0	0	2. 00
3.00	40.00	SUBPROVIDER - IPF	572, 506			0	0	3. 00
4.00		SUBPROVIDER - IRF	131, 000	21, 000		142, 500	1, 040	
5. 00		OPERATING ROOM	9, 625	9, 62!	·	0	0	5. 00
6. 00		ANESTHESI OLOGY	1, 775, 496	1, 775, 496		0	0	6. 00
7. 00		LABORATORY	150, 000			0	0	7. 00
8. 00		RESPI RATORY THERAPY	1, 915			l o	0	8. 00
9. 00		PHYSI CAL THERAPY	4, 672	3, 672		142, 500	1	9. 00
10. 00		ELECTROCARDI OLOGY	453, 923					
11. 00		CLI NI C	321, 308			142, 300	000	
12. 00	90. 01		191, 458			0	0	12. 00
13. 00		EMERGENCY	4, 097, 871	4, 089, 453		142, 500	10	
14. 00		RADI OLOGY-DI AGNOSTI C	1, 208, 453			142, 300	0	14. 00
200.00	34.00	Adirocodi - Di Adirosi i C	10, 768, 394			0	1, 891	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Provi der	Physici an Cost	200.00
	WKSt. A LITTE #	I denti fi er	Li mi t		Memberships &	Component	of Malpractice	
		ruentiffer	Limit	Li mi t	Continuing	Share of col.	Insurance	
				LIIIII	Education	12	i iisui ance	
	1. 00	2.00	8.00	9. 00	12. 00	13. 00	14.00	
1. 00	4 00	EMPLOYEE BENEFITS DEPARTMENT	0.00		0 0		0	1. 00
2. 00		ADMINISTRATIVE & GENERAL	0	1			_	
3. 00		SUBPROVI DER - I PF	0		1	0	0	i e
4. 00		SUBPROVIDER - IRF	71, 250		-	0	0	i e
5. 00		OPERATING ROOM	71,230	3, 30.	0	0	0	5. 00
6. 00		ANESTHESI OLOGY)		0	0	
7. 00		LABORATORY)		0	0	7. 00
8. 00		RESPI RATORY THERAPY)	0	0	0	8. 00
9. 00		PHYSI CAL THERAPY	2, 809	140) 0	0	0	9. 00
10. 00		ELECTROCARDI OLOGY	54, 808			0		10.00
11. 00		CLI NI C	34, 606	2, 740		0	0	
	90.00		1		-	0	0	
12.00			0		0	0		12.00
13.00		EMERGENCY	685	34		0	0	13.00
14. 00	54.00	RADI OLOGY-DI AGNOSTI C	120 552	, 47	0	0	0	14. 00
200.00	W/I+ A I : //	C+ C+ (Db	129, 552			0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE Di cal Lewanea	Adjustment		
		ldentifier	Component Share of col.	Limit	Di sal I owance			
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		EMPLOYEE BENEFITS DEPARTMENT	15.00		0 0			1. 00
2. 00		ADMINISTRATIVE & GENERAL				1		2. 00
		SUBPROVIDER - IPF)		l		3. 00
3. 00 4. 00				71, 250	20.750	572, 506	1	4. 00
		SUBPROVIDER - IRF OPERATING ROOM	0			l		
5. 00			0	,	0	1,		5. 00
6.00		ANESTHESI OLOGY	0	,	0	, , , , , ,	1	6. 00
7. 00		LABORATORY	0		0		1	7. 00
8. 00		RESPI RATORY THERAPY	0		0	1		8. 00
9.00		PHYSI CAL THERAPY	0					9.00
10.00		ELECTROCARDI OLOGY	0	1		399, 115	1	10.00
11. 00		CLI NI C	0		0	321, 308	1	11.00
12. 00	90. 01		0		0	191, 458		12.00
13.00		EMERGENCY	0				1	13.00
14. 00	54. 00	RADI OLOGY-DI AGNOSTI C	0		0	1, 208, 453	1	14.00
200. 00			0	129, 552	197, 259	10, 640, 651		200. 00

Provider CCN: 150115

Peri od:

COST ALLOCATION - GENERAL SERVICE COSTS

From 07/01/2014 Part I Date/Time Prepared: 06/30/2015 11/23/2015 9:52 am CAPITAL RELATED COSTS Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal Cost Center Description for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 5, 731, 120 00100 CAP REL COSTS-BLDG & FLXT 5, 731, 120 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 8, 568, 355 8, 568, 355 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 16, 017, 439 32, 414 48, 460 16, 098, 313 4.00 00500 ADMINISTRATIVE & GENERAL 1, 507, 239 5 00 1, 222, 982 1 828 430 27, 226, 429 5 00 22, 667, 778 6.00 00600 MAINTENANCE & REPAIRS 7, 361, 719 417, 173 623, 698 299, 356 8, 701, 946 6.00 8.00 00800 LAUNDRY & LINEN SERVICE 328, 676 21, 116 31, 570 41, 609 422, 971 8.00 00900 HOUSEKEEPI NG 1, 237, 652 18, 188 27, 192 184, 131 1, 467, 163 9.00 9.00 01000 DI ETARY 10.00 506, 795 71.754 107, 276 64.834 750, 659 10 00 11.00 01100 CAFETERI A 620, 374 14, 473 21,638 133, 683 790, 168 11.00 01300 NURSING ADMINISTRATION 12, 608 18, 850 169, 970 1, 229, 376 13.00 1,027,948 13.00 01400 CENTRAL SERVICES & SUPPLY 281, 757 18, 306 43, 629 14.00 12.244 355, 936 14.00 39, 676 15.00 01500 PHARMACY 11, 670, 548 59, 317 342.040 12, 111, 581 15.00 01600 MEDICAL RECORDS & LIBRARY 1, 138, 084 33, 229 49,680 198, 652 1, 419, 645 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4. 318. 000 372, 748 557, 280 811, 988 6, 060, 016 30.00 31.00 03100 INTENSIVE CARE UNIT 2, 674, 126 151, 470 226, 456 461, 643 3, 513, 695 31 00 40.00 04000 SUBPROVIDER - IPF 1, 679, 057 119, 661 178, 899 402, 107 2, 379, 724 40.00 41.00 04100 SUBPROVIDER - IRF 708, 711 62, 431 93, 337 116, 623 981, 102 41.00 04300 NURSERY 43.00 686, 605 47, 025 70.305 113, 202 917, 137 43.00 04400 SKILLED NURSING FACILITY 44.00 1, 281, 671 82,068 122, 697 233, 414 1, 719, 850 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 8, 926, 723 407, 063 608, 583 844, 055 10, 786, 424 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 1, 258, 776 128, 849 207, 536 1, 681, 345 86, 184 52.00 53.00 05300 ANESTHESI OLOGY 351, 463 622, 455 973, 918 53.00 05400 RADI OLOGY-DI AGNOSTI C 737, 014 4, 498, 269 54.00 3, 383, 857 151, 258 226, 140 54.00 56.00 05600 RADI OI SOTOPE 796, 974 12, 929 19, 330 40, 716 869, 949 56.00 60.00 06000 LABORATORY 6,071,022 61,710 92, 259 437.986 6, 662, 977 60.00 06500 RESPIRATORY THERAPY 1, 128, 200 22, 085 33, 018 188, 542 1, 371, 845 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 2, 202, 613 90, 918 135, 928 363, 700 2, 793, 159 66.00 06900 ELECTROCARDI OLOGY 69 00 2,080,677 164, 012 245, 208 397, 216 2, 887, 113 69.00 69.01 06901 PULMONARY 0 69.01 06902 CARDI OPULMONARY 69.02 90, 314 12, 827 19, 177 17, 778 140,096 69.02 06903 SLEEP LAB 35, 269 69.03 218, 898 27, 867 300, 674 69.03 18, 640 07000 ELECTROENCEPHALOGRAPHY 70.00 C 0 0 Λ 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 4, 614, 536 C 0 0 4, 614, 536 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 9, 317, 329 0 0 9, 317, 329 72.00 ol 07300 DRUGS CHARGED TO PATIENTS 0 73 00 Ω 0 73 00 07400 RENAL DIALYSIS 74.00 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 345, 768 21, 065 31, 494 444, 001 88.00 45,674 08801 RURAL HEALTH CLINIC LI 677, 411 88 01 474, 129 72, 178 82, 826 88 01 48, 278 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 09000 CLI NI C 709, 582 60, 362 90, 245 46, 746 906, 935 90.00 90.00 09001 I MED 90.01 287,005 7, 925 11.848 67, 569 374, 347 90.01 09002 ONCOLOGY 170, 688 90 02 2, 247, 010 114, 168 238, 597 2, 770, 463 90 02 90.03 09003 OUTPATIENT CENTER 298, 178 41, 222 339, 400 90.03 09100 EMERGENCY 169, 730 1, 235, 351 91.00 3, 152, 993 113, 527 4, 671, 601 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 20, 956 2, 191, 218 95.00 1, 817, 580 31, 330 321, 352 09600 DURABLE MEDICAL EQUIP-RENTED 96 00 96.00 101.00 10100 HOME HEALTH AGENCY 1, 484, 291 18, 785 28, 085 236, 764 1, 767, 925 101. 00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 116.00 11, 3<u>32, 488</u> SUBTOTALS (SUM OF LINES 1-117) 139, 764, 333 4, 163, 952 6, 225, 348 131, 088, 333 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 10, 846 16, 215 27, 061 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 4, 157, 167 27, 431, 674 850, 917 1, 272, 170 33, 711, 928 192. 00 192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 27, 948 41, 785 914, 483 192. 01 711, 525 133, 225 194, 00 07950 LODGE 215 314, 630 470, 390 14 785, 249 194, 00 194. 02 07952 MEMORIAL HOSPITAL FOUNDATION 139, 389 5, 594 8, 363 25, 807 179, 153 194. 02 194. 03 07953 MKT/PHY SERVICES 3, 369, 659 68, 382 102, 234 309, 277 3, 849, 552 194. 03 194. 04 07954 COMMUNITY EDUCATION 762, 639 194. 04 531.980 63, 632 95. 134 71, 893 194. 05 07955 VOLUNTEER 164, 908 7, 102 10, 618 29, 838 212, 466 194. 05 194. 06 07956 MAB 0 194. 06 194. 08 07958 PUBLIC RELATIONS 770,800 14, 218 21, 257 38, 604 844, 879 194. 08 194. 09 07959 UNUSED SPACE 508, 740 194. 09 203, 899 0 304, 841 0 200.00 Cross Foot Adjustments 0 200.00

Health Financial Systems	MEMORIAL HOSP & I	HEALTH CARE CTF	₹	In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B		
				From 07/01/2014 To 06/30/2015	Part Date/Time Pre	pared:	
					11/23/2015 9:		
		CAPI TAL REI	LATED COSTS				
Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal		
	Allocation			DEPARTMENT			
	(from Wkst A						
	col . 7)						
	0	1. 00	2.00	4. 00	4A		
201.00 Negative Cost Centers		0		0 0	0	201. 00	
202.00 TOTAL (sum lines 118-201)	172, 884, 483	5, 731, 120	8, 568, 35	5 16, 098, 313	172, 884, 483	202. 00	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150115

| Peri od: | Worksheet B | From 07/01/2014 | Part | To 06/30/2015 | Date/Time Prepared: | 11/23/2015 9: 52 am

					00,00,20.0	11/23/2015 9:	52 am
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	REPAI RS	LINEN SERVICE			
		5. 00	6. 00	8.00	9. 00	10. 00	
	AL SERVICE COST CENTERS						4 00
	CAP REL COSTS ANVEL F FOULD						1.00
	CAP REL COSTS-MVBLE EQUIP						2.00
	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	27 224 420					4.00
	MAINTENANCE & REPAIRS	27, 226, 429 1, 626, 568	10, 328, 514				5. 00 6. 00
	LAUNDRY & LINEN SERVICE	79, 062	53, 738				8. 00
	HOUSEKEEPI NG	274, 242	46, 286		1, 787, 691		9. 00
	DI ETARY	140, 313	182, 605		31, 915	1, 111, 007	10.00
	CAFETERI A	147, 698	36, 832		6, 437	0	11.00
	NURSI NG ADMI NI STRATI ON	229, 795	32, 087		5, 608	0	13. 00
	CENTRAL SERVICES & SUPPLY	66, 532	31, 160		5, 446	0	14.00
	PHARMACY	2, 263, 897	100, 970		17, 647	0	15. 00
	MEDICAL RECORDS & LIBRARY	265, 360	84, 565		14, 780	0	16. 00
I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30. 00 03000	ADULTS & PEDIATRICS	1, 132, 738	948, 598	154, 047	165, 792	440, 388	30. 00
31.00 03100	INTENSIVE CARE UNIT	656, 780	385, 471	49, 808	67, 371	175, 762	31. 00
	SUBPROVIDER - IPF	444, 818	304, 521		53, 223	153, 761	
	SUBPROVIDER - IRF	183, 388	158, 878		27, 768	54, 593	41. 00
	NURSERY	171, 431	119, 673			82, 647	43. 00
	SKILLED NURSING FACILITY	321, 474	208, 853	28, 415	36, 502	203, 856	44. 00
	LARY SERVICE COST CENTERS	0.044.400	1 005 005		101 051		
	OPERATING ROOM	2, 016, 198	1, 035, 925		181, 054	0	50.00
	DELIVERY ROOM & LABOR ROOM	314, 277	219, 327		38, 333	0	52.00
	ANESTHESI OLOGY	182, 045	204 024	1	(7.277	0	53.00
	RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	840, 816 162, 611	384, 934		67, 277	0	54. 00 56. 00
	LABORATORY	1, 245, 444	32, 903 157, 043		5, 751 27, 447	0	60.00
	RESPIRATORY THERAPY	256, 425	56, 203	,	9, 823	0	65. 00
	PHYSI CAL THERAPY	522, 097	231, 375		40, 439	0	66. 00
	ELECTROCARDI OLOGY	539, 659	417, 391		72, 950	0	69.00
	PULMONARY	0	117, 371		72, 700	0	69. 01
	CARDI OPULMONARY	26, 187	32, 643		5, 705	0	69. 02
	SLEEP LAB	56, 202	47, 435		8, 291	0	69. 03
	ELECTROENCEPHALOGRAPHY	0	0	0	o	0	70. 00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	862, 549	0	0	o	0	71. 00
72. 00 07200	IMPL. DEV. CHARGED TO PATIENTS	1, 741, 595	0	0	o	0	72. 00
	DRUGS CHARGED TO PATIENTS	0	0	0	o	0	73. 00
74. 00 07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPA	TIENT SERVICE COST CENTERS						
	RURAL HEALTH CLINIC	82, 993	53, 608	0	9, 369	0	88. 00
	RURAL HEALTH CLINIC II	126, 622	122, 861	0	21, 473	0	88. 01
	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
	CLINIC	169, 524	153, 614		26, 848	0	90.00
90. 01 09001		69, 973	20, 168			0	90. 01
	ONCOLOGY	517, 855	290, 545		50, 780	0	90. 02
	OUTPATIENT CENTER	63, 441	200 012	0	50 405	0	90. 03
	EMERGENCY	873, 216	288, 913	61, 740	50, 495	0	91.00
	OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS						92. 00
	AMBULANCE SERVICES	409, 582	53, 330	0	9, 321	0	95. 00
	DURABLE MEDICAL EQUIP-RENTED	107, 302	33, 330	o o	7, 321	0	96.00
	HOME HEALTH AGENCY	330, 461	47, 806		8, 355		101. 00
	AL PURPOSE COST CENTERS	0007.01	.,, 000	<u>, </u>	0,000	-	
116. 00 11600		0	0	0	0	0	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	19, 413, 868	6, 340, 261	554, 504	1, 090, 641	1, 111, 007	
NONRE	I MBURSABLE COST CENTERS			•			
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 058	27, 601	0	4, 824	0	190. 00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	6, 301, 459	2, 165, 482	1, 039	378, 473	0	192. 00
192. 01 19201	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	170, 935	71, 125	0	12, 431	0	192. 01
194. 00 07950	LODGE	146, 779	800, 694	0	139, 942	0	194. 00
194. 02 07952	MEMORIAL HOSPITAL FOUNDATION	33, 487	14, 236	0	2, 488	0	194. 02
194. 03 07953	MKT/PHY SERVICES	719, 558	174, 023	0	30, 415	0	194. 03
	COMMUNITY EDUCATION	142, 552	161, 937	0	28, 303		194. 04
194. 05 07955		39, 714	18, 073	1	3, 159		194. 05
194. 06 07956		0	0	0	0		194. 06
	PUBLIC RELATIONS	157, 925	36, 184		6, 324		194. 08
	UNUSED SPACE	95, 094	518, 898	228	90, 691	0	194. 09
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0 27 224 420	10 222 54	1	0 0		201.00
202. 00	TOTAL (sum lines 118-201)	27, 226, 429	10, 328, 514	555, 771	1, 787, 691	1, 111, 007	J202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150115

			10	06/30/2015	Date/lime Pre 11/23/2015 9:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11.00	13. 00	SUPPLY 14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS	11100	10.00	11100	10100	.0.00	
1.00 00100 CAP REL COSTS-BLDG & FLXT						1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 6. 00 00600 MAI NTENANCE & REPAI RS						5. 00 6. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10. 00
11. 00 01100 CAFETERI A	981, 135					11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	13, 451	1, 510, 317	405 444			13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	7, 588 22, 766	0	495, 444 0	14, 516, 861		14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	25, 794	0	0	14, 310, 661	1, 810, 194	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	==,		-1		.,	
30. 00 03000 ADULTS & PEDIATRICS	81, 379	531, 994	0	2, 963	68, 719	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	45, 983	300, 602	0	95	35, 425	31. 00
40. 00 04000 SUBPROVI DER - 1 PF	34, 534	225, 760 73, 315	0	50	24, 138	40.00
41. 00 04100 SUBPROVI DER - RF 43. 00 04300 NURSERY	11, 215 9, 905	64, 748	0	0	7, 621 8, 733	41. 00 43. 00
44. 00 04400 SKI LLED NURSING FACILITY	25, 193	04, 740	0	6	7, 806	44. 00
ANCILLARY SERVICE COST CENTERS	207 170	<u> </u>	<u> </u>	<u> </u>	7,7000	
50. 00 05000 OPERATING ROOM	65, 560	0	0	1, 465	311, 144	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	18, 158	118, 706	0	0	20, 186	52.00
53. 00 05300 ANESTHESI OLOGY	13, 787	0	0	1, 317	14, 028	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 56. 00 05600 RADI OI SOTOPE	41, 709 2, 657	0	0	154, 507	215, 178 38, 080	54. 00 56. 00
60. 00 06000 LABORATORY	49, 992	0	0	1, 201	160, 040	60.00
65. 00 06500 RESPIRATORY THERAPY	19, 658	o	Ö	71, 665	28, 674	
66. 00 06600 PHYSI CAL THERAPY	31, 425	0	0	8, 624	36, 908	66. 00
69. 00 06900 ELECTROCARDI OLOGY	28, 737	0	0	44, 073	120, 826	69. 00
69. 01 06901 PULMONARY	0	0	0	0	0	69. 01
69. 02 06902 CARDI OPULMONARY	1, 825	0	0	0	3, 066	69. 02
69. 03 06903 SLEEP LAB 70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 814	0	0	0	6, 494 0	69. 03 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	495, 444	0	50, 911	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	l o	Ö	0	o	83, 727	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	0	0	13, 675, 814	345, 669	73. 00
74. 00 07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
OUTPATIENT SERVICE COST CENTERS	0.404	٥		44.04	0.054	00.00
88. 00 08800 RURAL HEALTH CLINIC 88. 01 08801 RURAL HEALTH CLINIC II	3, 606 6, 267	0	0	14, 016 17, 855	3, 851 0	88. 00 88. 01
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0, 207	0	0	17, 655	0	89. 00
90. 00 09000 CLINIC	5, 311	o	O	12, 503	14, 040	90.00
90. 01 09001 I MED	5, 556	36, 319	0	37, 168	2, 574	90. 01
90. 02 09002 0NC0L0GY	24, 303	158, 873	0	1, 081	46, 129	
90. 03 09003 OUTPATIENT CENTER	0	0	0	7	3, 445	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	53, 261	0	0	23, 337	111, 937	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	40, 267	0	0	21, 113	21, 096	95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0	0	0	0	96. 00
101.00 10100 HOME HEALTH AGENCY	22, 972	0	0	757	11, 739	101. 00
SPECIAL PURPOSE COST CENTERS			_1	_1		
116. 00 11600 HOSPICE 118. 00 SUBTOTALS (SUM OF LINES 1-117)	714 472	0 1, 510, 317	405 444	14 000 447	0 1, 802, 184	116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	716, 673	1,510,317	495, 444	14, 089, 667	1, 802, 184	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	o	0	0	0	190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	209, 970	0	0	427, 194	8, 010	192. 00
192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	O		192. 01
194. 00 07950 LODGE	20	0	0	0		194. 00
194. 02 07952 MEMORI AL HOSPI TAL FOUNDATION	2, 397	0	0	0		194. 02
194. 03 07953 MKT/PHY SERVICES 194. 04 07954 COMMUNITY EDUCATION	35, 520 10, 562	0	0	0		194. 03 194. 04
194. 04 07954 COMMUNITY EDUCATION 194. 05 07955 VOLUNTEER	2, 230	0	0	0		194. 04
194. 06 07956 MAB	2, 230	ol	o	ol		194. 06
194. 08 07958 PUBLIC RELATIONS	3, 763	ō	0	o	0	194. 08
194. 09 07959 UNUSED SPACE	0	0	0	0		194. 09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	001 135	1 510 217	405 444	14 514 041		201.00
202.00 TOTAL (sum lines 118-201)	981, 135	1, 510, 317	495, 444	14, 516, 861	1, 810, 194	1202.00

In Lieu of Form CMS-2552-10 Health Financial Systems

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150115 Peri od: Worksheet B From 07/01/2014 Part I 06/30/2015 Date/Time Prepared: 11/23/2015 9:52 am Cost Center Description Subtotal Intern & Total Residents Cost & Post Stepdown Adj ustments 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 00600 MAINTENANCE & REPAIRS 6.00 6.00 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 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 9, 586, 634 9, 586, 634 30.00 03100 INTENSIVE CARE UNIT 5, 230, 992 5, 230, 992 31 00 0 31 00 04000 SUBPROVIDER - IPF 40.00 3, 640, 972 0 3, 640, 972 40.00 04100 SUBPROVIDER - IRF 1, 509, 361 0 1, 509, 361 41.00 41.00 43.00 04300 NURSERY 1, 398, 815 0 1, 398, 815 43.00 04400 SKILLED NURSING FACILITY 44.00 2, 551, 955 Ω 2, 551, 955 44 00 ANCILLARY SERVICE COST CENTERS 14, 500, 761 50.00 05000 OPERATING ROOM 14, 500, 761 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 410, 332 0 2, 410, 332 52.00 53 00 05300 ANESTHESI OLOGY 1, 185, 095 0 1, 185, 095 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 6, 250, 520 0 6, 250, 520 54.00 05600 RADI OI SOTOPE 1, 111, 951 1, 111, 951 56.00 56.00 06000 LABORATORY 8, 305, 590 8, 305, 590 60.00 60.00 06500 RESPIRATORY THERAPY 1, 815, 222 1, 815, 222 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 3, 669, 929 3, 669, 929 66.00 06900 ELECTROCARDI OLOGY 69 00 4, 137, 233 4, 137, 233 69 00 69.01 06901 PULMONARY 69.01 C 06902 CARDI OPULMONARY 209, 522 209, 522 69 02 69 02 06903 SLEEP LAB 422, 910 422, 910 69.03 69.03 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 6,023,440 0 6, 023, 440 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 11, 142, 651 11, 142, 651 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 14, 021, 483 14, 021, 483 73.00 74.00 07400 RENAL DIALYSIS 74.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 611, 444 611, 444 88.00 88. 01 08801 RURAL HEALTH CLINIC II 972, 489 0 972, 489 88.01 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 0 C 1, 288, 775 1, 288, 775 90.00 09000 CLI NI C 0 90.00 90.01 09001 I MED 549, 645 549, 645 90.01 09002 ONCOLOGY 3, 865, 080 0 3, 865, 080 90.02 90.02 09003 OUTPATIENT CENTER 0 90.03 90.03 406, 293 406, 293 91.00 09100 EMERGENCY 6, 134, 500 0 6, 134, 500 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 2, 745, 927 2, 745, 927 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 101.00 10100 HOME HEALTH AGENCY 2, 190, 015 0 2, 190, 015 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1-117) 117, 889, 536 117, 889, 536 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 64 544 64, 544 190 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 43, 203, 555 43, 203, 555 192.00 192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 1, 168, 974 1, 168, 974 192. 01 1, 872, 684 1, 872, 684 194. 00 07950 LODGE 194.00 194. 02 07952 MEMORIAL HOSPITAL FOUNDATION 231, 761 194 02 231, 761 194. 03 07953 MKT/PHY SERVICES 4, 809, 068 4, 809, 068 194.03 1, 105, 993 1, 105, 993 194. 04 07954 COMMUNITY EDUCATION 194. 04 194. 05 07955 VOLUNTEER 275, 642 275, 642 194. 05 194. 06 07956 MAB 194.06 194. 08 07958 PUBLIC RELATIONS 1, 049, 075 1, 049, 075 194. 08 194. 09 07959 UNUSED SPACE 1, 213, 651 0 1, 213, 651 194. 09 Cross Foot Adjustments 200.00 0 200. 00 0 C 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118-201) 172, 884, 483 172, 884, 483 202.00

Provi der CCN: 150115

Peri od:

From 07/01/2014

ALLOCATION OF CAPITAL RELATED COSTS

Part II

06/30/2015 Date/Time Prepared: 11/23/2015 9:52 am CAPITAL RELATED COSTS Cost Center Description Directly BLDG & FIXT MVBLE EQUIP Subtotal **EMPLOYEE** Assigned New **BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 2A 4.00 0 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 32, 414 48, 460 80, 874 80, 874 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 0 0 0 1, 222, 982 1, 828, 430 3, 051, 412 7, 569 5.00 00600 MAINTENANCE & REPAIRS 1, 040, 871 1, 503 6 00 417, 173 623, 698 6 00 00800 LAUNDRY & LINEN SERVICE 8.00 21, 116 31, 570 52, 686 209 8.00 9.00 00900 HOUSEKEEPI NG 18, 188 27, 192 45, 380 925 9.00 01000 DI ETARY 0000 71. 754 107, 276 179, 030 326 10.00 10 00 01100 CAFETERI A 11.00 14, 473 21, 638 36, 111 671 11.00 13.00 01300 NURSING ADMINISTRATION 12, 608 18, 850 31, 458 854 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 12, 244 18, 306 30, 550 219 14.00 01500 PHARMACY 98 993 1, 718 15 00 15 00 39, 676 59 317 16.00 01600 MEDICAL RECORDS & LIBRARY 33, 229 49,680 82, 909 998 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 0 30.00 03000 ADULTS & PEDIATRICS 372, 748 557, 280 930, 028 4, 078 30.00 31.00 03100 INTENSIVE CARE UNIT 226, 456 151, 470 377, 926 2.318 31 00 40.00 04000 SUBPROVIDER - IPF 0 119, 661 178, 899 298, 560 2,019 40.00 155, 768 04100 SUBPROVI DER - I RF 41.00 62, 431 93, 337 586 41.00 0 04300 NURSERY 47, 025 70, 305 43.00 43.00 117, 330 569 04400 SKILLED NURSING FACILITY 82, 068 44.00 122, 697 204, 765 1, 172 44.00 ANCILLARY SERVICE COST CENTERS 4, 239 0 50.00 05000 OPERATING ROOM 407, 063 608, 583 1, 015, 646 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 1,042 52.00 86, 184 128, 849 215, 033 52.00 05300 ANESTHESI OLOGY 3, 126 53.00 53 00 3, 701 05400 RADI OLOGY-DI AGNOSTI C 00000000 151, 258 226, 140 377, 398 54.00 54.00 56.00 05600 RADI OI SOTOPE 12, 929 19, 330 32, 259 204 56.00 06000 LABORATORY 92.259 153, 969 60.00 61,710 2, 200 60.00 06500 RESPIRATORY THERAPY 65.00 22, 085 33, 018 55, 103 947 65.00 06600 PHYSI CAL THERAPY 90, 918 135, 928 226, 846 66,00 1.827 66,00 69.00 06900 ELECTROCARDI OLOGY 164, 012 245, 208 409, 220 1, 995 69.00 69.01 06901 PULMONARY 69.01 Λ 69.02 06902 CARDI OPULMONARY 12,827 19, 177 32,004 89 69.02 06903 SLEEP LAB 69.03 0 0 18, 640 27, 867 46, 507 177 69.03 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 C 0 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 C 0 0 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 o 73.00 73.00 0 0 07400 RENAL DIALYSIS O 74.00 0 74.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 21, 065 31, 494 52, 559 229 88.00 08801 RURAL HEALTH CLINIC II 00000 48, 278 88.01 72.178 120, 456 416 88.01 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 Ω 89 00 90.00 09000 CLI NI C 60, 362 90, 245 150, 607 235 90.00 09001 I MED 90. 01 7, 925 11,848 19,773 339 90.01 90 02 09002 ONCOLOGY 90 02 170, 688 284, 856 1, 198 114, 168 90.03 09003 OUTPATIENT CENTER 207 90.03 09100 EMERGENCY 0 113, 527 169, 730 283, 257 6, 204 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 20, 956 31, 330 52, 286 1, 614 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 101.00 10100 HOME HEALTH AGENCY 1, 189 101. 00 0 18, 785 28, 085 46, 870 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 0 116. 00 SUBTOTALS (SUM OF LINES 1-117) 0 4, 163, 952 6, 225, 348 10, 389, 300 56, 912 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN <u>ក</u>ា190. 00 0 10.846 16, 215 27,061 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 850, 917 1, 272, 170 2, 123, 087 20, 905 192. 00 192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 27, 948 41, 785 69, 733 669 192. 01 194. 00 07950 LODGE 314, 630 0 194 00 470, 390 785, 020 194. 02 07952 MEMORIAL HOSPITAL FOUNDATION 5, 594 8, 363 13, 957 130 194. 02 1, 553 194. 03 194. 03 07953 MKT/PHY SERVICES 68, 382 102, 234 170, 616 0 194. 04 07954 COMMUNITY EDUCATION 63, 632 95, 134 158, 766 361 194. 04 194. 05 07955 VOLUNTEER 150 194. 05 7, 102 10, 618 17, 720 194.06 07956 MAB 0 194.06 194. 08 07958 PUBLIC RELATIONS 0 14, 218 21, 257 35, 475 194 194. 08 194.09 07959 UNUSED SPACE 0 194. 09 203, 899 304, 841 508, 740 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00

Health Financial Systems Mi	EMORIAL HOSP & F	HEALTH CARE CTR	?	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 07/01/2014 To 06/30/2015		narod:
				10 00/30/2013	11/23/2015 9:	
		CAPI TAL REI	LATED COSTS			
	D: 11	DI DO A FLVT	MANUEL FOLLIE		ENDL OVEE	
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1. 00	2. 00	2A	4. 00	
202.00 TOTAL (sum lines 118-201)	0	5, 731, 120	8, 568, 35	5 14, 299, 475	80, 874	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	11/23/2015 9: DI ETARY	52 am
cost center bescription	& GENERAL	REPAI RS	LINEN SERVICE	HOUSEKEEFING	DILIAKI	
	5. 00	6. 00	8. 00	9. 00	10.00	
GENERAL SERVICE COST CENTERS			1			
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	3, 058, 981					5.00
6. 00 00600 MAI NTENANCE & REPAI RS	182, 750	1, 225, 124				6. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	8, 883	6, 374				8. 00
9. 00 00900 HOUSEKEEPI NG	30, 812	5, 490				9. 00
10. 00 01000 DI ETARY	15, 765	21, 660			218, 932	
11. 00 01100 CAFETERI A	16, 594	4, 369	1	297	0	11. 00
13. 00 01300 NURSING ADMINISTRATION	25, 818	3, 806	1	259	0	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	7, 475	3, 696	l	l	0	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY	254, 355 29, 814	11, 977 10, 031	1	815 683	0	15. 00 16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	29,014	10, 031		003	0	16.00
30. 00 03000 ADULTS & PEDIATRICS	127, 266	112, 519	18, 892	7, 661	86, 782	30.00
31. 00 03100 INTENSIVE CARE UNIT	73, 791	45, 723			34, 635	1
40. 00 04000 SUBPROVI DER - 1 PF	49, 977	36, 121		2, 459	30, 300	
41. 00 04100 SUBPROVI DER - 1 RF	20, 604	18, 845	1, 408	1, 283	10, 758	41. 00
43. 00 04300 NURSERY	19, 261	14, 195		l	16, 286	
44. 00 04400 SKILLED NURSING FACILITY	36, 119	24, 773	3, 484	1, 687	40, 171	44. 00
ANCILLARY SERVICE COST CENTERS	22/ 52/	122 077	10 (00	0.244		FO 00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	226, 526 35, 310	122, 877 26, 016	1	l	0	
53. 00 05300 ANESTHESI OLOGY	20, 453	20,010	1	1, //1	0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	94, 468	45, 659	_	3, 109	0	54.00
56. 00 05600 RADI 0I SOTOPE	18, 270	3, 903		266	0	56.00
60. 00 06000 LABORATORY	139, 929	18, 628			0	60.00
65. 00 06500 RESPI RATORY THERAPY	28, 810	6, 667	114	454	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	58, 659	27, 445	724	1, 869	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	60, 632	49, 509	3, 248	3, 371	0	69. 00
69. 01 06901 PULMONARY	0	0	1		0	69. 01
69. 02 06902 CARDI OPULMONARY	2, 942	3, 872			0	69. 02
69. 03 06903 SLEEP LAB	6, 314	5, 627	0	383	0	69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0(010	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	96, 910 195, 673	0		0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATTENTS	195, 673	0	0	0	0	73.00
74. 00 07400 RENAL DIALYSIS		0			0	
OUTPATIENT SERVICE COST CENTERS	-1		-			
88. 00 08800 RURAL HEALTH CLINIC	9, 324	6, 359	0	433	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	14, 226	14, 573	0	992	0	1
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	_		0	89. 00
90. 00 09000 CLI NI C	19, 047	18, 221		., =	0	90.00
90. 01 09001 MED	7, 862	2, 392	1	163	0	90. 01
90. 02 09002 0NCOLOGY 90. 03 09003 OUTPATI ENT CENTER	58, 182 7, 128	34, 463	619	2, 346	0	90. 02 90. 03
91. 00 09100 EMERGENCY	98, 108	34, 270	7, 571	2, 333	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	70, 100	34, 270	7,371	2, 333	O	92.00
OTHER REIMBURSABLE COST CENTERS			1	L. L.		72.00
95. 00 09500 AMBULANCE SERVICES	46, 018	6, 326	0	431	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	· ·	0	
101.00 10100 HOME HEALTH AGENCY	37, 128	5, 671	0	386	0	101. 00
SPECIAL PURPOSE COST CENTERS	T al		1			
116. 00 11600 HOSPI CE	2 101 202	752.057				116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	2, 181, 203	752, 057	67, 997	50, 397	218, 932	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	568	3, 274	0	223	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	708, 003	256, 856	1	17, 489		192. 00
192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	19, 205	8, 437				192. 01
194. 00 07950 LODGE	16, 491	94, 975	0	6, 467	0	194. 00
194.02 07952 MEMORIAL HOSPITAL FOUNDATION	3, 762	1, 689	0	115	0	194. 02
194. 03 07953 MKT/PHY SERVICES	80, 844	20, 642	0	1, 405	0	194. 03
194. 04 07954 COMMUNITY EDUCATION	16, 016	19, 208	1	1, 308		194. 04
194. 05 07955 VOLUNTEER	4, 462	2, 144	0	146		194. 05
194. 06 07956 MAB	0	0	0	0		194. 06
194. 08 07958 PUBLI C RELATI ONS	17, 743	4, 292	1			194. 08
194.09 07959 UNUSED SPACE 200.00 Cross Foot Adjustments	10, 684	61, 550	28	4, 191	0	194. 09 200. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0	_		0	200.00
202. 00 TOTAL (sum lines 118-201)	3, 058, 981	1, 225, 124	68, 152	82, 607	218, 932	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150115

						11/23/2015 9:	<u>52 am</u>
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11. 00	13. 00	14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5. 00 6. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	58, 042					11. 00
13.00	01300 NURSING ADMINISTRATION	796	62, 991				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	449	1	46, 170			14. 00
15. 00	01500 PHARMACY	1, 347	1	0	369, 205		15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	1, 526	0	0	1	125, 962	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 014	22 100	0	7.5	4 700	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	4, 814 2, 720		0	75 2	4, 780 2, 464	30. 00 31. 00
40. 00	04000 SUBPROVI DER - I PF	2, 043	1	0	1	1, 679	40.00
41. 00	04100 SUBPROVI DER - I RF	663	1	ő	ó	530	41.00
43.00	04300 NURSERY	586	1	0	o	607	43.00
44.00	04400 SKILLED NURSING FACILITY	1, 490	o	0	o	543	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 878	1	0	37	21, 642	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 074		0	0	1, 404	52.00
53.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	816	1	0	33	976	53.00
54. 00 56. 00	05600 RADI OLOGY - DI AGNOSTI C	2, 467 157	1	0	3, 929	14, 967 2, 649	54. 00 56. 00
60.00	06000 LABORATORY	2, 957	1	0	31	11, 132	60.00
65. 00	06500 RESPI RATORY THERAPY	1, 163	1	0	1, 823	1, 994	65.00
66. 00	06600 PHYSI CAL THERAPY	1, 859	1	0	219	2, 567	66. 00
69.00	06900 ELECTROCARDI OLOGY	1, 700		0	1, 121	8, 404	69.00
69. 01	06901 PULMONARY	C	o	0	0	0	69. 01
69. 02	06902 CARDI OPULMONARY	108	1	0	0	213	69. 02
69. 03	06903 SLEEP LAB	226	1	0	0	452	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	C	-	0	0	0	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	C		46, 170 0	0	3, 541 5, 824	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		1	0	347, 817	24, 094	73.00
74. 00	1 1		o o	ő	0 17, 017	0	74. 00
	OUTPATIENT SERVICE COST CENTERS			· "	- 1		
88. 00	08800 RURAL HEALTH CLINIC	213	0	0	356	268	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	371	1	0	454	0	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	C		0	0	0	89. 00
90.00	09000 CLINIC	314		0	318	977	90.00
90. 01 90. 02	09001 I MED	329 1, 438	1	0	945 28	179 3, 209	90. 01 90. 02
90. 02		1, 430	1	0	0	240	90.02
	09100 EMERGENCY	3, 151	1	ő	594	7, 786	•
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	,				,	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	2, 382	1	0	537	1, 467	95. 00
	09600 DURABLE MEDI CAL EQUI P-RENTED	C			0	0	96. 00
101.00	10100 HOME HEALTH AGENCY	1, 359	0	0	19	817	101. 00
116 0	SPECIAL PURPOSE COST CENTERS 0.11600 HOSPI CE	C	ol ol	0	٥	0	116. 00
118. 00		42, 396		46, 170	358, 340		
110.00	NONREI MBURSABLE COST CENTERS	42,370	02, 771	40, 170	330, 340	125, 405	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	0	0	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	12, 422	0	0	10, 865		192. 00
	1 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	C	0	0	0		192. 01
	07950 LODGE	1	0	0	0		194. 00
	2 07952 MEMORIAL HOSPITAL FOUNDATION	142		0	0		194. 02
	3 07953 MKT/PHY SERVI CES	2, 101		0	0		194. 03 194. 04
	4 07954 COMMUNI TY EDUCATI ON 5 07955 VOLUNTEER	625 132		0	0		194. 04
	07935 VOLUNTEER 5 07956 MAB	132	1	0	٥		194. 05
	3 07 735 MIND 3 07958 PUBLIC RELATIONS	223	1	0	ő		194. 08
	9 07959 UNUSED SPACE		ol ol	o	o		194. 09
200.00	Cross Foot Adjustments						200. 00
201.00		C	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	58, 042	62, 991	46, 170	369, 205	125, 962	202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150115 Peri od: Worksheet B From 07/01/2014 Part II 06/30/2015 Date/Time Prepared: 11/23/2015 9:52 am Cost Center Description Subtotal Intern & Total Residents Cost & Post Stepdown Adj ustments 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 00600 MAINTENANCE & REPAIRS 6.00 6.00 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 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 319, 083 1, 319, 083 30.00 03100 INTENSIVE CARE UNIT 561, 337 561, 337 31 00 Ω 31 00 04000 SUBPROVIDER - IPF 435, 082 40.00 0 435, 082 40.00 04100 SUBPROVIDER - IRF 213, 503 0 213, 503 41.00 41.00 43.00 04300 NURSERY 172, 945 0 172, 945 43.00 <u>314,</u> 204 <u>314,</u> 204 04400 SKILLED NURSING FACILITY 44.00 0 44 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 415, 840 1, 415, 840 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 286, 601 0 286, 601 52.00 05300 ANESTHESI OLOGY 53 00 25, 404 0 25, 404 53 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 551, 563 0 551, 563 54.00 05600 RADI OI SOTOPE 57, 708 0 57, 708 56.00 56.00 06000 LABORATORY 330, 291 330, 291 60.00 60.00 06500 RESPIRATORY THERAPY 97.075 0 97, 075 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 322, 015 0 322, 015 66.00 06900 ELECTROCARDI OLOGY 69 00 539, 200 539, 200 69 00 69.01 06901 PULMONARY 0 69.01 C 06902 CARDI OPULMONARY 0 39, 492 69 02 39, 492 69 02 06903 SLEEP LAB 59, 686 69.03 69.03 59,686 07000 ELECTROENCEPHALOGRAPHY 0 70.00 C 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 146, 621 0 146, 621 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 201, 497 201, 497 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 371, 911 0 371, 911 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 69, 741 0 69, 741 88.00 88. 01 08801 RURAL HEALTH CLINIC II 151, 488 0 151, 488 88.01 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 0 C 90.00 09000 CLI NI C 190, 960 0 190, 960 90.00 90.01 09001 I MED 33, 499 33, 499 90.01 90. 02 09002 ONCOLOGY 392, 965 0 392, 965 90.02 09003 OUTPATIENT CENTER 0 90.03 90.03 7.575 7. 575 91.00 09100 EMERGENCY 443, 274 C 443, 274 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 111, 061 111, 061 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 101.00 10100 HOME HEALTH AGENCY 93, 439 0 93, 439 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1-117) 8, 955, 060 0 8, 955, 060 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 31, 126 31, 126 190 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 3, 150, 311 0 3, 150, 311 192.00 192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 98, 618 192. 01 98.618 194. 00 07950 LODGE 902, 954 902, 954 194.00 19, 795 194. 02 07952 MEMORIAL HOSPITAL FOUNDATION 19, 795 194 02 0 194. 03 07953 MKT/PHY SERVICES 277, 161 0 277, 161 194.03 194. 04 07954 COMMUNITY EDUCATION 194. 04 196, 284 196, 284 194. 05 07955 VOLUNTEER 24, 754 0 24, 754 194. 05 194. 06 07956 MAB 0 194.06 194. 08 07958 PUBLIC RELATIONS 58, 219 58, 219 194. 08 194. 09 07959 UNUSED SPACE 585, 193 0 585, 193 194. 09 Cross Foot Adjustments 200.00 0 200. 00 0 C 201.00 Negative Cost Centers 201.00

14, 299, 475

14, 299, 475

202.00

TOTAL (sum lines 118-201)

202.00

| Peri od: | Worksheet B-1 | From 07/01/2014 | To 06/30/2015 | Date/Time Prepared: Provi der CCN: 150115

					To 06/30/2015	Date/Time Pre 11/23/2015 9:	
		CAPI TAL REI	LATED COSTS			1172372015 4.	JZ dili
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	SALARI ES) 4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	J.A.	3.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	786, 816					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		786, 816				2. 00
4. 00 5. 00	OO400	4, 450 167, 901	4, 450 167, 901	84, 656, 195 7, 926, 121		145, 658, 054	4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS	57, 273					6. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	2, 899				422, 971	8. 00
9. 00	00900 HOUSEKEEPI NG	2, 497				1, 467, 163	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	9, 851				750, 659	10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 987 1, 731				790, 168 1, 229, 376	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 681	1, 681				14. 00
15. 00	01500 PHARMACY	5, 447					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY I NPATIENT ROUTINE SERVICE COST CENTERS	4, 562	4, 562	1, 044, 653	3 0	1, 419, 645	16. 00
30. 00	03000 ADULTS & PEDIATRICS	51, 174	51, 174	4, 270, 002	2 0	6, 060, 016	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	20, 795					31. 00
40. 00	04000 SUBPROVI DER - I PF	16, 428				_, -, -, , ,	40. 00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	8, 571				981, 102 917, 137	41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	6, 456 11, 267					44. 00
	ANCILLARY SERVICE COST CENTERS	, =	, =	., == .,	-	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
50.00	05000 OPERATI NG ROOM	55, 885					50.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	11, 832	11, 832 0	1, 091, 371 3, 273, 303			52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	20, 766	,			4, 498, 269	54. 00
56.00	05600 RADI OI SOTOPE	1, 775					56. 00
60.00	06000 LABORATORY	8, 472				6, 662, 977	60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	3, 032 12, 482				., ,	65. 00 66. 00
69. 00	06900 ELECTROCARDI OLOGY	22, 517	22, 517				69. 00
69. 01	06901 PULMONARY	0	0		0	0	69. 01
69. 02	06902 CARDI OPULMONARY	1, 761	1, 761	93, 488		140, 096	69. 02
69. 03 70. 00	06903 SLEEP LAB 07000 ELECTROENCEPHALOGRAPHY	2, 559		185, 471		300, 674	69. 03 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			,	1	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			·	9, 317, 329	72. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0				0	73. 00 74. 00
74.00	OUTPATIENT SERVICE COST CENTERS	0	0) 0	0	74.00
88. 00	08800 RURAL HEALTH CLINIC	2, 892		240, 184	1 0	444, 001	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	6, 628	6, 628	435, 558	0		
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	8, 287	8, 287	245, 825	5 0	906, 935	89. 00 90. 00
90. 01	09001 I MED	1, 088				374, 347	90. 01
90. 02	09002 ONCOLOGY	15, 674				2, 770, 463	90. 02
90. 03 91. 00	09003 OUTPATIENT CENTER 09100 EMERGENCY	0 15, 586	1	216, 775 6, 496, 345		339, 400 4, 671, 601	90. 03 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	15, 560	15, 560	0, 490, 340		4, 071, 001	92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	2, 877	2, 877	1, 689, 892			95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED 10100 HOME HEALTH AGENCY	2, 579	2, 579	1, 245, 071	0	_	96. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS	2,017	2,077	1, 210, 07		1,707,720	101.00
	11600 H0SPI CE	0					116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	571, 662	571, 662	59, 594, 181	-27, 226, 429	103, 861, 904	118. 00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 489	1, 489		0	27, 061	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	116, 821			7 0		
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 837				914, 483	
	0/07950 LODGE 207952 MEMORIAL HOSPITAL FOUNDATION	43, 195 768				785, 249 179, 153	
	07953 MKT/PHY SERVICES	9, 388				3, 849, 552	
194. 04	07954 COMMUNITY EDUCATION	8, 736	8, 736	378, 064	1 0	762, 639	194. 04
	07955 VOLUNTEER	975	975	156, 910	0	212, 466	
	07956 MAB 07958 PUBLIC RELATIONS	1, 952	1, 952	203, 008) 3) 0	844, 879	194. 06 194. 08
	07959 UNUSED SPACE	27, 993			Ö	508, 740	
200.00	Cross Foot Adjustments	<u> </u>	<u> </u>	<u> </u>		<u> </u>	200. 00

Health Financial Sys	stems ME	MORIAL HOSP & F	HEALTH CARE CTE	2	In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - S	TATISTICAL BASIS		Provi der		Period: From 07/01/2014	Worksheet B-1	
					To 06/30/2015	Date/Time Pre 11/23/2015 9:	
		CAPITAL REL	_ATED COSTS				
Cost Ce	nter Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
				SALARI ES)			
		1.00	2. 00	4. 00	5A	5. 00	
201.00 Negativ	e Cost Centers						201. 00
202.00 Cost to	be allocated (per Wkst. B,	5, 731, 120	8, 568, 355	16, 098, 313	3	27, 226, 429	202. 00
Part I)							
203.00 Unit co	st multiplier (Wkst. B, Part I)	7. 283939	10. 889909	0. 190161		0. 186920	203. 00
204.00 Cost to	be allocated (per Wkst. B,			80, 874	1	3, 058, 981	204.00
Part II)						
205.00 Unit co	st multiplier (Wkst. B, Part			0. 000955	5	0. 021001	205.00
11)							

	*	IEMURIAL HUSP & I				U OF FORM CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provi der	F	reniod: from 07/01/2014 fo 06/30/2015	Worksheet B-1 Date/Time Pre 11/23/2015 9:	pared:
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	CAFETERI A (HOURS)	
		6. 00	8.00	9. 00	10.00	11. 00	
-	GENERAL SERVICE COST CENTERS	_	1	1			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUI P						2. 00 4. 00
4. 00 5. 00	OO400						5.00
6. 00	00600 MAI NTENANCE & REPAI RS	557, 192					6.00
8.00	00800 LAUNDRY & LINEN SERVICE	2, 899					8. 00
9.00	00900 HOUSEKEEPI NG	2, 497	l .		1		9. 00
10.00	01000 DI ETARY	9, 851	l ·			2 045 275	10.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON	1, 987 1, 731	l .	1, 987 1, 731	l l	2, 045, 375 28, 041	
14. 00	01400 CENTRAL SERVI CES & SUPPLY	1, 681	l .		l l	15, 819	1
15. 00	01500 PHARMACY	5, 447	1				15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	4, 562	0	4, 562	0	53, 773	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	51, 174	257, 084	51, 174	10, 769	169, 651	30.00
31. 00	03100 NTENSI VE CARE UNIT	20, 795				95, 861	
40. 00	04000 SUBPROVI DER - I PF	16, 428				71, 994	
41. 00	04100 SUBPROVI DER - I RF	8, 571				23, 380	•
43.00	04300 NURSERY	6, 456				20, 648	
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	11, 267	47, 421	11, 267	4, 985	52, 519	44. 00
50.00	05000 OPERATI NG ROOM	55, 885	171, 879	55, 885	0	136, 672	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	11, 832	l .	,		37, 855	1
53.00	05300 ANESTHESI OLOGY	00.7//		20.7(/	_	28, 742	1
54. 00 56. 00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	20, 766 1, 775	1	20, 766 1, 775		86, 951 5, 540	1
60.00	06000 LABORATORY	8, 472	l .			104, 219	1
65.00	06500 RESPI RATORY THERAPY	3, 032				40, 981	1
66. 00	06600 PHYSI CAL THERAPY	12, 482	l ·			65, 511	1
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 PULMONARY	22, 517		1		59, 908 0	1
69. 02	06902 CARDI OPULMONARY	1, 761	_		_	3, 805	1
69. 03	06903 SLEEP LAB	2, 559			l l	7, 952	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	-	0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	-	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS		0		-	0	1
74. 00	07400 RENAL DIALYSIS	0	0	C	0	0	74. 00
00.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	2 002	1 0	1 2 000	ا	7 510	00.00
88. 00 88. 01	08800 RURAL HEALTH CLINIC	2, 892 6, 628	l .	1		7, 518 13, 064	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0,020	l .	1		0	
	09000 CLI NI C	8, 287				11, 071	
	09001 I MED	1, 088				11, 582	
90. 02 90. 03	O9002 ONCOLOGY O9003 OUTPATI ENT CENTER	15, 674		15, 674		50, 664 0	1
91. 00	09100 EMERGENCY	15, 586	1	1	-	111, 034	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
05 00	OTHER REIMBURSABLE COST CENTERS	2 077	1 0	2 077	O	83, 945	05 00
95. 00 96. 00	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	2, 877		_, _,		83, 945	1
	10100 HOME HEALTH AGENCY	2, 579		-			101.00
	SPECIAL PURPOSE COST CENTERS			_			ļ
116. 00 118. 00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	342, 038	_				116.00
110.00	NONREI MBURSABLE COST CENTERS	342,030	725, 374	330, 042	27, 100	1, 494, 049	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 489				0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	116, 821				437, 726	
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 07950 LODGE	3, 837 43, 195		3, 837 43, 195			192. 01 194. 00
	07952 MEMORIAL HOSPITAL FOUNDATION	768		768			194. 02
	07953 MKT/PHY SERVICES	9, 388		9, 388			194. 03
	07954 COMMUNITY EDUCATION	8, 736		8, 736			194. 04
	07955 VOLUNTEER 07956 MAB	975		975 0			194. 05 194. 06
	07958 PUBLIC RELATIONS	1, 952	_				194. 08
194. 09	07959 UNUSED SPACE	27, 993					194. 09
200.00	1 1						200.00
201.00 202.00		10, 328, 514	555, 771	1, 787, 691	1, 111, 007	981, 135	201.00
202.00	Part I)	10, 520, 514	333,771	1, 707, 071	1, 111, 507	701, 133	
					·		

Health Fina	ncial Systems ME	EMORIAL HOSP & I	HEALTH CARE CTR	2	In Lie	u of Form CMS-2	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der		eriod: rom 07/01/2014	Worksheet B-1	
		_			o 06/30/2015	Date/Time Pre 11/23/2015 9:	pared: 52 am_
	Cost Center Description	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		REPAI RS	LINEN SERVICE	(SQUARE FEET)	(PATIENT DAYS)	(HOURS)	
		(SQUARE FEET)	(POUNDS OF				
			LAUNDRY)				
		6. 00	8. 00	9. 00	10.00	11. 00	
203. 00	Unit cost multiplier (Wkst. B, Part I)	18. 536723	0. 599208	3. 239768	40. 893956	0. 479685	203. 00
204.00	Cost to be allocated (per Wkst. B,	1, 225, 124	68, 152	82, 607	218, 932	58, 042	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	2. 198747	0. 073479	0. 149706	8. 058451	0. 028377	205. 00
	11)						

Heal th	Financial Systems	MEMORIAL HOSP & H	EALTH CARE CTR		In Lie	u of Form CMS-2552-1
COST A	LLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1
					From 07/01/2014 To 06/30/2015	
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NURS.	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (REVENUE)	11/23/2015 9:52 am
		HRS.) 13. 00	REQUI S.) 14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS	10.00		10.00	10.00	
2. 00 4. 00 5. 00 6. 00 8. 00 9. 00 10. 00 11. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01100 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION	481, 635				1. 00 2. 00 4. 00 5. 00 6. 00 8. 00 9. 00 10. 00 11. 00 13. 00
	01400 CENTRAL SERVICES & SUPPLY	461, 633	100			14. 00
	01500 PHARMACY	O	0	10, 416, 73	1	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	3	6 322, 826, 747	16. 00
30. 00	O3000 ADULTS & PEDIATRICS	169, 651	ol	2, 12	6 12, 255, 887	20.00
	03100 INTENSIVE CARE UNIT	95, 861	0		8 6, 317, 920	30. 00 31. 00
	04000 SUBPROVI DER - I PF	71, 994	Ō		6 4, 304, 985	40. 00
	04100 SUBPROVI DER - I RF	23, 380	0		0 1, 359, 170	41. 00
	04300 NURSERY 04400 SKILLED NURSING FACILITY	20, 648	0		0 1, 557, 555 4 1, 392, 222	43. 00 44. 00
44.00	ANCILLARY SERVICE COST CENTERS	<u> </u>	<u> </u>		4 1, 372, 222	44.00
	05000 OPERATING ROOM	0	0	1, 05		50.00
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	37, 855	0	94	0 3, 600, 165 5 2, 501, 876	52. 00 53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	o	110, 86		54.00
56. 00	05600 RADI OI SOTOPE	0	0	•	0 6, 791, 477	56.00
	06000 LABORATORY	0	0	86		60.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0	51, 42 6, 18		65. 00 66. 00
	06900 ELECTROCARDI OLOGY	0	o	31, 62		69. 00
	06901 PULMONARY	0	0		0 0	69. 01
	06902 CARDI OPULMONARY	0	0		0 546, 769	69. 02
	06903 SLEEP LAB 07000 ELECTROENCEPHALOGRAPHY	0	0		0 1, 158, 141 0 0	69. 03 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	100		9, 079, 968	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 14, 932, 609	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	9, 813, 22	9 61, 630, 852 0 0	73. 00 74. 00
	OUTPATIENT SERVICE COST CENTERS	ı y			0 0	74.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	10, 05	7 686, 785	
	08801 RURAL HEALTH CLINIC II 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	12, 81	2 0	88. 01
	09000 CLINIC		0	8, 97	2 2, 503, 982	89. 00 90. 00
90. 01	09001 I MED	11, 582	Ō	26, 67		90. 01
	09002 ONCOLOGY	50, 664	0	77		
	09003 OUTPATI ENT CENTER 09100 EMERGENCY	0	0	16, 74	5 614, 377 6 19, 963, 848	90. 03 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		J	10, 74	17, 703, 040	92.00
	OTHER REIMBURSABLE COST CENTERS		_[
	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED		ol Ol	15, 15	0 3, 762, 378	95. 00 96. 00
	10100 HOME HEALTH AGENCY	0	0	54	3 2, 093, 608	
	SPECIAL PURPOSE COST CENTERS					
116. 00 118. 00	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117)	0 481, 635	0 100	10, 110, 19	0 0	
116.00	NONREIMBURSABLE COST CENTERS	461,033	100[10, 110, 19	3 321, 398, 192	116.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	306, 53	8 1, 428, 555	192. 00 192. 01
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 07950 LODGE	0	0		0 0	194. 00
194. 02	07952 MEMORIAL HOSPITAL FOUNDATION	0	Ö		o o	194. 02
	07953 MKT/PHY SERVICES	0	0		0 0	194. 03
	07954 COMMUNITY EDUCATION 07955 VOLUNTEER	0	0		0	194. 04 194. 05
	07956 MAB		0		o o	194. 06
194. 08	07958 PUBLIC RELATIONS	o	ō		0 0	194. 08
	07959 UNUSED SPACE	0	0		0 0	194. 09
200. 00 201. 00	,					200. 00 201. 00
201.00	1.1.5gati vo oost oontois	ı l	l		1	1 1201.00

Health Fina	ancial Systems M	EMORIAL HOSP & H	HEALTH CARE CTF	₹	In Lie	u of Form CMS-2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1
					From 07/01/2014 To 06/30/2015	Date/Time Prepared: 11/23/2015 9:52 am
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
			SUPPLY	REQUIS.)	LI BRARY	
		(DI RECT NURS.	(COSTED		(REVENUE)	
		HRS.)	REQUIS.)			
		13.00	14.00	15. 00	16.00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 510, 317	495, 444	14, 516, 86	1 1, 810, 194	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	3. 135812	4, 954. 440000	1. 39361	0. 005607	203. 00
204.00	Cost to be allocated (per Wkst. B, Part II)	62, 991	46, 170	369, 20	5 125, 962	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 130786	461. 700000	0. 03544	0.000390	205. 00

COMPUT	FATION OF RATIO OF COSTS TO CHARGES			Provi der	CCN: 150115	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Pre 11/23/2015 9:	pared:
				Title	e XVIII	Hospi tal	PPS	02 0
						Costs		
	Cost Center Description	Total Cost	Ther	apy 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	9, 586, 634			9, 586, 63	4 0	9, 586, 634	30. 00
31.00	03100 INTENSIVE CARE UNIT	5, 230, 992			5, 230, 99	2 0	5, 230, 992	31.00
40.00	04000 SUBPROVI DER - I PF	3, 640, 972			3, 640, 97	2 0	3, 640, 972	40.00
41.00	04100 SUBPROVI DER - I RF	1, 509, 361	İ		1, 509, 36	1 38, 750	1, 548, 111	41.00
43.00	04300 NURSERY	1, 398, 815	İ		1, 398, 81	5 0	1, 398, 815	43.00
44.00	04400 SKILLED NURSING FACILITY	2, 551, 955			2, 551, 95	5 0	2, 551, 955	44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	14, 500, 761			14, 500, 76	1 0	14, 500, 761	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 410, 332			2, 410, 33	2 0	2, 410, 332	52. 00
53.00	05300 ANESTHESI OLOGY	1, 185, 095			1, 185, 09	5 0	1, 185, 095	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 250, 520			6, 250, 52	0 0	6, 250, 520	54.00
56.00	05600 RADI OI SOTOPE	1, 111, 951			1, 111, 95	1 0	1, 111, 951	56.00
60.00	06000 LABORATORY	8, 305, 590			8, 305, 59	0 0	8, 305, 590	60.00
65.00	06500 RESPIRATORY THERAPY	1, 815, 222		o	1, 815, 22	2 0	1, 815, 222	65. 00
66.00	06600 PHYSI CAL THERAPY	3, 669, 929		o	3, 669, 92	9 0	3, 669, 929	66. 00
69.00	06900 ELECTROCARDI OLOGY	4, 137, 233			4, 137, 23	3 150, 776	4, 288, 009	69. 00
69. 01	06901 PULMONARY	0				o o	0	69. 01
69. 02	06902 CARDI OPULMONARY	209, 522			209, 52	2 0	209, 522	69. 02
69. 03	06903 SLEEP LAB	422, 910			422, 91	o o	422, 910	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	İ			o o	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 023, 440	İ		6, 023, 44	o o	6, 023, 440	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	11, 142, 651	İ		11, 142, 65		11, 142, 651	
73. 00	07300 DRUGS CHARGED TO PATIENTS	14, 021, 483			14, 021, 48		14, 021, 483	
74. 00	07400 RENAL DIALYSIS	0				0	0	•
	OUTPATIENT SERVICE COST CENTERS					-1		
88. 00	08800 RURAL HEALTH CLINIC	611, 444			611, 44	4 0	611, 444	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	972, 489	İ		972, 48		972, 489	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	İ			o o	0	89. 00
90.00	09000 CLI NI C	1, 288, 775	İ		1, 288, 77	5 0	1, 288, 775	
90. 01	09001 I MED	549, 645	İ		549, 64		549, 645	
90. 02	09002 ONCOLOGY	3, 865, 080	İ		3, 865, 08		3, 865, 080	
90. 03	09003 OUTPATIENT CENTER	406, 293	İ		406, 29		406, 293	
91.00	09100 EMERGENCY	6, 134, 500			6, 134, 50		6, 142, 233	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 621, 934	İ		1, 621, 93		1, 621, 934	
	OTHER REIMBURSABLE COST CENTERS				, , ,	,		
95.00	09500 AMBULANCE SERVICES	2, 745, 927			2, 745, 92	7 0	2, 745, 927	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	İ			o o	0	96.00
101.00	10100 HOME HEALTH AGENCY	2, 190, 015			2, 190, 01	5	2, 190, 015	
	SPECIAL PURPOSE COST CENTERS							
116.00	11600 HOSPI CE	0				0	0	116. 00
200.00		119, 511, 470		o	119, 511, 47	0 197, 259	119, 708, 729	200.00
201.00		1, 621, 934			1, 621, 93		1, 621, 934	201. 00
202.00	Total (see instructions)	117, 889, 536		O	117, 889, 53	6 197, 259	118, 086, 795	202. 00

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150115	Peri od:	Worksheet C	
					From 07/01/2014 To 06/30/2015	Part I Date/Time Pre	nared.
					10 00/00/2010	11/23/2015 9:	52 am
			Ti tl	e XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.		TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10.055.007		10.055.00	.=1		
30.00	03000 ADULTS & PEDI ATRI CS	12, 255, 887		12, 255, 88			30.00
31.00	03100 NTENSI VE CARE UNI T	6, 317, 920		6, 317, 92			31.00
40.00	04000 SUBPROVI DER - I PF	4, 304, 985		4, 304, 98			40.00
41. 00	04100 SUBPROVI DER - I RF	1, 359, 170		1, 359, 17			41.00
43.00	04300 NURSERY	1, 577, 555		1, 577, 55			43.00
44. 00	04400 SKILLED NURSING FACILITY	1, 392, 222		1, 392, 22	[2]		44. 00
F0 00	ANCILLARY SERVICE COST CENTERS	0.040.004	47.040.007	FF 400 44	0 0/4040	0.00000	F0 00
50.00	05000 OPERATING ROOM	8, 248, 304	47, 243, 836			0. 000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 600, 165	0	3, 600, 16		0. 000000	52.00
53.00	05300 ANESTHESI OLOGY	812, 392	1, 689, 484	2, 501, 87		0.000000	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 710, 077	33, 666, 669	38, 376, 74		0.000000	54.00
56. 00	05600 RADI OI SOTOPE	379, 295	6, 412, 182	6, 791, 47		0.000000	56. 00
60.00	06000 LABORATORY	6, 472, 010	22, 070, 878	28, 542, 88		0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	2, 506, 135	2, 607, 899	5, 114, 03		0.000000	65.00
66. 00 69. 00	06600 PHYSI CAL THERAPY	3, 965, 421	2, 617, 019	6, 582, 44		0.000000	66.00
	06900 ELECTROCARDI OLOGY 06901 PULMONARY	6, 523, 866	15, 025, 349	21, 549, 21		0.000000	69. 00
69. 01 69. 02	06902 CARDI OPULMONARY	0 987	O	E4/ 7/	0.000000	0.000000	69. 01
69. 02 69. 03	06903 SLEEP LAB	1,700	545, 782	546, 76 1, 158, 14		0. 000000 0. 000000	69. 02 69. 03
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 700	1, 156, 441	1, 130, 14		0. 000000	70.00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 551, 094	5, 528, 874	9, 079, 96	0.000000 8 0.663377	0. 000000	70.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	9, 139, 079	5, 793, 530	14, 932, 60		0. 000000	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	22, 089, 818	39, 541, 034	61, 630, 85		0. 000000	73.00
74. 00	07400 RENAL DIALYSIS	22,009,010	39, 341, 034	01, 030, 03	0. 227508	0. 000000	74.00
74.00	OUTPATIENT SERVICE COST CENTERS	U U	U		0.000000	0.000000	74.00
88. 00	08800 RURAL HEALTH CLINIC	0	686, 785	686, 78	5		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	000, 703	000, 70	1		88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90. 00	09000 CLINIC	9, 102	2, 494, 880	2, 503, 98	0. 514690	0. 000000	90.00
90. 01	09001 I MED	9, 102	459, 075	459, 07		0. 000000	90.00
90. 01	09002 ONCOLOGY	86, 017	8, 141, 063	8, 227, 08		0. 000000	90.01
90. 02	09003 OUTPATIENT CENTER	50, 000	564, 377	614, 37		0. 000000	90.02
91. 00	09100 EMERGENCY	3, 540, 060	16, 423, 788	19, 963, 84		0. 000000	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	792, 000	1, 649, 344	2, 441, 34		0. 000000	92.00
72.00	OTHER REIMBURSABLE COST CENTERS	172,000	1, 047, 344	2, 441, 54	0.004301	0.000000	72.00
95. 00	09500 AMBULANCE SERVICES	1, 100, 036	2, 662, 342	3, 762, 37	0. 729838	0. 000000	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	2, 002, 342	3, 702, 37	0. 000000	0. 000000	96.00
	10100 HOME HEALTH AGENCY	0	2, 093, 608	2, 093, 60		0.00000	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	,	2,070,000	2,0,0,00	y		1.51.00
116, 00	11600 HOSPI CE	0	0		0		116. 00
200.00		104, 785, 297	219, 074, 240	323, 859, 53	9		200. 00
201.00	, ,	,	,, 2.10	,, 00			201. 00
202.00	1 · · · · · · · · · · · · · · · · · · ·	104, 785, 297	219, 074, 240	323, 859, 53	7		202. 00
					1		

Health Financial Systems	MEMORIAL HOSP & HEALT	TH CARE CTR	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150115	From 07/01/2014	Worksheet C Part I Date/Time Prepared: 11/23/2015 9:52 am
		T: +1 - \/\/1 1	11	DDC

			Title XVIII	Hospi tal	PPS	32 alli
	Cost Center Description	PPS Inpatient	TI LIE XVIII	1103pi tai	113	
	oust contain boson per on	Ratio				
		11.00				
11	NPATIENT ROUTINE SERVICE COST CENTERS	11100				
	03000 ADULTS & PEDIATRICS					30.00
	03100 NTENSI VE CARE UNI T					31. 00
	04000 SUBPROVI DER - I PF					40.00
	04100 SUBPROVI DER – I RF					41.00
	04300 NURSERY					43. 00
	04400 SKILLED NURSING FACILITY					44. 00
	NCI LLARY SERVICE COST CENTERS					1 44. 00
_	05000 OPERATING ROOM	0. 261312				50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 669506				52. 00
1	05300 ANESTHESI OLOGY	0. 473683				53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0. 473063				54.00
	05600 RADI OI SOTOPE	0. 163727				56.00
		1				1
	06000 LABORATORY	0. 290986				60.00
	06500 RESPI RATORY THERAPY	0. 354949				65. 00
	06600 PHYSI CAL THERAPY	0. 557533				66.00
	06900 ELECTROCARDI OLOGY	0. 198987				69.00
	06901 PULMONARY	0. 000000				69. 01
	06902 CARDI OPULMONARY	0. 383200				69. 02
	06903 SLEEP LAB	0. 365163				69. 03
	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 663377				71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 746196				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 227508				73. 00
	07400 RENAL DIALYSIS	0. 000000				74. 00
	OUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC					88. 00
	08801 RURAL HEALTH CLINIC II					88. 01
	08900 FEDERALLY QUALIFIED HEALTH CENTER					89. 00
	09000 CLI NI C	0. 514690				90.00
	09001 I MED	1. 197288				90. 01
	09002 ONCOLOGY	0. 469800				90. 02
90. 03 0	09003 OUTPATIENT CENTER	0. 661309				90. 03
91.00 0	09100 EMERGENCY	0. 307668				91.00
92.00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 664361				92. 00
0	THER REIMBURSABLE COST CENTERS					
95.00 0	09500 AMBULANCE SERVICES	0. 729838				95. 00
96.00 0	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				96.00
101.001	10100 HOME HEALTH AGENCY					101. 00
S	SPECIAL PURPOSE COST CENTERS					
116. 00 1	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

		EMURIAL HUSP & I				u or Form CW3	2332-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150115	Peri od: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Pre 11/23/2015 9:	pared:
			Ti t	le XIX	Hospi tal	Cost	JZ dili
			1110	I C AIA	Costs	0031	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	cost center bescription	(from Wkst. B,	Adj.	10141 00313	Di sal I owance	10141 00313	
		Part I, col.	Auj .		Di Sai i Owanice		
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00		0.00	
30. 00	03000 ADULTS & PEDIATRICS	9, 586, 634		9, 586, 63	34 0	9, 586, 634	30.00
31. 00	03100 NTENSI VE CARE UNI T	5, 230, 992		5, 230, 99		5, 230, 992	
40. 00	04000 SUBPROVI DER - I PF	3, 640, 972		3, 640, 97		3, 640, 972	
41. 00	04100 SUBPROVIDER - IRF	1, 509, 361		1, 509, 36		1, 548, 111	
43. 00	04300 NURSERY	1, 398, 815		1, 398, 81		1, 398, 815	
44. 00	04400 SKILLED NURSING FACILITY	2, 551, 955		2, 551, 95		2, 551, 955	
44.00	ANCI LLARY SERVI CE COST CENTERS	2, 331, 733		2, 331, 73	0	2, 331, 733	44.00
50. 00	05000 OPERATING ROOM	14, 500, 761		14, 500, 76	0	14, 500, 761	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 410, 332		2, 410, 33		2, 410, 332	
53. 00	05300 ANESTHESI OLOGY	1, 185, 095				1, 185, 095	
	1 1			1, 185, 09			
54. 00	05400 RADI OLOGY-DI AGNOSTI C	6, 250, 520		6, 250, 52		6, 250, 520	
56.00	05600 RADI OI SOTOPE	1, 111, 951		1, 111, 95		1, 111, 951	
60.00	06000 LABORATORY	8, 305, 590	l	8, 305, 59		8, 305, 590	
65. 00	06500 RESPI RATORY THERAPY	1, 815, 222	0	1, -, -,		1, 815, 222	
66. 00	06600 PHYSI CAL THERAPY	3, 669, 929		3, 669, 92		3, 669, 929	
69. 00	06900 ELECTROCARDI OLOGY	4, 137, 233		4, 137, 23	150, 776	4, 288, 009	1
69. 01	06901 PULMONARY	0			0	0	69. 01
69. 02	06902 CARDI OPULMONARY	209, 522		209, 52		209, 522	
69. 03	06903 SLEEP LAB	422, 910		422, 91		422, 910	
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 023, 440		6, 023, 44		6, 023, 440	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	11, 142, 651		11, 142, 65	0	11, 142, 651	
73.00	07300 DRUGS CHARGED TO PATIENTS	14, 021, 483		14, 021, 48	0	14, 021, 483	73. 00
74.00	07400 RENAL DIALYSIS	0			0 0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	611, 444		611, 44	4 0	611, 444	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	972, 489		972, 48	0	972, 489	88. 01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	89. 00
90.00	09000 CLI NI C	1, 288, 775		1, 288, 77	75 0	1, 288, 775	90.00
90. 01	09001 I MED	549, 645		549, 64	5 0	549, 645	90. 01
90. 02	09002 ONCOLOGY	3, 865, 080		3, 865, 08	0	3, 865, 080	90. 02
90. 03	09003 OUTPATIENT CENTER	406, 293		406, 29	0	406, 293	90. 03
91.00	09100 EMERGENCY	6, 134, 500	l e	6, 134, 50			1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 621, 934		1, 621, 93		1, 621, 934	
	OTHER REIMBURSABLE COST CENTERS	.,		., .,		.,, -= .,,	
95. 00	09500 AMBULANCE SERVICES	2, 745, 927		2, 745, 92	27 0	2, 745, 927	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0			0 0	0	1
	10100 HOME HEALTH AGENCY	2, 190, 015		2, 190, 01	-	2, 190, 015	
101.00	SPECIAL PURPOSE COST CENTERS	2, 170, 013	l	2, 170, 01	<u> </u>	2, 170, 013	101.00
116 00	11600 HOSPI CE	0			0	n	116. 00
200.00		119, 511, 470	l	1	-		
201.00	1 /	1, 621, 934	١	1, 621, 93		1, 621, 934	
202.00	1	117, 889, 536	O				
202.00	Total (300 matruotions)	117,007,000	1	7 117,007,55	177, 239	110,000,793	1202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 150115 Peri od: Worksheet C From 07/01/2014 Part I Date/Time Prepared: 06/30/2015 11/23/2015 9:52 am Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 12, 255, 887 12, 255, 887 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 6, 317, 920 6, 317, 920 31.00 04000 SUBPROVIDER - IPF 4, 304, 985 40.00 4, 304, 985 40.00 41.00 04100 SUBPROVI DER - I RF 1, 359, 170 1, 359, 170 41.00 04300 NURSERY 1, 577, 555 43.00 1, 577, 555 43.00 44.00 04400 SKILLED NURSING FACILITY 1, 392, 222 1, 392, 222 44.00 ANCILLARY SERVICE COST CENTERS 8, 248, 304 50.00 05000 OPERATING ROOM 55, 492, 140 0. 261312 0.000000 50.00 47, 243, 836 05200 DELIVERY ROOM & LABOR ROOM 52 00 3, 600, 165 3, 600, 165 0.669506 0.000000 52 00 53.00 05300 ANESTHESI OLOGY 812, 392 1, 689, 484 2, 501, 876 0.473683 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 710, 077 33, 666, 669 38, 376, 746 0.162873 0.000000 54.00 379, 295 05600 RADI OI SOTOPE 6, 791, 477 0.000000 56,00 6, 412, 182 0.163727 56,00 60.00 06000 LABORATORY 6, 472, 010 22, 070, 878 28, 542, 888 0.290986 0.000000 60.00 06500 RESPIRATORY THERAPY 2, 506, 135 2,607,899 5, 114, 034 0. 354949 0.000000 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 3, 965, 421 2, 617, 019 6, 582, 440 0.557533 0.000000 66.00 06900 ELECTROCARDI OLOGY 0 191990 69.00 6, 523, 866 15, 025, 349 21, 549, 215 0.000000 69 00 69.01 06901 PULMONARY 0.000000 0.000000 69.01 06902 CARDI OPULMONARY 987 0.383200 0.000000 69.02 545, 782 546, 769 69.02 1, 700 06903 SLEEP LAB 0.365163 0.000000 69.03 69.03 1, 156, 441 1, 158, 141 07000 ELECTROENCEPHALOGRAPHY 70.00 0.000000 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 551, 094 5, 528, 874 9, 079, 968 0.663377 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 9, 139, 079 5, 793, 530 14, 932, 609 0.746196 0.000000 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 22, 089, 818 39, 541, 034 61, 630, 852 0 227508 0.000000 73 00 07400 RENAL DIALYSIS 74.00 0.000000 0.000000 74.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 686, 785 686, 785 0.890299 0.000000 88.00 08801 RURAL HEALTH CLINIC II 1 972, 489. 000000 88.01 0 0.000000 88.01 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 O 0.000000 0.000000 89.00 0.514690 90.00 09000 CLI NI C 9, 102 2, 494, 880 2, 503, 982 0.000000 90.00 90 01 09001 I MED 459, 075 459 075 1. 197288 0 000000 90 01 0 09002 ONCOLOGY 90.02 86,017 8, 141, 063 8, 227, 080 0.469800 0.000000 90.02 90.03 09003 OUTPATIENT CENTER 50,000 614, 377 0.661309 0.000000 90.03 564, 377 91.00 09100 EMERGENCY 3, 540, 060 16, 423, 788 19, 963, 848 0.307280 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 92 00 792,000 1, 649, 344 2, 441, 344 0.664361 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 1, 100, 036 0.729838 0.000000 95.00 2, 662, 342 3, 762, 378 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0.000000 96.00 101.00 10100 HOME HEALTH AGENCY 2,093,608 2, 093, 608 0 101.00 SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE 116.00 Subtotal (see instructions) 219, 074, 240 200.00 104, 785, 297 323, 859, 537 200. 00 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 104, 785, 297 219, 074, 240 323, 859, 537 202.00

					11/23/2015 9:52 am
			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
	03100 I NTENSI VE CARE UNI T				31.00
	04000 SUBPROVI DER – I PF				40.00
	04100 SUBPROVI DER - I RF	1			41. 00
	04300 NURSERY				43. 00
	04400 SKILLED NURSING FACILITY				44. 00
44.00	ANCI LLARY SERVI CE COST CENTERS				44.00
50. 00	05000 OPERATING ROOM	0. 000000			50.00
		1			
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
	05300 ANESTHESI OLOGY	0. 000000			53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
	05600 RADI 01 S0T0PE	0. 000000			56. 00
60. 00	06000 LABORATORY	0. 000000			60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000			65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000			66. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000			69.00
69. 01	06901 PULMONARY	0. 000000			69. 01
69. 02	06902 CARDI OPULMONARY	0. 000000			69. 02
	06903 SLEEP LAB	0. 000000			69. 03
	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
	07400 RENAL DIALYSIS	0. 000000			74. 00
7 1. 00	OUTPATIENT SERVICE COST CENTERS	0. 000000			71.00
88. 00	08800 RURAL HEALTH CLINIC	0. 000000			88. 00
	08801 RURAL HEALTH CLINIC II	0. 000000			88. 01
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89. 00
	09000 CLINIC	0. 000000			90.00
		1			
	09001 I MED	0.000000			90.01
	09002 ONCOLOGY	0.000000			90. 02
	09003 OUTPATIENT CENTER	0. 000000			90. 03
	09100 EMERGENCY	0. 000000			91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
	OTHER REIMBURSABLE COST CENTERS				
	09500 AMBULANCE SERVI CES	0. 000000			95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96. 00
101.00	10100 HOME HEALTH AGENCY				101. 00
	SPECIAL PURPOSE COST CENTERS				
116.00	11600 HOSPI CE		·		116. 00
200.00	Subtotal (see instructions)				200. 00
201.00	Less Observation Beds				201. 00
	Total (see instructions)				202. 00

Health Financial Systems	MEMORIAL HOSP &	HEALTH CARE CTF	?	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	_ COSTS	Provi der		Peri od: From 07/01/2014 To 06/30/2015		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng 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	1, 319, 083	0	1, 319, 08	3 13, 092	100. 75	30. 00
31.00 INTENSIVE CARE UNIT	561, 337	1	561, 33	7 4, 298	130. 60	31.00
40. 00 SUBPROVI DER - I PF	435, 082	2	435, 08	2 3, 760	115. 71	40.00
41. 00 SUBPROVI DER - I RF	213, 503	0	213, 50	3 1, 335	159. 93	41.00
43. 00 NURSERY	172, 945		172, 94	5 2, 021	85. 57	43.00
44.00 SKILLED NURSING FACILITY	314, 204		314, 20	4, 985	63.03	44.00
200.00 Total (lines 30-199)	3, 016, 154		3, 016, 15	4 29, 491		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	5, 151					30.00
31.00 INTENSIVE CARE UNIT	2, 812	367, 247				31. 00
40. 00 SUBPROVI DER - I PF	2, 232					40. 00
41. 00 SUBPROVI DER - I RF	1, 011	161, 689				41. 00
43. 00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	4, 073	256, 721				44. 00
200.00 Total (lines 30-199)	15, 279	1, 562, 885				200. 00

Health Financial Systems ME	EMORIAL HOSP &	HEALTH CARE CTI	R	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der		Period: From 07/01/2014 To 06/30/2015	Worksheet D Part II Date/Time Pre 11/23/2015 9:	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	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	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 415, 840				114, 592	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	286, 601				0	52.00
53. 00 05300 ANESTHESI OLOGY	25, 404				2, 949	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	551, 563				42, 946	54.00
56. 00 05600 RADI 0I SOTOPE	57, 708				2, 428	56. 00
60. 00 06000 LABORATORY	330, 291				40, 783	
65. 00 06500 RESPIRATORY THERAPY	97, 075		1		25, 462	65. 00
66. 00 06600 PHYSI CAL THERAPY	322, 015				57, 550	66. 00
69. 00 06900 ELECTROCARDI OLOGY	539, 200	21, 549, 215			89, 927	69. 00
69. 01 06901 PULMONARY	0	1	0.00000		0	69. 01
69. 02 06902 CARDI OPULMONARY	39, 492				28	69. 02
69. 03 06903 SLEEP LAB	59, 686				34	69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0) C	0.00000	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	146, 621	9, 079, 968			30, 274	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	201, 497				70, 164	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	371, 911	61, 630, 852			67, 733	73. 00
74. 00 07400 RENAL DIALYSIS	0) C	0.00000	0 0	0	74. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	69, 741				0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	151, 488	1	151, 488. 00000		0	88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1	0.00000		0	89. 00
90. 00 09000 CLI NI C	190, 960	2, 503, 982	0. 07626	3 185	14	90. 00
90. 01 09001 I MED	33, 499	459, 075			0	90. 01
90. 02 09002 0NCOLOGY	392, 965	8, 227, 080	0. 04776	5 6, 984	334	90. 02
90. 03 09003 OUTPATI ENT CENTER	7, 575	614, 377	0. 01233	0 0	0	90. 03
91. 00 09100 EMERGENCY	443, 274	19, 963, 848	0. 02220	4 2, 056, 739	45, 668	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	223, 172	2, 441, 344	0. 09141	4 247, 574	22, 632	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0) C	0.00000		0	96. 00
200.00 Total (lines 50-199)	5, 957, 578	290, 795, 812	2	38, 303, 829	613, 518	200. 00

Health Financial Systems	MEMORIAL HOSP &	HEALTH CARE CT	₹	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	TS Provi der	F	Period: From 07/01/2014 To 06/30/2015		pared: 52 am
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cost		1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	(0	0	
31.00 03100 INTENSIVE CARE UNIT	0	0	(0	01.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	(0	0	
41. 00 04100 SUBPROVI DER - I RF	0	0	(0	0	
43. 00 04300 NURSERY	0	0	(0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0			0	1
200.00 Total (lines 30-199)	0	0	(0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	13, 092					30. 00
31.00 03100 INTENSIVE CARE UNIT	4, 298	l .				31. 00
40. 00 04000 SUBPROVI DER - 1 PF	3, 760		2, 232	2 0		40. 00
41. 00 04100 SUBPROVI DER - I RF	1, 335	0.00	1, 011	0		41. 00
43. 00 04300 NURSERY	2, 021	0.00	(0		43.00
44.00 04400 SKILLED NURSING FACILITY	4, 985	0.00	4, 073	3 0		44. 00
200.00 Total (lines 30-199)	29, 491		15, 279	9 0		200. 00

Health Financial Systems	MEMORIAL HOSP & HEALT	H CARE CTR	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provider CCN: 150115		Worksheet D
TUDOUCU COSTS			From 07/01/2014	Part IV

THROUGH COSTS To 06/30/2015 Date/Time Prepared: 11/23/2015 9:52 am Title XVIII Hospi tal PPS Cost Center Description Non Physician Nursing School Allied Health All Other Total Cost Anestheti st Medi cal (sum of col 1 through col. Cost Education Cost 4) 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 0 0 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 54.00 05600 RADI OI SOTOPE 0 56.00 0 0 56.00 06000 LABORATORY 0 60.00 0 60.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06900 ELECTROCARDI OLOGY 0 69.00 0 0 69.00 69.01 06901 PULMONARY 0 69.01 69. 02 06902 CARDI OPULMONARY 69. 02 06903 SLEEP LAB 0 69.03 0 69.03 0 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73 00 0 0 07400 RENAL DIALYSIS 74.00 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 0 0 0 0 0 0 0 0 88.00 08801 RURAL HEALTH CLINIC II 0 88. 01 Ω 0 0 0 0 0 Ω 88 01 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 09000 CLI NI C 0 90.00 90.00 0 0 90.01 09001 I MED 0 Ω 90.01 09002 ONCOLOGY 0 0 90.02 90.02 0 90.03 09003 OUTPATIENT CENTER 0 0 90.03 09100 EMERGENCY 0 0 0 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 96.00 200.00 0 200.00 Total (lines 50-199)

Health Financial Systems	MEMORIAL HOSP & HEALT	TH CARE CTR	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150115		Worksheet D
TUDQUEU COSTS			From 07/01/2014	Part IV

THROUGH COSTS To 06/30/2015 Date/Time Prepared: 11/23/2015 9:52 am Title XVIII Hospi tal PPS Total Charges Ratio of Cost I npati ent Cost Center Description Total Outpati ent (from Wkst. C, to Charges Outpati ent Ratio of Cost Program Cost (sum of Part I, col. (col. 5 ÷ col to Charges Charges 7) col. 2, 3 and 8) $(col. 6 \div col$ 4) 7) 6.00 7.00 8.00 9.00 10.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 55, 492, 140 0.000000 0.000000 4, 491, 339 50.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 3, 600, 165 0.000000 0.000000 0 52.00 05300 ANESTHESI OLOGY 2, 501, 876 0.000000 0.000000 290, 386 53.00 000000000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 38, 376, 746 0.000000 0.000000 2, 988, 177 54.00 54.00 285, 805 05600 RADI OI SOTOPE 6, 791, 477 0.000000 0.000000 56.00 56,00 60.00 06000 LABORATORY 28, 542, 888 0.000000 0.000000 3, 524, 295 60.00 65.00 06500 RESPIRATORY THERAPY 5, 114, 034 0.000000 0.000000 1, 341, 355 65.00 06600 PHYSI CAL THERAPY 6, 582, 440 0.000000 0.000000 1, 176, 420 66 00 66 00 06900 ELECTROCARDI OLOGY 0.000000 69.00 21, 549, 215 0.000000 3, 593, 921 69.00 69. 01 06901 PULMONARY 0.000000 0.000000 0 69.01 06902 CARDI OPULMONARY 0.000000 69.02 546, 769 0.000000 388 69.02 06903 SLEEP LAB 0.000000 0.000000 69 03 69 03 1, 158, 141 669 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 9, 079, 968 0.000000 0.000000 1, 874, 796 71.00 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 5, 199, 639 72 00 14, 932, 609 0.000000 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 61, 630, 852 0.000000 0.000000 11, 225, 157 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0.000000 74.00 0 OUTPATIENT SERVICE COST CENTERS 686, 785 88 00 0000000 0.000000 0.000000 n 88 00 08800 RURAL HEALTH CLINIC 88.01 08801 RURAL HEALTH CLINIC II 0.000000 0.000000 0 88.01 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0.000000 89.00 89.00 0 90.00 09000 CLI NI C 2,503,982 0.000000 0.000000 185 90.00 90 01 09001 LMED 459, 075 0.000000 0.000000 90.01 0 90.02 09002 ONCOLOGY 8, 227, 080 0.000000 0.000000 6, 984 90.02 09003 OUTPATIENT CENTER 0.000000 0.000000 90.03 90.03 614, 377 0 09100 EMERGENCY 19, 963, 848 0.000000 2, 056, 739 91.00 91.00 0.000000 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 2, 441, 344 92.00 92.00 0.000000 247, 574 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95 00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0.000000 0.000000 96, 00 0 290, 795, 812 200.00 Total (lines 50-199) 38, 303, 829 200. 00

Date/Time Prepared:

96.00

200.00

11/23/2015 9:52 am Title XVIII Hospi tal PPS I npati ent Outpati ent Outpati ent Cost Center Description Program Program Program Pass-Through Pass-Through Charges Costs (col. Costs (col. x col. 10) x col. 12) 13.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 0 50.00 05000 OPERATING ROOM 12, 506, 785 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 05300 ANESTHESI OLOGY 936, 586 0 53.00 53.00 000000000000000 54.00 05400 RADI OLOGY-DI AGNOSTI C 14, 648, 248 0 54.00 05600 RADI OI SOTOPE 2, 442, 641 0 56.00 56, 00 60.00 06000 LABORATORY 3, 494, 696 60.00 65.00 06500 RESPIRATORY THERAPY 73, 035 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 29, 181 66.00 0 06900 ELECTROCARDI OLOGY 69.00 6, 714, 189 69.00 69. 01 06901 PULMONARY 69.01 06902 CARDI OPULMONARY 0 69.02 0 69.02 0 06903 SLEEP LAB 69. 03 69 03 Ω 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 1, 717, 738 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 2, 908, 270 72.00 72 00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 19, 153, 350 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 OUTPATIENT SERVICE COST CENTERS 88. 00 0 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 n 08801 RURAL HEALTH CLINIC II 0 0 88. 01 0 88.01 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 90.00 09000 CLI NI C 1, 466, 899 90.00 09001 I MED 90 01 0 90.01 09002 ONCOLOGY 90.02 869, 835 90.02 90.03 09003 OUTPATIENT CENTER 130, 193 0 90.03 91.00 09100 EMERGENCY 3, 848, 292 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 482, 267 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00

0

71, 422, 205

0

0

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

200.00

Total (lines 50-199)

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 150115 Peri od: Worksheet D From 07/01/2014 Part V Date/Time Prepared: 06/30/2015 11/23/2015 9:52 am Title XVIII Hospi tal Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see 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. 261312 12, 506, 785 0 3, 268, 173 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.669506 0 0 52.00 05300 ANESTHESI OLOGY 0 53 00 0 473683 936, 586 443, 645 53 00 |05400| RADI OLOGY-DI AGNOSTI C 0 54.00 0.162873 14, 648, 248 0 2, 385, 804 54.00 56.00 05600 RADI OI SOTOPE 0. 163727 2, 442, 641 0 399, 926 56.00 60.00 06000 LABORATORY 0. 290986 3, 494, 696 1,043 0 1, 016, 908 60.00 06500 RESPIRATORY THERAPY 0. 354949 65.00 73, 035 0 25, 924 65.00 66.00 06600 PHYSI CAL THERAPY 0.557533 29, 181 0 16, 269 66.00 06900 ELECTROCARDI OLOGY 69.00 0. 191990 6, 714, 189 0 0 1, 289, 057 69.00 06901 PUL MONARY 0.000000 0 69 01 69 01 0 69.02 06902 CARDI OPULMONARY 0.383200 0 0 0 69.02 69.03 06903 SLEEP LAB 0.365163 0 0 69.03 C 0 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0.000000 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS o 0 1, 139, 508 71.00 71 00 0.663377 1, 717, 738 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.746196 2, 908, 270 0 0 2, 170, 139 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 227508 19, 153, 350 98, 322 4, 357, 540 73.00 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 0.000000 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 08801 RURAL HEALTH CLINIC II 0.000000 88.01 88.01 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0.000000 89.00 0 09000 CLI NI C 90.00 0.514690 1, 466, 899 0 754, 998 90 00 90.01 09001 I MED 1. 197288 0 90.01 0 09002 ONCOLOGY 90.02 0.469800 869, 835 0 408, 648 90.02 09003 OUTPATIENT CENTER 0 86, 098 90.03 0.661309 130, 193 90.03 0 91.00 09100 EMERGENCY 0.307280 3, 848, 292 0 1, 182, 503 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.664361 482, 267 320, 399 92.00 92.00 0

0. 729838

0.000000

71, 422, 205

71, 422, 205

0

0

98, 322

98, 322

1,043

1,043

95.00

200.00

201.00

0 96.00

19, 265, 539 202. 00

19, 265, 539

OTHER REIMBURSABLE COST CENTERS

09600 DURABLE MEDICAL EQUIP-RENTED

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 +/- line 201)

09500 AMBULANCE SERVICES

Only Charges

95.00

96.00

200.00

201.00

202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 150115 Peri od: Worksheet D From 07/01/2014 Part V 06/30/2015 Date/Time Prepared: 11/23/2015 9:52 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 53. 00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 54.00 0 56. 00 05600 RADI 0I SOTOPE 0 56.00 60.00 06000 LABORATORY 0 60.00 303 06500 RESPIRATORY THERAPY 0 0 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06900 ELECTROCARDI OLOGY 0 69.00 00000000 69.00 06901 PULMONARY 0 69 01 69 01 69.02 06902 CARDI OPULMONARY 0 69.02 69.03 06903 SLEEP LAB 0 69.03 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 22, 369 73.00 73.00 07400 RENAL DIALYSIS
OUTPATIENT SERVICE COST CENTERS 74.00 74.00 88.00 08800 RURAL HEALTH CLINIC 0 88.00 08801 RURAL HEALTH CLINIC II 000000 0 88.01 88. 01 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 0 09000 CLI NI C 0 90.00 90 00 90.01 09001 I MED 0 90.01 09002 ONCOLOGY 0 90. 02 90.02 09003 OUTPATIENT CENTER 0 90.03 90.03 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 200. 00 200.00 Subtotal (see instructions) 303 22, 369 Less PBP Clinic Lab. Services-Program

0

22, 369

303

201.00

202.00

201.00

202.00

Only Charges

Net Charges (line 200 +/- line 201)

111 41-	Figure 1 Contains	MODIAL HOCD &	LIENTIL CADE CT	2	l = 1; -	-	2552 10
	Financial Systems ME TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	MORIAL HOSP & I		CCN: 150115	Period:	u of Form CMS-: Worksheet D	2552-10
AFFORT	TOUNDENT OF THEATTENT ANGILLARY SERVICE CAPITA	AL 00313		t CCN: 15S115	From 07/01/2014 To 06/30/2015	Part II Date/Time Pre 11/23/2015 9:	pared:
			Ti tl	e XVIII	Subprovi der -	PPS	<u> </u>
					I PF		
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	1,	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	0.00	0.00	4.00	F 00	
	ANOULLARY CERVICE COCT CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	1 415 040	FF 400 140	0.00551	2 500	00	F0 00
50.00		1, 415, 840				90	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	286, 601				0	
53. 00	05300 ANESTHESI OLOGY	25, 404				4	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	551, 563				2, 017	1
56. 00	05600 RADI OI SOTOPE	57, 708				0	
60. 00	06000 LABORATORY	330, 291				2, 980	1
65. 00	06500 RESPI RATORY THERAPY	97, 075				233	65. 00
66. 00	06600 PHYSI CAL THERAPY	322, 015				1, 541	66. 00
69. 00	06900 ELECTROCARDI OLOGY	539, 200				416	
69. 01	06901 PULMONARY	0		1 0.0000		0	69. 01
69. 02	06902 CARDI OPULMONARY	39, 492				0	
69. 03	06903 SLEEP LAB	59, 686				0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	_			0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	146, 621				204	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	201, 497				0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	371, 911				2, 618	
74. 00	07400 RENAL DI ALYSI S	0	0	0.00000	00 0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	69, 741				0	
88. 01	08801 RURAL HEALTH CLINIC II	151, 488	l .	151, 488. 00000		0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		1 0.0000		0	
90.00	09000 CLI NI C	190, 960				0	90.00
90. 01	09001 I MED	33, 499				0	
90. 02	09002 ONCOLOGY	392, 965				0	90. 02
90. 03	09003 OUTPATI ENT CENTER	7, 575				0	90. 03
91. 00	09100 EMERGENCY	443, 274		1		4, 176	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 441, 344	0.00000	00	0	92. 00
	OTHER REIMBURSABLE COST CENTERS	_					
95.00	09500 AMBULANCE SERVI CES						95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	_	1		0	
200.00	Total (lines 50-199)	5, 734, 406	290, 795, 812	2	1, 096, 787	14, 279	200. 00

llool +h	Financial Customs	MODIAL HOCD 0 1	UEALTH CARE CT	2	le li e	of Form CMC	2552 10
APPORT	Financial Systems ME TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	MORIAL HOSP & I	S Provi der	CCN: 150115 t CCN: 15S115	Peri od: From 07/01/2014	Date/Time Pre	pared:
			Ti tl	e XVIII	Subprovi der - I PF	11/23/2015 9: PPS	<u>52 am</u>
	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Healt		Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0		0 0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0)	0	0	
56.00	05600 RADI OI SOTOPE	0	0)	0	0	56. 00
60.00	06000 LABORATORY	0	0)	0	0	60.00
65.00	06500 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. 01	06901 PULMONARY	0	0)	0	0	
69. 02	06902 CARDI OPULMONARY	0	0)	0	0	69. 02
69. 03	06903 SLEEP LAB	0	0)	0	0	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0		2	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		2	0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0		2	0	0	
73.00		0		(0 0	0	73.00
74.00	07400 RENAL DI ALYSI S	0		ή	0 0	0	74. 00
00 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0		<u>, </u>	0 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC	0			0	0	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	89. 00
90.00	09000 CLINIC	0				0	90.00
90. 00	09001 LIMED					0	1
90.01	09001 T MED 09002 ONCOLOGY				0 0	0	90.01
90. 02	09003 OUTPATIENT CENTER					0	90. 02
91. 00	09100 EMERGENCY					0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	
72.00	OTHER RELIGIONALE COST CENTERS			7	9, 0		1 /2.00

0 96. 00 0 200. 00

0 92.00 95.00

0

0

91. 00 | 09100 | EMERGENCY 92. 00 | 09200 | OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS 95. 00 | 09500 | AMBULANCE SERVI CES 96. 00 | 09600 | DURABLE MEDI CAL EQUI P-RENTED 200. 00 | Total (Lines 50-199)

Heal th	Financial Systems ME	EMORIAL HOSP &	HEALTH CARE CTI	₹	In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provi der	CCN: 150115	Peri od:	Worksheet D	
THROUG	H COSTS		Componen	t CCN: 15S115	From 07/01/2014 To 06/30/2015	Part IV Date/Time Pre 11/23/2015 9:	pared: 52 am
			Ti tl	e XVIII	Subprovi der -	PPS	
	C+ C+ D	T-4-1	T-+-1 Ch	D-+:6 C	I PF	1 + : +	
	Cost Center Description	Total Outpatient	Total Charges (from Wkst. C,		t Outpatient Ratio of Cost	Inpatient Program	
		Cost (sum of	Part I, col.			Charges	
		col . 2, 3 and		7)	(col . 6 ÷ col .	chai ges	
		4)	0)	')	7)		
		6.00	7.00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
50.00	05000 OPERATI NG ROOM	0	55, 492, 140	0.00000	0.000000	3, 508	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0				0	1
53. 00	05300 ANESTHESI OLOGY	0		•		369	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	,	1		140, 371	
56. 00	05600 RADI OI SOTOPE	0	6, 791, 477			0	1
60.00	06000 LABORATORY	0				257, 537	60.00
65.00	06500 RESPIRATORY THERAPY	0	5, 114, 034			12, 295	
66.00	06600 PHYSI CAL THERAPY	0	6, 582, 440	0.00000	0. 000000	31, 493	66.00
69.00	06900 ELECTROCARDI OLOGY	0	21, 549, 215	0. 00000	0. 000000	16, 628	69. 00
69. 01	06901 PULMONARY	0	d c	0. 00000	0. 000000	0	69. 01
69. 02	06902 CARDI OPULMONARY	0	546, 769	0.00000	0. 000000	0	69. 02
69. 03	06903 SLEEP LAB	0	1, 158, 141	0.00000	0. 000000	0	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C	0. 00000	0. 000000	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	,,0,,,,00			12, 651	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	,			0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0				433, 852	
74.00	07400 RENAL DIALYSIS	0	C	0.00000	0. 000000	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0				0	
88. 01	08801 RURAL HEALTH CLINIC II	0		0.00000		0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C			0	
90. 00	09000 CLI NI C	0	_, _,	1		0	
90. 01	09001 I MED	0	,			0	
90. 02	09002 ONCOLOGY	0	8, 227, 080			0	1
90. 03	09003 OUTPATIENT CENTER	0				0	
91.00	09100 EMERGENCY	0		1		188, 083	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		2, 441, 344	0.00000	0. 000000	0	92. 00
95. 00	09500 AMBULANCE SERVICES						95. 00
96. 00	109600 DURABLE MEDICAL EQUIP-RENTED	0	C	0. 00000	0. 000000	0	1
200.00				•	3. 000000	1, 096, 787	

Health Financial Systems	MEMORIAL HOSP & HEALT	H CARE CTR	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150115 Component CCN: 15S115	From 07/01/2014 To 06/30/2015	
		Title XVIII	Subprovi der -	PPS

ANCILLARY SERVICE COST CENTERS				Ti tl	e XVIII	Subprovi der - I PF	PPS	
Program Charges Program Ch		Cost Center Description	Inpati ent	Outpati ent	Outpatient		<u> </u>	
Pass-Through Costs (col. 9 x col. 10) 12.00 13.00								
Costs (col. 8 x col. 10) x col. 12 x col. 12 x col. 10 x col. 12 x col. 10 x col. 12 x col. 10 x col. 12 x col. 10 x col. 12 x col. 10 x col. 12 x col. 10 x col. 12 x col. 10 x col. 12 x col. 10 x col. 12 x col. 10 x col. 12 x col. 10 x col. 12 x col. 10 x col. 12 x col. 10 x col. 12 x col. 10 x col. 12 x col. 10								
X COI . 10) X COI . 12)				3)		
ANCILLARY SERVICE COST CENTERS								
50. 00 05000 DERATING ROOM 50. 00 50. 00 52. 00 52. 00 52. 00 52. 00 52. 00 52. 00 52. 00 52. 00 52. 00 53. 00 63.			11.00	12.00	13.00			
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0		ANCILLARY SERVICE COST CENTERS						
53.00 05300 AMESTHESI OLOGY 0 0 0 0 0 54.00	50.00	05000 OPERATING ROOM	0	C) (O		50. 00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		O		52.00
56. 00 05600 RADI OI SOTOPE 0 0 0 0 66. 00	53.00	05300 ANESTHESI OLOGY	0	C		O		53.00
60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0	54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		O		54. 00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 66.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 66.00 67. 00 06900 ELECTROCARPIO LOGY 0 0 0 0 69.00 69. 01 06901 PULMONARY 0 0 0 0 0 0 69.00 69. 01 06901 PULMONARY 0 0 0 0 0 0 0 69.01 69. 02 06902 CARDI OPULMONARY 0 0 0 0 0 0 69.01 69. 03 06903 SLEEP LAB 0 0 0 0 0 69.03 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 69.03 71. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	56.00	05600 RADI OI SOTOPE	0	C		O		56. 00
66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 69.01 06900 ELECTROCARDI OLOGY 0 0 0 0 69.01 06901 DUMONARY 0 0 0 0 69.01 69.01 06902 CARDI OPULMONARY 0 0 0 0 69.02 06903 SLEEP LAB 0 0 0 0 69.03 06903 SLEEP LAB 0 0 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 74.00 07400 RENAL DI ALYSIS 0 0 0 74.00 07400 RENAL DI ALYSIS 0 0 0 74.00 007400 RENAL DI ALYSIS 0 0 0 88.01 08801 RURAL HEALTH CLINIC 1 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 90.01 09000 CLINIC 0 0 90.01 09000 CLINIC 0 0 90.02 09000 ONCOLOGY 0 0 90.03 09003 OUTPATIENT CENTER 0 0 0 90.04 09000 ONCOLOGY 0 0 90.05 09000 ONCOLOGY 0 0 90.07 09000 ONCOLOGY 0 0 90.07 09000 ONCOLOGY 0 0 90.08 ONCOLOGY 0 0 90.09 ONCOLOGY 0 0 90.00 09000 ONCOLOGY 0 0 90.01 ONCOLOGY 0 0 90.02 09000 ONCOLOGY 0 0 90.03 09000 ONCOLOGY 0 0 90.04 09000 ONCOLOGY 0 0 90.05 ONCOLOGY 0 0 90.07 ONCOLOGY 0 0 90.07 ONCOLOGY 0 0 90.08 ONCOLOGY 0 0 90.09 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCOLOGY 0 0 90.00 ONCO	60.00	06000 LABORATORY	0	C		O		60.00
69. 00	65.00	06500 RESPIRATORY THERAPY	0	C		O		65. 00
69. 01 06901 PULMONARY 0 0 0 0 0 69. 01 69. 01 69. 02 06902 CARDI OPULMONARY 0 0 0 0 0 0 69. 02 06903 SLEEP LAB 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	66.00	06600 PHYSI CAL THERAPY	0	C		O		66. 00
69. 02 06902 CARDI OPULMONARY 0 0 0 0 0 69. 02 69. 03 06903 SLEEP LAB 0 0 0 0 0 69. 03 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 73. 00 00TPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 1 0 0 0 0 88. 01 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 88. 01 99. 00 09000 CLI NI C 0 0 0 0 0 99. 00 90. 01 09001 IMED 0 0 0 0 99. 00 90. 01 09001 IMED 0 0 0 0 99. 01 90. 02 09002 ONCOLOGY 0 0 0 0 99. 02 90. 03 09003 OUTPATI ENT CENTER 0 0 0 0 0 99. 03 91. 00 09100 EMERGENCY 0 0 0 0 99. 03 91. 00 09500 ABBULANCE SERVI CES 9 95. 00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 99. 00 96. 00 09500 DURABLE MEDI CAL EQUI P-RENTED	69.00	06900 ELECTROCARDI OLOGY	0	C		O		69. 00
69. 03	69. 01	06901 PULMONARY	0	C		O		69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0	69. 02	06902 CARDI OPULMONARY	0	C		O		69. 02
71. 00	69. 03	06903 SLEEP LAB	0	C		O		69. 03
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72. 00 73. 00 73. 00 73. 00 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 0 0	70.00	07000 ELECTROENCEPHALOGRAPHY	0	C		O		70. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 74. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 88. 01 08800 RURAL HEALTH CLINIC 1 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 90. 00 09000 CLINIC 0 0 0 90. 01 09001 IMED 0 0 0 90. 02 09002 ONCOLOGY 0 0 0 90. 03 09003 OUTPATIENT CENTER 0 0 0 90. 04 09100 EMERGENCY 0 0 90. 05 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 90. 00 OTHER REIMBURSABLE COST CENTERS 90. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 90. 00 0 0 0 90. 00 0 90. 00 0 0 90. 00 0 0 90. 00 0 0 90. 00 0 0 90. 00 0 0 90. 00 0 0 90. 00 0 0 90. 00 0 0 90. 00 0 0 90. 00 0 0 90. 00 0 0 90. 00 0 0 90. 00 0 0 90. 00 0 0 90. 00 0 0 90. 00 0 0 90. 00 0 0 90. 00 0 90. 00 0 0 90. 00 0 0 90. 00 0 90. 00 0 90. 00 0 90. 00 0 90. 00 0 90. 00 0 90. 00	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	C		O		71.00
74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 74. 00 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 888. 01 88. 01 08801 RURAL HEALTH CLINI C II 0 0 0 0 888. 01 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 889. 00 90. 00 09000 CLINI C 0 0 0 0 0 90. 00 90. 01 09001 IMED 0 0 0 0 0 90. 01 90. 02 09002 ONCOLOGY 0 0 0 0 0 90. 02 90. 03 09003 OUTPATI ENT CENTER 0 0 0 0 0 90. 03 91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 96. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	C		O		72. 00
SECTION SUPPRINTENT SERVICE COST CENTERS SECTION	73.00	07300 DRUGS CHARGED TO PATIENTS	O	C		O		73. 00
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 88. 00 88. 01 08801 RURAL HEALTH CLINIC 11 0 0 0 0 0 0 88. 01 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0	74.00	07400 RENAL DIALYSIS	O	C		O		74.00
88. 01 08801 RURAL HEALTH CLINIC II 0 0 0 0 88. 01 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0		OUTPATIENT SERVICE COST CENTERS				·		
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 01 MED 0 0 0 0 0 90. 01 90. 02 90. 02 90. 03 90. 03 90. 03 90. 03 90. 03 90. 03 90. 03 90. 04 90. 05	88. 00	08800 RURAL HEALTH CLINIC	0	C) (0		88. 00
90. 00 09000 CLI NI C 0 0 0 0 90. 00 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 02 90. 02 90. 02 90. 03 90. 03 90. 03 90. 03 90. 03 90. 03 90. 03 90. 04 90. 05 90.	88. 01	08801 RURAL HEALTH CLINIC II	0	C		O		88. 01
90. 01 09001 IMED 0 0 0 90. 01 90. 02 90. 02 90. 03 09002 0NCOLOGY 0 0 0 0 0 0 90. 02 90. 03 09003 0UTPATI ENT CENTER 0 0 0 0 0 91. 00 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 0	89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		O		89. 00
90. 02 09002 0NCOLOGY 0 0 0 0 90. 02 90. 03 09003 0UTPATIENT CENTER 0 0 0 0 0 91. 00 91. 00 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 0	90.00	09000 CLI NI C	0	C		O		90.00
90. 03 09003 0UTPATI ENT CENTER 0 0 0 0 91. 00 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 0	90. 01	09001 I MED	0	C		O		90. 01
91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0	90. 02	09002 ONCOLOGY	0	C		O		90. 02
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96. 00	90. 03	09003 OUTPATIENT CENTER	0	C		O		90. 03
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 96. 00	91.00	09100 EMERGENCY	0	C		O		91.00
95. 00 09500 AMBULANCE SERVICES 95. 00 96. 00 0 0 0 96. 00 96. 00 96. 00 96. 00 96. 00 97. 00 98. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		O		92. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96. 00		OTHER REIMBURSABLE COST CENTERS						
	95.00	09500 AMBULANCE SERVICES						95. 00
200. 00 Total (lines 50-199) 0 0 200. 00	96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	C		O		96.00
	200.00	Total (lines 50-199)	0	C) (O		200. 00

Hool th	Financial Systems ME	MORIAL HOSP &	HEALTH CADE CT	0	In Lio	u of Form CMS-2	2552 10
	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CCN: 150115	Peri od:	Worksheet D	2332-10
711 7 0101	TOTAL OF THE PROPERTY OF THE P			t CCN: 15T115	From 07/01/2014 To 06/30/2015	Part II Date/Time Pre 11/23/2015 9:	pared: 52 am
			Ti tl	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	·	Related Cost	(from Wkst. C,	to Charges	Program	. (column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 415, 840				153	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	286, 601				0	52. 00
53.00	05300 ANESTHESI OLOGY	25, 404	2, 501, 876	0. 01015		9	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	551, 563	38, 376, 746	0. 01437	2 24, 926	358	54. 00
56.00	05600 RADI OI SOTOPE	57, 708	6, 791, 477	0. 00849	7 0	0	56. 00
60.00	06000 LABORATORY	330, 291	28, 542, 888	0. 01157	2 71, 433	827	60.00
65.00	06500 RESPI RATORY THERAPY	97, 075	5, 114, 034	0. 01898	2 44, 250	840	65.00
66.00	06600 PHYSI CAL THERAPY	322, 015	6, 582, 440	0. 04892	0 671, 512	32, 850	66. 00
69.00	06900 ELECTROCARDI OLOGY	539, 200	21, 549, 215	0. 02502	2 5, 122	128	69. 00
69. 01	06901 PULMONARY	0	0	0.00000	0 0	0	69. 01
69. 02	06902 CARDI OPULMONARY	39, 492	546, 769	0. 07222	8 0	0	69. 02
69. 03	06903 SLEEP LAB	59, 686	1, 158, 141	0.05153	6 0	0	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	O	0.00000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	146, 621	9, 079, 968	0. 01614	8 37, 833	611	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	201, 497	14, 932, 609	0. 01349	4 356	5	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	371, 911	61, 630, 852	0. 00603	4 370, 519	2, 236	73. 00
74.00	07400 RENAL DI ALYSI S	0		0. 00000		0	74. 00
	OUTPATIENT SERVICE COST CENTERS	1	•	•			1
88.00	08800 RURAL HEALTH CLINIC	69, 741	686, 785	0. 10154	.7 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	151, 488	1	151, 488. 00000	0 0	0	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	0	0	89. 00
90.00	09000 CLI NI C	190, 960	2, 503, 982	0. 07626	3 0	0	90.00
90. 01	09001 I MED	33, 499	459, 075	0. 07297	1 0	0	90. 01
90. 02	09002 ONCOLOGY	392, 965	8, 227, 080	0.04776	5 0	0	90. 02
90. 03	09003 OUTPATI ENT CENTER	7, 575	614, 377	0. 01233	0	0	90. 03
91.00	09100 EMERGENCY	443, 274	19, 963, 848	0. 02220	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 441, 344	0.00000	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.00000	0	0	
200.00	Total (lines 50-199)	5, 734, 406	290, 795, 812	!	1, 232, 847	38, 017	200. 00

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY : HROUGH COSTS	SERVICE OTHER PAS		CCN: 150115 t CCN: 15T115	Peri od: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Pre 11/23/2015 9:	
		Ti t	e XVIII	Subprovi der – I RF	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	through col. 4)	
	1, 00	2, 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
0. 00 05000 OPERATING ROOM	0)		0 0	0	50.00
2.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	52.00
3. 00 05300 ANESTHESI OLOGY	0			0 0	0	53.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0		o l	0 0	0	54.00
6. 00 05600 RADI 01 SOTOPE	0		o	0 0	0	56.00
0. 00 06000 LABORATORY	0		o	0	0	60.0
5. 00 06500 RESPI RATORY THERAPY	0))	0	0	65. 0
6. 00 06600 PHYSI CAL THERAPY	0))	0	0	66. 0
9. 00 06900 ELECTROCARDI OLOGY	0))	0	0	
9. 01 06901 PULMONARY	0			0	0	
9. 02 06902 CARDI OPULMONARY	0)	P	0	0	1
9. 03 06903 SLEEP LAB	0)	P	0	0	
0. 00 07000 ELECTROENCEPHALOGRAPHY	0)	P	0	0	1 , 0. 0
1. 00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0	0	1
3. 00 07300 DRUGS CHARGED TO PATIENTS	0			0	0	
4.00 O7400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0) (<u> </u>	0 0	0	74.0
8. 00 08800 RURAL HEALTH CLINIC) (٦	0 0	0	88. 0
8. 01 08801 RURAL HEALTH CLINIC				0 0	0	
9. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER				0	0	
0. 00 09000 CLINIC				0 0	0	
0. 01 09001 I MED			ก		Ö	
0. 02 09002 0NCOLOGY			้	0 0	Ö	
0. 03 09003 OUTPATI ENT CENTER	0			0 0	Ō	
1. 00 09100 EMERGENCY	0			0 0	0	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		ol	0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS			•			
5. 00 09500 AMBULANCE SERVICES						95.0
6. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0)	o	0 0	0	96.00
00.00 Total (lines 50-199)	0			0	l o	200. 0

Health Financial Systems ME	EMORIAL HOSP & I	HEALTH CARE CTF	?	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER			CCN: 150115	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15T115	From 07/01/2014 To 06/30/2015	Part IV Date/Time Pre 11/23/2015 9:	pared: 52 am
		Ti tl	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cos		I npati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col . 2, 3 and	8)	7)	(col. 6 ÷ col.	Ü	
	4)			7)		
	6.00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	,,			5, 993	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	-,,			0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	_, -,,			903	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	,,			24, 926	
56. 00 05600 RADI 0I SOTOPE	0	-, ,			0	
60. 00 06000 LABORATORY	0	28, 542, 888			71, 433	
65. 00 06500 RESPI RATORY THERAPY	0	-, ,	l .		44, 250	
66. 00 06600 PHYSI CAL THERAPY	0	-,,			671, 512	
69. 00 06900 ELECTROCARDI OLOGY	0	= ., , =			5, 122	
69. 01 06901 PULMONARY	0	ľ	0.0000		0	
69. 02 06902 CARDI OPULMONARY	0	,			0	
69. 03 06903 SLEEP LAB	0	.,,			0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0.0000		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9, 079, 968			37, 833	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0				356	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	,,			370, 519	
74. 00 07400 RENAL DI ALYSI S	0	0	0. 00000	0. 000000	0	74. 00
OUTPATIENT SERVICE COST CENTERS		/0/ 705	0.0000	0 000000		
88. 00 08800 RURAL HEALTH CLINIC 88. 01 08801 RURAL HEALTH CLINIC II	0	,	0. 00000 0. 00000		0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		•		0	
90. 00 009000 CLINIC		ı			0	
90. 00 09000 CETNIC 90. 01 09001 I MED		2, 503, 982 459, 075			0	1
90. 02 09002 0NCOLOGY					0	90.01
90. 02 09002 0NCOLOGY 90. 03 09003 OUTPATI ENT CENTER		614, 377			0	1
91. 00 09100 EMERGENCY					0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			•		0	92.00
OTHER REIMBURSABLE COST CENTERS	0	2,441,344	0.00000	0.000000	0	92.00
95. 00 09500 AMBULANCE SERVI CES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.00000	0. 000000	0	96.00
200.00 Total (lines 50-199)	0	290, 795, 812			1, 232, 847	1000 00

Health Financial Systems	MEMORIAL HOSP & HEALT	H CARE CTR	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150115 Component CCN: 15T115	From 07/01/2014 To 06/30/2015	
		Title XVIII	Subprovi der -	PPS

			Ti tl	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent	TIXI		
	oost content boson per on	Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8	onal ges	Costs (col. 9	,		
		x col . 10)		x col . 12)			
		11.00	12. 00	13.00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C) (O		50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		O		52.00
53.00	05300 ANESTHESI OLOGY	0	C		O		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	O	C		O		54.00
56.00	05600 RADI OI SOTOPE	O	C		O		56. 00
60.00	06000 LABORATORY	O	C		O		60.00
65.00	06500 RESPIRATORY THERAPY	O	C		O		65. 00
66.00	06600 PHYSI CAL THERAPY	O	C		O		66. 00
69.00	06900 ELECTROCARDI OLOGY	0	C		0		69. 00
69. 01	06901 PULMONARY	0	C		0		69. 01
69. 02	06902 CARDI OPULMONARY	0	C		0		69. 02
69. 03	06903 SLEEP LAB	0	C		0		69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C		0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C		0		73. 00
74.00	07400 RENAL DI ALYSI S	0	C		0		74.00
	OUTPATIENT SERVICE COST CENTERS			•	•		
88.00	08800 RURAL HEALTH CLINIC	0	C		0		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	C		0		88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0		89. 00
90.00	09000 CLI NI C	0	C		O		90.00
90. 01	09001 I MED	0	C		O		90. 01
90. 02	09002 ONCOLOGY	0	C		0		90. 02
90. 03	09003 OUTPATI ENT CENTER	0	C		0		90. 03
91.00	09100 EMERGENCY	0	C		0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	C		0		92.00
	OTHER REIMBURSABLE COST CENTERS	, -,			_		
95.00	09500 AMBULANCE SERVI CES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	C		O		96.00
200.00	1 1	0	C	1	Ö		200. 00
				•	10		•

Heal th	Financial Systems ME	MORIAL HOSP &	HEALTH CARE CT	-R	In Lie	eu of Form CMS	2552-10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	VICE OTHER PAS		CCN: 150115	Period: From 07/01/2014		
			Componer	it CCN: 155305	To 06/30/2015	Date/Time Pre 11/23/2015 9:	
			Ti t	le XVIII	Skilled Nursing		
	Cost Conton Decemintion	Non Dhyoi ei en	Nursing Schoo	I Alliad Haal +	h All Other	Total Cost	
	Cost Center Description	Anesthetist	Nursing school	i Ailled Healt	Medical	(sum of col 1	
		Cost			Education Cost		
		0031			EddCatt Oil COSt	4)	
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	'	•				
50.00	05000 OPERATING ROOM	C		0	0 0	0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM			0	0 0	0	52. 00
53.00	05300 ANESTHESI OLOGY	C		0	0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	(C		0	0	0	54. 00
56.00	05600 RADI OI SOTOPE	(C		0	0	0	56. 00
60.00	06000 LABORATORY	C		0	0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	C		0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0		0	0 0	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	(0	0	0	69. 00
69. 01	06901 PULMONARY	(0	0	0	69. 01
69. 02	06902 CARDI OPULMONARY	(0	0	0	69. 02
69. 03	06903 SLEEP LAB	(0	0	0	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	(0	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	(0	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	C)	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	C)	0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	C)	0	0 0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS			_			_
	08800 RURAL HEALTH CLINIC	0		0	0	0	
88. 01	08801 RURAL HEALTH CLINIC II	0		0	0	0	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89. 00
90. 00	09000 CLI NI C	C		0	0 0	0	90.00
90. 01	09001 I MED	(0	0	0	90. 01
90. 02	09002 ONCOLOGY			0	0	0	90. 02
90. 03	09003 OUTPATIENT CENTER			0	0 0	0	90. 03
91. 00	09100 EMERGENCY			0	0 0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART))	D	0 0	. 0	92. 00

0

0

0 92.00 95.00

0 96. 00 0 200. 00

91. 00 | 09100 | EMERGENCY 92. 00 | 09200 | OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS 95. 00 | 09600 | AMBULANCE SERVI CES 96. 00 | 09600 | DURABLE MEDI CAL EQUI P-RENTED 200. 00 | Total (Lines 50-199)

APPORT	Financial Systems ME IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	EMORIAL HOSP & BYLLE OTHER PAS	S Pr	ovi der	CCN: 1501	F	rom 07/01/2014 o 06/30/2015	u of Form CMS-2 Worksheet D Part IV Date/Time Pre 11/23/2015 9:	pared:
				Titl	e XVIII	S	Skilled Nursing PPS Facility		
	Cost Center Description	Total			Ratio of		Outpati ent	Inpati ent	
			(from W				Ratio of Cost	Program	
		Cost (sum of			(col. 5 ÷	col.	to Charges	Charges	
		col. 2, 3 and	8)	7)		(col . 6 ÷ col .		
		4)		00	0.00		7)	40.00	
	ANGLILADY CEDVICE COCT CENTERS	6. 00	7.	00	8. 00)	9. 00	10. 00	
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	55	492, 140	0.0	000000	0. 000000	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM			600, 165		000000		0	
53.00	05300 ANESTHESI OLOGY			500, 165 501, 876		000000		0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C			376, 746		000000		19, 452	
56. 00	05600 RADI OI SOTOPE			791, 477		000000		17, 432	1
60.00	06000 LABORATORY			542, 888		00000		261, 439	
	06500 RESPIRATORY THERAPY			114, 034		00000		155, 270	
66. 00	06600 PHYSI CAL THERAPY		1	582, 440		00000		1, 113, 837	66.00
	06900 ELECTROCARDI OLOGY	0		549, 215		000000		4, 817	69.00
69. 01	06901 PULMONARY	0		0		000000		0	69. 01
69. 02	06902 CARDI OPULMONARY	0		546, 769	0.0	00000	0. 000000	0	69. 02
69. 03	06903 SLEEP LAB	0	1,	158, 141	0.0	000000	0. 000000	0	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0.0	000000	0. 000000	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,	079, 968		000000		130, 349	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0		932, 609		000000		0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0		630, 852		000000		1, 442, 119	
74.00	07400 RENAL DIALYSIS	0		0	0.0	000000	0. 000000	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						1		
	08800 RURAL HEALTH CLINIC	0	1	686, 785		000000		0	
	08801 RURAL HEALTH CLINIC II	0		1		000000		0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0		000000		0	89.00
	09000 CLI NI C 09001 I MED	0	1 -/	503, 982 459, 075		00000		0	90.00
	09002 ONCOLOGY			459, 075 227, 080		000000		0	90.01
	09003 OUTPATIENT CENTER			614, 377		000000		0	1
	09100 EMERGENCY			963, 848		000000		0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			441, 344	1	000000		31, 434	92.00
12.00	OTHER REIMBURSABLE COST CENTERS		'I Z,	TT1, 344	0.0	,00000	0.000000	31, 434	72.00
95. 00	09500 AMBULANCE SERVICES								95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0.0	00000	0. 000000	0	
	Total (lines 50-199)		1	795, 812			1 2:223000	3, 158, 717	

Health Financial Systems	MEMORIAL HOSP & HEALT	H CARE CTR	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150115 Component CCN: 155305	From 07/01/2014 To 06/30/2015	
		Title YVIII	Skilled Nursing	

		Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent	Taciffty		
oost ochter beschiptron	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8	onal goo	Costs (col.			
	x col. 10)		x col . 12)			
	11.00	12. 00	13.00			
ANCILLARY SERVICE COST CENTERS			•			
50.00 05000 OPERATING ROOM	0	0		0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52. 00
53. 00 05300 ANESTHESI OLOGY	0	0		0		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
56. 00 05600 RADI 0I SOTOPE	0	0		0		56. 00
60. 00 06000 LABORATORY	0	0		0		60.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0		69. 00
69. 01 06901 PULMONARY	0	0		0		69. 01
69. 02 06902 CARDI OPULMONARY	0	0		0		69. 02
69. 03 06903 SLEEP LAB	0	0		0		69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0		73. 00
74.00 07400 RENAL DIALYSIS	0	0		0		74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0)	0		88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	0)	0		88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0)	0		89. 00
90. 00 09000 CLI NI C	0	0)	0		90. 00
90. 01 09001 I MED	0	0)	0		90. 01
90. 02 09002 0NC0L0GY	0	0)	0		90. 02
90. 03 09003 OUTPATI ENT CENTER	0	0		0		90. 03
91. 00 09100 EMERGENCY	0	0		0		91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0)	0		92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0)	0		96. 00
200.00 Total (lines 50-199)	0	0)	0		200. 00

Health Financial Systems	MEMORIAL HOSP & HEALT	TH CARE CTR	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150115 Component CCN: 155305	From 07/01/2014	

Cost Center Description				Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description					Charges	гасттту	Costs	
Ratio From Worksheet C, Part I, col. 9 Services Services Services Services Services Services Services Services Services Subject To Ded. & Coins. Services Subject To Ded. & Coins. Services Subject To Ded. & Coins. Services Subject To Ded. & Coins. Services Subject To Ded. & Coins. Services		Cost Center Description	Cost to Charge	PPS Reimbursed		Cost		
Worksheet C, Part I, col. 9		oost conten beschiption						
Part I, col. 9 Budject To Ded. & Colns. Subject To Ded. & Colns. See Inst.) Ded. & Colns. Ded. & Colns. See Inst.) Ded. & Colns. See Inst.) Ded. & Colns. Ded. & Ded. & Ded. & Ded. & Ded. & Ded. & Ded. & Ded. & Ded. Ded. & Ded. & Ded. & Ded. & Ded. & Ded. Ded. & Ded. & Ded. & Ded. & Ded. & Ded. & Ded. & Ded. & Ded. Ded. & Ded. & Ded. & Ded. & Ded. & Ded. & Ded. & D							(300 111011)	
ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00								
NAMELILARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5			,					
NACILLARY SERVICE COST CENTERS								
50 00 05000 05000 05000 0 0			1.00	2.00			5. 00	
S2 00 05200 05200 05200 05200 05200 05200 05200 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 0540		ANCILLARY SERVICE COST CENTERS						
53.00 05300 ABSTHESI OLOGY 0.473683 0 0 0 0 53.00	50.00	05000 OPERATING ROOM	0. 261312	0		0 0	0	50. 00
54.00 05400 RADI OLOGY-DI AGNOSTIC 0.162873 0 0 0 0 0 0 54.00	52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 669506	0		0	0	52. 00
56.00 0500 CABIO INSTOPE 0.163727 0 0 0 0 0 56.00	53. 00	05300 ANESTHESI OLOGY	0. 473683	0		0	0	53.00
60. 00 06000 LABORATORY 0. 290986 0 0 0 0 0 0 0 0 0	54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 162873	0		0 0	0	54.00
65. 00 06500 RESPIRATORY THERAPY 0.354949 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.557533 0 0 0 0 66. 00 69. 01 06900 ELECTROCARDI OLOGY 0.191990 0 0 0 0 0 69. 00 69. 01 06901 PULMONARY 0.000000 0 0 0 0 0 69. 01 69. 02 06902 CARDI OPULMONARY 0.383200 0 0 0 0 0 69. 02 69. 03 06903 SLEEP LAB 0.365163 0 0 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.663377 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0.746196 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.227508 0 0 606 0 73. 00 74. 00 07400 RENAL DIALYSIS 0.000000 0 0 0 0 74. 00 07400 RENAL DIALYSIS 0.000000 0 0 0 0 74. 00 07400 RENAL HEALTH CLINIC 0.000000 0 0 0 0 79. 00 08900 RURAL HEALTH CLINIC 1 0.000000 79. 01 09800 RURAL HEALTH CLINIC 1 0.000000 79. 00 090000 LINED 0.000000 0 0 0 0 79. 01 09001 IMED 1.197288 0 0 0 0 0 79. 02 09002 0NCOLOGY 0.469800 0 0 0 0 0 79. 03 09003 0UTATIENT CENTER 0.661309 0 0 0 0 79. 04 09003 0UTATIENT CENTER 0.664361 0 0 0 0 79. 00 09000 ONCOLOGY 0.469800 0 0 0 0 79. 00 09000 ONCOLOGY 0.469800 0 0 0 0 79. 00 09000 00000 00000 000000 000000 79. 00 09000 0000000 0000000 00000000	56. 00	05600 RADI 0I SOTOPE	0. 163727	0		0 0	0	56. 00
66. 00 06600 PHYSICAL THERAPY 0.557533 0 0 0 0 0 66. 00 69. 00 06900 ELECTROCARDIOLOGY 0.191990 0 0 0 0 0 69. 01 06901 PULMONARY 0.000000 0 0 0 0 69. 02 06902 CARDIOPULMONARY 0.383200 0 0 0 0 69. 03 06903 SLEEP LAB 0.365163 0 0 0 0 69. 00 07000 ELECTROCREPHALOGRAPHY 0.000000 0 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.663377 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.746196 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.746196 0 0 0 74. 00 07400 RENAL DIALYSIS 0.000000 0 0 0 74. 00 07400 RENAL DIALYSIS 0.000000 0 0 0 74. 00 08800 RURAL HEALTH CLINIC 0.000000 88. 01 08800 RURAL HEALTH CLINIC 1 0.000000 89. 00 08800 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 90. 00 09000 CLINIC 0.514690 0 0 0 0 90. 01 09001 IMED 1.197288 0 0 0 0 90. 02 09002 ONCOLOGY 0.469800 0 0 0 0 90. 03 09003 OUTPATIENT CENTER 0.661309 0 0 0 0 90. 04 09000 OUTPATIENT CENTER 0.661309 0 0 0 90. 05 09000 OUTPATIENT CENTER 0.661309 0 0 0 90. 07 07000 OUTPATIENT CENTER 0.661309 0 0 0 90. 07 07000 OUTPATIENT CENTER 0.661309 0 0 0 90. 07 07000 OUTPATIENT CENTER 0.661309 0 0 0 90. 07 07000 OUTPATIENT CENTER 0.661309 0 0 0 90. 00 07000 OUTPATIENT CENTER 0.661309 0 0 0 90. 00 07000 OUTPATIENT CENTER 0.661309 0 0 0 90. 00 07000 OUTPATIENT CENTER 0.661309 0 0 0 90. 00 07000 OUTPATIENT CENTER 0.661309 0 0 0 90. 00 07000 OUTPATIENT CENTER 0.661309 0 0 0 90. 00 07000 OUTPATIENT CENTER 0.661309 0 0 0 90. 00 07000 OUTPATIENT CENTER 0.661309 0 0 0 90. 00 07000 OUTPATIENT CENTER 0.661309 0 0 0 90. 00 07000 OUTPATIENT CENTER 0.661309 0 0 0 90. 00 07000 OUTPATIENT CENTER	60.00	06000 LABORATORY	0. 290986	0		0 0	0	60.00
69. 00 06900 ELECTROCARDIOLOGY 0. 191990 0 0 0 0 0 69. 00 69. 01 06901 PULMONARY 0. 000000 0 0 0 0 0 0 69. 02 06902 CARDIOPULMONARY 0. 383200 0 0 0 0 0 69. 03 06903 SLEEP LAB 0. 365163 0 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 0 0 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 663377 0 0 0 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 746196 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 746196 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 227508 0 0 606 0 73. 00 74. 00 07400 RENAL HEALTH CLINIC 0. 000000 0 0 0 74. 00 000000 0 0 0 0 74. 00 000000 0 0 0 0 88. 01 08800 RURAL HEALTH CLINIC 0. 000000 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0. 000000 0 0 0 90. 01 09000 CLINIC 0. 514690 0 0 0 0 90. 02 09002 ONCOLOGY 0. 469800 0 0 0 0 90. 02 09002 ONCOLOGY 0. 469800 0 0 0 0 90. 02 09002 ONCOLOGY 0. 469800 0 0 0 0 90. 02 09002 ONCOLOGY 0. 469800 0 0 0 0 90. 02 09002 ONCOLOGY 0. 469800 0 0 0 0 90. 02 09002 ONCOLOGY 0. 469800 0 0 0 0 90. 03 09003 OUTPATI ENT CENTER 0. 661309 0 0 0 0 90. 04 09100 EMERGENCY 0. 307280 0 0 0 0 90. 05 09200 ONSERVATI ON BEDS (NON-DISTINCT PART) 0. 664361 0 0 0 0 90. 02 09400 ONCOLOGY 0. 000000 0 0 0 90. 03 09600 DURABLE MEDICAL EQUI P-RENTED 0. 664361 0 0 0 0 90. 01 09400 CLINIC CLINI	65. 00	06500 RESPI RATORY THERAPY	0. 354949	0		0 0	0	65. 00
69. 00 06900 ELECTROCARDIOLOGY 0.191990 0 0 0 0 0 69. 00 69. 01 06901 PULMONARY 0.000000 0 0 0 0 0 69. 02 06902 CARDIOPULMONARY 0.383200 0 0 0 0 69. 03 06903 SLEEP LAB 0.365163 0 0 0 0 0 69. 03 06903 SLEEP LAB 0.365163 0 0 0 0 69. 03 070. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.663377 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.746196 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.227508 0 0 0 0 74. 00 07400 RENAL DI ALYSIS 0.000000 0 0 0 74. 00 07400 RENAL DI ALYSIS 0.000000 0 0 0 74. 00 08900 RURAL HEALTH CLINIC 0.000000 75. 00 08900 RURAL HEALTH CLINIC 0.000000 0 0 76. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 76. 01 09001 IMED 0.514690 0 0 0 0 77. 02 09002 ONCOLOGY 0.469800 0 0 0 0 78. 00 09003 OUTPATIENT ENTIFER 0.661309 0 0 0 79. 00 09000 OUTPATIENT CENTER 0.664361 0 0 0 79. 00 09200 OSERVATI ON BEDS (NON-DISTINCT PART) 0.664361 0 0 0 75. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.664361 0 0 0 75. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.664361 0 0 0 75. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 0 0 75. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 0 0 0 75. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 0 0 0 75. 00 09100 CESS PEP CLINIC CAS CESS PROGRAM 0 0 0 0 75. 00 09100 CESS PEP CLINIC CAS CESS PROGRAM 0 0 0 0 75. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 0 0 0 75. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 0 0 0 75. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 0 0 0 75. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 0 0 0 75.	66. 00	06600 PHYSI CAL THERAPY	0. 557533	0		0 0	0	66.00
69. 02 06902 CARDI OPULMONARY 0.383200 0 0 0 0 0 69. 02 69. 03 06903 SLEEP LAB 0.365163 0 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.0000000 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.663377 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.746196 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.227508 0 0 606 0 74. 00 07400 RENAL DI ALYSIS 0.000000 0 0 0 74. 00 07400 RENAL DI ALYSIS 0.000000 0 0 0 74. 00 00TPATI ENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0.000000 88. 01 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 89. 00 09000 CLINIC 0.514690 0 0 0 0 90. 01 09001 IMED 1.197288 0 0 0 0 90. 02 09002 ONCOLOGY 0.469800 0 0 0 0 90. 03 09003 OUTPATI ENT CENTER 0.661309 0 0 0 0 91. 00 09100 EMEGENCY 0.469800 0 0 0 0 92. 00 07100 DEMERGENCY 0.037280 0 0 0 0 95. 00 09500 DIABLE MEDI CAL EQUIP -RENTED 0.664361 0 0 0 0 90. 00 09600 DURABLE MEDI CAL EQUIP -RENTED 0.000000 0 0 0 00 09600 CLISIC SERVICES 0.729838 0 0 0 0 00 09600 CLISIC SERVICES 0.000000 0 0 0 00 09600 CLISIC SERVICES 0.000000 0 0 0 00 09600 CLISIC SERVICES 0.0000000 0 0 0 00 09600 DURABLE MEDI CAL EQUIP -RENTED 0.0000000 0 0 0 00 00 00			0. 191990	0		0 0	0	69. 00
69. 03 06903 SLEEP LAB 0.365163 0 0 0 0 0 0 0 0 0 0 0 70. 00	69. 01	06901 PULMONARY	0. 000000	0		0 0	0	69. 01
69. 03 06903 SLEEP LAB 0.365163 0 0 0 0 0 0 0 0 0 0 0 70. 00	69. 02	06902 CARDI OPULMONARY	0. 383200	l o		0 0	0	69. 02
71. 00				0		0 0	0	69. 03
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 746196 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 227508 0 0 0 606 0 73. 00 74. 00 07400 RENAL DIALYSIS 0. 000000 0 0 0 0 0	70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 746196 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 227508 0 0 6066 0 73. 00 74. 00 07400 RENAL DIALYSIS 0. 000000 0 0 0 0	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 663377	0		0 0	0	71.00
73. 00				0		0 0	0	1
74.00 07400 RENAL DI ALYSI S 0.000000 0 0 0 0 0 0 0	73. 00	07300 DRUGS CHARGED TO PATIENTS				0 606	0	73. 00
SERVICE COST CENTERS SERVICE COST CENTERS SERVICE COST CENTERS SERVICE COST CENTERS SERVICE COST CENTERS SERVICE COST CENTERS SERVICE COST CENTERS SERVICE COST CENTERS SERVICE COST CENTERS SERVICE COST CENTERS SERVICE COST CENTERS SERVICE COST CENTERS SERVICE COST CENTERS SERVICE							0	74.00
88. 00								
89. 00			0. 000000				0	88. 00
90. 00	88. 01	08801 RURAL HEALTH CLINIC II	0. 000000				0	88. 01
90. 01	89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90. 02	90. 00	09000 CLI NI C	0. 514690	0		0 0	0	90.00
90. 03	90. 01	09001 I MED	1. 197288	0		0 0	0	90. 01
91. 00	90. 02	09002 ONCOLOGY	0. 469800	0		0 0	0	90. 02
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0. 664361 0 0 0 0 0 92. 00	90. 03	09003 OUTPATIENT CENTER	0. 661309	0		0 0	0	90. 03
95. 00 09500 AMBULANCE SERVICES 0. 729838 0 95. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0. 000000 0 0 0 0 0 0 0	91. 00	09100 EMERGENCY	0. 307280	0		0 0	0	91.00
95. 00	92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 664361	0		0 0	0	92.00
96. 00		OTHER REIMBURSABLE COST CENTERS				-		1
200.00 Subtotal (see instructions) 0 0 606 0 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 201.00	95. 00	09500 AMBULANCE SERVICES	0. 729838			0		95. 00
201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00 Only Charges	96. 00	09600 DURABLE MEDICAL EQUIP-RENTED				0 0	0	96.00
201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00 Only Charges	200.00	Subtotal (see instructions)		0		0 606	0	200.00
Only Charges	201.00					0 0		201.00
202.00 Net Charges (Line 200 +/- Line 201) 0 606 0/202.00		Only Charges						
202. 00 Net that ges (1116 200 17 1116 201) 0 0 0 0	202.00	Net Charges (line 200 +/- line 201)		0		0 606	0	202. 00

Health Financial Systems	MEMORIAL HOSP & HEALT	TH CARE CTR	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150115	Period: From 07/01/2014	Worksheet D
		Component CCN: 155305	To 06/30/2015	
		Title XVIII	Skilled Nursing	PPS
			Facility	

		Ti tl	e XVIII	Skilled Nursing	PPS	
				Facility Pacility		
Cost Conton Description	Cost	Cost				
Cost Center Description	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS	,					
50. 00 05000 OPERATING ROOM	0	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53. 00 05300 ANESTHESI OLOGY	0	0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54. 00
56. 00 05600 RADI OI SOTOPE	0	0				56. 00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
69. 01 06901 PULMONARY	0	0				69. 01
69. 02 06902 CARDI OPULMONARY	0	0				69. 02
69. 03 06903 SLEEP LAB	0	0				69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO		0				71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIE	NTS 0	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	138				73. 00
74. 00 07400 RENAL DIALYSIS	0	0				74. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0				88. 00
88. 01 08801 RURAL HEALTH CLINIC II	CENTED	0				88. 01
89. 00 08900 FEDERALLY QUALIFIED HEALTH 90. 00 09000 CLINIC	CENTER	0				89. 00
90. 00 09000 CLI NI C 90. 01 09001 MED		0				90. 00 90. 01
90. 01 09001 TMED 90. 02 09002 0NCOLOGY		0				90.01
90. 02 09002 0NCOLOGY 90. 03 09003 OUTPATI ENT CENTER		0				90.02
91. 00 09100 EMERGENCY		0				91.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI	NCT DADT)	0				91.00
OTHER REIMBURSABLE COST CENTERS	NCI FARI) 0	U				72.00
95. 00 09500 AMBULANCE SERVICES	0					95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTE	1	0				96.00
200.00 Subtotal (see instructions)	l l	138				200.00
201.00 Less PBP Clinic Lab. Service		150				201.00
Only Charges						
202.00 Net Charges (line 200 +/- I	ine 201) 0	138				202. 00
						•

		INIONTAL HOST & I				d of Form CM3-	2332-10
APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150115	Peri od:	Worksheet D	
					From 07/01/2014	Part V	
					To 06/30/2015	Date/Time Pre	epared:
						11/23/2015 9:	52 am
			Ti	tle XIX	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimburse	d Cost	Cost	PPS Services	
	•	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(, , , , , , , , , , , , , , , , , , ,	
		Part I, col. 9		Subject To	Subject To		
		1 41 6 1, 661. 7		Ded. & Coins			
		1 00	2.00	(see inst.)	(see inst.)	F 00	
	ANOLLI ADV. CEDVI OF COCT CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	0.0/4040		ol = =00 //			
50. 00	05000 OPERATING ROOM	0. 261312		0 5, 523, 60		1	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 669506		O	0	1	02.00
53.00	05300 ANESTHESI OLOGY	0. 473683		0 192, 41		0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 162873		0 3, 221, 82	23 0	0	54.00
56.00	05600 RADI OI SOTOPE	0. 163727		0 318, 27	77 0	0	56.00
60.00	06000 LABORATORY	0. 290986		0 1, 840, 26	56 0	1 0	60.00
65. 00	06500 RESPIRATORY THERAPY	0. 354949		0 146, 48		1	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 557533		0 285, 88			66.00
69. 00	06900 ELECTROCARDI OLOGY	0. 337333		0 1, 149, 78			1
	i i	1		1, 149, 70	0	0	
69. 01	06901 PULMONARY	0. 000000		0	0	0	69. 01
69. 02	06902 CARDI OPULMONARY	0. 383200		9, 3		0	69. 02
69. 03	06903 SLEEP LAB	0. 365163		0 61, 68	39 0	0	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000		0	0	0	1 , 0, 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 663377		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 746196		0	0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 227508		0 1, 851, 9	51 0	0	73. 00
74.00	07400 RENAL DI ALYSI S	0. 000000		o	0 0	l o	74.00
	OUTPATIENT SERVICE COST CENTERS			-			1
88. 00	08800 RURAL HEALTH CLINIC	0. 890299				0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	972, 489. 000000				0	1
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000					1
90.00	09000 CLINIC	0. 514690		0 162, 83	22		1
	09001 LIMED	1				· -	
90. 01		1. 197288		1	92 0	0	, , , , , ,
90. 02	09002 ONCOLOGY	0. 469800		0 1, 243, 94		0	1 /0.02
90. 03	09003 OUTPATIENT CENTER	0. 661309		이	0	0	
91. 00	09100 EMERGENCY	0. 307280		0 2, 794, 73	36 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 664361		0	0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0. 729838		0 312, 22	22		95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000		ol ,	0 0	0	96.00
200.00				0 19, 115, 5°	15 0	1	200.00
200.00				17, 113, 3	0	I	201.00
201.00	Only Charges						201.00
202.00				0 19, 115, 5 ⁻	15 0		202. 00
202. UL	/ INCLUDIALYCS (TITLE 200 +/ - TITLE 201)	1	I	ol 13, 110, 5	19	1	1202.00

| Period: | Worksheet D | From 07/01/2014 | Part V | To 06/30/2015 | Date/Time Prepared: | 11/23/2015 9:52 am
 Heal th Financial
 Systems
 MEMORIAL HOSP &

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 Provi der CCN: 150115

					11/23/2015 9:52 am
		Ti t	le XIX	Hospi tal	Cost
	Co:	sts			
Cost Center Description	Cost	Cost			
	Rei mbursed	Reimbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
	Ded. & Coins.	Ded. & Coins.			
	(see inst.)	(see inst.)			
	6. 00	7. 00			
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	1, 443, 385	0			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52. 00
53. 00 05300 ANESTHESI OLOGY	91, 145	0			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	524, 748	1			54. 00
56. 00 05600 RADI OI SOTOPE	52, 111	1			56. 00
60. 00 06000 LABORATORY	535, 492	1			60.00
65. 00 06500 RESPIRATORY THERAPY	51, 996				65. 00
66. 00 06600 PHYSI CAL THERAPY	159, 388		1		66. 00
69. 00 06900 ELECTROCARDI OLOGY	220, 748		1		69.00
69. 01 06901 PULMONARY	220,710		1		69. 01
69. 02 06902 CARDI OPULMONARY	3, 600	1	1		69. 02
69. 03 06903 SLEEP LAB	22, 527		1		69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	22, 327		1		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			ł		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			1		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	421, 334	1	1		73. 00
74. 00 07400 RENAL DIALYSIS	421, 334	0			74.00
OUTPATIENT SERVICE COST CENTERS		0			74.00
88. 00 08800 RURAL HEALTH CLINIC		0			88. 00
88. 01 08801 RURAL HEALTH CLINIC I		0	1		88. 01
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0	1		89. 00
90. 00 09000 CLINIC	83, 809	1	ł		90.00
90. 01 09001 MED	230				90.00
90. 01 09001 TMED 90. 02 09002 0NCOLOGY		1			90. 01
90. 02 09002 0NCOLOGY 90. 03 09003 OUTPATIENT CENTER	584, 406	1			90. 02
		1			
91. 00 09100 EMERGENCY	858, 766		1		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92. 00
OTHER REIMBURSABLE COST CENTERS	207 074				05.00
95. 00 09500 AMBULANCE SERVICES	227, 871				95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	5 004 55	0			96.00
200.00 Subtotal (see instructions)	5, 281, 556	9			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0	'			201. 00
Only Charges	E 201 FF/				202.00
202.00 Net Charges (line 200 +/- line 201)	5, 281, 556	0	1		202. 00

Heal th	Financial Systems	MEMORIAL HOSP & HEALT	TH CARE CTR	In Lie	u of Form CMS-2	552-10		
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN: 150115	Peri od:	Worksheet D-1			
				From 07/01/2014 To 06/30/2015	Date/Time Prep 11/23/2015 9:5			
			Title XVIII	Hospi tal	PPS			
	Cost Center Description							
					1.00			
	PART I - ALL PROVIDER COMPONENTS							
	INPATIENT DAYS							
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn) 13,092							
2.00	2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 13,092							
3 00								

	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13, 092	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13, 092	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	10, 877	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		/ 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period	٥	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	-	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	5, 151	9. 00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12 00	through December 31 of the cost reporting period	0	12 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	٠Į	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
10.00	SWING BED ADJUSTMENT		10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
00	report in g peri od	0.00	
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
	reporting period		
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19.00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	9, 586, 634	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
22.00	5 x line 17)		22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	o	24. 00
24.00	7 x line 19)	٥	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)	-	
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9, 586, 634	27.00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	9, 586, 634	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
00.05	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	700	00.00
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	732. 25	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	3, 771, 820	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	3, 771, 820	41.00

23.00	Swing-bed cost approcable to swintype services after becember 31 of the cost reporting period (fine of	٥	23.00
24. 00	,	0	24. 00
2 00	7 x line 19)	ŭ.	1
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	26. 00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9, 586, 634	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29.00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi - 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 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	9, 586, 634	37.00
	27 minus line 36)		I
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		l
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		l
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	732. 25	38.00
	Program general inpatient routine service cost (line 9 x line 38)	3, 771, 820	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3, 771, 820	41.00

	ATION OF INPATIENT OPERATING COST		Provi der	R CCN: 150115	Peri od: From 07/01/2014	worksheet D-1	
					To 06/30/2015		
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)	3	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
. 00	NURSERY (title V & XIX only)	0	(0.	00 0	0	42.
00	Intensive Care Type Inpatient Hospital Units	F 000 000	4 000	1 017	0.010	2 400 400	4.0
. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	5, 230, 992	4, 298	1, 217.	08 2, 812	3, 422, 429	43. 44.
. 00	BURN INTENSIVE CARE UNIT						44.
	SURGICAL INTENSIVE CARE UNIT						46.
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						
	10		2 11 222			1.00	1.0
. 00	Program inpatient ancillary service cost (Wks			,,,,		13, 195, 851	
. 00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS	11 through 48)	(see instruction	ons)		20, 390, 100	49
. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst D sui	m of Parts I and	886, 210	50
. 00		atront routine	301 11 003 (11 01	ii iiitst. D, sai	ii or rai to r ana	000, 210	
. 00	Pass through costs applicable to Program inpa	atient ancillar	ry services (fr	om Wkst. D,	sum of Parts II	613, 518	51
	and IV)	-01				4 46= =**	
. 00	Total Program excludable cost (sum of lines!			: -:	4:-4	1, 499, 728	
. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !	9 1	erated, non-pny	/Sician anesti	netrst, and	18, 890, 372	33
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
. 00	Program di scharges					0	54
. 00	Target amount per discharge					0.00	55
. 00	Target amount (line 54 x line 55)					0	
. 00	Difference between adjusted inpatient operati	ng cost and ta	arget amount (I	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)		anding 100/	undated and a	ampaumdad by the	0	
. 00	Lesser of lines 53/54 or 55 from the cost reparket basket	porting period	ending 1996, t	ipaatea ana c	ompounded by the	0.00	59
. 00	Lesser of lines 53/54 or 55 from prior year	cost report, up	odated by the r	narket basket		0.00	60
. 00	If line 53/54 is less than the lower of lines	s 55, 59 or 60	enter the less	ser of 50% of	the amount by	0	61
	which operating costs (line 53) are less than		ts (lines 54 x	60), or 1% o	f the target		
	amount (line 56), otherwise enter zero (see i	nstructions)					١.,
. 00	Relief payment (see instructions)	/ !				0	
. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mistro	actions)			0	63
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost report	ing period (See	0	64
	instructions)(title XVIII only)				5 1		
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the o	cost reportin	g period (See	0	65
00	instructions)(title XVIII only)						١.,
. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line	64 plus line 6	ob)(title XVI	II only). For	0	66
. 00	· · · · · · · · · · · · · · · · · · ·	e costs through	n December 31 (of the cost re	enorting period	0	67
	(line 12 x line 19)	3			7 3 1	Ĭ	"
. 00	Title V or XIX swing-bed NF inpatient routing	e costs after [December 31 of	the cost rep	orting period	0	68
	(line 13 x line 20)						
. 00	Total title V or XIX swing-bed NF inpatient					0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili)		70
. 00	Adjusted general inpatient routine service of	•		•	,		71
. 00	Program routine service cost (line 9 x line			,			72
. 00	Medically necessary private room cost applica	able to Program	m (line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine servi	•					74
. 00	Capital-related cost allocated to inpatient	routine service	e costs (from V	Vorksheet B, I	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76
. 00	Program capital -related costs (line 9 x line	,					77
00	Inpatient routine service cost (line 74 minus						78
00	Aggregate charges to beneficiaries for excess			*			79
00	Total Program routine service costs for compa		cost limitation	n (line 78 mi	nus line 79)		80
. 00	Inpatient routine service cost per diem limi		1)				81
. 00	Inpatient routine service cost limitation (li		•				82
. 00 . 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		13)				83
	Utilization review - physician compensation		ons)				85
	Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
. 00	Total observation bed days (see instructions; Adjusted general inpatient routine cost per d					2, 215 732. 25	

Health Financial Systems ME	MORIAL HOSP &	HEALTH CARE CT	₹	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 07/01/2014 To 06/30/2015	Date/Time Pre 11/23/2015 9:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost		Total	Observati on	
		(from line 27)	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	1, 319, 083	9, 586, 634	0. 13759	6 1, 621, 934	223, 172	90.00
91.00 Nursing School cost	(9, 586, 634	0.00000	0 1, 621, 934	0	91.00
92.00 Allied health cost	(9, 586, 634	0.00000	0 1, 621, 934	0	92.00
93.00 All other Medical Education	(9, 586, 634	0. 00000	0 1, 621, 934	0	93. 00

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150115		Worksheet D-1
	Component CCN: 15S115	From 07/01/2014 To 06/30/2015	
	Title XVIII	Subprovi der -	PPS

PART ALL PROVIDER CONVOIRENTS 1.00			TI LIE AVIII	I PF	FF3	
NAMELIE LOWS Inpattlet 1 days (rict uid ing private room days and saling-bed days, oxcluding nonborn) 3,760 1.00		Cost Center Description			1.00	
MARTIENT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
1.00 Impatient days (including private room days, excluding swing-bed and neberor days) 1.7 you have not yet vate room days, coulding swing-bed and observation bed days) 1.7 you have not yet vate room days, 3.70 3.00 1.						
2.00 A private room days (excluding swing-hed and observation bed days). If you have only private room days. 0 3.760						
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23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 Private room charges (excluding swing-bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room per diem charges (ine 29 ± line 3) 30. 00 Average per diem private room charge (line 29 ± line 3) 30. 00 Average per diem private room charge (line 20 ± line 4) 30. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 30. 00 Average per diem private room cost differential (line 34 x line 31) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost differential (line 3 x line 35) 30. 00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 3, 640, 972) 37. 00 Ceneral inpatient routine service cost per diem (see instructions) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost per diem (see instructions) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically neces	22. 00		31 of the cost reporti	ng period (line	0	22. 00
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7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 29 ÷ line 4) 34.00 Average per diem private room cost differential (line 30 ÷ line 4) 35.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 36.00 Private room cost differential adjustment (line 3 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 640, 972) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 640, 972) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 dedically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 dedically necessary private room cost applicable to the Program (line 14 x line 35)		x line 18)		, , ,		
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X I i ne 20 Total swing-bed cost (see instructions) 0 26.00	25. 00		of the cost reporting	period (line 8	0	25. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 3,640,972 27.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00 29.00 29.00 30.00 Semi-private room charges (excluding swing-bed charges) 0 30.00 30.00 Semi-private room charges (excluding swing-bed charges) 0 30.00 30.00 Semi-private room charges (excluding swing-bed charges) 0 30.00 30.00 Average private room per diem charge (line 29 ÷ line 3) 0.00 32.00 30.00 Average private room per diem charge (line 30 ÷ line 4) 0.00 33.00 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34.00 30.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 30.00 Average per diem private room cost differential (line 3 x line 35) 0 36.00 30.00 Average per diem private room cost differential (line 3 x line 35) 0 36.00 30.00 Average per diem private room cost differential (line 3 x line 35) 0 36.00 30.00 Average per diem private room cost differential (line 3 x line 35) 0 36.00 30.00 Average per diem private room cost differential (line 3 x line 35) 0 36.00 30.00 Average per diem private room cost differential (line 3 x line 35) 0 36.00 30.00 30.00 30.00 30.00 30.		3				
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-pri vate room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average pri vate room per diem charge (line 29 ÷ line 3) 33.00 Average semi-pri vate room per diem charge (line 30 ÷ line 4) 34.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem pri vate room cost differential (line 34 x line 31) 36.00 Pri vate room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 3, 640, 972) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 968.34 38.00 97.00 Medically necessary pri vate room cost applicable to the Program (line 14 x line 35) 0 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 20.00 20.00 20.00 32.			04 ' '' 04)		-	
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29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 Semi-private room charges (excluding swing-bed charges) 32. 00 Semi-private room per diem charge (line 29 ÷ line 39 33. 00 Average private room per diem charge (line 29 ÷ line 30 + line 30) 34. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 640, 972) 37. 00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 38. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 39. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	28. 00		and observation bed cha	arges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 640, 972) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.000 0000 32.00 0.000 32.00 0.000 33.00 0.000 34.00 35.00 96.000 35.00 36.00 97.000 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 640, 972) 97.000 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 98.00 Program general inpatient routine service cost (line 9 x line 38) 0.000 Medically necessary private room cost applicable to the Program (line 14 x line 35)	29. 00	Private room charges (excluding swing-bed charges)				
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36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3,640,972 and part 11 - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 968.34 and 97.00 Program general inpatient routine service cost (line 9 x line 38) 2, 161, 335 and 90.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				tions)		
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PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 968.34 38.00 Program general inpatient routine service cost (line 9 x line 38) 2, 161, 335 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		27 minus line 36)			., , . , . , . ,	
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 968.34 38.00 Program general inpatient routine service cost (line 9 x line 38) 2, 161, 335 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			MENTO			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 2, 161, 335 39.00 40.00	38 NO			T	QAQ 24	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 2,161,335 41.00	40.00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		0	40.00
	41. 00	lotal Program general inpatient routine service cost (line 39 +	line 40)	I	2, 161, 335	41. 00

		MORIAL HOSP & I				eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST			CCN: 150115 nt CCN: 15S115	Peri od: From 07/01/2014 To 06/30/2015	Date/Time Pre	pared:
			Ti t	le XVIII	Subprovi der -	11/23/2015 9: PPS	<u>52 am</u>
	Cost Center Description	Total Inpatient Cost	Total	Average Per		Program Cost (col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4)	
42. 00	NURSERY (title V & XIX only)	0		0 0.			42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0		0 0.	00 0	0	43. 00
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1.00	
48. 00 49. 00	Total Program inpatient costs (sum of lines			ons)		289, 090 2, 450, 425	1
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, su	m of Parts I and	258, 265	50.00
51. 00	Pass through costs applicable to Program inpaland IV)	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	14, 279	51.00
52. 00	Total Program excludable cost (sum of lines !					272, 544	1
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION		elated, non-ph	iysician anest	hetist, and	2, 177, 881	53. 00
54. 00	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operati	ing cost and ta	arget amount (line 56 minus	line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost repearket basket	porting period	endi ng 1996,	updated and c	ompounded by the	0.00	58. 00 59. 00
60.00	Lesser of lines 53/54 or 55 from prior year of					0.00	1
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							61.00
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	63. 00
64. 00		ts through Dece	ember 31 of th	e cost report	ing period (See	0	64. 00
65. 00		ts after Decemb	per 31 of the	cost reportin	g period (See	0	65. 00
66. 00	1	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	n December 31	of the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after [December 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient I PART III - SKILLED NURSING FACILITY, OTHER NU		•			0	69. 00
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	ty/ICF/IID rou	utine service	cost (line 37)		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line 3	71)					72. 00
73. 00 74. 00	Medically necessary private room cost application of the cost application of t		•				73.00
75. 00	Capital-related cost allocated to inpatient (26, line 45)	•		•	Part II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limit	tati on			,		81.00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s		· .				82. 00 83. 00
84. 00 85. 00	Program inpatient ancillary services (see insultilization review - physician compensation	structions)	•				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum						86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷				0.00	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions))			0	89.00

Health Financial Systems ME	MORIAL HOSP & F	HEALTH CARE CTR	2	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component	CCN: 15S115	From 07/01/2014 To 06/30/2015		
		Ti tl	e XVIII	Subprovi der – I PF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	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	435, 082	3, 640, 972	0. 11949	6 0	0	90.00
91.00 Nursing School cost	0	3, 640, 972	0. 00000	0	0	91.00
92.00 Allied health cost	0	3, 640, 972	0. 00000	0	0	92.00
93.00 All other Medical Education	0	3, 640, 972	0. 00000	0	o	93. 00

Health Financial Systems	MEMORIAL HOSP & HEALT	H CARE CTR	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115	Peri od: From 07/01/2014	Worksheet D-1
		Component CCN: 15T115		
		Title XVIII	Subprovi der -	PPS

PART L. ALL REQUISER COMPONENTS PART L. ALL REQUISER COMPONENTS			TI LIE AVIII	I RF	FF3	
NeXT F - ALL REVISER COMPONENTS NeXT F - ALL REVISER COMPONENTS NeXT F - ALL REVISER COMPONENTS 1.335 1.00 1.0		Cost Center Description			1.00	
IMPATIENT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpatient days (Including private room days, excluding saing-bed and nebborn days) 1,335 2,00						
Devivate room days (excluding swing-bed and observation bed days). If you have only private room days. do not complete this line. do not complete this line. Semi-private room days (excluding swing-bed and observation bed days). To total swing-bed SMF type inpatient days (including private room days) through December 31 of the cost reporting period (if call endar year, enter 0 on this line). Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line). Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line). Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line). Total swing-bed MF type inpatient days explicable to the Program (excluding swing-bed and neoborn days). 10. Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after becomes 31 of the cost reporting period (if call endar year, enter 0 on this line). 11. Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after becomes 31 of the cost reporting period (if call endar year, enter 0 on this line). 12. Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after becomes 31 of the cost reporting period (if call endar year, enter 0 on this line). 13. Swing-bed SMF type inpatient days applicable to title X VIII XV only (including private room days) after becomes 31 of the cost reporting period (including YVIII XV only XV						
do not complete this line. 4. 05 Sell-private room days (secluding swing-bed and observation bed days) through December 31 of the cost						
5.00 Total swing-bed SRF type inpatient days (including private room days) after December 31 of the cost proporting period (Fig. 2 and total days) (including private room days) after December 31 of the cost proporting period (Fig. 2 and total days) (including private room days) after December 31 of the cost proporting period (Fig. 2 and total days) (including private room days) after December 31 of the cost proporting period (Fig. 2 and total days) (including private room days) after December 31 of the cost proporting period (Fig. 2 and total days) (including private room days) after December 31 of the cost proporting period (Fig. 3 and total days) (including private room days) after December 31 of the cost proporting period (Fig. 3 and total days) (including private room days) after December 31 of the cost proporting period (Fig. 3 and total days) (including private room days) (including priv	3.00		i. II you have only pri	vate room days,	U	3.00
report in period (4.00		days)		1, 335	4. 00
Total swing-bed SNF type Inpatient days (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this Line)	5.00		days) through December	31 of the cost	0	5. 00
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7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 548, 111) 37.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) 38.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Program general inpatient routine service cost per diem (see instructions) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 1, 548, 111) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 1, 548, 111) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 1		x line 18)		, ,		
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x line 20) 26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1,548,111) 27.00 PRIVATE ROOM DIFFERENTIAL ADD SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 26.00 26.00 27.00 28.00 28.00 29.00 28.00 29.00 29.00 30.00 29.00 30.00 29.00 30.00 30.0	25. 00	1	of the cost reporting	period (line 8	0	25. 00
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29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 31.00 Average private room per diem charge (line 29 + line 3) 32.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1,548,111) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0.00 30.00 29.00 30.00 30.00 30.00 30.00 31.00 30.00 32	28. 00		and observation bed cha	arges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi -private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1,548,111) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.000 000 32.00 0.000 33.00 0.000 34.00 35.00 Private room cost differential (line 1,548,111) 0.000 35.00 36.00 36.00 37.00 General inpatient routine service cost per diem (see instructions) 1, 1548,111 37.00 1, 159.63 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	29. 00	Private room charges (excluding swing-bed charges)				
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36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1,548,111 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 79.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 9 36.00 1,548,111 37.00		, , ,		i ons)		
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PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 159.63 38.00 Program general inpatient routine service cost (line 9 x line 38) 1, 172, 386 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		27 minus line 36)	,		., 5.5, .11	
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,159.63 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,172,386 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			MENTO			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,172,386 39.00 40.00	38 00				1 150 62	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,	-			
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 1,172,386 41.00	40.00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		0	40. 00
	41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		1, 172, 386	41. 00

		MORIAL HOSP & H				eu of Form CMS-2	
COMPUTATI	ION OF INPATIENT OPERATING COST			CCN: 150115 t CCN: 15T115	Period: From 07/01/2014 To 06/30/2015		
			·	e XVIII	Subprovi der -	11/23/2015 9: PPS	
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
		Inpatient Cost				(col. 3 x col. 4)	
42 00 NI	URSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42. 00
Ιn	ntensive Care Type Inpatient Hospital Units	J					42.00
	NTENSIVE CARE UNIT ORONARY CARE UNIT	0	(0.0	00	0	43. 00 44. 00
45. 00 BL	URN INTENSIVE CARE UNIT						45. 00
	URGICAL INTENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00 01	Cost Center Description						47.00
48. 00 Pr	rogram inpatient ancillary service cost (Wks	st. D-3. col. 3	3. Line 200)	-		1. 00 527, 615	48. 00
49. 00 To	otal Program inpatient costs (sum of lines 4			ons)		1, 700, 001	•
50. 00 Pa	ass through costs applicable to Program inpa	atient routine	services (from	m Wkst. D, sur	n of Parts I and	161, 689	50. 00
51. 00 Pa	II) ass through costs applicable to Program inpa nd IV)	atient ancillar	ry services (fi	rom Wkst. D, s	sum of Parts II	38, 017	51.00
52. 00 To	otal Program excludable cost (sum of lines 5					199, 706	1
me	otal Program inpatient operating cost excluded in the second of the seco		elated, non-phy	ysician anesth	netist, and	1, 500, 295	53. 00
	rogram discharges					0	54. 00
	arget amount per discharge arget amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00 Di	ifference between adjusted inpatient operati	ng cost and ta	arget amount (I	ine 56 minus	line 53)	0	57. 00
59. 00 Le	onus payment (see instructions) esser of lines 53/54 or 55 from the cost rep	porting period	endi ng 1996, u	updated and co	ompounded by the	0.00	58. 00 59. 00
	arket basket esser of lines 53/54 or 55 from prior year o	cost report. up	odated by the r	market basket		0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							61. 00
amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)							62. 00
63. 00 AI	llowable Inpatient cost plus incentive payme	ent (see instru	ıctions)				63. 00
64.00 Me	ROGRAM INPATIENT ROUTINE SWING BED COST edicare swing-bed SNF inpatient routine cost	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00 Me	nstructions)(title XVIII only) edicare swing-bed SNF inpatient routine cost	ts after Decemb	per 31 of the o	cost reportino	g period (See	0	65. 00
66. 00 To	nstructions)(title XVIII only) otal Medicare swing-bed SNF inpatient routir	ne costs (line	64 plus line o	65)(title XVII	I only). For	0	66. 00
67. 00 Ti	AH (see instructions) itle V or XIX swing-bed NF inpatient routine line 12 x line 19)	e costs through	December 31 o	of the cost re	eporting period	0	67. 00
68. 00 Ti	itle V or XIX swing-bed NF inpatient routing line 13 x line 20)	e costs after D	December 31 of	the cost repo	orting period	0	68. 00
69. 00 To	otal title V or XIX swing-bed NF inpatient m ART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00 Sk	killed nursing facility/other nursing facili	ty/ICF/IID rou	ıtine service (cost (line 37))		70.00
	djusted general inpatient routine service co rogram routine service cost (line 9 x line 7		ine /U ÷ IINe	۷)			71. 00 72. 00
1	edically necessary private room cost applica			,			73.00
75. 00 Ca	otal Program general inpatient routine servi apital-related cost allocated to inpatient r 6, line 45)	•			Part II, column		74. 00 75. 00
76. 00 Pe	o, line 43) er diem capital-related costs (line 75 ÷ lin rogram capital-related costs (line 9 x line	. *					76. 00 77. 00
78. 00 I r	npatient routine service cost (line 74 minus	s line 77)					78. 00
-	ggregate charges to beneficiaries for excess otal Program routine service costs for compa				nus line 79)		79. 00 80. 00
81. 00 I r	npatient routine service cost per diem limit	tati on		. (70 11111	, ,		81.00
1	npatient routine service cost limitation (li easonable inpatient routine service costs (s		* .				82. 00 83. 00
84. 00 Pr	rogram inpatient ancillary services (see ins	structions)	,				84. 00
	tilization review - physician compensation (otal Program inpatient operating costs (sum						85. 00 86. 00
PA	ART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST	Jug., 00)			1	1
	otal observation bed days (see instructions) djusted general inpatient routine cost per o		· line 2)			0.00	87. 00 88. 00
4	bservation bed cost (line 87 x line 88) (see	•					89. 00

Health Financial Systems ME	MORIAL HOSP &	HEALTH CARE CTF	₹	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der		Peri od:	Worksheet D-1		
	Component	CCN: 15T115	From 07/01/2014 To 06/30/2015	Date/Time Pre	pared:	
					11/23/2015 9:	52 am
		Ti tl	e XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	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	213, 503	1, 548, 111	0. 13791	2 0	0	90. 00
91.00 Nursing School cost	0	1, 548, 111	0.00000	0	0	91.00
92.00 Allied health cost	0	1, 548, 111	0.00000	0	0	92. 00
93.00 All other Medical Education	0	1, 548, 111	0. 00000	0 0	0	93. 00

Health Financial Systems	MEMORIAL HOSP & HEALT	H CARE CTR	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150115	Peri od: From 07/01/2014	Worksheet D-1	
		Component CCN: 155305	To 06/30/2015		
		Title XVIII	Skilled Nursing	PPS	

		litle XVIII	Facility	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			4, 985	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed	<i>3</i> /		4, 985	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days) do not complete this line.). If you have only pr	ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		4, 985	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0	5. 00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room o	days) through December	31 of the cost	0	7. 00
7.00	reporting period	days) through becomber	31 of the cost	O	7.00
8.00	Total swing-bed NF type inpatient days (including private room o	days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)			4 070	0.00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	4, 073	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	(including private r	oom days)	0	10. 00
	through December 31 of the cost reporting period (see instruction	ons)	,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enters Swing-bed NF type inpatient days applicable to titles V or XIX of		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	only (Therauting privat	e room days)	O	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX of			0	13. 00
	after December 31 of the cost reporting period (if calendar year				44.00
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 21 of	the cost	0.00	18. 00
16.00	reporting period	arter becember 31 or	the cost	0.00	16.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
	reporting period				
20. 00	Medicald rate for swing-bed NF services applicable to services a reporting period	after December 31 of t	he cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)			2, 551, 955	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00
22.00	5 x line 17)	1 of the cost managetin	a nominal (line (0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3'x line 18)	i or the cost reportin	g perrou (Trile 6	U	23. 00
24.00	Swing-bed cost applicable to NF type services through December 3	31 of the cost reporti	ng period (line	0	24. 00
05 00	7 x line 19)				05.00
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	or the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (li	ne 21 minus line 26)		2, 551, 955	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			0	20.00
29. 00	General inpatient routine service charges (excluding swing-bed a Private room charges (excluding swing-bed charges)	and observation bed cn	arges)	0	
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 ÷ 1	ine 28)		0.000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus	a line 22)(coe instrue	tions)	0.00	33.00
34. 00 35. 00	Average per diem private room cost differential (line 34 x line	, ,	LI UIIS)	0. 00 0. 00	•
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost di	fferential (line	2, 551, 955	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see in				38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38				39. 00
40.00	Medically necessary private room cost applicable to the Program	,			40.00
41.00	Total Program general inpatient routine service cost (line 39 +	1111e 40)	l		41. 00

		MORIAL HOSP &					u of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST				CCN: 150115 CCN: 155305	Period: From 07/01/2014 To 06/30/2015		pared:
				Ti tl	e XVIII	Skilled Nursing Facility	11/23/2015 9: PPS	52 am
	Cost Center Description	Total Inpatient Cost		otal ent Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2	. 00	3.00	4. 00	5. 00	
12.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units		<u> </u>					42.0
13. 00	INTENSIVE CARE UNIT		Τ					43. 0
14. 00	CORONARY CARE UNIT							44. 0
15.00	BURN INTENSIVE CARE UNIT							45. 0
16.00 17.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)							46. 0 47. 0
17.00	Cost Center Description		1					17.0
	In the second se						1. 00	
48.00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4				nc)			48. 0 49. 0
19.00	PASS THROUGH COST ADJUSTMENTS	ri tili ougii 46)	(See III	Structio	115)			49.0
50. 00	Pass through costs applicable to Program inpa	ntient routine	servi c	es (from	Wkst. D, su	m of Parts I and		50.0
51. 00	Pass through costs applicable to Program inpa and IV)	itient ancillai	ry serv	ices (fr	om WKST. D,	sum or Parts II		51.0
52. 00	Total Program excludable cost (sum of lines 5	iO and 51)						52. 0
53. 00	Total Program inpatient operating cost exclud		el ated,	non-phy	sician anest	hetist, and		53.0
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	02)						-
54. 00	Program di scharges							54.0
5.00	Target amount per discharge							55.0
	Target amount (line 54 x line 55)	ng cost and to	argat a	mount (I	ino E4 minus	lino E2)		56. C
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and ta	arget a	mount (i	ine so minus	11 ne 53)		58.0
59. 00	Lesser of lines 53/54 or 55 from the cost rep	orting period	endi ng	1996, u	pdated and c	ompounded by the		59.0
	market basket							,,,,
50.00	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines							60.0
01.00	which operating costs (line 53) are less than							01.0
	amount (line 56), otherwise enter zero (see i	nstructions)						
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	nt (saa instri	uctions)				62. 0 63. 0
33.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mistro	uc ti ons)] 03.0
64. 00	Medicare swing-bed SNF inpatient routine cost	s through Dec	ember 3	1 of the	cost report	ing period (See		64.0
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	s after Decemb	her 31	of the c	ost reportin	a period (See		65. 0
55.00	instructions)(title XVIII only)	.s arter becenn	bei 31	or the c	ost reportin	g perrou (see		05.0
66. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plu	s line 6	5)(title XVI	II only). For		66.0
67 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	costs through	h Decem	har 31 a	f the cost r	enorting period		67. 0
37.00	(line 12 x line 19)	costs till odgi	II DCCCIII	ber 51 0	THE COST I	cportring perrou		07.0
68. 00	Title V or XIX swing-bed NF inpatient routine	costs after l	Decembe	r 31 of	the cost rep	orting period		68. 0
59. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient r	couting costs	(line 6	7 ± lino	68)			69. 0
. 7. UU	PART III - SKILLED NURSING FACILITY, OTHER NU		•					1 07. 0
70. 00	Skilled nursing facility/other nursing facili	ty/ICF/IID ro	utine s	ervi ce c	ost (line 37)	2, 551, 955	1
71. 00 72. 00	Adjusted general inpatient routine service co		line 70	÷ line	2)		511. 93	
72.00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica		m (line	14 x I i	ne 35)		2, 085, 091 0	1
74. 00	Total Program general inpatient routine servi	9	•		,		2, 085, 091	
75. 00	Capital-related cost allocated to inpatient r	outine servic	e costs	(from W	orksheet B,	Part II, column	0	75. 0
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lir	ne 2)					0. 00	76. 0
77. 00	Program capital related costs (line 9 x line						0.00	1
78. 00	Inpatient routine service cost (line 74 minus	•			`		0	
79. 00 30. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa					nus line 70)	0	1
31. 00	Inpatient routine service costs for compa		COSE II	tatī Ull	(1116 /0 1111	1143 1116 /7)	0. 00	
32. 00	Inpatient routine service cost limitation (li	ne 9 x line 8	* .				0	82. 0
33.00	Reasonable inpatient routine services costs (s		ns)				2, 085, 091 1, 101, 721	1
34. 00 35. 00	Program inpatient ancillary services (see ins Utilization review - physician compensation (ons)				1, 191, 731 0	
	Total Program inpatient operating costs (sum			85)			3, 276, 822	
27.00	PART IV - COMPUTATION OF OBSERVATION BED PASS						=	67.
87. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		÷ in≏	2)			0 00	87. 0 88. 0
38. 00							0.00	

Heal th	Financial Systems ME	EMORIAL HOSP &	HEALTH CA	ARE CTF	?	In Lieu of Form CMS-255		
COMPUTA	ATION OF INPATIENT OPERATING COST		Pro	ovi der	CCN: 150115	Peri od:	Worksheet D-1	
					From 07/01/2014			
			Con	mponent	CCN: 155305	To 06/30/2015		
				T: ±1	- \(\lambda \tau \tau \tau \tau \tau \tau \tau \ta	Chilled Normalian	11/23/2015 9:	oz alli
				11 11	e XVIII	Skilled Nursing	PPS	
						Facility		
	Cost Center Description	Cost	Routi ne	Cost	column 1 ÷	Total	Observation	
			(from li	ne 27)	column 2	Observati on	Bed Pass	
						Bed Cost (from	Through Cost	
						line 89)	(col. 3 x col.	
							4) (see	
							instructions)	
		1.00	2.0	00	3. 00	4. 00	5. 00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00	Capital -related cost	0		0	0.0000	00 0	0	90.00
91. 00	Nursing School cost	0	1	0	0. 00000	00	0	91.00
92.00	Allied health cost	0		0	0. 00000	00	0	92.00
93. 00	All other Medical Education	0		0	0. 00000	00	0	93.00

Heal th	Financial Systems	MEMORIAL HOSP & HEALT	H CARE CTI	2	In Lie	eu of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 150115	Peri od:	Worksheet D-3	
					From 07/01/2014 To 06/30/2015		nared:
					10 00/30/2013	11/23/2015 9:	52 am
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description			Ratio of Cos	•	Inpati ent	
				To Charges	Program	Program Costs	
					Charges	(col. 1 x col.	
						2)	
				1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS				5, 831, 864		30. 00
	03100 I NTENSI VE CARE UNI T				3, 918, 560		31. 00
	04000 SUBPROVI DER - I PF				5, 925		40. 00
	04100 SUBPROVI DER - I RF				0		41. 00
43.00	04300 NURSERY						43. 00
	ANCILLARY SERVICE COST CENTERS				. T	Г .	
	05000 OPERATING ROOM			0. 26131			
	05200 DELIVERY ROOM & LABOR ROOM			0. 66950		0	52. 00
	05300 ANESTHESI OLOGY			0. 47368			
	05400 RADI OLOGY-DI AGNOSTI C			0. 16287			
	05600 RADI 01 S0T0PE			0. 16372			
60. 00	06000 LABORATORY			0. 29098	3, 524, 295	1, 025, 521	60. 00

0.557533

0. 198987

0.000000

0.383200

0.365163

0.000000

0.663377

0.746196

0. 227508

0.000000

0.000000

0.000000

0.000000

0.514690

1. 197288

0.469800

0.661309

0.307668

0.664361

0.000000

1, 341, 355

1, 176, 420

3, 593, 921

1, 874, 796

5, 199, 639

11, 225, 157

388

669

185

6, 984

2, 056, 739

38, 303, 829

38, 303, 829

247, 574

65.00

66.00

69.00

69 01 Ω

69.02

69.03

70.00

71 00

72.00

73.00

74.00

89.00

90.00

90.02

90.03 0

91.00

92.00

95.00

201.00

202. 00

476, 113

655, 893

715, 144

1, 243, 697

3, 879, 950

2, 553, 813

149

244

0

0

0 88.00

0 88.01

0

95

0 90.01

0 96.00

13, 195, 851 200. 00

3, 281

632, 793

164, 479

06500 RESPIRATORY THERAPY

07000 ELECTROENCEPHALOGRAPHY

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

07200 IMPL. DEV. CHARGED TO PATIENTS

08900 FEDERALLY QUALIFIED HEALTH CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

06600 PHYSI CAL THERAPY

06902 CARDI OPULMONARY

07400 RENAL DIALYSIS

08800 RURAL HEALTH CLINIC

09003 OUTPATIENT CENTER

109500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

08801 RURAL HEALTH CLINIC II

06901 PULMONARY

06903 SLEEP LAB

09000 CLI NI C

09002 ONCOLOGY

09100 EMERGENCY

09001 I MED

06900 ELECTROCARDI OLOGY

65.00

66.00

69.00 69 01

69.02

69.03

70.00

71 00 72.00

73.00

74.00

88.00

88. 01

89 00

90.00

90. 01

90.02

90.03

91.00

92.00

95.00

200.00

201.00

	Financial Systems MEMORIAL HOSE ENT ANCILLARY SERVICE COST APPORTIONMENT	P & HEALTH CARE CTI Provi der	CCN: 150115	Peri od:	u of Form CMS-2 Worksheet D-3	
		Componen	t CCN: 15S115	From 07/01/2014 To 06/30/2015	Date/Time Pre 11/23/2015 9:	pared 52 am
		Ti tI	e XVIII	Subprovi der – I PF	PPS	
	Cost Center Description		Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col. 2) 3.00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
0.00	03000 ADULTS & PEDI ATRI CS			0		30. (
1. 00	03100 I NTENSI VE CARE UNI T			0		31.
0. 00	04000 SUBPROVI DER – I PF			2, 448, 600		40.
1. 00	04100 SUBPROVI DER – I RF			0		41.
3. 00	04300 NURSERY			_		43.
	ANCI LLARY SERVI CE COST CENTERS					
0. 00	05000 OPERATI NG ROOM		0. 2613	12 3, 508	917	50.
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 66950	06	0	52.
3. 00	05300 ANESTHESI OLOGY		0. 47368	369	175	53.
1. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1628	73 140, 371	22, 863	54.
5. 00	05600 RADI OI SOTOPE		0. 16372	27 0	0	56.
0. 00	06000 LABORATORY		0. 29098		74, 940	60.
5. 00	06500 RESPI RATORY THERAPY		0. 35494	12, 295	4, 364	65.
5. 00	06600 PHYSI CAL THERAPY		0. 55753	31, 493	17, 558	66.
9. 00	06900 ELECTROCARDI OLOGY		0. 19898	37 16, 628	3, 309	69.
9. 01	06901 PULMONARY		0.00000		0	69.
9. 02	06902 CARDI OPULMONARY		0. 38320	00	0	69.
9. 03	06903 SLEEP LAB		0. 36516	63 0	0	69.
0. 00	07000 ELECTROENCEPHALOGRAPHY		0.00000	00	0	70.
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 6633	77 12, 651	8, 392	71.
2. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 74619	96 0	0	72.
3. 00	07300 DRUGS CHARGED TO PATIENTS		0. 22750	08 433, 852	98, 705	73.
4. 00	07400 RENAL DIALYSIS		0.00000	00	0	74.
	OUTPATIENT SERVICE COST CENTERS					
8. 00	08800 RURAL HEALTH CLINIC		0.00000		0	88.
3. 01	08801 RURAL HEALTH CLINIC II		0.00000		0	88.
9. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	89.
0. 00	09000 CLI NI C		0. 5146		0	90.
0. 01	09001 I MED		1. 19728		0	90.
0. 02	09002 ONCOLOGY		0. 46980		0	90.
0. 03	09003 OUTPATIENT CENTER		0. 66130		0	90.
1. 00	09100 EMERGENCY		0. 30766		57, 867	91.
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 66436	51 0	0	92.
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVI CES					95.
6 00	109600 DURABLE MEDICAL FOLLP-RENTED		0 00000	0.0	0	96

1, 096, 787 1, 096, 787 96.00

202. 00

289, 090 200. 00 201. 00

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

Net Charges (line 200 minus line 201)

200.00

202.00

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

INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150115	Peri od:	Worksheet D-3	
		Componen	t CCN: 15T115	From 07/01/2014 To 06/30/2015	Date/Time Pre 11/23/2015 9:	
		Ti tI	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00	03000 ADULTS & PEDI ATRI CS		I	0		30.00
31. 00	03100 INTENSIVE CARE UNIT			0		31.00
40. 00	04000 SUBPROVI DER - I PF			0		40. 00
41. 00	04100 SUBPROVI DER - I RF			1, 025, 365		41. 00
43. 00	04300 NURSERY			1, 122, 111		43. 00
	ANCILLARY SERVICE COST CENTERS		•			
50.00	05000 OPERATI NG ROOM		0. 2613	5, 993	1, 566	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 66950	06	0	52.00
53. 00	05300 ANESTHESI OLOGY		0. 47368	903	428	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 16287	73 24, 926	4, 060	54.00
56. 00	05600 RADI 0I SOTOPE		0. 16372		0	
60.00	06000 LABORATORY		0. 29098		20, 786	
65. 00	06500 RESPI RATORY THERAPY		0. 35494	· ·	15, 706	
66. 00	06600 PHYSI CAL THERAPY		0. 55753		374, 390	
69. 00	06900 ELECTROCARDI OLOGY		0. 19898		1, 019	
69. 01	06901 PULMONARY		0.00000		0	
69. 02	06902 CARDI OPULMONARY		0. 38320		0	69. 02
69. 03 70. 00	06903 SLEEP LAB 07000 ELECTROENCEPHALOGRAPHY		0. 36516 0. 00000		0	69. 03 70. 00
70.00	07100 BEDICAL SUPPLIES CHARGED TO PATIENTS		0. 66337		0 25, 098	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 74619		25, 096	1
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 22750		84, 296	
74. 00	07400 RENAL DIALYSIS		0. 00000		04, 270	
7 1. 00	OUTPATIENT SERVICE COST CENTERS		0.0000	50 0		7 1. 00
88. 00	08800 RURAL HEALTH CLINIC		0.00000	00	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II		0.00000		0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	89. 00
90. 00	09000 CLI NI C		0. 51469	90 0	0	90.00
90. 01	09001 I MED		1. 19728	38 0	0	90. 01
90. 02	09002 ONCOLOGY		0. 46980	00	0	90. 02
90. 03	09003 OUTPATIENT CENTER		0. 66130		0	
91. 00	09100 EMERGENCY		0. 30766		0	
02 NA	DOCOD ORSEDVATION DEDS (NON DISTINCT DADT)		0 66424	.1 Λ	Λ .	02 00

0.000000

1, 232, 847

1, 232, 847

92.00

95.00

96.00

202.00

527, 615 200. 00 201. 00

92.00

95.00

96.00

200.00

202.00

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

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

09600 DURABLE MEDICAL EQUIP-RENTED

09500 AMBULANCE SERVICES

	Financial Systems	MEMORIAL HOSP & HEALTH CARE CTI	₹	In Li€	eu of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150115	Peri od:	Worksheet D-3	
		Componen	t CCN: 155305	From 07/01/2014 To 06/30/2015	Date/Time Pre 11/23/2015 9:	pared: 52 am
		Ti tl	e XVIII	Skilled Nursing Facility		
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program	Inpatient Program Costs	
			To onal ges	Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30.00	03000 ADULTS & PEDIATRICS			0		30.00
31.00	03100 INTENSIVE CARE UNIT			0		31.00
40.00	04000 SUBPROVI DER - I PF			0		40. 00
	04100 SUBPROVI DER - I RF			0		41. 00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATI NG ROOM		0. 2613		_	
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 66950		_	
53. 00	05300 ANESTHESI OLOGY		0. 47368		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1628			
56.00	05600 RADI OI SOTOPE		0. 16372		0	
60.00	06000 LABORATORY		0. 29098			
65. 00	06500 RESPI RATORY THERAPY		0. 35494			
66.00	06600 PHYSI CAL THERAPY		0. 55753			1
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 PULMONARY		0. 19199 0. 00000			1
	06902 CARDI OPULMONARY		•		0	1
69. 02 69. 03	06903 SLEEP LAB		0. 38320 0. 36510		0	69. 02 69. 03
	07000 ELECTROENCEPHALOGRAPHY		0. 00000		0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 6633		_	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	,	0. 74619		00,471	1
	07300 DRUGS CHARGED TO PATIENTS		0. 22750		_	
	07400 RENAL DIALYSIS		0. 00000		0	1
7 1. 00	OUTPATIENT SERVICE COST CENTERS		0.0000	50 0		7 1. 00
88. 00	08800 RURAL HEALTH CLINIC		0.00000	00	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II		0.00000	00	0	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000	00	0	89. 00
90.00	09000 CLI NI C		0. 51469	90 0	0	90.00
90. 01	09001 I MED		1. 19728	38 0	0	90. 01
90. 02	09002 ONCOLOGY		0. 46980		0	90. 02
	09003 OUTPATI ENT CENTER		0. 66130			
91 00	09100 EMERGENCY		0 30729	an n	n 0	91 00

0. 307280

0. 664361

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1, 191, 731 200. 00

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09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
09500 AMBULANCE SERVICES

Net Charges (line 200 minus line 201)

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

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

	Financial Systems MEMORIAL HOSP &				eu of Form CMS-2	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od: From 07/01/2014	Worksheet D-3	
				To 06/30/2015		
		Ti +	le XIX	Hospi tal	Cost	32 <u>alli</u>
	Cost Center Description		Ratio of Cos		Inpati ent	
	5555 551151 55551 Pt. 611		To Charges	Program	Program Costs	
			"" "" "	Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS			2, 327, 973		30. 00
31.00	03100 INTENSIVE CARE UNIT			285, 598		31.00
40.00	04000 SUBPROVI DER - I PF			96, 893		40.00
41.00	04100 SUBPROVI DER - I RF			0		41.00
	04300 NURSERY			280, 853		43. 00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0. 26131	2 452, 697	118, 295	50. 00
	05200 DELIVERY ROOM & LABOR ROOM		0. 66950		0	52. 00
	05300 ANESTHESI OLOGY		0. 47368			1
	05400 RADI OLOGY-DI AGNOSTI C		0. 16287			
	05600 RADI OI SOTOPE		0. 16372	,		
	06000 LABORATORY		0. 29098			
	06500 RESPI RATORY THERAPY		0. 35494			
	06600 PHYSI CAL THERAPY		0. 55753			
	06900 ELECTROCARDI OLOGY		0. 19199			
	06901 PULMONARY		0.00000		0	69. 01
	06902 CARDI OPULMONARY		0. 38320		0	69. 02
	06903 SLEEP LAB		0. 36516		0	69. 03
	07000 ELECTROENCEPHALOGRAPHY		0.00000		0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 66337		56	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 74619		0	72. 00
	07300 DRUGS CHARGED TO PATIENTS		0. 22750		321, 751	73. 00
	07400 RENAL DI ALYSI S		0.00000	00	0	74. 00
	OUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC		0. 89029		_	88. 00
	08801 RURAL HEALTH CLINIC II		972, 489. 00000		_	88. 01
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	89. 00
00000			0 51440	NOI 0		

1. 197288

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90. 00 09000 CLINIC

09001 I MED

09002 ONCOLOGY

09100 EMERGENCY

09003 OUTPATIENT CENTER

09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

OTHER REIMBURSABLE COST CENTERS

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

90. 01

90.02

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	Financial Systems MEMORIAL HOS ENT ANCILLARY SERVICE COST APPORTIONMENT	SP & HEALTH CARE CTI Provider	CCN: 150115	Peri od:	u of Form CMS-2 Worksheet D-3	
	ZIII 7 MOI ZZI W. CZIWI CZ COCC 7 M T CW T CMMZIN			From 07/01/2014		
		Componen	CCN: 15S115	To 06/30/2015	Date/Time Pre 11/23/2015 9:	52 am
		Ti t	le XIX	Subprovi der - I PF	Cost	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				3	2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDIATRICS			0		30.0
1.00	03100 INTENSIVE CARE UNIT			0		31.0
0.00	04000 SUBPROVI DER - I PF			483, 880		40.0
1. 00	04100 SUBPROVI DER - I RF			0		41. 0
3. 00	04300 NURSERY			0		43. (
	ANCILLARY SERVICE COST CENTERS					4
0. 00	05000 OPERATING ROOM		0. 2613		_	
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 66950		_	
3. 00	05300 ANESTHESI OLOGY		0. 47368		0	
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1628		_	
6. 00	05600 RADI OI SOTOPE		0. 16372		0	
0. 00	06000 LABORATORY		0. 29098	•		1
5. 00	06500 RESPI RATORY THERAPY		0. 35494	•	1, 870	
6. 00	06600 PHYSI CAL THERAPY		0. 55753		0	
9. 00	06900 ELECTROCARDI OLOGY		0. 1919	•		
9. 01	06901 PULMONARY		0.00000		0	
9. 02	06902 CARDI OPULMONARY		0. 38320		0	
9. 03	06903 SLEEP LAB		0. 36516		0	1
0. 00	07000 ELECTROENCEPHALOGRAPHY		0.00000		_	
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 6633		_	1
2. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 74619		Ĭ	1
3. 00	07300 DRUGS CHARGED TO PATIENTS		0. 22750	•	18, 199	
4. 00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS		0.00000	00 0	0	74.
8. 00	08800 RURAL HEALTH CLINIC		0. 89029	99 0	0	88.
8. 01	08801 RURAL HEALTH CLINIC II		972, 489. 00000			
9. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	
). 00). 00	09000 CLINIC		0. 51469		0	90.
0. 01	09001 I MED		1. 19728		0	1
0. 02	09002 ONCOLOGY		0. 46980		_	90.
0. 02	09003 OUTPATIENT CENTER		0. 66130		0	
1. 00	09100 EMERGENCY		0. 30728			
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 66436			
2.00	OTHER REIMBURSABLE COST CENTERS		0.00430	5.1		/2.
5. 00	09500 AMBULANCE SERVICES					95.
	09600 DURABLE MEDI CAL EQUI P-RENTED		0. 00000	00	0	

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97, 657 200. 00 201. 00

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200.00

202.00

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

Net Charges (line 200 minus line 201)

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

Hool +b	Financial Systems MEMORIAL HOSP & HEAL	TH CARE CTI	0	In Lie	eu of Form CMS-:	DEE2 10
	Financial Systems MEMORIAL HOSP & HEAL ENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150115	Peri od:	Worksheet D-3	
		Componen	t CCN: 15T115		Date/Time Pre 11/23/2015 9:	
		Ti t	le XIX	Subprovi der - I RF	Cost	
	Cost Center Description	,	Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 31. 00 40. 00 41. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY			0 0 0 7, 105 0		30. 00 31. 00 40. 00 41. 00 43. 00
	ANCILLARY SERVICE COST CENTERS		•	•		
50.00	05000 OPERATI NG ROOM		0. 2613		0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 6695		0	
53.00	05300 ANESTHESI OLOGY		0. 4736		0	53.00
54. 00 56. 00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE		0. 1628 0. 1637		0	54. 00 56. 00
60.00	06000 LABORATORY		0. 1637		54	1
65. 00	06500 RESPIRATORY THERAPY		0. 2509		0	65.00
66. 00	06600 PHYSI CAL THERAPY		0. 5575		3, 279	
69. 00	06900 ELECTROCARDI OLOGY		0. 1919		0,2,7	69.00
69. 01	06901 PULMONARY		0.0000		o o	
69. 02	06902 CARDI OPULMONARY		0. 3832		Ō	69. 02
69. 03	06903 SLEEP LAB		0. 3651		Ō	
70. 00	07000 ELECTROENCEPHALOGRAPHY		0.0000		0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 6633	77 0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 7461	96 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 2275	1, 280	291	73.00
74.00	07400 RENAL DIALYSIS		0.0000	00	0	74. 00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC		0. 8902		0	
88. 01	08801 RURAL HEALTH CLINIC II		972, 489. 0000		0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
90.00	09000 CLINIC		0. 5146		0	
90. 01	09001 I MED 19000 1900		1. 1972		0	
90. 02	09002 ONCOLOGY		0.4698		0	
90. 03 91. 00	O9003 OUTPATI ENT CENTER O9100 EMERGENCY		0. 6613 0. 3072		0	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 3072		0	1
9 2. UU	OTHER REIMBURSABLE COST CENTERS		0.0043	0 1		72.00
95. 00	09500 AMBULANCE SERVICES					95. 00
96 00	100600 DUBARI E MEDI CAL FOLLI D. PENTED		0 0000	20	۸ ا	96.00

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96.00 | 09600 | DURABLE MEDICAL EQUIP-RENTED |
200.00 | Total (sum of lines 50-94 and 96-98) |
201.00 | Less PBP Clinic Laboratory Services-Program only charges (line 61) |
202.00 | Net Charges (line 200 minus line 201)

96.00

3, 624 200. 00 201. 00 202. 00

	ATION OF REIMBURSEMENT SETTLEMENT		CCN: 150115	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Date/Time Pre 11/23/2015 9:	
		Ti tl	e XVIII	Hospi tal	PPS	
			before 1/1	on/after 1/1		
	DADT A LANDATI FAIT HOODI TALL OF DIVILOFO LINDED LIDDO	0	1.00	1. 01	2. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		1	0		1.00
1. 00	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges		4, 652, 96	-		1. 00
1.01	occurring prior to October 1 (see instructions)		4, 032, 90	07		1.01
1. 02	DRG amounts other than outlier payments for discharges		13, 958, 90	00		1. 02
1.02	occurring on or after October 1 (see instructions)		13, 730, 70	,0		1.02
1. 03	DRG for federal specific operating payment for Model 4			0		1.03
	BPCI for discharges occurring prior to October 1 (see					
	instructions)					
1.04	DRG for federal specific operating payment for Model 4			0		1.04
	BPCI for discharges occurring on or after October 1 (see					
	instructions)					
2.00	Outlier payments for discharges. (see instructions)		63, 43			2.00
2. 01	Outlier reconciliation amount			0		2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see			0		2. 02
	instructions)					
3.00	Managed Care Simulated Payments			0		3.00
4. 00	Bed days available divided by number of days in the cost		104. 9	93		4. 00
	reporting period (see instructions)					
F 00	Indirect Medical Education Adjustment		0.0	20		5.00
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before		0.0	00		3.00
	12/31/1996. (see instructions)					
6. 00	FTE count for allopathic and osteopathic programs which		0.0	00		6. 00
0.00	meet the criteria for an add-on to the cap for new		0.0	,0		0.00
	programs in accordance with 42 CFR 413.79(e)					
7. 00	MMA Section 422 reduction amount to the IME cap as		0.0	00		7.00
	specified under 42 CFR §412.105(f)(1)(iv)(B)(1)					
7. 01	ACA Section 5503 reduction amount to the IME cap as		0.0	00		7. 01
	specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the					
	cost report straddles July 1, 2011 then see instructions.					
8. 00	Adjustment (increase or decrease) to the FTE count for		0.0	00		8.00
	allopathic and osteopathic programs for affiliated					
	programs in accordance with 42 CFR 413.75(b),					
	413. 79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR					
0.01	50069 (August 1, 2002).			20		0.01
8. 01	The amount of increase if the hospital was awarded FTE cap		0.0	00		8. 01
	slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.					
8. 02	The amount of increase if the hospital was awarded FTE cap		0.0	10		8. 02
0.02	slots from a closed teaching hospital under section 5506		0.0	,0		0.02
	of ACA. (see instructions)					
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus		0.0	00		9, 00
	lines (8, 8,01 and 8,02) (see instructions)					
10.00	FTE count for allopathic and osteopathic programs in the		0.0	00		10.00
	current year from your records					
11. 00	FTE count for residents in dental and podiatric programs.		0.0	00		11. 00
12. 00	Current year allowable FTE (see instructions)		0.0			12. 00
13. 00	Total allowable FTE count for the prior year.		0.0			13. 00
14. 00	Total allowable FTE count for the penultimate year if that		0.0	00		14. 00
	year ended on or after September 30, 1997, otherwise enter					
45 00	zero.			20		45.00
15.00	Sum of lines 12 through 14 divided by 3.		0.0			15.00
16.00	Adjustment for residents in initial years of the program		0.0			16.00
17. 00	Adjusment for residents displaced by program or hospital		0.0	00		17. 00
18. 00	closure Adjusted rolling average FTE count		0.0	00		18. 00
19. 00	Current year resident to bed ratio (line 18 divided by		0. 00000			19.00
19.00	line 4).		0.00000	00		19.00
20. 00	Prior year resident to bed ratio (see instructions)		0. 00000	10		20.00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)		0. 00000			21. 00
22. 00	IME payment adjustment (see instructions)		0.0000	0		22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0		22. 01
22.0.	Indirect Medical Education Adjustment for the Add-on for Sect	ion 422 of t	he MMA	<u> </u>		1 22.0.
23. 00	Number of additional allopathic and osteopathic IME FTE		0.0	00		23. 00
	resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).					
24. 00	IME FTE Resident Count Over Cap (see instructions)		0.0	00		24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter		0.0			25. 00
	the lower of line 23 or line 24 (see instructions)					
26. 00	Resident to bed ratio (divide line 25 by line 4)		0.00000			26. 00
27. 00	IME payments adjustment factor. (see instructions)		0.00000	00		27. 00
20 00	IME add-on adjustment amount (see instructions)			0		28. 00
28. 00			1	0		28. 01
28. 01	IME add-on adjustment amount - Managed Care (see			U I		
28. 01	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment (sum of lines 22 and 28)			0		29. 00

Heal th	Financial Systems ME	MORIAL HOSP & H	EALTH CARE CT	R	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provi der	F	Period: From 07/01/2014 To 06/30/2015		pared: 52 am
			Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
			·	before 1/1	on/after 1/1		
			0	1. 00	1. 01	2. 00	
29. 01	Total IME payment - Managed Care (sum of line	es 22.01 and)		29. 01
	28.01) Di sproporti onate Share Adjustment						1
30. 00	Percentage of SSI recipient patient days to	Medicare Part		2. 82)		30.00
00.00	A patient days (see instructions)			2.02			00.00
31.00	Percentage of Medicaid patient days (see inst	tructions)		14. 67	'		31.00
32.00	Sum of lines 30 and 31	_		17. 49			32.00
33. 00	Allowable disproportionate share percentage	see		4. 12	2		33. 00
34. 00	instructions) Disproportionate share adjustment (see instru	ictions)		191, 703			34.00
01.00	prisproporti onate share daj astmert (see Tristro	30 (1 0113)		Pri or to		On/After	01.00
				October 1		October 1	
		0		1.00	1. 01	2. 00	
05.00	Uncompensated Care Adjustment			T 0 047 000 447		7 / 47 / 44 005	05.00
35. 00	Total uncompensated care amount (see instructions)			9, 046, 380, 143	5	7, 647, 644, 885	35. 00
35. 01	Factor 3 (see instructions)			0. 000008608	3	0. 000083679	35. 01
35. 02	Hospital uncompensated care payment (If			778, 744		639, 948	
	line 34 is zero, enter zero on this line)			·			
	(see instructions)						
35. 03	Pro rata share of the hospital uncompensated			196, 286		478, 646	35. 03
36. 00	care payment amount (see instructions) Total uncompensated care (sum of columns 1			674, 932	,		36. 00
30.00	and 2 on line 35.03)			074, 932			30.00
	Additional payment for high percentage of ESF	RD beneficiary o	discharges (Li	nes 40 through	46)		
40.00	Total Medicare discharges on Worksheet S-3,			(40. 00
	Part I excluding discharges for MS-DRGs 652,						
41. 00	682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding						41.00
41.00	MS-DRGs 652, 682, 683, 684 an 685. (see				,		41.00
	instructions)						
41.01	Total ESRD Medicare covered and paid				0		41. 01
	discharges excluding MS-DRGs 652, 682, 683,						
40.00	684 an 685. (see instructions)			0.00			40.00
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)			0.00	,		42. 00
43.00	Total Medicare ESRD inpatient days excluding						43.00
	MS-DRGs 652, 682, 683, 684 an 685. (see						
	instructions)						
44. 00	Ratio of average length of stay to one week			0.000000)		44. 00
	(line 43 divided by line 41 divided by 7 days)						
45. 00	Average weekly cost for dialysis treatments			0.00	0.00		45. 00
10.00	(see instructions)			0.00	0.00		10.00
46.00	Total additional payment (line 45 times line)		46. 00
	44 times line 41.01)						
47. 00	Subtotal (see instructions)			19, 541, 938	3		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals				,		48. 00
	only. (see instructions)						
49.00	Total payment for inpatient operating costs			19, 541, 938	3	•	49.00
	(see instructions)						
50. 00	Payment for inpatient program capital (from			1, 471, 303	3		50. 00
51. 00	Wkst. L, Pt. I and Pt. II, as applicable) Exception payment for inpatient program						51.00
31.00	capital (Wkst. L, Pt. III, see instructions)						31.00
52.00	Direct graduate medical education payment						52. 00
	(from Wkst. E-4, line 49 see instructions).						
53. 00	Nursing and Allied Health Managed Care)		53. 00
54. 00	payment						54.00
55. 00	Special add-on payments for new technologies Net organ acquisition cost (Wkst. D-4 Pt.						55. 00
55. 00	III, col. 1, line 69)						33.00
56.00	Cost of physicians' services in a teaching)		56.00
	hospital (see intructions)						
57. 00	Routine service other pass through costs)		57. 00
	(from Wkst. D, Pt. III, column 9, lines 30 through 35).						
58. 00	Ancillary service other pass through costs						58. 00
- 5. 50	from Wkst. D, Pt. IV, col. 11 line 200)						-0.00
59. 00	Total (sum of amounts on lines 49 through			21, 013, 241			59. 00
	58)						
60.00	Primary payer payments			26, 246			60.00
61. 00	Total amount payable for program beneficiaries (line 59 minus line 60)			20, 986, 995			61.00
62. 00	1			2, 300, 644			62. 00
	1			, , , , , , , , , , , , , , , , , , , ,	I .	1	1

Provi der CCN: 150115

Peri od:

From 07/01/2014

CALCULATION OF REIMBURSEMENT SETTLEMENT

Part A

Date/Time Prepared: 06/30/2015 11/23/2015 9:52 am Title XVIII Hospi tal Prior to On/After October 1 October 1 1. 01 n 2 00 1 00 Coinsurance billed to program beneficiaries 1, 216 63.00 Allowable bad debts (see instructions) 63, 996 64.00 65.00 Adjusted reimbursable bad debts (see 41, 597 65.00 instructions) 66.00 Allowable bad debts for dual eligible 8.588 66.00 beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 18, 726, 732 67.00 62 and 63) Credits received from manufacturers for 68.00 68.00 0 replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of 0 69.00 lines 93, 95 and 96). (For SCH see instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 70.00 70.00 (SPECLEY) 70.50 RURAL DEMONSTRATION PROJECT 70.50 0 Pioneer ACO demonstration payment adjustment 70.89 70.89 amount (see instructions) 70.90 HSP bonus payment HVBP adjustment amount C 70.90 (see instructions) HSP bonus payment HRR adjustment amount (see 70.91 0 70.91 instructions) 70.92 Bundled Model 1 discount amount (see 0 70.92 instructions) 70 93 HVBP payment adjustment amount (see 105, 362 70 93 instructions) 70 94 70 94 HRR adjustment amount (see instructions) 0 70. 95 Recovery of accelerated depreciation 0 70.95 70. 96 70.96 Low volume adjustment for federal fiscal 0 year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1) 70.97 70.97 Low volume adjustment for federal fiscal 0 year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) 70.98 Low Volume Payment-3 70. 98 70.99 HAC adjustment amount (see instructions) 162, 214 70.99 71.00 Amount due provider (line 67 minus lines 68 18, 669, 880 71.00 plus/minus lines 69 & 70) 71.01 Sequestration adjustment (see instructions) 373, 398 71.01 72.00 18, 199, 411 72.00 Interim payments 73.00 Tentative settlement (for contractor use 73.00 onl v) 74.00 Balance due provider (Program) (line 71 97, 071 74.00 minus lines 71.01, 72, and 73) 75.00 Protested amounts (nonallowable cost report 63, 653 75.00 items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) Operating outlier amount from Wkst. E, Pt. 0 90.00 90.00 A, line 2 (see instructions) 91.00 Capital outlier from Wkst. L, Pt. I, line 2 0 91.00 Operating outlier reconciliation adjustment 0 92.00 92.00 amount (see instructions) 93.00 Capital outlier reconciliation adjustment 0 93.00 amount (see instructions) 94.00 0.00 94.00 The rate used to calculate the time value of money (see instructions) 95.00 Time value of money for operating expenses 0 95.00 (see instructions) Time value of money for capital related 96.00 expenses (see instructions)

Health Financial Systems	MEMORIAL HOSP & HEAL	TH CARE CTI	R	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 150115	From 07/01/2014		
				To 06/30/2015	Date/Time Pre 11/23/2015 9:	pareu: 52 am_
		Ti tl	e XVIII	Hospi tal	PPS	
			Prior to 10/	′1	On/After 10/1	
			1.00	1. 01	2. 00	
HSP Bonus Payment Amount						
100.00 HSP bonus amount (see instructions)				0	0	100. 00
HVBP Adjustment for HSP Bonus Payment						
101.00 HVBP adjustment factor (see instructions)				0	0	101. 00
102.00 HVBP adjustment amount for HSP bonus paym	ent (see instructions)			0	0	102.00
HRR Adjustment for HSP Bonus Payment						
103.00 HRR adjustment factor (see instructions)			0.00	00	0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus payme	ent (see instructions)		[0	0	104. 00

Provider CCN: 150115

Peri od:

From 07/01/2014

06/30/2015

LOW VOLUME CALCULATION EXHIBIT 4

Part A Exhibit 4

Date/Time Prepared:

11/23/2015 9:52 am Title XVIII Hospi tal Period Prior Total (Col 2 W/S E, Part A Amounts (from Pre/Post Peri od to 10/01 On/After 10/01 line Part A) Entitlement through 4) 0 1 00 2 00 3 00 4 00 5 00 1.00 DRG amounts other than outlier 1.00 1.00 1.01 DRG amounts other than outlier 1.01 4, 652, 967 1.01 payments for discharges occurring prior to October 1 1 02 1.02 DRG amounts other than outlier 1 02 13, 958, 900 0 18, 611, 867 18, 611, 867 payments for discharges occurring on or after October DRG for Federal specific 1.03 0 1.03 1.03 operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific 1.04 1.04 operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for 63.436 2 00 63.436 63, 436 2.00 discharges (see instructions) 2.01 Outlier payments for 2.02 C 2.01 discharges for Model 4 BPCI Operating outlier 0 3.00 2.01 3.00 reconciliation 4.00 4.00 Managed care simulated 0 3.00 payments Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part 21.00 0.000000 0.000000 0.000000 0.000000 5.00 A, line 21 (see instructions) 6.00 IME payment adjustment (see 22.00 0 0 0 6.00 instructions) 6.01 IME payment adjustment for 22.01 C 6.01 managed care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 0.000000 7.00 0.000000 0.000000 0.000000 7 00 IME payment adjustment factor 27 00 (see instructions) 8.00 IME adjustment (see 28.00 0 8.00 0 instructions) 8.01 IME payment adjustment add on 28.01 8.01 for managed care (see instructions) 9.00 Total IME payment (sum of 29.00 0 9.00 lines 6 and 8) 9.01 Total IME payment for managed 29.01 9.01 care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate 33.00 0.0412 0.0412 0.0412 0.0412 10.00 share percentage (see instructions) 11.00 Di sproporti onate share 34.00 191.703 0 191.703 191, 703 11.00 adjustment (see instructions) 11.01 Uncompensated care payments 36.00 674.932 196, 286 478, 646 674, 932 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment 46. 00 12.00 (see instructions) 13 00 47.00 19, 541, 938 196, 286 19, 345, 652 19, 541, 938 Subtotal (see instructions) 13 00 14.00 Hospital specific payments 48.00 14.00 (completed by SCH and MDH, small rural hospitals only.) (see instructions) 49.00 15.00 Total payment for inpatient 19, 541, 938 196, 286 19, 345, 652 19, 541, 938 15.00 operating costs (see instructions) Payment for inpatient program 50.00 1, 471, 303 0 1, 471, 303 1, 471, 303 16.00 16.00 capi tal 17.00 Special add-on payments for 54.00 17.00 0 0 new technologies 17 01 55 00 O Net organ aquisition cost 17 01 Credits received from 68.00 C 17.02 17.02 manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 18.00 adjustment amount (see instructions)

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 150115 Peri od: Worksheet E From 07/01/2014 Part A Exhibit 4
Date/Time Prepared: 06/30/2015 11/23/2015 9:52 am Title XVIII Hospi tal W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od Part A) to 10/01 On/After 10/01 line Ε, Entitlement through 4) 4 00 0 1 00 2 00 3.00 5 00 19.00 SUBTOTAL 20, 816, 955 196, 286 21, 013, 241 19. 00 W/S L, line (Amounts from L) 1.00 2.00 3.00 5. 00 0 4.00 20.00 Capital DRG other than outlier 1, 467, 580 1, 467, 580 1, 467, 580 20.00 1 00 0 20.01 Model 4 BPCI Capital DRG other 1.01 0 20.01 than outlier 21.00 Capital DRG outlier payments 2.00 3,723 0 3, 723 3, 723 21.00 Model 4 BPCI Capital DRG 0 21.01 21.01 2.01 outlier payments 22.00 Indirect medical education 5.00 0.0000 0.0000 0.0000 0.0000 22.00 percentage (see instructions) Indirect medical education 23.00 23.00 6.00 0 adjustment (see instructions) Allowable disproportionate 0.0000 0.0000 24.00 10.00 0.0000 0.0000 24.00 share percentage (see instructions) 25.00 Di sproporti onate share 11.00 0 0 25.00 adjustment (see instructions) Total prospective capital 26.00 12.00 1, 471, 303 0 1, 471, 303 1, 471, 303 26.00 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 1.00 2.00 3.00 4.00 5.00 27.00 Low volume adjustment factor 0.000000 0.000000 27. 00 Low volume adjustment 70.96 28.00 28.00 (transfer amount to Wkst. E, Pt. A, line) Low volume adjustment 70.97 29.00 (transfer amount to Wkst. E, Pt. A. line) 100.00 Transfer low volume 100.00 adjustments to Wkst. E, Pt. A.

Provider CCN: 150115

Peri od:

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

From 07/01/2014 Part A Exhibit 5 Date/Time Prepared: 06/30/2015 11/23/2015 9:52 am Hospi tal Title XVIII Period to Total (cols. 2 Wkst. E, Pt. Amt. from Period 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 4, 652, 967 4, 652, 967 4, 652, 967 1.01 discharges occurring prior to October 1 DRG amounts other than outlier payments for 1.02 1.02 13, 958, 900 13, 958, 900 13, 958, 900 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 1.04 0 0 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 63, 436 63, 436 63, 436 2.00 0 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 C 0 2.01 0 **BPCI** Operating outlier reconciliation 3 00 2 01 O 0 0 3 00 4.00 Managed care simulated payments 3.00 0 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) 6 00 IME payment adjustment (see instructions) 22 00 0 0 0 6 00 IME payment adjustment for managed care (see 0 0 6.01 22.01 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 0.000000 0.000000 7.00 IME payment adjustment factor (see 27.00 0.000000 instructions) 8.00 IME adjustment (see instructions) 28.00 0 8.00 IME payment adjustment add on for managed 8.01 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 9.00 29.00 0 0 0 9.00 9.01 Total IME payment for managed care (sum of 29.01 C 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage 10.00 0.0412 0.0412 0.0412 10.00 33.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 191, 703 47, 926 143.777 191, 703 11.00 instructions) 196, 286 11.01 Uncompensated care payments 36.00 674, 932 478, 646 674, 932 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment (see 12 00 12 00 46 00 0 0 instructions) 13.00 Subtotal (see instructions) 47.00 19, 541, 938 4, 897, 179 14, 644, 759 19, 541, 938 13.00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 19, 541, 938 15.00 49.00 19, 541, 938 4, 897, 179 14, 644, 759 15.00 (see instructions) 16.00 Payment for inpatient program capital 50.00 1, 471, 303 1, 471, 303 1, 471, 303 16.00 Special add-on payments for new technologies 17.00 54.00 0 17.00 55.00 Net organ aquisition cost 0 17.01 17.01 C 0 0 17.02 Credits received from manufacturers for 68.00 0 0 0 17.02 replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment 18.00 93.00 0 18.00 amount (see instructions) 4, 897, 179 19 00 SUBTOTAL 16, 116, 062 21, 013, 241 19. 00

Heal th	Financial Systems ME	MORIAL HOSP & H	HEALTH CAR	E CTF	₹	In Li€	eu of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi			Period: From 07/01/2014 To 06/30/2015	Date/Time Pre 11/23/2015 9:	pared:
				Ti tl	e XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. fr					
			Wkst. L	_)				
	,	0	1.00		2. 00	3. 00	4. 00	
20. 00	Capital DRG other than outlier	1. 00	1, 467	7, 580	1	0 1, 467, 580	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] 3	3, 723		0 3, 723	1	
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01		0	1	0 0	0	1
22. 00	Indirect medical education percentage (see	5. 00	0.	0000	0.000	0.0000)	22. 00
23. 00	<pre>instructions) Indirect medical education adjustment (see instructions)</pre>	6.00		0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0.	0000	0.000	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	1, 471	, 303		0 1, 471, 303	1, 471, 303	26. 00
		Wkst. E, Pt. A, line	(Amt. fr Wkst. E, 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		0	1	0	0	28. 00
29.00	Low volume adjustment on or after October 1	70. 97		0)	C	o l	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	105	, 362		0 105, 362	105, 362	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90		0		0 0	0	30. 01
31. 00	HRR adjustment (see instructions)	70. 94		0)	0 0	0	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91		0		0 0	0	31. 01
							(Amt. to Wkst. E, Pt. A)	
		0	1.00		2.00	3. 00	4.00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99				0 162, 214	162, 214	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y					100. 00

Health Financial Systems	MEMORIAL HOSP & HEALT	H CARE CTR	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150115	From 07/01/2014	Worksheet E Part B Date/Time Prepared: 11/23/2015 9:52 am
		T: +1 - \/\/1.1.1	11: 4-1	DDC

			10 06/30/2015	11/23/2015 9:	
-		Title XVIII	Hospi tal	PPS	<u> </u>
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			22, 672	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		19, 265, 539	
3.00	PPS payments			20, 774, 770	
4.00	Outlier payment (see instructions)			23, 048	
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	
6.00	Line 2 times line 5			0	
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	
8. 00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		0	
10. 00	Organ acquisitions			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			22, 672	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
40.00	Reasonable charges			00.045	
12. 00	Ancillary service charges			99, 365	1
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	ie 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			99, 365	14. 00
45.00	Customary charges				4- 00
15. 00	Aggregate amount actually collected from patients liable for pa			0	
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(e)			0 000000	47.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00	Total customary charges (see instructions)	. ! & ! 10	11) (99, 365	
19. 00	Excess of customary charges over reasonable cost (complete only	TIT TIME 18 exceeds II	ne II) (See	76, 693	19. 00
20.00	instructions)	ifling 11 ayaaada li	no 10) (coo		20. 00
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	II Tine II exceeds II	ne 18) (See	0	20.00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		22, 672	21.00
22. 00	Interns and residents (see instructions)	Tristructions)		22, 0/2	
23. 00	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	ictions)		20, 797, 818	1
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			20, 797, 818	24.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH see instructions)		4, 309, 820	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl		and 231 (see	16, 510, 670	
27.00	instructions)	ds the sum of filles 22	una 20] (300	10,010,070	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	ie 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	,		0	
30. 00	Subtotal (sum of lines 27 through 29)			16, 510, 670	
31. 00	Primary payer payments			12, 437	
32. 00	Subtotal (line 30 minus line 31)			16, 498, 233	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)		,,	1
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34. 00	Allowable bad debts (see instructions)			341, 774	
35. 00	Adjusted reimbursable bad debts (see instructions)			222, 153	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ıctions)		263, 997	
37. 00				16, 720, 386	
	MSP-LCC reconciliation amount from PS&R				38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			Ō	
39. 98	Partial or full credits received from manufacturers for replace		tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	(,	0	39. 99
40. 00	Subtotal (see instructions)			16, 720, 752	40.00
40. 01	Sequestration adjustment (see instructions)			334, 415	
41. 00	Interim payments			16, 338, 843	
42. 00	Tentative settlement (for contractors use only)			0	
43. 00	Balance due provider/program (see instructions)			47, 494	
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2	chapter 1	0	
44.00	§115. 2	e with the construction is 2,	chapter 1,	l	14.00
	TO BE COMPLETED BY CONTRACTOR				1
90. 00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			Ö	
	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)				94. 00
00	1		ļ		,

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15011!		Worksheet E
		From 07/01/2014	Part B
	Component CCN: 15530	5 To 06/30/2015	Date/Time Prepared:
	·		11/23/2015 9:52 am
	Title XVIII	Skilled Nursing	PPS

	Title XVIII Skilled Nursing Facility	PPS	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	138	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2. 00
3.00	PPS payments		3. 00
4.00	Outlier payment (see instructions)		4.00
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5	o	5. 00 6. 00
7. 00	Sum of line 3 plus line 4 divided by line 6	0.00	
8.00	Transitional corridor payment (see instructions)	0.00	8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	ő	9. 00
10.00	Organ acqui si ti ons	o	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	138	
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12. 00	Ancillary service charges		12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	606	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	ا	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17. 00
18.00	Total customary charges (see instructions)	606	18. 00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	468	19. 00
	instructions)		
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20. 00
21 00	instructions)	120	21 00
21. 00 22. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) Interns and residents (see instructions)	0	21. 00 22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	
21.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	J	21.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)	0	25. 00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	138	27. 00
	instructions)	_	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29. 00
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments	138 0	30. 00 31. 00
32. 00	Subtotal (line 30 minus line 31)	138	
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	100	02.00
33.00		0	33. 00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36. 00
37. 00		138	
38. 00	MSP-LCC reconciliation amount from PS&R		38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	0	39. 00 39. 50
39. 50 39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 30
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
40. 00	Subtotal (see instructions)	138	
40. 01	Sequestration adjustment (see instructions)	3	40. 01
41.00	Interim payments	131	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	4	43.00
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44. 00
	§115. 2		
00 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)		00 00
90. 00 91. 00	Outlier reconciliation adjustment amount (see instructions)		90. 00 91. 00
91.00	The rate used to calculate the Time Value of Money		91.00
93. 00	Time Value of Money (see instructions)		93. 00
	Total (sum of lines 91 and 93)	ļ	94. 00
	· '	'	

(Mo/Day/Yr)

2 00

8.00

Number

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 150115 Peri od: Worksheet E-1 From 07/01/2014 Part I 06/30/2015 Date/Time Prepared: 11/23/2015 9:52 am Title XVIII Hospi tal PPS Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 18, 199, 411 16, 338, 843 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 0 3.02 0 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 0 3.51 0 0 3.52 3.52 0 3.53 0 3.53 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.99 3.50-3.98) 18, 199, 411 16, 338, 843 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 97, 071 47, 494 6.01 6 02 SETTLEMENT TO PROGRAM 0 6.02 7.00 Total Medicare program liability (see instructions) 18, 296, 482 16, 386, 337 7.00 Contractor NPR Date

8.00 Name of Contractor

Health Financial Systems MEMORIA ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Impatient Part A			11 11	e XVIII	Subprovider - IPF	PPS	
1.00			Innatien	t Part A			
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			mpatren		Tui		
1.00							
Interim payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or neter a zero.			1. 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						_	
Services rendered in the cost reporting period. If none, write "NONE" or netre a zero.	2.00			0		0	2.00
write "NONE" or enter a zero .0 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider .0 0 0 3.02 .03 .03 0 0 0 3.03 .04 0 0 0 3.03 .05 .07 .00 0 0 3.05 .00 0 0 0 3.05 .00 0 0 0 3.05 .00 0 0 0 3.05 .00 0 0 0 3.05 .00 0 0 0 3.05 .00 0 0 0 0 3.05 .00 0 0 0 0 3.05 .00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
3.00 State separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		1 91					
amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment, If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.04 3.05 Provider to Program 3.51 3.52 ADJUSTMENTS TO PROGRAM ADJUSTMENTS ADJUSTMENTS TO PROGRAM ADJUSTMENTS TO PRO	3.00						3.00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02					T	T	
3.03 0		ADJUSTMENTS TO PROVIDER					
3. 04							
ADJUSTMENTS TO PROGRAM							
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.50							
ADJUSTMENTS TO PROGRAM	3.03	Provider to Program				0	3.03
3.52 3.53 3.54 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50 3.50 3.99 3.50	3.50			0		0	3. 50
3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.54 3.54 3.59 3.50-3.98 0 0 0 0 3.59 3.50-3.98 0 0 0 0 3.59 3.50-3.98 0 0 0 0 3.59 3.50-3.98 0 0 0 0 3.59 0 0 0 3.59 0 0 0 0 3.59 0 0 0 0 3.59 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 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 0 3.54 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,870,816 0 4.00 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3.52			0		0	3. 52
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98) 4.00 3.50-3.98) 1,870,816 0 4.00 4.00 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR	3.53			0			3. 53
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) 1,870.816 0 4.00							
A. 00 Total interim payments (sum of lines 1, 2, and 3.99) 1,870,816 0 4.00	3. 99	· ·		0		0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	4 00			1 070 014			4 00
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			1,870,816		0	4.00
TO BE COMPLETED BY CONTRACTOR Solution							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					II.		
Write "NONE" or enter a zero. (1) Program to Provider	5.00	List separately each tentative settlement payment after					5.00
Program to Provider							
TENTATI VE TO PROVIDER							
Solution Solution	E 04						F 04
Solution Solution		TENTATIVE TO PROVIDER					
Provider to Program							
TENTATI VE TO PROGRAM	5.05	Provider to Program					3.03
5.51	5.50			0		0	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 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00				0		0	
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5.52			0		0	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 99			0		0	5. 99
the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00							
6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00	6.00	,					6.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6 01			6 047		_	6.01
7.00 Total Medicare program liability (see instructions) 1,877,683 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							1
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				1		_	
Number (Mo/Day/Yr) 0 1.00 2.00		(((((((((((((((((((., ., ., , 300			1.00
8.00 Name of Contractor 8.00			()	1. 00	2. 00	
	8.00	Name of Contractor					8.00

Health Financial Systems MEMORIA
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		Ti tl	e XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 471, 732		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		0		0	2. 00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			T		
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02 3. 03			0		0	3. 02 3. 03
3. 03			0			3. 03
3. 05			0		0	3. 05
3.03	Provider to Program				0	3.03
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		1, 471, 732		0	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		1,4/1,/32		U	4.00
	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)					
F 01	Program to Provider TENTATIVE TO PROVIDER		0			F 01
5. 01 5. 02	TENTATIVE TO PROVIDER		0		0	5. 01 5. 02
5. 02			0			5. 02
5.05	Provider to Program					3.03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5.52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		11, 378		0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 460, 354		Ö	7. 00
			, ,	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor			l		8. 00

Health Financial Systems MEMORIA ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		וו דו	e XVIII	Facility	PPS	
		Innation	t Part A		t B	
		<u> </u>				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 300, 449		131	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3. 05	Provider to Program		0		0	3. 05
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	ADSUSTINIENTS TO TROUBLAND		0		0	3. 51
3. 52			Ö		ő	3. 52
3. 53			ő		o	3. 53
3.54			0		0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 300, 449		131	4. 00
	(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					5. 00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provi der to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51 5. 52			0		0	5. 51 5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
J. 77	5. 50-5. 98)					5. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVI DER		5, 648		4	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		1, 306, 097		135	7. 00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor)	1.00	∠. ∪∪	8. 00
0.00	maine of sofiti detai			ļ	ı	0.00

Heal th	Financial Systems MEMORIAL HOSP & HEAL	TH CARE CTR	In lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 150115	Peri od: From 07/01/2014 To 06/30/2015	Worksheet E-1 Part II Date/Time Prep 11/23/2015 9:	pared:
		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	Total hospital discharges as defined in AARA §4102 from Wkst. S	S-3, Pt. I col. 15 line	14	5, 941	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-1	12		7, 963	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			365	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-1	12		15, 175	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			323, 859, 537	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lir	ne 20		3, 216, 273	6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of cer	tified HIT technology	Wkst. S-2, Pt. I	0	7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)			1, 229, 881	8. 00
9.00	Sequestration adjustment amount (see instructions)			24, 598	9. 00
10.00	Calculation of the HIT incentive payment after sequestration (s	see instructions)		1, 205, 283	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)	·		1, 187, 998	30.00
31.00	Other Adjustment (specify)			0	31.00
22 00	Delenge due provider (line 0 (or line 10) minus line 20 and lin	o 21) (coo i notrusti on	a)	17 205	22 00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

187, 998 30. 00 0 31. 00 17, 285 32. 00

Health Financial Systems	MEMORIAL HOSP & HEALTH (CARE CTR	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pr	Provider CCN: 150115	Peri od: From 07/01/2014	Worksheet E-3
	Co	Component CCN: 15S115	To 06/30/2015	
		Title XVIII	Subprovi der -	PPS

		THE CONTIN	I PF	110	
				1. 00	
PART II - MEDICARE	PART A SERVICES - IPF PPS			1.00	
	S Payments (excluding outlier, ECT, and medic	al education payments)		2, 113, 011	1 -
00 Net IPF PPS Outlier		ar sausarren paymente,		22, 989	
00 Net IPF PPS ECT Pay	3			0	3
- 1	and resident FTE count in the most recent cos	t report filed on or b	efore November	0.00	
15, 2004. (see ins		t 19port 1110a on or 2		0.00	
Cap increases for program or hospital CFR §412.424(d)(1)	the unweighted intern and resident FTE count closure, that would not be counted without (iii)(F)(1) or (2) (see instructions)			0.00	2
	am adjustment. (see instructions)			0. 00	
	eighted FTE count of I&R excluding FTEs in th	e new program growth p	eriod of a "new	0. 00	(
teaching program"					١.
teachi ng program"				0.00	
1	count for IPF PPS medical education adjustm	ent (see instructions)		0.00	
	us (see instructions)			10. 301370	
5 5	Factor {((1 + (line 8/line 9)) raised to th	e power of .5150 -1}.		0. 000000	
5 5	(line 1 multiplied by line 10).			0	1
1 3	PPS Payments (sum of lines 1, 2, 3 and 11)			2, 136, 000	
	Health Managed Care payment (see instruction)		0	
	(DO NOT USE THIS LINE)				1
	services in a teaching hospital (see instru	ctions)		0	
00 Subtotal (see insti				2, 136, 000	
OO Primary payer payme				0	1 '
00 Subtotal (line 16 l	ess line I/).			2, 136, 000	
Deductibles				197, 860	
00 Subtotal (line 18 m	ninus line 19)			1, 938, 140	
OO Coinsurance				29, 115	
00 Subtotal (line 20 r				1, 909, 025	
	s (exclude bad debts for professional service	s) (see instructions)		10, 736	
1 -	ole bad debts (see instructions)			6, 978	
	s for dual eligible beneficiaries (see instru	CTI ONS)		8, 304	
00 Subtotal (sum of li		10)		1, 916, 003	
ũ	dical education payments (from Wkst. E-4, lin	e 49)		0	2
	costs (see instructions)			0	
Outlier payments re				0	
1	(SEE INSTRUCTIONS) (SPECIFY)			0	3
1	cration payment adjustment (see instructions)			0	
Recovery of Accel er	•			0	1 ~
	e to the provider (see instructions)			1, 916, 003	
1 .	stment (see instructions)			38, 320	
00 Interim payments	1.76			1, 870, 816	
1	nt (for contractor use only)	22)		0	
	er/program (line 31 minus lines 31.01, 32 and	,		6, 867	
§115. 2	(nonallowable cost report items) in accordanc	e with CMS Pub. 15-2,	chapter i,	0	3
TO BE COMPLETED BY				22.000	۱.
9	mount from Worksheet E-3, Part II, line 2			22, 989	
1	ion adjustment amount (see instructions)			0	
4	alculate the Time Value of Money			0.00	
00 Time Value of Money	(See Instructions)			0	5

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR	In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150115		Worksheet E-3	
		From 07/01/2014		
	Component CCN: 15T11	5 To 06/30/2015	Date/Time Prepared:	
			11/23/2015 9:52 am	
	Title XVIII	Subprovi der -	PPS	
		IRF		

	İRF		
		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1.00	Net Federal PPS Payment (see instructions)	1, 483, 767	1. 00
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0064	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	8, 309	3. 00
4. 00	Outlier Payments	23, 280	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior		5. 00
	to November 15, 2004 (see instructions)		
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	7.00
	teaching program" (see instructions)		
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	8.00
	teaching program" (see instructions)		
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00
10. 00	Average Daily Census (see instructions)	3. 657534	
11. 00	Teaching Adjustment Factor (see instructions)	0. 000000	
12. 00	Teaching Adjustment (see instructions)	0	12. 00
13. 00	Total PPS Payment (see instructions)	1, 515, 356	13. 00
14. 00	Nursing and Allied Health Managed Care payments (see instruction)	0	14. 00
15. 00	Organ acquisition (DO NOT USE THIS LINE)		15. 00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17. 00	Subtotal (see instructions)	1, 515, 356	17. 00
18.00	Primary payer payments	7, 695	
19.00	Subtotal (line 17 less line 18).	1, 507, 661	19. 00
20.00	Deductibles	14, 768	
21. 00	Subtotal (line 19 minus line 20)	1, 492, 893	
22. 00	Coinsurance	2, 736	
23. 00	Subtotal (line 21 minus line 22)	1, 490, 157	23. 00
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24. 00 25. 00
25. 00	Adjusted reimbursable bad debts (see instructions)		
26. 00 27. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1 400 157	26. 00 27. 00
28. 00	Subtotal (sum of lines 23 and 25)	1, 490, 157 0	28.00
29. 00	Direct graduate medical education payments (from Wkst. E-4, line 49) Other pass through costs (see instructions)		29. 00
30.00	Outlier payments reconciliation		30.00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		31. 00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)		31. 50
31. 99	Recovery of Accel erated Depreciation		31. 99
32. 00	Total amount payable to the provider (see instructions)	1, 490, 157	32. 00
32. 01	Sequestration adjustment (see instructions)	29, 803	
33. 00	Interim payments	1, 471, 732	33. 00
34. 00	Tentative settlement (for contractor use only)	0	34. 00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	-11, 378	
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	36. 00
	§115. 2	_	
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	23, 280	50.00
51.00		0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
		·	

	· · · · · · · · · · · · · · · · · · ·	SP & HEALTH CARE CTR		u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150115	Peri od:	Worksheet E-3	
		Component CCN: 155305	From 07/01/2014 To 06/30/2015		narod:
		Component Con. 133303	10 00/30/2013	11/23/2015 9:	52 am
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - SERVICES	ALL OTHER HEALTH SERVICES FOR T	ITLE XVIII PART A	A PPS SNF	
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1. 00	Resource Utilization Group Payment (RUGS)			1, 506, 628	1. 00
2. 00	Routine service other pass through costs			0	2. 00
3.00	Ancillary service other pass through costs		0	3. 00	
4.00	Subtotal (sum of lines 1 through 3)		1, 506, 628	4. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as v	accine costs are included in lin	e 1 of W/S E,		5. 00
	Part B. This line is now shaded.)				
6. 00	Deducti bl e			0	6. 00
7. 00	Coinsurance			179, 639	7. 00
8. 00	Allowable bad debts (see instructions)			7, 947	8. 00
9. 00	Reimbursable bad debts for dual eligible beneficiarie	s (see instructions)		5, 427	9. 00
10. 00	Adjusted reimbursable bad debts (see instructions)			5, 763	
	Utilization review			0	11. 00
	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus	lines 10 and 11)(see instruction	ns)	1, 332, 752	
13. 00	Inpatient primary payer payments			0	13. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	14. 00
	Pioneer ACO demonstration payment adjustment (see ins	tructi ons)		0	14. 50
	Recovery of Accelerated Depreciation			0	14. 99
	Subtotal (see instructions			1, 332, 752	
	Sequestration adjustment (see instructions)			26, 655	
16 00	Interim navments			1 300 440	1 16 00

18.00 Balance due provider/program (line 15 minus lines 15.01, 16, and 17)
19.00 Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2

16.00

18.00 19. 00

1, 300, 449

0 17.00

5, 648

16.00

Interim payments

17.00 Tentative settlement (for contractor use only)

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

Provi der CCN: 150115 | Peri od: From 07/01/2014

Peri od: Worksheet G From 07/01/2014 To 06/30/2015 Date/Time Prepared: 11/23/2015 9:52 am

			'	0 00/30/2013	11/23/2015 9:	
	<u> </u>	General Fund	Speci fi c	Endowment 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	56, 390, 183	B	O	0	1.00
2.00	Temporary investments	938, 519		o	0	2. 00
3.00	Notes receivable	C	0	0	0	3. 00
4.00	Accounts receivable	24, 785, 862	2 0	0	0	4. 00
5.00	Other recei vable	0	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0		0	0	6.00
7. 00 8. 00	Inventory Prepai d expenses			0	0	7. 00 8. 00
9. 00	Other current assets	7, 831, 992		0	0	9.00
10. 00	Due from other funds	0		o	0	10.00
11. 00	Total current assets (sum of lines 1-10)	89, 946, 556	o .	О	0	11.00
	FIXED ASSETS					
12. 00	Land	7, 585, 948	1	_	0	12.00
13. 00	Land improvements	0	0		0	13. 00
14. 00	Accumulated depreciation	100 001 070		0	0	14.00
15. 00 16. 00	Buildings Accumulated depreciation	109, 931, 972 -56, 995, 535	1	0	0	15. 00 16. 00
17. 00	Leasehold improvements	-30, 993, 333		0	0	17. 00
18. 00	Accumulated depreciation			Ö	0	18. 00
19. 00	Fi xed equipment	95, 665, 287	d	Ö	0	19. 00
20.00	Accumulated depreciation	-61, 201, 729	o c	0	0	20. 00
21. 00	Automobiles and trucks	C) c	0	0	21. 00
22. 00	Accumul ated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	0		0	0	23. 00
24. 00 25. 00	Accumulated depreciation	0		0	0	24. 00 25. 00
26. 00	Minor equipment depreciable Accumulated depreciation				0	26.00
27. 00	HIT designated Assets			_	0	27. 00
28. 00	Accumulated depreciation		ol o	Ö	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	C		0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	94, 985, 943	3 C	0	0	30.00
	OTHER ASSETS					
31. 00	Investments	62, 013, 741			0	31.00
32. 00	Deposits on leases	0		_	0	32. 00 33. 00
33. 00 34. 00	Due from owners/officers Other assets	2, 474, 788) C		0	34.00
35. 00	Total other assets (sum of lines 31-34)	64, 488, 529		_	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	249, 421, 028	1	_	0	36. 00
	CURRENT LIABILITIES					
37.00	Accounts payable	4, 465, 543		0	0	37. 00
38. 00	Salaries, wages, and fees payable	14, 695, 013	B C	0	0	38. 00
39. 00	Payroll taxes payable	0		0	0	39. 00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	1, 615, 000		0	0	40. 00 41. 00
42. 00	Accel erated payments	3, 767, 400		U	0	42.00
43. 00	Due to other funds	3,707,400	ól c	0	0	43. 00
44. 00	Other current liabilities	Ö		Ö	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	24, 542, 956	o c	o	0	
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	0	_	0	46. 00
47. 00	Notes payable	55, 047, 095			0	47.00
48. 00 49. 00	Unsecured Loans Other Long term Liabilities			_	0	48. 00 49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49	55, 047, 095			0	50.00
51. 00	Total liabilites (sum of lines 45 and 50)	79, 590, 051		_	0	51.00
01100	CAPI TAL ACCOUNTS	7,70,0700	· · · · · · ·	٥,		0 00
52.00	General fund balance	169, 830, 977	7			52. 00
53.00	Specific purpose fund		0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0	0	56.00
57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	57. 00 58. 00
აი. 00	replacement, and expansion				0	30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	169, 830, 977	, c	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	249, 421, 028		o	0	60.00
	[59]		1			

19.00

STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 150115 Peri od: Worksheet G-1 From 07/01/2014 06/30/2015 Date/Time Prepared: 11/23/2015 9:52 am General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 165, 358, 962 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 5, 032, 110 2.00 Total (sum of line 1 and line 2) 3.00 170, 391, 072 0 3.00 4.00 FOUNDATION EXPENSE 0 -1, 156, 454 0 4.00 5.00 0 5.00 6.00 0 6.00 0 0 7.00 0 7.00 0 8.00 0 8.00 0 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) -1, 156, 454 10.00 Subtotal (line 3 plus line 10) 169, 234, 618 0 11.00 11.00 12.00 NET ASSETS RELEASED -596, 359 0 12.00 13.00 13.00 14.00 0 14.00 0 0 0 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 -596, 359 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 169, 830, 977 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 FOUNDATION EXPENSE 4.00 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 0 0 Subtotal (line 3 plus line 10) 11.00 12.00 NET ASSETS RELEASED 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00

0

0

0

18.00

19.00

Fund balance at end of period per balance

sheet (line 11 minus line 18)

Provi der CCN: 150115

Peri od:

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

From 07/01/2014 Parts I & II Date/Time Prepared: 06/30/2015 11/23/2015 9:52 am Cost Center Description Inpati ent Outpati ent Total 1.00 2. 00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 19, 452, 714 19, 452, 714 1.00 2.00 SUBPROVIDER - IPF 4, 376, 952 4, 376, 952 2.00 SUBPROVIDER - IRF 1, 359, 170 3.00 1, 359, 170 3.00 4.00 SUBPROVI DER 4.00 5.00 Swing bed - SNF 5.00 Swing bed - NF 6.00 6.00 0 0 SKILLED NURSING FACILITY 7.00 1, 465, 117 1, 465, 117 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) 26, 653, 953 26, 653, 953 10 00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 6, 898, 676 6, 898, 676 11.00 12.00 CORONARY CARE UNIT 12.00 BURN INTENSIVE CARE UNIT 13 00 13 00 14.00 SURGICAL INTENSIVE CARE UNIT 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 Total intensive care type inpatient hospital services (sum of lines 16, 00 6, 898, 676 6, 898, 676 16,00 11 - 15) 17.00 33, 552, 629 33, 552, 629 Total inpatient routine care services (sum of lines 10 and 16) 17.00 18.00 Ancillary services 81, 843, 052 248, 780, 901 330, 623, 953 18.00 19.00 Outpatient services 19.00 0 Ω RURAL HEALTH CLINIC 686, 785 20.00 0 686, 785 20.00 20.01 RURAL HEALTH CLINIC II 0 0 0 20.01 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 21.00 HOME HEALTH AGENCY 2, 093, 608 2, 093, 608 22.00 22.00 AMBULANCE SERVICES 23.00 1, 100, 036 2, 662, 342 3, 762, 378 23.00 24.00 CMHC 24.00 AMBULATORY SURGICAL CENTER (D. P.) 25.00 25.00 26.00 HOSPI CE 0 0 26.00 PHYSI CLANS 46, 733, 172 27.00 \cap 46, 733, 172 27.00 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 116, 495, 717 300, 956, 808 417, 452, 525 28.00 line 1) PART II - OPERATING EXPENSES 29.00 190, 899, 121 29 00 Operating expenses (per Wkst. A, column 3, line 200) 30.00 ADD (SPECIFY) 0 30.00 31.00 31.00 32.00 0 32.00 0 33.00 33.00 0 34.00 34.00 35.00 0 35.00 Total additions (sum of lines 30-35) 36, 00 0 36, 00 37.00 37.00 38.00 0 38.00 39.00 39.00 0 40.00 40.00 0 41.00 41.00 42.00 Total deductions (sum of lines 37-41) 42.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 190, 899, 121 43.00 43.00 to Wkst. G-3, line 4)

	MENODIAL HOOD A HEAL	TH CARE OTE		6.5. 000.0	2550 40			
	Th Financial Systems MEMORIAL HOSP & HEAL			u of Form CMS-2	2552-10			
STAT	EMENT OF REVENUES AND EXPENSES	Provi der CCN: 150115	Peri od: From 07/01/2014	Worksheet G-3				
			To 06/30/2015	Date/Time Pre	pared.			
				11/23/2015 9:				
				1. 00				
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		417, 452, 525	1. 00			
2.00	Less contractual allowances and discounts on patients' accounts	6		227, 229, 497	2. 00			
3.00	Net patient revenues (line 1 minus line 2)			190, 223, 028	3. 00			
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		190, 899, 121	4. 00			
5.00	Net income from service to patients (line 3 minus line 4)			-676, 093	5. 00			
	OTHER I NCOME							
6.00	Contributions, donations, bequests, etc			0 227, 870	6. 00 7. 00			
7.00	7.00 Income from investments							
8.00	Revenues from telephone and other miscellaneous communication s	servi ces		0	8. 00			
9.00				0	9. 00			
10.0				0	10.00			
11. C				0	11. 00			
12.0				0	12. 00			
13.0				0	13. 00			
14. C	Revenue from meals sold to employees and guests			599, 395	14. 00			
15. C	3 1			0	15. 00			
16. C		an patients		0	16. 00			
17. C	1			214, 810				
18.0				0	18. 00			
19. C				0	19. 00			
20.0	3			0	20. 00			
21. 0				406	21. 00			
22. 0				0	22. 00			
23.0				0	23. 00			
24.0	MI SCELLANEOUS			4, 665, 722	24. 00			

5, 032, 110 29. 00

25.00

26. 00

28. 00

0 27.00

5, 708, 203

5, 032, 110

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

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)

27. 00 OTHER EXPENSES (SPECIFY)

Health Financial Systems	MEI	MORIAL HOSP &	HEALTH CARE CT	R	In Lie	u of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED HOME HEALT	H AGENCY COSTS		Provi der	CCN: 150115		Worksheet H
					From 07/01/2014	
			HHA CCN:	157222	To 06/30/2015	Date/Time Prepared:
						11/23/2015 9:52 am
					Home Health	PPS
					Agency I	
	Sal ari es	Empl oyee	Transportati or	nContracted/P	ur Other Costs	Total (sum of

				TITIA CCN.	137222 1	0 00/30/2013	11/23/2015 9:	
						Home Health	PPS	
		Sal ari es	Employee	Transportation	Contracted/Pur	Agency I Other Costs	Total (sum of	
		Sai ai i es	Benefits	(see	chased	Other costs	cols. 1 thru	
				instructions)	Servi ces		5)	
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
4 00	GENERAL SERVICE COST CENTERS	1		1	ı	1 0	· ·	1 4 00
1. 00	Capital Related - Bldg. & Fixtures					0	0	1. 00
2.00	Capital Related - Movable					0	0	2. 00
	Equi pment						_	
3.00	Plant Operation & Maintenance	0	C	0	C	0	0	3. 00
4.00	Transportation	0	C	_	C	0	0	4. 00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	343, 408	C		53, 263	87, 234	483, 905	5. 00
6. 00	Skilled Nursing Care	583, 226	C	61, 223) 0	644, 449	6. 00
7. 00	Physical Therapy	83, 162	C		l .	-	107, 676	•
8.00	Occupational Therapy	58, 606	C			0	66, 359	•
9.00	Speech Pathology	6, 358	C	603	C	0	6, 961	9. 00
10.00	Medical Social Services	204	C	_	C	0	212	•
11. 00	Home Heal th Aide	156, 917	C	34, 249	C	0	191, 166	
12. 00 13. 00	Supplies (see instructions) Drugs	0	C	_		0	0	12. 00 13. 00
14. 00	DME	0	C	_		0		14. 00
14.00	HHA NONREI MBURSABLE SERVI CES					,		14.00
15. 00	Home Dialysis Aide Services	0	C	C	C	0	0	15. 00
16. 00	Respiratory Therapy	0	C	O	C	0	0	16. 00
17. 00	Private Duty Nursing	0	C	0	C	0	0	17. 00
18. 00	Clinic	0	C	0	C	0	0	18.00
19. 00 20. 00	Health Promotion Activities Day Care Program	0					0	19. 00 20. 00
21. 00	Home Delivered Meals Program	0				0	0	21.00
22. 00	Homemaker Service	0	C		i c	o o	Ö	22. 00
23. 00	All Others (specify)	0	C	0	c	0	0	23. 00
24.00	Total (sum of lines 1-23)	1, 231, 881	C	128, 350	53, 263	87, 234	1, 500, 728	24.00
						07, 234	1, 300, 720	24.00
		Recl assi fi cati	Reclassified	Adjustments	Net Expenses		1, 300, 720	24.00
			Trial Balance		Net Expenses for Allocation		1, 300, 720	24.00
		Recl assi fi cati			Net Expenses		1, 300, 720	24.00
		Recl assi fi cati	Trial Balance (col. 6 +		Net Expenses for Allocation (col. 8 + col.		1, 300, 720	24. 00
	GENERAL SERVICE COST CENTERS	Recl assi fi cati on 7.00	Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		1, 300, 720	
1.00	Capital Related - Bldg. &	Recl assi fi cati on	Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		1, 300, 720	1. 00
1. 00	Capital Related - Bldg. & Fixtures	Recl assi fi cati on 7.00	Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		1, 300, 720	1.00
	Capital Related - Bldg. &	Recl assi fi cati on 7.00	Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		1, 300, 720	
1. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable	Recl assi fi cati on 7.00	Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		1, 300, 720	1.00
1. 00 2. 00 3. 00 4. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation	Reclassification 7.00 0 0 0 0	Tri al Balance (col. 6 + col. 7) 8.00	9.00	Net Expenses for Allocation (col. 8 + col. 9) 10.00		1, 300, 720	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General	Recl assi fi cati on 7.00	Trial Balance (col. 6 + col.7)	9.00	Net Expenses for Allocation (col. 8 + col. 9)		1, 300, 720	1. 00 2. 00 3. 00
1.00 2.00 3.00 4.00 5.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES	Recl assi fi cati on 7.00 0 0 0 -16,437	Tri al Balance (col. 6 + col.7) 8.00	9.00	Net Expenses for Allocation (col. 8 + col. 9) 10.00		1, 300, 720	1. 00 2. 00 3. 00 4. 00 5. 00
1.00 2.00 3.00 4.00 5.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care	Reclassification 7.00 0 0 0 0	Tri al Balance (col. 6 + col. 7) 8.00 Col. 6 + Col. 7) 8.00 Col. 6 + Col. 70	9.00	Net Expenses for Allocation (col. 8 + col. 9) 10.00		1, 300, 720	1. 00 2. 00 3. 00 4. 00 5. 00
1.00 2.00 3.00 4.00 5.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy	Recl assi fi cati on 7.00 0 0 0 -16,437	Tri al Balance (col. 6 + col. 7) 8.00 C 467, 468	9.00	Net Expenses for Allocation (col. 8 + col. 9) 10.00		1, 300, 720	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care	Recl assi fi cati on 7.00 0 0 0 -16,437	Tri al Balance (col. 6 + col. 7) 8.00 Col. 6 + Col. 7) 8.00 Col. 6 + Col. 70	9.00	Net Expenses for Allocation (col. 8 + col. 9) 10.00		1, 300, 720	1. 00 2. 00 3. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	Recl assi fi cati on 7.00 0 0 0 -16,437	Tri al Bal ance (col . 6 + col . 7) 8.00 C 467, 468 644, 449 107, 676 66, 359 6, 961 212	9.00	Net Expenses for Al Location (col. 8 + col. 9) 10.00 10.00 467,468 644,449 107,676 66,359 6,961		1, 300, 720	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	Recl assi fi cati on 7.00 0 0 0 -16,437	Tri al Bal ance (col . 6 + col . 7) 8. 00 Col 467, 468 644, 449 107, 676 66, 359 6, 961	9.00	Net Expenses for Allocation (col. 8 + col. 9) 10.00 COL. 467, 468 644, 449 107, 676 66, 359 6, 961		1, 300, 720	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	Recl assi fi cati on 7.00 0 0 0 -16,437	Tri al Bal ance (col . 6 + col . 7) 8.00 Col 467, 468 644, 449 107, 676 66, 359 6, 961 212 191, 166	9.00	Net Expenses for Allocation (col. 8 + col. 9) 10.00 COL. 467, 468 644, 449 107, 676 66, 359 6, 961 212 191, 166		1, 300, 720	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
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	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	Recl assi fi cati on 7.00 0 0 0 -16, 437	Tri al Bal ance (col. 6 + col. 7) 8.00 Col. 6 + Col. 7) 8.00 Col. 6 + Col. 7) 6.00 Col. 6 + Col. 70	9.00	Net Expenses for Allocation (col. 8 + col. 9) 10.00 10.00 467,468 644,449 107,676 66,359 6,961 212 191,166		1, 300, 720	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
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	Recl assi fi cati on 7.00 0 0 0 -16, 437	Tri al Bal ance (col . 6 + col . 7) 8.00 Col 467, 468 644, 449 107, 676 66, 359 6, 961 212 191, 166	9.00	Net Expenses for Allocation (col. 8 + col. 9) 10.00 10.00 467,468 644,449 107,676 66,359 6,961 2112 191,166		1, 300, 720	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
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	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	Recl assi fi cati on 7.00 0 0 0 -16, 437	Tri al Bal ance (col. 6 + col. 7) 8.00 Col. 6 + Col. 7) 8.00 Col. 6 + Col. 7) 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00	9.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	Net Expenses for Al Location (col. 8 + col. 9) 10.00 COL. 467, 468 644, 449 107, 676 66, 359 6, 961 212 191, 166		1, 300, 720	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
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	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy	Recl assi fi cati on 7.00 0 0 0 -16, 437 0 0 0 0 0 0 0 0 0 0 0 0 0	Tri al Bal ance (col . 6 + col . 7) 8. 00 0 467, 468 644, 449 107, 676 66, 359 6, 961 212 191, 166	9.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	Net Expenses for Al Location (col. 8 + col. 9) 10.00 COL. 467, 468 644, 449 107, 676 66, 359 6, 961 212 191, 166		1, 300, 720	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	Recl assi fi cati on 7.00 0 0 0 -16, 437 0 0 0 0 0 0 0 0 0 0 0 0 0	Tri al Bal ance (col . 6 + col . 7) 8.00 0 467, 468 644, 449 107, 676 66, 359 6, 961 212 191, 166	9.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	Net Expenses for Al Location (col. 8 + col. 9) 10.00 10.00 467,468 644,449 107,676 66,359 6,961 212 191,166		1, 300, 720	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
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	Recl assi fi cati on 7.00 0 0 0 -16, 437 0 0 0 0 0 0 0 0 0 0 0 0 0	Tri al Bal ance (col . 6 + col . 7) 8.00 0 467, 468 644, 449 107, 676 66, 359 6, 961 212 191, 166	9.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	Net Expenses for Al Location (col. 8 + col. 9) 10.00 10.00 467,468 644,449 107,676 66,359 6,961 212 191,166		1, 300, 720	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 18. 00
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 18. 00 19. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	Recl assi fi cati on 7.00 0 0 0 -16, 437 0 0 0 0 0 0 0 0 0 0 0 0 0	Tri al Bal ance (col . 6 + col . 7) 8.00 0 467, 468 644, 449 107, 676 66, 359 6, 961 212 191, 166	9.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	Net Expenses for Al Location (col. 8 + col. 9) 10.00 10.00 467,468 644,449 107,676 66,359 6,961 212 191,166		1, 300, 720	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
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 18. 00 19. 00 20. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	Recl assi fi cati on 7.00 0 0 0 -16, 437 0 0 0 0 0 0 0 0 0 0 0 0 0	Tri al Bal ance (col . 6 + col . 7) 8.00 0 467, 468 644, 449 107, 676 66, 359 6, 961 212 191, 166	9.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	Net Expenses for Al Location (col. 8 + col. 9) 10.00 10.00 467,468 644,449 107,676 66,359 6,961 212 191,166		1, 300, 720	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 18. 00 20. 00
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 18. 00 19. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	Recl assi fi cati on 7.00 0 0 0 -16, 437 0 0 0 0 0 0 0 0 0 0 0 0 0	Tri al Bal ance (col . 6 + col . 7) 8.00 0 467, 468 644, 449 107, 676 66, 359 6, 961 212 191, 166	9.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	Net Expenses for Al Location (col. 8 + col. 9) 10.00 10.00 467,468 644,449 107,676 66,359 6,961 212 191,166		1, 300, 720	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	Recl assi fi cati on 7.00 0 0 -16, 437 0 0 0 0 0 0 0 0 0 0 0 0 0	Tri al Bal ance (col . 6 + col . 7) 8.00 Col . 6 + col . 7) 8.00 Col . 6 - col . 7 -	9.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	Net Expenses for Al Location (col. 8 + col. 9) 10.00 10.00 467,468 644,449 107,676 66,359 6,961 212 191,166		1, 300, 720	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 18. 00 19. 00 20. 00 21. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	Recl assi fi cati on 7.00 0 0 0 -16, 437 0 0 0 0 0 0 0 0 0 0 0 0 0	Tri al Bal ance (col . 6 + col . 7) 8.00 Col . 6 + col . 7) 8.00 Col . 6 - col . 7 -	9.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	Net Expenses for Al location (col. 8 + col. 9) 10.00 467, 468 644, 449 107, 676 66, 359 6, 961 212 191, 166		1, 300, 720	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00

	COST ALLOCATION - HHA GENERAL SERVICE COST				Provi der	CCN: 150115	Peri od:	Worksheet H-1	1002 10
					HHA CCN:		From 07/01/2014 To 06/30/2015	Part I Date/Time Pre	nared:
					TITIA CON.	137222		11/23/2015 9:	52 am
							Home Health	PPS	
			Capital Rela	ted	Costs		Agency I		
		Net Expenses	BI dgs &		vabl e	PI ant	Transportati on	Subtotal	
		for Cost Allocation	Fixtures	Equ	ipment	Operation &		(cols. 0-4)	
		(from Wkst. H,				Mai ntenance			
		col . 10)							
		0	1.00	2	2. 00	3.00	4. 00	4A. 00	
4 00	GENERAL SERVICE COST CENTERS	1	ما						4 00
1. 00	Capital Related - Bldg. & Fixtures	0	O					0	1. 00
2.00	Capital Related - Movable	O			0			0	2. 00
	Equi pment								
3.00	Plant Operation & Maintenance	0	0		0		0	0	3.00
4. 00 5. 00	Transportation Administrative and General	467, 468	0		0		0 0 0	467, 468	4. 00 5. 00
5.00	HHA REIMBURSABLE SERVICES	407, 400	······································		U	l	0 0	407, 400	3.00
6.00	Skilled Nursing Care	644, 449	0		0		0 0	644, 449	6. 00
7.00	Physical Therapy	107, 676	0		0		0 0	107, 676	
8.00	Occupational Therapy	66, 359	0		0		0 0	66, 359	
9. 00 10. 00	Speech Pathology Medical Social Services	6, 961 212	0		0		0 0	6, 961 212	
11. 00	Home Heal th Aide	191, 166	Ö		0			191, 166	
12. 00	Supplies (see instructions)	0	Ö		0		o o	0	
13.00	Drugs	0	О		0		0	0	13. 00
14. 00	DME	0	0		0		0 0	0	14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	O	O		0		ol ol	0	15. 00
16. 00	Respiratory Therapy	l ő	Ö		0		o o	0	16. 00
17. 00	Private Duty Nursing	0	o		0		0 0	0	17. 00
18. 00	Clinic	0	0		0	•	0 0	0	18. 00
19. 00	Health Promotion Activities	0	0		0		0 0	0	19.00
20. 00 21. 00	Day Care Program Home Delivered Meals Program		O O		0			0	20.00
22. 00	Homemaker Service		o		0			0	22. 00
	All Others (specify)	0	o		0		0 0	0	23. 00
24. 00	Total (sum of lines 1-23)	1, 484, 291	0		0		0 0	1, 484, 291	24. 00
		Admi ni strati ve & General	Total (cols. 4A + 5)						
		5. 00	6.00						
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. &								1. 00
2. 00	Fixtures Capital Related - Movable								2. 00
2.00	Equipment								2.00
3.00	Plant Operation & Maintenance								3. 00
4.00	Transportation								4. 00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	467, 468							5. 00
6. 00	Skilled Nursing Care	296, 276	940, 725						6. 00
7. 00	Physical Therapy	49, 502	157, 178						7. 00
8.00	Occupational Therapy	30, 507	96, 866						8. 00
9.00	Speech Pathology	3, 200	10, 161						9. 00
10. 00 11. 00	Medical Social Services Home Health Aide	97 87, 886	309 279, 052						10. 00 11. 00
12. 00	Supplies (see instructions)	07,000	279, 052						12. 00
13. 00	Drugs	l o	o						13. 00
14.00	DME	0	0						14. 00
45.00	HHA NONREI MBURSABLE SERVI CES	I al							4- 00
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0						15. 00 16. 00
17. 00	Private Duty Nursing		0						17. 00
18. 00	Clinic	l o	Ö						18. 00
19. 00	Health Promotion Activities	0	0						19. 00
20.00		0	0						20.00
	Home Delivered Meals Program Homemaker Service	0	0						21. 00 22. 00
22. 00 23. 00	All Others (specify)		0						22. 00
	Total (sum of lines 1-23)		1, 484, 291						24. 00
	•	'	'						

						Home Health Agency I	PPS	<u> </u>
		Capital Rel	ated Costs					
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MI LEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1. 00	2. 00	3.00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS		<u> </u>					
1.00	Capital Related - Bldg. &	0				0		1. 00
2.00	Fixtures Capital Related - Movable		0			0		2. 00
3.00	Equipment Plant Operation & Maintenance	_	0	(0		3. 00
4.00	Transportation (see	0	0			1		4. 00
4.00	instructions)	0	0		΄			4.00
5.00	Administrative and General	0	0	d		-467, 468	1, 016, 823	5. 00
	HHA REIMBURSABLE SERVICES	•			•			
6.00	Skilled Nursing Care	0	0	C) (0	644, 449	6. 00
7.00	Physi cal Therapy	0	0	() (0	107, 676	
8.00	Occupational Therapy	0	0	() (0	66, 359	
9.00	Speech Pathology	0	0	() (0	6, 961	
10.00	Medical Social Services	0	0	() (0	212	
11. 00	Home Health Aide	0	0	C)	0	191, 166	
12.00	Supplies (see instructions)	0	0	() (0	0	12. 00
13.00	Drugs	0	0		1	0	0	13. 00
14. 00	DME	0	0) (0	0	14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	(0	0	15. 00
16. 00	Respiratory Therapy	0	0	1	1		0	16. 00
17. 00	Private Duty Nursing	0	0				0	17. 00
18. 00	Clinic	0	0				0	18. 00
19. 00	Health Promotion Activities	0	0			0	0	19. 00
20. 00	Day Care Program	0	0				0	20.00
21. 00	Home Delivered Meals Program	0	0	Ì		0	0	21. 00
22. 00	Homemaker Service	0	0	Ì		0	0	22. 00
	All Others (specify)	0	0	d		0	0	23. 00
24.00	Total (sum of lines 1-23)	0	0	l c		-467, 468	1, 016, 823	24. 00
25. 00	Cost To Be Allocated (per	0	0	c		o l	467, 468	25. 00
	Worksheet H-1, Part I)							
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 000000	0	0. 459734	26. 00

Health Financial Systems MEMORIA ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 11/23/2015 9: 52 am Provi der CCN: 150115 Peri od: From 07/01/2014 To 06/30/2015 HHA CCN: 157222 Home Health

						Agency I	113	
			CAPITAL REL	LATED COSTS				
	Cost Center Description	HHA Trial Balance (1)	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1. 00	2. 00	4. 00	4A	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00	Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	0 940, 725 157, 178 96, 866 10, 161 309 279, 052 0 0 0 0 0 0 0 0 0	1.00 18, 785 0 0 0 0 0 0 0 0 0 0 0 0 0	28, 085 0 0 0 0 0 0 0 0 0 0 0 0 0	66, 002 112, 094 15, 984 11, 264 1, 222 39 30, 159 0 0 0 0 0	112, 872 1, 052, 819 173, 162 108, 130 11, 383 348 309, 211 0 0 0 0 0 0 0 0 1, 767, 925 0. 000000	21, 098 196, 793 32, 367 20, 212 2, 128 65 57, 798 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 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00
	of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description	MAI NTENANCE & REPAI RS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	
	T	6. 00	8. 00	9. 00	10.00	11. 00	13. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2)	47, 806 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8, 355 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	5, 845 10, 268 1, 784 809 88 4 4, 174 0 0 0 0 0 0 0 0 222, 972	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 17. 00 18. 00 20. 00 21. 00

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

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10 ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Provi der CCN: 150115 Peri od: Worksheet H-2 From 07/01/2014 Part I 157222 06/30/2015 Date/Time Prepared: HHA CCN: To 11/23/2015 9:52 am Home Health **PPS** Agency I Cost Center Description CENTRAL **PHARMACY** MEDI CAL Subtotal Intern & Subtotal Residents Cost SERVICES & RECORDS & LIBRARY **SUPPLY** & Post Stepdown Adjustments 26.00 14. 00 15. 00 16. 00 24.00 25. 00 1.00 Administrative and General 757 196, 733 196, 733 1.00 0 0 5, 600 1, 265, 480 2 00 2 00 Skilled Nursing Care 0 1, 265, 480 3.00 Physical Therapy 0 0 2, 242 209, 555 0 209, 555 3.00 4.00 Occupational Therapy 0 000000000000 709 129, 860 0 129,860 4.00 Speech Pathology 0 13, 654 5 00 13, 654 5 00 55 6.00 Medical Social Services 418 418 6.00 0 0 7.00 Home Heal th Aide 3, 132 374, 315 374, 315 7.00 0 8.00 Supplies (see instructions) 0 0 0 0 0 0 0 0 0 8.00 C 0 0 0 0 9.00 9 00 Drugs Ω 0 10.00 DMF C 0 10.00 Home Dialysis Aide Services 0 0 11.00 0 11.00 Respiratory Therapy 0 12.00 12.00 0 0 0 0 Private Duty Nursing 0 13.00 0 13.00 14.00 Clinic 0 0 14.00 Health Promotion Activities 15.00 15.00 0 Day Care Program 0 0 0 16.00 16, 00 17.00 Home Delivered Meals Program C 0 17 00 18.00 Homemaker Service 0 18.00 19.00 All Others (specify) 0 0 O 0 19.00 20.00 Total (sum of lines 1-19) (2) 757 11, 739 2, 190, 015 2, 190, 015 20.00 21.00 Unit Cost Multiplier: column 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Allocated HHA Cost Center Description Total HHA A&G (see Part Costs 27. 00 28. 00 1.00 Administrative and General 1.00 1, 390, 380 2.00 Skilled Nursing Care 124, 900 2.00 3.00 Physical Therapy 20, 683 230, 238 3.00 Occupational Therapy 4.00 12,817 142, 677 4.00 Speech Pathology 1, 348 15, 002 5 00 5 00 6.00 Medical Social Services 41 459 6.00 7.00 Home Heal th Aide 36, 944 411, 259 7.00 8.00 Supplies (see instructions) 0 0 8.00 9.00 Drugs 0 0 9 00 10.00 DMF 0 0 10.00 Home Dialysis Aide Services 0 11.00 11.00 0 Respiratory Therapy 12.00 12.00 0 Private Duty Nursing 13.00 13.00 0 0 14.00 Clinic 14.00 Health Promotion Activities 0 15.00 15.00 0 0 16.00 16.00 Day Care Program Home Delivered Meals Program 0 17.00 17 00 Homemaker Service 0 18.00 19.00 All Others (specify) 0 19.00 Total (sum of lines 1-19) (2) 2, 190, 015 20.00 20.00 196, 733

21.00

0.098698

21.00

Unit Cost Multiplier: column

26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to

6 decimal places.

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

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

Provi der CCN: 150115 BASIS HHA CCN: 157222

						Home Health Agency I	PPS	
		CAPITAL REL	ATED COSTS			Agency i		
	Cost Contar Doscription	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Doconci Li ati on	ADMI NI STRATI VE	MAINTENANCE 0	
	Cost Center Description	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	Reconciliation	& GENERAL	REPAIRS	
		(**************************************	(,	DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	
				(GROSS				
		1.00	2.00	SALARI ES) 4. 00	5A	5. 00	6. 00	
1. 00	Administrative and General	2, 579	2, 579				2, 579	1. 00
2.00	Skilled Nursing Care	0	0	589, 471		1	0	2. 00
3.00	Physical Therapy	0	0	84, 053			0	3. 00
4. 00 5. 00	Occupational Therapy Speech Pathology	0	0	59, 233 6, 426			0	4. 00 5. 00
6. 00	Medical Social Services	0	0		1	,	0	6. 00
7. 00	Home Heal th Aide	0	0				0	7. 00
8.00	Supplies (see instructions)	0	0	1	1		0	
9.00	Drugs	0	0	0	1		0	9. 00
10. 00 11. 00	DME Home Dialysis Aide Services	0	0	0	1		0	10. 00 11. 00
12. 00	Respiratory Therapy	0	0	_	1	1	0	12. 00
13. 00	Private Duty Nursing	0	0	o	0	0	0	13. 00
14.00	Clinic	0	0	O	٦ -	_	0	14. 00
15. 00	Health Promotion Activities	0	0	0			0	15.00
16. 00 17. 00	Day Care Program Home Delivered Meals Program	0	0	0	1		0	16. 00 17. 00
18. 00	Homemaker Service		0			_	0	18. 00
19. 00	All Others (specify)	0	0	o	0	0	0	19. 00
20. 00	Total (sum of lines 1-19)	2, 579	2, 579			1, 767, 925	2, 579	
21. 00	Total cost to be allocated	18, 785	28, 085		•	330, 461	47, 806	
22. 00	Unit cost multiplier Cost Center Description	7. 283831 LAUNDRY &	10. 889880 HOUSEKEEPI NG	0. 190161 DI ETARY	CAFETERI A	0. 186920 NURSI NG	18. 536642 CENTRAL	22. 00
	oost conten bescriptron	LINEN SERVICE		(PATIENT DAYS)		ADMI NI STRATI ON	SERVICES &	
		(POUNDS OF					SUPPLY	
		LAUNDRY)				(DI RECT NURS. HRS.)	(COSTED REQUIS.)	
		8.00	9. 00	10.00	11. 00	13.00	14. 00	
1. 00	Administrative and General	0	2, 579	C			0	1. 00
2.00	Skilled Nursing Care	0	0	0			0	2. 00
3. 00 4. 00	Physical Therapy	0	0	1	-,		0	3. 00 4. 00
4. 00 5. 00	Occupational Therapy Speech Pathology	0	0	0	1 .,		0	5. 00
6. 00	Medical Social Services	0	0			Ö	ő	6. 00
7.00	Home Health Aide	0	0	O	8, 701	0	0	7. 00
8.00	Supplies (see instructions)	0	0			_	0	8. 00
9. 00 10. 00	Drugs DME	0	0	0	1		0	9. 00 10. 00
11. 00	Home Dialysis Aide Services	0	0		1		0	10.00
12. 00	Respiratory Therapy	0	0	Ö	1		ő	12. 00
13.00	Private Duty Nursing	0	0	0	1		0	13.00
14.00	Clinic	0	0	0	1	1	0	14.00
15. 00 16. 00	Health Promotion Activities Day Care Program	0	0	0	1	1	0	15. 00 16. 00
17. 00	Home Delivered Meals Program		0	0		1	0	17. 00
18. 00	Homemaker Service	0	0		o	_	Ö	18. 00
19. 00	All Others (specify)	0	0	0	0	0	0	19. 00
20.00	Total (sum of lines 1-19)	0	2, 579	0	17,007		0	20. 00
21.00	Total cost to be allocated Unit cost multiplier	0. 000000	8, 355 3. 239628	0. 000000	22, 972 0. 479693		0. 000000	21.00
22.00	Tour coost mar cipitei	1 0.000000	5. 257020	0.000000	7 U. 477073	, J. 000000	0.000000	22.00

Health Financial Systems	MEMORIAL HOSP & HEALT	TH CARE CTR	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS	TO HHA COST CENTERS STATISTICAL	Provi der CCN: 150115 HHA CCN: 157222	From 07/01/2014	Worksheet H-2 Part II Date/Time Prepared: 11/23/2015 9:52 am
				11/23/2015 9: 52 alli

				Home Health	PPS	
				Agency I		
	Cost Center Description	PHARMACY	MEDI CAL	·		
		(COSTED	RECORDS &			
		REQUIS.)	LI BRARY			
			(REVENUE)			
		15. 00	16. 00			
1. 00 Ad	dministrative and General	543	0			1. 00
2. 00 Sł	killed Nursing Care	0	998, 655			2. 00
3. 00 Pł	hysical Therapy	0	399, 866			3. 00
4.00 00	ccupati onal Therapy	0	126, 465			4. 00
5. 00 Sp	peech Pathology	0	9, 832			5. 00
6.00 Me	edical Social Services	0	135			6. 00
7. 00 Ho	ome Health Aide	0	558, 655			7. 00
8. 00 St	upplies (see instructions)	0	0			8. 00
9. 00 Dr	rugs	0	0			9. 00
10.00 DN	ME	0	0			10. 00
11. 00 Ho	ome Dialysis Aide Services	0	0			11. 00
12. 00 Re	espi ratory Therapy	0	O			12. 00
13. 00 Pr	rivate Duty Nursing	0	0			13. 00
14. 00 CI	linic	0	O			14. 00
15. 00 He	ealth Promotion Activities	0	O			15. 00
16. 00 Da	ay Care Program	0	O			16. 00
17. 00 Ho	ome Delivered Meals Program	0	O			17. 00
	omemaker Service	0	o			18. 00
19. 00 AI	II Others (specify)	0	o			19. 00
	otal (sum of lines 1-19)	543	2, 093, 608			20. 00
	otal cost to be allocated	757	11, 739			21. 00
22. 00 Ur	nit cost multiplier	1. 394107	0. 005607			22. 00

Heal th	Financial Systems	ME	MORIAL HOSP & F	HEALTH CARE (TR		In Lie	u of Form CMS-2	2552-10
	IONMENT OF PATIENT SERVICE COST				r CCN: 150115	Fro	iod: m 07/01/2014	Worksheet H-3 Part I Date/Time Prep	
				Ti	tle XVIII	Н	Home Health	11/23/2015 9: 5 PPS	52 am_
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HH.	A T	Agency I Fotal Visits	Average Cost	
	·	H-2, Part I,	(from Wkst.	Ancillary	Costs (cols			Per Visit	
		col. 28, line	H-2, Part I)	Costs (from Part II)	+ 2)			(col. 3 ÷ col. 4)	
	DADT 1 0000UTATION OF 1 50050	0	1.00	2.00	3.00		4. 00	5. 00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF	THE PROGRAM L	IMI IA	TION COST, OR	?	
1.00	Skilled Nursing Care	2. 00	1, 390, 380		1, 390,	380	7, 415	187. 51	1. 00
2.00	Physical Therapy	3. 00	230, 238		0 230,		2, 969	77. 55	
3.00	Occupational Therapy	4. 00	· ·		0 142,		939	151. 95	
4. 00 5. 00	Speech Pathology Medical Social Services	5. 00 6. 00	· ·		0 15,	002 459	73 1	205. 51 459. 00	4. 00 5. 00
6. 00	Home Heal th Aide	7. 00			411,		4, 148	99. 15	
7.00	Total (sum of lines 1-6)		2, 190, 015		0 2, 190,		15, 545		7. 00
			I		Program Vis				
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Part	Subject to		
	cost center bescription	COST LIMITS	CBSA NO. (1)	Pait A	Deducti bl e	s & [Deducti bl es		
	To a second seco	0	1.00	2. 00	3. 00		4. 00	5. 00	
8. 00	Limitation Cost Computation Skilled Nursing Care	I	99915		0 4.	882			8. 00
8. 01	Skilled Nursing Care		50031		0 4,	002			8. 00
9. 00	Physical Therapy		99915			205			9. 00
9. 01	Physical Therapy		50031		0	0			9. 01
10.00	Occupational Therapy	1	99915		0	687			10.00
10. 01 11. 00	Occupational Therapy Speech Pathology	•	50031 99915		0	0 25			10. 01 11. 00
11. 00	Speech Pathology		50031			0			11. 00
12. 00	Medical Social Services		99915		o	1			12. 00
12. 01	Medical Social Services		50031		0	0			12. 01
13. 00	Home Health Aide		99915			042			13. 00
13. 01	Home Heal th Aide		50031		0	0			13. 01
14.00	Total (sum of lines 8-13) Cost Center Description	From Wkst. H-2	Facility Costs	Shared	Total HH	842 Δ Τα	otal Charges	Ratio (col. 3	14. 00
	cost center bescription	Part I, col.	(from Wkst.	Ancillary	Costs (cols		(from HHA	÷ col. 4)	
		28, line	H-2, Part I)	Costs (from			Record)	,	
		0	1.00	Part II)	2.00		4.00	F 00	
	Supplies and Drugs Cost Computa	ations	1.00	2. 00	3.00		4. 00	5. 00	
15. 00	Cost of Medical Supplies	8. 00	0		0	0	62, 002	0. 000000	15. 00
16. 00	Cost of Drugs	9. 00			0	0	0	0. 000000	16. 00
			Program Visits		Cost of Services				
			Par	t B	_ Services	` -	Part B		
	Cost Center Description	Part A	Not Subject to		Part A	No	ot Subject to	Subj ect to	
			Deductibles &				eductibles &	Deductibles &	
		6.00	Coi nsurance 7.00	Coi nsurance 8.00	9.00	(Coi nsurance 10.00	Coi nsurance 11.00	
	PART I - COMPUTATION OF LESSER					I MI TA			
	BENEFICIARY COST LIMITATION								
1 00	Cost Per Visit Computation	1 -	4.000				045 40 1		1 00
1. 00 2. 00	Skilled Nursing Care Physical Therapy	0 0				0	915, 424 170, 998		1. 00 2. 00
3. 00	Occupati onal Therapy					0	170, 998		3. 00
4. 00	Speech Pathology	0				0	5, 138		4. 00
5.00	Medical Social Services	0	1			0	459		5. 00
6.00	Home Heal th Aide	0	· ·			0	202, 464		6. 00
7. 00	Total (sum of lines 1-6)	0	9, 842		I	O	1, 398, 873		7. 00

APPORT	FIONMENT OF PATIENT SERVICE COST	TS			CCN: 150115	Peri od: From 07/01/2014 To 06/30/2015	Worksheet H-3 Part I	
				HHA CCN:	157222	To 06/30/2015	Date/Time Pre 11/23/2015 9:	
				Ti tl	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	Limitation Cost Computation	0.00	7.00	8.00	7.00	10.00	11.00	
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 12. 01 13. 00 13. 01	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide Home Health Aide							8. 00 8. 0' 9. 0' 10. 00' 11. 00' 11. 0' 12. 00' 12. 0' 13. 0'
14. 00	Total (sum of lines 8-13)							14.00
		Progi	ram Covered Cha	rges	Cost of Services			
	Cost Center Description	Part A	Par Not Subject to Deductibles & Coinsurance	Subject to	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00	10. 00	11.00	
	Supplies and Drugs Cost Comput							
15. 00 16. 00		0	0 3, 746	0		0 0	C	
10.00	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00	3, 740	J				- 10.00
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LII	MITATION COST, OR		
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							1
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	915, 424 170, 998 104, 390 5, 138 459 202, 464 1, 398, 873						1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
		12. 00						
8. 00 8. 01 9. 00 9. 01 10. 00 10. 01 11. 00 11. 01 12. 00 12. 01	Speech Pathology Medical Social Services							8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 12. 01 13. 00

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552							2552-10		
APPORT	TIONMENT OF PATIENT SERVICE COST	S			Provi der	CCN: 150115	Peri od:	Worksheet H-3	
					HHA CCN:	157222	From 07/01/2014 To 06/30/2015		
					Ti tl	e XVIII	Home Health	PPS	
Agency I									
	Cost Center Description	From Wkst. C,	Cost to Charge	То	tal HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Char	rge (from	Ancillary	Part I as		
		9, line		pr	rovi der	Costs (col.	1 Indicated		
				re	ecords)	x col. 2)			
		0	1. 00		2. 00	3.00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	CES FURNI SHED B	Y SHA	ARED HOSPI	TAL DEPARTMEN	NTS		
1.00	Physical Therapy	66. 00	0. 557533		0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy								2. 00
3.00	Speech Pathology								3.00
4.00	Cost of Medical Supplies	71.00	0. 663377		0		0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 227508		0		0 col. 2, line 1		5. 00

LCUL	Financial Systems MEMORIAL HOSP & HEALTH ATION OF HHA REIMBURSEMENT SETTLEMENT P		CCN: 150115	Peri		Worksheet H-4	2552
		IHA CCN:	157222	Fron To	n 07/01/2014 06/30/2015	Part I-II Date/Time Pre	pare
		Ti tl	e XVIII	Н	ome Health	11/23/2015 9: PPS	52 a
					Agency I	_	
			Part A	No	Par t Subject to	t B Subject to	
			Part A			Deductibles &	
					Coi nsurance	Coi nsurance	
			1.00		2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMAR' Reasonable Cost of Part A & Part B Services	Y CHARGE	S				
0	Reasonable cost of services (see instructions)			0	0	0	1
0	Total charges			0	o	0	
	Customary Charges						
00	Amount actually collected from patients liable for payment for se	rvi ces		0	0	0	3
00	on a charge basis (from your records)	man+		0	0	0	Ι,
00	Amount that would have been realized from patients liable for pay for services on a charge basis had such payment been made in acco with 42 CFR §413.13(b)			U	O	0	4
0	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 00000	00	0. 000000	0.000000	
00	Total customary charges (see instructions)			0	0	0	6
00	Excess of total customary charges over total reasonable cost (com only if line 6 exceeds line 1)	plete		0	0	0	7
0	Excess of reasonable cost over customary charges (complete only i 1 exceeds line 6)	fline		0	0	0	8
0	Pri mary payer amounts			0	1, 361	0	(
					Part A	Part B	
					Servi ces 1. 00	Servi ces 2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			_		2.00	
00	Total reasonable cost (see instructions)				0	-1, 361	
00	Total PPS Reimbursement - Full Episodes without Outliers				0	1, 189, 102	
00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes				0	36, 382 21, 327	
00	Total PPS Reimbursement - PEP Episodes				0	22, 233	
00	Total PPS Outlier Reimbursement - Full Episodes with Outliers				0	13, 132	
00	Total PPS Outlier Reimbursement - PEP Episodes				o		16
00	Total Other Payments				0	0	17
00	DME Payments				0	0	
00	Oxygen Payments				0	0	
00	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsuran	co)			0	0	20
00	Subtotal (sum of lines 10 thru 20 minus line 21)	ce)			0	1, 280, 865	
00	Excess reasonable cost (from line 8)				o	0	23
00	Subtotal (line 22 minus line 23)				Ö	1, 280, 865	
00	Coinsurance billed to program patients (from your records)					0	25
00	Net cost (line 24 minus line 25)				0	1, 280, 865	
00	Reimbursable bad debts (from your records)						27
00	Reimbursable bad debts for dual eligible beneficiaries (see instr					1 200 045	28
00	Total costs - current cost reporting period (line 26 plus line 27 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY))			0	1, 280, 865 0	30
50	Pioneer ACO demonstration payment adjustment (see instructions)				0	0	30
00	Subtotal (see instructions)				o	1, 280, 865	
01	Sequestration adjustment (see instructions)				О	25, 618	
00	Interim payments (see instructions)				0	1, 255, 247	
00	Tentative settlement (for contractor use only)	00)			0	0	
	Balance due provider/program (line 31 minus lines 31.01, 32, and	33)			0	0	34
00	Protested amounts (nonallowable cost report items) in accordance	+b 0140	Dub 1F 0			0	35

PROGRAM BENEFICIARIES

Provi der CCN: 150115 HHA CCN: 157222

Peri od: From 07/01/2014 To 06/30/2015 Date/Ti me Prepared: 11/23/2015 9:52 am PPS

				Home Health	PPS	
		Innation	it Part A	Agency I	rt B	
		Tripatren	it Fai t A	rai	СВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		C		1, 255, 247 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	Program to Provider	I			0	3. 01
3. 02						3. 02
3. 03						3. 03
3.04)	0	3. 04
3.05			C		0	3. 05
	Provider to Program					
3.50			C		0	3. 50
3. 51 3. 52			C		0	3. 51 3. 52
3. 52 3. 53						3. 52
3. 54						3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		ď		0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)				1, 255, 247	4. 00
00	(transfer to Wkst. H-4, Part II, column as appropriate, line 32)				1, 200, 217	
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider	1	1 -	1	_	
5. 01			C		0	5. 01
5. 02 5. 03					0	5. 02 5. 03
5.05	Provider to Program	1		1		3.03
5.50	· · · · · · · · · · · · · · · · · · ·		C)	0	5. 50
5. 51			[c		0	5. 51
5. 52			(0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		C		0	5. 99
6.00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER				0	6. 01
6. 02	SETTLEMENT TO PROGRAM					6. 02
7. 00	Total Medicare program liability (see instructions)				1, 255, 247	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
)	1. 00	2. 00	
8. 00	Name of Contractor					8. 00
		•		•		•

	Financial Systems MEMORIAL HOSP & I ATION OF CAPITAL PAYMENT	HEALTH CARE CTR Provider CCN: 150115	Peri od:	eu of Form CMS-2 Worksheet L	2002-
	ATTON OF CALLIAL PAINENT	Trovider con. 130113	From 07/01/2014 To 06/30/2015	Parts I-III	
		Title XVIII	Hospi tal	PPS	<u> </u>
				1 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
. 00	Capital DRG other than outlier			1, 467, 580	1. 0
. 01	Model 4 BPCI Capital DRG other than outlier			0	1. (
. 00	Capital DRG outlier payments			3, 723	2. (
. 01	Model 4 BPCI Capital DRG outlier payments			0	2. (
. 00	Total inpatient days divided by number of days in the cost	reporting period (see inst	ructi ons)	42. 61	3. (
. 00	Number of interns & residents (see instructions)			0.00	4. (
5. 00 5. 00	Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by t	the cum of lines 1 and 1 01	calumna 1 and	0.00	5. (6. (
. 00	1.01) (see instructions)	ne sum of times I and 1.01	, corumns i and	ا	0. (
. 00	Percentage of SSI recipient patient days to Medicare Part A	natient davs (Worksheet F	. part A line	0.00	7. (
	30) (see instructions)	. parrent bays (, par e		
. 00	Percentage of Medicaid patient days to total days (see inst	ructions)		0.00	8.
. 00	Sum of lines 7 and 8			0.00	
0. 00	Allowable disproportionate share percentage (see instruction	ons)		0.00	
1.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			0	11.
2. 00	Total prospective capital payments (see instructions)			1, 471, 303	12.
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
. 00	Program inpatient routine capital cost (see instructions)			0	1.
. 00 . 00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2)			0	2. 3.
. 00	Capital cost payment factor (see instructions)				4.
5. 00	Total inpatient program capital cost (line 3 x line 4)			ا	5.
		,			
	DADT III - COMDITATION OF EXCEPTION DAYMENTS			1.00	
00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program impatient capital costs (see instructions)				1
	Program inpatient capital costs (see instructions)	nnces (see instructions)		1.00	
. 00		nnces (see instructions)		0	2.
. 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta	nnces (see instructions)		0	2. 3.
. 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			0 0 0 0.00	2. 3. 4. 5.
. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see	instructions)		0 0 0 0.00 0 0.00	2. 3. 4. 5.
. 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina	instructions)	line 6)	0 0 0 0.00 0.00	2. 3. 4. 5. 6. 7.
.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7)	instructions) ary circumstances (line 2 x	line 6)	0 0 0 0.00 0.00 0.00	2. 3. 4. 5. 6. 7.
00 00 00 00 00 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstate Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinate Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as apprent of the program	instructions) ary circumstances (line 2 x blicable)	·	0 0 0 0.00 0 0.00 0	2. 3. 4. 5. 6. 7. 8.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstate Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinate Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to	instructions) ary circumstances (line 2 x olicable) o capital payments (line 8	less line 9)	0 0 0 0.00 0.00 0.00	2. 3. 4. 5. 6. 7. 8. 9.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstate Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinate Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as approximate)	instructions) ary circumstances (line 2 x olicable) o capital payments (line 8	less line 9)	0 0 0 0.00 0 0.00 0	2. 3. 4. 5. 6. 7. 8. 9.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital	instructions) ary circumstances (line 2 x plicable) b capital payments (line 8 capital payment (from pri-	less line 9) or year e 11)	0 0 0 0.00 0 0.00 0	2. 3. 4. 5. 6. 7. 8. 9. 10.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent	instructions) ary circumstances (line 2 x plicable) a capital payments (line 8 capital payment (from print payments (line 10 plus line the amount on this line	less line 9) or year e 11)	0 0 0 0.00 0.00 0 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11.
2. 00 3. 00 4. 00 5. 00 5. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstate Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinate Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent Carryover of accumulated capital minimum payment level over	instructions) ary circumstances (line 2 x plicable) a capital payments (line 8 capital payment (from print payments (line 10 plus line the amount on this line	less line 9) or year e 11)	0 0 0 0.00 0.00 0 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11.
2. 00 3. 00 4. 00 5. 00 5. 00 7. 00 8. 00 0. 00 0. 00 1. 00 2. 00 3. 00 4. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstate Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinate Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	instructions) ary circumstances (line 2 x plicable) a capital payments (line 8 a capital payment (from pri apayments (line 10 plus line are the amount on this line a capital payment for the fi	less line 9) or year e 11)	0 0 0 0.00 0 0.00 0 0 0	5. 6. 7. 8. 9. 10. 11.
1. 00 2. 00 3. 00 3. 00 5. 00 7. 00 7. 00 9. 00 1. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstate Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinate Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	instructions) ary circumstances (line 2 x plicable) capital payments (line 8 capital payment (from pri payments (line 10 plus line cer the amount on this line capital payment for the fo	less line 9) or year e 11)	0 0 0 0.00 0.00 0 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11.

Health Financial Systems	MEMORIAL HOSP & HEALT	In Lieu of Form CMS-2552-10			
ANALYSIS OF HOSPITAL-BASED RURAL HI	EALTH CLINIC/FEDERALLY QUALIFIED	Provi der CCN: 150115	Peri od: From 07/01/2014	Worksheet M-1	
HEALTH GENTER GOSTS		Component CCN: 158507			
			Rural Health	Cost	

			·			11/23/2015 9:	52 am_
					Rural Health	Cost	
					Clinic (RHC) I		
		Compensation	Other Costs	Total (col.	1 Reclassi ficati	Recl assi fi ed	
		·		+ col . 2)	ons	Trial Balance	
				_		(col. 3 + col.	
						4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	36, 332	0	36, 33	2 0	36, 332	1.00
2.00	Physician Assistant	0	0	1	0 0	0	2.00
3.00	Nurse Practitioner	125, 827	0	125, 82	7 0	125, 827	3.00
4. 00	Vi si ting Nurse	120,027	0	120,02	0	0	4. 00
5.00	Other Nurse	0	0		0	Ö	•
6. 00	Clinical Psychologist	0	0			0	•
7. 00	Clinical Social Worker	0	0		0	0	
		U	0		0	_	ı
8.00	Laboratory Techni ci an	0	0		0	0	8. 00
9.00	Other Facility Health Care Staff Costs	7, 752	0	7, 75			9. 00
10. 00	Subtotal (sum of lines 1 through 9)	169, 911	0	169, 91	1, 016	1	10. 00
11. 00	Physician Services Under Agreement	0	0		0	0	1
12. 00	Physician Supervision Under Agreement	0	0		0	0	12. 00
13. 00	Other Costs Under Agreement	0	0		0	0	13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14. 00
15. 00	Medical Supplies	0	17, 340	17, 34	.0	17, 340	15. 00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16. 00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17. 00
18.00	Professional Liability Insurance	0	0		0 0	0	18. 00
19.00	Other Health Care Costs	69, 257	92, 073	161, 33	0	161, 330	19. 00
20.00	Allowable GME Costs	o	0		0 0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	69, 257	109, 413	178, 67	0 0	178, 670	21.00
22. 00	Total Cost of Health Care Services (sum of	239, 168	109, 413				•
22.00	lines 10, 14, and 21)	2077 100	.077 110	0.0,00	., 0.0	017,077	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0		0 0	0	23. 00
24. 00	Dental	o	0		0 0	0	•
25. 00	Optometry	0	0		0 0	0	25. 00
26. 00	All other nonreimbursable costs	0	0		0	Ö	26. 00
27. 00	Nonallowable GME costs	0	0		0	0	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	ĺ	•
20.00	through 27)	ď	0			l o	20.00
	FACILITY OVERHEAD			l .		l	1
29. 00	Facility Costs	٥	0		0 0	0	29. 00
30. 00	Administrative Costs	0	0		0 0	0	30.00
31. 00	1	0	0			0	31.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	۷	0		U U		31.00
32. 00	Total facility costs (sum of lines 22, 28	239, 168	109, 413	348, 58	1, 016	349, 597	32. 00
32.00	and 31)	237, 108	109, 413	348, 58	1,010	347, 397	32.00
	and 31)	ı l		I	I	I	I

Health Financial Systems	H CARE CTR		In Lieu of Form CMS-2552-10					
ANALYSIS OF HOSPITAL-BASED RURAL	HEALTH CLINIC/FEDERALLY	QUALIFIED	Provi der CCN:	150115			Worksheet	M-1
HEALTH CENTER COSTS			0 1 001	450507	From 07/			Б
			Component CCN:	158507	10 06/			
							11/23/2015	9:52 am
					Rural	Heal th	Co	st

				Clinic (RHC) I	
		Adjustments	Net Expenses	CITILE (MIC) 1	
			for Allocation		
			(col . 5 + col .		
			6)		
		6. 00	7. 00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physi ci an	0	36, 332		1.00
2.00	Physici an Assistant	0	0	1	2.00
3.00	Nurse Practitioner	0	125, 827		3. 00
4.00	Visiting Nurse	0	0		4. 00
5.00	Other Nurse	0	0		5. 00
6.00	Clinical Psychologist	0	0		6.00
7. 00	Clinical Social Worker	0	0		7. 00
8. 00	Laboratory Techni ci an	0	0		8. 00
9. 00	Other Facility Health Care Staff Costs	0	8, 768	l .	9. 00
10. 00	Subtotal (sum of lines 1 through 9)	0	170, 927		10.00
11. 00	Physician Services Under Agreement	0	170, 727	1	11. 00
12. 00	Physician Supervision Under Agreement	0	ĺ	•	12.00
13. 00	Other Costs Under Agreement	0	0	l .	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0	l .	14. 00
15. 00	Medical Supplies	0	17, 340		15. 00
16. 00	Transportation (Health Care Staff)	0	17, 340	l .	16. 00
17. 00	Depreciation-Medical Equipment	0	0	•	17. 00
18. 00	Professional Liability Insurance	0	0		18. 00
19. 00	Other Health Care Costs	-3, 829	157, 501		19. 00
20. 00	Allowable GME Costs	-3, 02 9 O	137,301	1	20.00
21. 00	Subtotal (sum of lines 15 through 20)	-3, 829		1	21. 00
22. 00	Total Cost of Health Care Services (sum of	-3, 829		•	22. 00
22.00	lines 10, 14, and 21)	-5,029	343, 700		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23. 00	Pharmacy	0	0		23. 00
24. 00	Dental	0	0		24. 00
25. 00	Optometry	0	0		25. 00
26. 00	All other nonreimbursable costs	0	0		26, 00
27. 00	Nonallowable GME costs	0	0		27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		28. 00
	through 27)				
	FACILITY OVERHEAD				
29. 00	Facility Costs	0	0		29. 00
30.00	Administrative Costs	0	0		30. 00
31.00	Total Facility Overhead (sum of lines 29 and	0	0		31. 00
	30)				1
32.00	Total facility costs (sum of lines 22, 28	-3, 829	345, 768		32. 00
	and 31)				

Health Financial Systems	MEMORIAL HOSP & HEALT	In Lieu of Form CMS-2552-				
ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CENTER COSTS	. HEALTH CLINIC/FEDERALLY QUALIFIED	Provider CCN: 1 Component CCN:		From 07/01/2014	Worksheet M-1 Date/Time Prepared: 11/23/2015 9:52 am	
•					4 .	

						11/23/2015 9:	<u>52 am</u>
					Rural Health	Cost	
					Clinic (RHC) II		
		Compensation	Other Costs	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
				_		(col. 3 + col.	
						4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	180, 185	C	180, 18!	5 0	180, 185	1.00
2.00	Physician Assistant	0	O		0	0	2.00
3.00	Nurse Practitioner	102, 121	0	102, 12 ⁻	1 0	102, 121	3.00
4.00	Visiting Nurse	0	0		0	0	1
5. 00	Other Nurse	0	Ô			Ö	
6. 00	Clinical Psychologist	0	0			0	1
7. 00	Clinical Social Worker	0	0			0	
		0	0			0	1
8.00	Laboratory Techni ci an	04.5(0	U	0.4.57	4 500	0 101	8.00
9. 00	Other Facility Health Care Staff Costs	84, 568	U	84, 568			1
10. 00	Subtotal (sum of lines 1 through 9)	366, 874	0	366, 87	1, 538	1	1
11. 00	Physician Services Under Agreement	0	0)	0	0	
12. 00	Physician Supervision Under Agreement	0	0)	0	0	12. 00
13. 00	Other Costs Under Agreement	0	0)	0	0	13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0) (0	0	14. 00
15. 00	Medical Supplies	0	23, 858	23, 858	3 0	23, 858	15. 00
16. 00	Transportation (Health Care Staff)	0	0		0	0	16. 00
17.00	Depreciation-Medical Equipment	0	O) (0	0	17. 00
18. 00	Professional Liability Insurance	0	0		0	0	18. 00
	Other Health Care Costs	67, 146	34, 563	101, 709	9	101, 709	1
20. 00	Allowable GME Costs	0.,	0.,111),	0	0	1
21. 00	Subtotal (sum of lines 15 through 20)	67, 146	58, 421	125, 56	7	125, 567	
22. 00	Total Cost of Health Care Services (sum of	434, 020	58, 421	•			
22.00	lines 10, 14, and 21)	434, 020	30, 421	472, 44	1, 330	473, 777	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23. 00	Pharmacy	0	0		0	0	23. 00
24. 00	Dental	0	0	1		0	1
25. 00	Optometry	0	0			0	25. 00
26. 00	All other nonreimbursable costs	0				0	26.00
		0	0			0	
27. 00	Nonallowable GME costs	0	U			0	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0)	0	0	28. 00
	through 27)						
20.00	FACILITY OVERHEAD	0	0				20.00
29. 00	Facility Costs	0	0	(0	0	/
30. 00	Administrative Costs	0	0	'	0		30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	0		0	0	31. 00
	30)						
32. 00	Total facility costs (sum of lines 22, 28	434, 020	58, 421	492, 44	1, 538	493, 979	32. 00
	and 31)						

Health Financial Systems	MEMORI A	L HOSP & HEALT	H CARE CTR			In Lieu	of Form C	MS-2552-10
ANALYSIS OF HOSPITAL-BASED RURAL	HEALTH CLINIC/FEDERALLY	QUALIFIED	Provider CCN:	150115			Worksheet	M-1
HEALTH CENTER COSTS			C CON	150500	From 07/0			D
			Component CCN:	158508	10 06/30		11/23/2015	
					Rural He	al th	Cos	st

				Clinic (RHC) II	
		Adjustments	Net Expenses	CITILE (KIIC) II	
		Adj d3 tilicitt3	for Allocation		
			(col . 5 + col .		
			6)		
		6, 00	7. 00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physi ci an	0	180, 185		1.00
2.00	Physician Assistant	0	0		2. 00
3.00	Nurse Practitioner	0	102, 121		3.00
4.00	Visiting Nurse	0	0		4. 00
5.00	Other Nurse	0	0		5. 00
6.00	Clinical Psychologist	0	0		6. 00
7.00	Clinical Social Worker	0	0		7. 00
8.00	Laboratory Techni ci an	0	0		8. 00
9.00	Other Facility Health Care Staff Costs	0	86, 106		9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	368, 412		10.00
11.00	Physician Services Under Agreement	0	0		11. 00
12.00	Physician Supervision Under Agreement	0	0		12. 00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14. 00
15.00	Medical Supplies	0	23, 858		15. 00
16.00	Transportation (Health Care Staff)	0	0		16. 00
17.00	Depreciation-Medical Equipment	0	0		17. 00
18.00	Professional Liability Insurance	0	0		18. 00
19.00	Other Health Care Costs	-19, 850	81, 859		19. 00
20.00	Allowable GME Costs	0	0		20. 00
21.00	Subtotal (sum of lines 15 through 20)	-19, 850	105, 717		21. 00
22.00	Total Cost of Health Care Services (sum of	-19, 850	474, 129		22. 00
	lines 10, 14, and 21)				
	COSTS OTHER THAN RHC/FQHC SERVICS				
23. 00	Pharmacy	0	0		23. 00
24. 00	Dental	0	0		24. 00
25. 00	Optometry	0	0		25. 00
26. 00	All other nonreimbursable costs	0	0		26. 00
27. 00	Nonallowable GME costs	0	0		27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		28. 00
	through 27)				
00.00	FACILITY OVERHEAD			J	
29. 00	Facility Costs	0	1	l .	29. 00
30.00	Administrative Costs	0	0	1	30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	0		31. 00
32. 00	30) Total facility costs (sum of lines 22, 28	-19, 850	474 120		32. 00
32.00		- 19, 850	474, 129		32.00
	and 31)		I	I	1

Heal th	Financial Systems ME	MORIAL HOSP & F	HEALTH	I CARE CTF	₹	In Lie	u of Form CMS-2	2552-10
	TION OF OVERHEAD TO RHC/FQHC SERVICES			Provi der		Period: From 07/01/2014	Worksheet M-2	
				Component		To 06/30/2015	Date/Time Pre 11/23/2015 9:	
						Rural Health Clinic (RHC) I	Cost	
		Number of FTE	Total	l Visits	Producti vi ty	/ Minimum Visits	Greater of	
		Personnel				(col. 1 x col. 3)	4	
		1.00		2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY							
	Posi ti ons							
1.00	Physi ci an	0. 12		357				1. 00
2.00	Physician Assistant	0.00	1	0	_,			2. 00
3.00	Nurse Practitioner	0. 96	1	3, 171				3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 08		3, 528		2, 520		4. 00
5.00	Visiting Nurse	0. 00		0	•		0	5. 00
6.00	Clinical Psychologist	0. 00		0			0	6. 00
7.00	Clinical Social Worker	0. 00		0			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0. 00		0			0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0. 00		0			0	7. 02
8. 00	Total FTEs and Visits (sum of lines 4	1. 08		3, 528			3, 528	8. 00
	through 7)							
9.00	Physician Services Under Agreements			0			0	9. 00
							1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO							
10.00				e 22)			345, 768	
11. 00	Total nonreimbursable costs (from Wkst. M-1,						0	11. 00
12.00			and 1	1)			345, 768	
13.00							1. 000000	
14. 00	,						0	14.00
15. 00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			265, 676	
16. 00	,						265, 676	
17. 00	Allowable GME overhead (see instructions)						0	17. 00
18. 00							265, 676	
	Overhead applicable to RHC/FQHC services (li						265, 676	
20. 00	Total allowable cost of RHC/FQHC services (s	um of lines 10	and 1	9)			611, 444	20.00

		MORIAL HOSP & F				u of Form CMS-2			
ALLOCA	TION OF OVERHEAD TO RHC/FQHC SERVICES		Provi der		Peri od:	Worksheet M-2			
			Componen ⁻	t CCN: 158508	From 07/01/2014 To 06/30/2015	Date/Time Pre 11/23/2015 9:			
					Rural Health	Cost			
				1 - (Clinic (RHC) II				
		Number of FTE	Total Visits		Minimum Visits				
		Personnel		Standard (1)	(col . 1 x col .				
		1.00	2.00	3.00	3) 4. 00	5. 00			
	VISITS AND PRODUCTIVITY	1.00	2.00	3.00	4.00	5.00			
	Positions						1		
1. 00	Physi ci an	0.88	3, 863	4, 200	3, 696		1.00		
2. 00	Physician Assistant	0.00		1			2.00		
3. 00	Nurse Practitioner	0. 90	l				3.00		
4. 00	Subtotal (sum of lines 1 through 3)	1. 78			5, 586	6, 597			
5. 00	Visiting Nurse	0.00		i	3, 300	0, 377	1		
6. 00	Clinical Psychologist	0.00				0	6. 00		
7. 00	Clinical Social Worker	0.00	l e			0	7. 00		
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l e	,		0	7. 01		
7. 02	Diabetes Self Management Training (FQHC	0.00	l e)		0	7. 02		
	only)								
8.00	Total FTEs and Visits (sum of lines 4	1. 78	6, 597			6, 597	8. 00		
	through 7)								
9. 00	Physician Services Under Agreements		C)		0	9. 00		
						1. 00			
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO					17.1.100			
10.00						474, 129			
11.00						0	11. 00 12. 00		
12. 00 13. 00	Cost of all services (excluding overhead) (s Ratio of RHC/FQHC services (line 10 divided		and II)			474, 129 1. 000000			
14. 00						1.000000			
15. 00									
16. 00	· ·	ty (See This truc	. (1 0113)			498, 360 498, 360			
17. 00	Allowable GME overhead (see instructions)					470, 300	17. 00		
18. 00	Subtotal (see instructions)					498, 360			
	Overhead applicable to RHC/FQHC services (Ii	ne 13 x line 18	3)			498, 360			
			,			.,5,000			

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	TH CARE CTR Provider CCN: 150115	In Lie Period:	Worksheet M-3		
		Component CCN: 158507	From 07/01/2014 To 06/30/2015	Date/Time Pre 11/23/2015 9:		
		Title XVIII	Rural Health Clinic (RHC) I	Cost		
				1.00		
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			1. 00		
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, lin	e 20)		611, 444	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, lin	e 15)		3, 165		
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			608, 279		
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5, l	ino (I)		3, 528 0	4. 00 5. 00	
6. 00	Total adjusted visits (line 4 plus line 5)	The 9)		3, 528		
7. 00	Adjusted cost per visit (line 3 divided by line 6)			172. 41	7. 00	
			Cal cul ati on	of Limit (1)		
			Prior to	On on After		
			January 1	January 1		
0.00	Den visit segment limit (form CNC Date 100 OA shorter 0 COO	(1. 00	2. 00 79. 80	8. 00	
8. 00 9. 00						
7. 00	CALCULATION OF SETTLEMENT					
10.00						
11. 00	Program cost excluding costs for mental health services (line		0	107, 730		
12.00	Program covered visits for mental health services (from contra		0	0		
13. 00 14. 00	Program covered cost from mental health services (line 9 x lin Limit adjustment for mental health services (see instructions)	,	0	0		
15. 00	Graduate Medical Education Pass Through Cost (see instructions)			0	15.00	
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2			107, 730		
16. 01	Total program charges (see instructions)(from contractor's rec			257, 489	16. 01	
16. 02	Total program preventive charges (see instructions)(from provi			243		
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			102		
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03 (Titles V and XIX see instructions.)	and 18) times .80)		67, 562	16. 04	
16. 05	Total program cost (see instructions)			67, 664	16. 05	
17. 00	Primary payer amounts			283	17. 00	
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		23, 175	18. 00	
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	s) (from contractor		46, 814	19. 00	
20. 00	Net Medicare cost excluding vaccines (see instructions)			67, 381	20.00	
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		3, 024		
22. 00	Total reimbursable Program cost (line 20 plus line 21)			70, 405		
23. 00	Allowable bad debts (see instructions)			0	23. 00	
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0		
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	4011 0113)		0		
25. 50	Pioneer ACO demonstration payment adjustment (see instructions)		0		
26. 00	Net reimbursable amount (see instructions)			70, 405		
26. 01	Sequestration adjustment (see instructions)			1, 408		
27. 00 28. 00	Interim payments Tentative settlement (for contractor use only)			64, 537 0		
29. 00	Balance due component/program (line 26 minus lines 26.01, 27,	and 28)		4, 460		
30.00	Protested amounts (nonallowable cost report items) in accordan			0		

	Financial Systems MEMORIAL HOSP & HEAL ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 150115	Peri od:	u of Form CMS-2 Worksheet M-3		
		Component CCN: 158508	From 07/01/2014 To 06/30/2015	Date/Time Pre	pared:	
		Title XVIII	Rural Health Clinic (RHC) II	Cost		
				1.00		
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			1. 00		
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, lin	e 20)		972, 489	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, lin	e 15)		8, 841	2. 00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			963, 648		
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	i no (0)		6, 597	4.00	
5. 00 6. 00	Physicians visits under agreement (from Wkst. M-2, column 5, I Total adjusted visits (line 4 plus line 5)	The 9)		0 6, 597	5. 00 6. 00	
7. 00	Adjusted cost per visit (line 3 divided by line 6)			146. 07	7. 00	
	,		Cal cul ati on			
			Prior to	On on After		
			January 1	January 1		
			1. 00	2. 00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	79. 80	79. 80 79. 80	8. 00 9. 00	
9. 00	.00 Rate for Program covered visits (see instructions) 79.80 CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from	contractor records)	0	2, 094	10.00	
11.00	Program cost excluding costs for mental health services (line	167, 101	11. 00			
12.00	Program covered visits for mental health services (from contra		0	0	12. 00	
13.00	Program covered cost from mental health services (line 9 x lin		0	0	13.00	
14. 00 15. 00	Limit adjustment for mental health services (see instructions) Graduate Medical Education Pass Through Cost (see instructions		0	0	14. 00 15. 00	
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•		167, 101		
16. 01	Total program charges (see instructions) (from contractor's rec	•		307, 194	16. 01	
16. 02	Total program preventive charges (see instructions) (from provi	•		76	ł	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	line 16)		41	16. 03	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03 (Titles V and XIX see instructions.)	and 18) times .80)		106, 795	16. 04	
16. 05	Total program cost (see instructions)			106, 836	•	
17.00	Primary payer amounts	/f		357	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) records)			33, 566		
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	s) (Irom contractor		54, 711	19. 00	
20. 00	Net Medicare cost excluding vaccines (see instructions)			106, 479		
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		8, 707	21. 00	
22. 00	Total reimbursable Program cost (line 20 plus line 21)			115, 186 0		
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	23. 00 23. 01	
24. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	uctions)		0	24.00	
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	uet. ee,		0		
25. 50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25. 50	
26. 00	Net reimbursable amount (see instructions)			115, 186	ı	
26. 01	Sequestration adjustment (see instructions)			2, 304	26. 01	
27. 00 28. 00	Interim payments			102, 532	27. 00 28. 00	
28.00	Tentative settlement (for contractor use only) Balance due component/program (line 26 minus lines 26.01, 27,	and 28)		0 10, 350		
30.00	Protested amounts (nonallowable cost report items) in accordan			10, 350	30.00	
	chapter I, §115.2	•				

Heal th	Financial Systems MEMORIAL HOSP & HEAL	TH CARE CTR	In Lie	u of Form CMS-2	552-10
	ATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provi der CCN: 150115	Peri od:	Worksheet M-4	
		Component CCN: 158507	From 07/01/2014 To 06/30/2015	Date/Time Prep 11/23/2015 9:5	
		Title XVIII	Rural Health	Cost	
		Clinic (RHC) I			
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	170, 927	170, 927	1. 00	
2.00	Ratio of pneumococcal and influenza vaccine staff time to total	health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line	e 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from	om your records)	388	1, 402	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	line 4)	388	1, 402	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line	e 22)	345, 768	345, 768	6.00
7.00	Total overhead (from Wkst. M-2, line 16)		265, 676	265, 676	7.00
8.00	8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5			0. 004055	8. 00
0.00	divided by line 6)		000	4 077	0.00
9. 00	Overhead cost - pneumococcal and influenza vaccine (line 7 x li	ne 8)	298	1, 077	9. 00

686

686

114.33

2, 479 10.00

11.00

12.00

13.00

14.00

15.00

88

83

28. 17

2, 338

3, 165

3, 024 16. 00

10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of

Cost per pneumococcal and influenza vaccine injection (line 10/line 11)

Total Program cost of pneumococcal and influenza vaccine and its (their)

Total number of pneumococcal and influenza vaccine injections (from your records)

Number of pneumococcal and influenza vaccine injections administered to Program

Program cost of pneumococcal and influenza vaccine and its (their) administration

Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)

administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,

lines 5 and 9)

benefi ci ari es

line 21)

(line 12 x line 13)

11.00

12.00

13.00

14.00

15.00

Health Financial Systems	In Lieu of Form CMS-2552-10				
COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACO	CINE COST	Provider CCN: 150115		Worksheet M-4	
			From 07/01/2014		
		Component CCN: 158508	To 06/30/2015	Date/Time Pre	pared:
				11/23/2015 9:	52 am
		Title XVIII	Rural Health	Cost	
			Clinic (RHC) II		
			Pneumococcal	I nfl uenza	
			4 00	0.00	

		Clinic (RHC) II		
		Pneumococcal	I nfl uenza	
		1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	368, 412	368, 412	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2. 00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1, 618	2, 692	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1, 618	2, 692	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	474, 129	474, 129	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	498, 360	498, 360	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5	0. 003413	0. 005678	8. 00
	divided by line 6)			
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1, 701	2, 830	9. 00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of	3, 319	5, 522	10.00
	lines 5 and 9)			
11. 00	Total number of pneumococcal and influenza vaccine injections (from your records)	25	169	11. 00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	132. 76	32. 67	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program	24	169	13.00
	benefi ci ari es			
14. 00	Program cost of pneumococcal and influenza vaccine and its (their) administration	3, 186	5, 521	14. 00
	(line 12 x line 13)			
15. 00			8, 841	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			
16. 00	Total Program cost of pneumococcal and influenza vaccine and its (their)		8, 707	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,			
	line 21)			

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR						In Lieu of Form CMS-2552-10			
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED	RHC/FQHC PROVI DER	FOR SERVICES	Provi der	CCN:	150115			Worksheet M-5	
RENDERED TO PROGRAM BENEFICIARIES			Component	CCN:	158507		07/01/2014 06/30/2015	Date/Time Prepared:	
								11/23/2015 9:52 am	
						Rura	l Health	Cost	

			Rural Health	Cost	
			Clinic (RHC) I		
				t B	
			mm/dd/yyyy	Amount	
4 00			1. 00	2.00	4 00
1.00	Total interim payments paid to provider			64, 537 0	1.00
2.00	Interim payments payable on individual bills, either submitted the contractor for services rendered in the cost reporting;			U	2. 00
	"NONE" or enter a zero	berrod. It holle, write			
3. 00	List separately each retroactive lump sum adjustment amount	hasad on subsequent			3. 00
3.00	revision of the interim rate for the cost reporting period.				3. 00
	payment. If none, write "NONE" or enter a zero. (1)	711 30 311011 date of each			
	Program to Provider				
3. 01				0	3. 01
3.02				l ol	3. 02
3.03				0	3. 03
3.04				0	3. 04
3.05				0	3. 05
	Provider to Program				
3.50	-			0	3. 50
3.51				0	3. 51
3.52				0	3. 52
3.53				0	3. 53
3.54				0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9			0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transf	fer to Worksheet M-3, line		64, 537	4. 00
	27)				
	TO BE COMPLETED BY CONTRACTOR		- T	ı	
5. 00	List separately each tentative settlement payment after designed payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date of			5. 00
	Program to Provider				
5. 01	r ogram to rrottuo.			0	5. 01
5. 02				l ol	5. 02
5. 03				0	5. 03
	Provider to Program				
5.50				0	5. 50
5. 51				0	5. 51
5. 52				0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9	98)		0	5. 99
6.00	Determined net settlement amount (balance due) based on the	cost report. (1)			6. 00
6. 01	SETTLEMENT TO PROVIDER			4, 460	6. 01
6.02	SETTLEMENT TO PROGRAM			0	6. 02
7.00	Total Medicare program liability (see instructions)			68, 997	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
8. 00	Name of Contractor				8. 00

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR			In Lieu of Form CMS-2552-10		
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RENDERED TO PROGRAM BENEFICIARIES	RHC/FQHC PROVI DER FOR SE	ERVICES Provider (CCN: 150115	Peri od: From 07/01/2014	Worksheet M-5	
RENDERED TO TROOKAW BENEFFOR ARTES		Component	CCN: 158508		Date/Ti me Prepared: 11/23/2015 9:52 am	
				Rural Health	Cost	

				11/23/2013 /. 0	02 aiii
			Rural Health	Cost	
			Clinic (RHC) II		
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1. 00	Total interim payments paid to provider			102, 532	1.0
2. 00	Interim payments payable on individual bills, either submit		ا ا	2.0	
2.00	the contractor for services rendered in the cost reporting			Ĭ	0
		perrou. Il none, write			
	"NONE" or enter a zero				
3. 00	List separately each retroactive lump sum adjustment amount				3.0
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01				0	3.0
3. 02				Ö	3.0
3. 03				0	3.0
3. 04				0	3.0
3. 05				0	3.0
	Provider to Program				
3. 50				0	3.5
3. 51				ا	3. 5
				- 1	
3. 52				0	3. 5
3. 53				0	3.5
3. 54				0	3.5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3. 9
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans		102, 532	4.0	
00	27)	or to normandet in or time		102,002	0
	TO BE COMPLETED BY CONTRACTOR				
- 00		.l	-		
5. 00	List separately each tentative settlement payment after des	sk review. Also snow date of			5. C
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5. 01				0	5.0
5. 02				l ol	5. C
5. 03				l ol	5. C
00	Provider to Program				0.0
EO	Trovider to rrogram				
. 50				0	5. 5
. 51				0	5. 5
. 52				0	5. 5
. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5. 9
. 00	Determined net settlement amount (balance due) based on the cost report. (1)				6.0
. 01	SETTLEMENT TO PROVIDER			10, 350	6. (
5. 02	SETTLEMENT TO PROGRAM			10, 330	6.0
7. 00	Total Medicare program liability (see instructions)			112, 882	7.0
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
3. 00	Name of Contractor				8. 0
	1	ļ.	1	ı	,