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 07/01/2015 and ending 06/30/2016 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	135, 818	122, 728	-144, 429	0	1. 00
2.00	Subprovi der - I PF	0	9, 062	2		0	2. 00
3.00	Subprovider - IRF	0	12, 246	49		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	2, 096	-9		0	7. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		7, 706		0	10.00
10. 01	RURAL HEALTH CLINIC II	0		11, 725		0	10. 01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200.00	Total	0	159, 222	142, 201	-144, 429	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 07/01/2015 Part I Date/Time Prepared: 06/30/2016 11/28/2016 1:02 pm 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 99915 Р 4.00 Subprovider - IPF MEMORIAL HOSP & HCC 15S115 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 Hospi tal -Based Hospi ce 14.00 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 99915 15.01 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) 07/01/2015 06/30/2016 20.00 Type of Control (see instructions) 21.00 21 00 1 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for disproportionate γ 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 §412.106(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 5. 00 4 00 6 00 24.00 If this provider is an IPPS hospital, enter the 339 709 0 1, 494 184 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.

Health Financial Systems MEMORIAL H	IOSP & HEALT	TH CARE CTR			In Lieu	u of For	m CMS-2	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	·ΤΑ	Provi der	CCN: 150115	Period: From 07/0	1/2015	Worksho Part I	eet S-2			
					30/2016					
	In-State Medicaid	In-State Medicaid	Out-of State	Out-of State	Medi ca	id 0	ther di cai d			
	paid days	eligible	Medi cai d	Medi cai d	HMO da	J -	days			
		unpai d days	paid days	el i gi bl e unpai d						
	1.00	2. 00	3. 00	4. 00	5. 00		5. 00			
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	58	0	0		18		25. 00		
				Urban/F	Rural S	Date of 2.0		-		
26.00 Enter your standard geographic classification (not wa		at the beg	ginning of t		2		<u> </u>	26. 00		
cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not wa		at the end	d of the cos	t	2			27. 00		
reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi			opl i cabl e,							
35.00 If this is a sole community hospital (SCH), enter the			CH status in		0			35. 00		
effect in the cost reporting period.				Begi n	ni ng:	Endi	ng:			
36.00 Enter applicable beginning and ending dates of SCH st	tatus Subsi	crint line	36 for numb	1.	00	2. (00	36. 00		
of periods in excess of one and enter subsequent date	es.									
37.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	r the numbe	r or period	as MDH STATU	5	0			37.00		
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in Naccordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)										
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and										
enter subsequent dates.				Υ/	'N	Υ/	'N			
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume N N										
hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)										
40.00 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.	oer 1. Ente	r "Y" for y			V	XVIII	XI X	40. 00		
					1.00		3.00			
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital paymer	nt for disp	roporti onat	te share in	accordance	l N	N	l N	45. 00		
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exce	eption for	extraordi na	ary circumst	ances	N	N	N	46. 00		
pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300 PPS capi				G	N	N	N	47. 00		
48.00 Is the facility electing full federal capital payment Teaching Hospitals		,			N	N	N	48. 00		
56.00 Is this a hospital involved in training residents in or "N" for no.	approved G	ME programs	? Enter "Y	" for yes	N			56. 00		
57.00 If line 56 is yes, is this the first cost reporting p GME 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 "N	yes or "N th of this	" for no in cost report	n column 1. ting period?	If column Enter "Y				57. 00		
"N", complete Wkst. D, Parts III & IV and D-2, Pt. II	, if appli	cabl e.						F0 00		
58.00 If line 56 is yes, did this facility elect cost reimble defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			ans service	s as				58. 00		
59.00 Are costs claimed on line 100 of Worksheet A? If yes 60.00 Are you claiming nursing school and/or allied health				he	N N			59. 00 60. 00		
provider-operated criteria under §413.85? Enter "Y"	for yes or	"N" for no	. (see inst	ructions)				55.00		
	Y/N	IME	Direct GM	E IN	/IE	Di rec	t GME			
61.00 Did your hospital receive FTE slots under ACA	1. 00 N	2. 00	3. 00	4.	0.00	5. (61.00		
section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	IN				0.00		0.00			
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0. 00	0	. 00				61.01		

HOSPI T	FAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provi der		eriod: rom 07/01/2015 o 06/30/2016		pared:
		Y/N	IME	Direct GME	IME	Direct GME	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)	9	0.00	0.00			61. 02
61. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61. 03
61. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61. 04
61. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)	è	0.00	0.00			61. 05
61. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61. 06
		Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	Jan 11		1. 00	2. 00	3.00	4. 00	
61. 10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				O. OC	0.00	61. 10
61. 20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.	ו			O. OC	0.00	61. 20
						1.00	
(0.00	ACA Provisions Affecting the Health Resources and S				1.6	0.00	(0.00
62. 01	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruenter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC productions are continuously to the second secon	uctions) a Teachi	ing Health Cent	ter (THC) into			62. 00
	Teaching Hospitals that Claim Residents in Nonprovi	der Sett	ings				1
63. 00	Has your facility trained residents in nonprovider s "Y" for yes or "N" for no in column 1. If yes, compl				eri od? Enter	N	63. 00
				Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
64. 00		ore June ty trai:	e 30, 2010. ned residents	This base year 0.00			64.00
	in the base year period, the number of unweighted no resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighteresident FTEs that trained in your hospital. Enter in f (column 1 divided by (column 1 + column 2)). (see	on-priman n all non ed non-pr n column	ry care nprovider rimary care n 3 the ratio				
	Program Name		rogram 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	

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPI		OSP & HEALTH		CCN: 150115 Pe	eriod: om 07/01/	/2015	u of For Workshe Part I	et S-2		
					To	06/30/	/2016	Date/Ti 11/28/2			
		Program Name	Program	Code	Unwei ghted FTEs Nonprovi der Si te	Unwei gh FTEs i Hospi t	in	Ratio (c (col. 3 4)	col. 3/ + col.		
<u>/F 00</u>	Enter in column 1 if line (2)	1.00	2.00)	3.00	4. 00		5. 0		/F 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 at volumn 4)). (see instructions)				0.00		0. 00	U.	000000	65.00	
	i)). (See Thisti detroils)				Unwei ghted	Unwei gh		Ratio (d			
					FTEs Nonprovi der Si te	FTEs i Hospit		(col. 1 2)			
	Section 5504 of the ACA Current	Vear FTE Residents in	Setting	1.00	2.00		3.0				
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider SettingsEffective for cost rebeginning on or after July 1, 2010						<u> </u>				
66. 00	6.00 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)									66. 00	
		Program Name	Program	Code	Unwei ghted FTEs Nonprovi der Si te	Unwei gh FTEs i Hospi t	in	Ratio (col. 3	+ col .		
		1. 00	2. 00)	3. 00 4. 0			5. C			
67. 00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.00		0.00	U.	000000	67.00	
							1. 00	2.00	3.00		
70, 00	Inpatient Psychiatric Facility P Is this facility an Inpatient Ps		PF), or does	it conta	ain an IPF subn	rovi der?	Υ			70. 00	
 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. 71.00 If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 									0	71. 00	
75. 00		habilitation Facility	(IRF), or d	oes it co	ontain an IRF		Υ			75. 00	
76. 00	75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF Y subprovider? Enter "Y" for yes and "N" for no.										

Health Financial Systems MEMORIAL HOSP & HE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CCN: 150115	Period: From 07/01/2015 To 06/30/2016		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 o "Y" for yes and "N" for no.			ng period? Enter	N N	80. 00
TEFRA Providers 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		-		N	85. 00 86. 00
\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital a "subclause (II)" LTCH classified under sefor yes or "N" for no.	ction 1886(d)	(1)(B)(iv)(I	I)? Enter "Y"	N	87. 00
I or yes or in tor no.			V	XIX	
Title V and XIX Services			1. 00	2.00	
90.00 Does this facility have title V and/or XIX inpatient hospita	I services? E	nter "Y" for	N	Υ	90.00
yes or "N" for no in the applicable column. 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	he cost repor	t either in	N	N	91. 00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (du instructions) Enter "Y" for yes or "N" for no in the applica	al 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.		d XIX? Enter	N	N	93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for n	o in the	N	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	0. 00 N	0. 00 N	95. 00 96. 00		
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the app	licable colum	n.	0. 00	0.00	97. 00
Rural Providers 105.00 Does this hospital qualify as a critical access hospital (CA 106.00 of this facility qualifies as a CAH, has it elected the all-		had of nayma	N		105. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost 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.	reimbursemen 1. (see inst	t for I&R ructions) If			107. 00
reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	•	-			108. 00
	Physi cal	Occupati on		Respi ratory	<u>'</u>
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00	2.00	3.00	4.00	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"	l Demonstrati for no.	on project (410A Demo)for	N	110. 00
			1. 0	0 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" percen psychiatric, rehabilitation and long term hospitals provider	If column 2 t for long te	is "E", ente rm care (inc	r in column Iudes	0	115. 00
Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insurance.			r "N" for Y		116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1	if the polic	y is 1		118. 00
		Premi ums	Losses	Insurance	
		1. 00	2.00	3.00	
118.01 List amounts of malpractice premiums and paid losses:		1, 264, 0			0 118. 01

149.00 Was there a change to the simplified cost finding method? E	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	m the applicati	on of the lowe	r of costs	
or charges? Enter "Y" for yes or "N" for no for each compor	ent for Part A	and Part B. (S	See 42 CFR §413	. 13)	
155. 00 Hospi tal	N	N	N	N	155. 00
156. 00 Subprovi der - IPF	N	N	N	N	156. 00
157.00 Subprovider - IRF	N	N	N	N	157. 00
158. 00 SUBPROVI DER					158. 00
159. 00 SNF	N	N	N	N	159. 00
160. OO HOME HEALTH AGENCY	N	N	N	N	160. 00
161. 00 CMHC		N	N	N	161. 00

Health Financial Systems		P & HEALTH CARE CTF	?		In Lie	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provi der	CCN: 1501	From O	7/01/2015	Worksheet S- Part I Date/Time Pro 11/28/2016 1	epared:
						1. 00	
Multicampus 165.00 s this hospital part of a Multicam Enter "Y" for yes or "N" for no.	npus hospital that ha	s one or more camp	uses in di	ifferent CB	SAs?	N	165. 00
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. 0	0 166. 00
						1.00	
Health Information Technology (HIT)							
167.00 Is this provider a meaningful user						Υ	167. 00
168.00 If this provider is a CAH (line 105 reasonable cost incurred for the HI			e 167 is '	"Y"), enter	the		0168.00
168.01 If this provider is a CAH and is no exception under §413.70(a)(6)(ii)?					lshi p		168. 01
169.00 If this provider is a meaningful us transition factor. (see instruction		and is not a CAH	(line 105	iś"N"), e	nter the	0. 5	0169. 00
				Be	gi nni ng	Endi ng	
					1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR be period respectively (mm/dd/yyyy)	eginning date and end	ing date for the re	eporti ng	10/	′01/2014	12/29/2015	170. 00
						1. 00	\perp
171.00 If line 167 is "Y", does this provi Medicare cost plans reported on Wks (see instructions)						N	171. 00

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der	CCN: 150115	Peri od: From 07/01/2015 To 06/30/2016		epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO so	ananasa Ent	1.00	2.00	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation	TOP ALL NO FE	esponses. Ento	er all dates in i	Line	
00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in c		instructions			
			Y/N 1.00	2. 00	V/I 3. 00	
00	Has the provider terminated participation in the Medicare P	rogram2 lf	1.00 N	2.00	3.00	2.0
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	n 3, "V" for				
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and othe	ffices, drug er or its f the board	N			3.0
	relationships? (see instructions)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports					
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date ava	or Compiled,	Y	А	11/03/2016	4.0
00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit recipied to the cost report total expenses and total revenues difference to the cost of		N			5. 0
	THOSE OF THE TITE THATELET STATEMENTS. IT YOU, SUMMET TOO	oner i i a ci on.		Y/N	Legal Oper.	
				1. 00	2. 00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the Legal operator of the program?	If yes, is th	ne provider i	S N		6.0
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		I during the	N N		7. 0 8. 0
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	S.		N		9. 00
00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			N N		10.0
	Teaching Program on Worksheet A? If yes, see instructions.	<u>а к ги ан др</u>			Y/N	1110
	Bad Debts				1. 00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y N	12. 0 13. 0
. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	nts waived? If	yes, see in:	structions.	N	14. 0
. 00	Did total beds available change from the prior cost reporti				N	15.0
		Y/N	T A	Y/N	t B	
		1. 00	2.00	3.00	Date 4. 00	
	PS&R Data	1.00	2.00	0.00	1. 00	
00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	11/02/2016	Y	11/02/2016	16.0
00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17. 0
00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18. 0
	but are not included on the PS&R Report used to file this					1

Heal th	Financial Systems MEMORIAL HOSP &	HEALTH CARE CTI	2	In Lie	eu of Form CMS	S-2552-10					
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 150115	Peri od: From 07/01/2015 To 06/30/2016	Worksheet S Part II	-2 repared:					
			i pti on	Y/N	Y/N						
20.00	If line 1/ on 17 is use were adjustments made to DCOD		0	1. 00	3.00	20.00					
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00					
	report data for other. Beserve the other day astiments.	Y/N	Date	Y/N	Date						
_		1.00	2.00	3. 00	4. 00						
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00					
					1. 00						
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCI	EPT CHILDRENS H	IOSPI TALS)		1.00						
	Capital Related Cost		Í								
22. 00	Have assets been relifed for Medicare purposes? If yes, see					22. 00					
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprais	sals made dur	ing the cost		23. 00					
24. 00	reporting period? If yes, see instructions. 1.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period?										
21.00	If yes, see instructions	ca mito danning	11113 0031 10	por tring perrou.		24. 00					
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	If yes, see		25. 00					
01.00	instructions.		. 10.1	6		04.00					
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	•	0.			26. 00					
27. 00	Has the provider's capitalization policy changed during the copy. Interest Expense	e cost reportir	g perrou? II	yes, subili t		27. 00					
28. 00	Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting										
29. 00											
30. 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 instructions.										
31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes	, see		31. 00					
	Purchased Servi ces										
32. 00	Have changes or new agreements occurred in patient care se		ed through co	ntractual		32. 00					
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 applied to the second section of the section of the second section of the section of the second section of the section of the second section of the secti		ng to competi	tive bidding? If		33. 00					
	no, see instructions. Provider-Based Physicians				l						
34.00	Are services furnished at the provider facility under an a	rrangement with	n provi der-ba	sed physicians?		34. 00					
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	isting agreemer	nts with the p	provi der-based		35. 00					
	physicians during the cost reporting period? If yes, see in	nstructions.		N/ /N	5 .						
				1. 00	2.00						
	Home Office Costs			1.00	2.00						
36. 00						36. 00					
37. 00	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	repared by the	home office?			37. 00					
38. 00						38. 00					
39. 00	If line 36 is yes, did the provider render services to other see instructions.			,		39. 00					
40. 00		home office?	If yes, see			40. 00					
		1	00	2	00						
	Cost Report Preparer Contact Information										
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	ВОВ		BRANDENBURG		41. 00					
42. 00	respectively. Enter the employer/company name of the cost report	BKD, LLP				42. 00					
43. 00	preparer. Enter the telephone number and email address of the cost	(317) 383-3787		BBRANDENBURG@B	KD. COM	43. 00					
	report preparer in columns 1 and 2, respectively.	1		I		II					

CMS-2552-10
S-2
Prepared:
6 1:02 pm
41. 00
42. 00
43.00

Health Financial Systems MEMORIAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 150115

						10	00/ 30/ 2010	11/28/2016		
								I/P Days / (
								Visits / Tri		
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V		
	•	Line Number			Avai I abl e					
		1.00		2.00	3.00		4. 00	5. 00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		85	31, 11	10	0.00		0	1. 00
	8 exclude Swing Bed, Observation Bed and									
	Hospice days)(see instructions for col. 2									
	for the portion of LDP room available beds)									
2.00	HMO and other (see instructions)									2. 00
3.00	HMO IPF Subprovider									3.00
4.00	HMO IRF Subprovider									4.00
5.00	Hospital Adults & Peds. Swing Bed SNF								0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF								0	6. 00
7. 00	Total Adults and Peds. (exclude observation			85	31, 11	10	0. 00		0	7. 00
	beds) (see instructions)									
8. 00	INTENSIVE CARE UNIT	31. 00		26	9, 51	16	0. 00		0	8. 00
9.00	CORONARY CARE UNIT									9. 00
10. 00	BURN INTENSIVE CARE UNIT									10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT									11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)									12. 00
13. 00	NURSERY	43. 00							0	13. 00
14. 00	Total (see instructions)			111	40, 62	26	0. 00		0	14. 00
15. 00	CAH visits								0	15. 00
16. 00	SUBPROVI DER - I PF	40. 00		19					0	16. 00
17. 00	SUBPROVI DER - I RF	41. 00		8	2, 92	28			0	17. 00
18.00	SUBPROVI DER	44.00		00	7.00					18.00
19. 00	SKILLED NURSING FACILITY	44. 00		20	7, 32	20			0	19. 00
20.00	NURSING FACILITY									20.00
21. 00	OTHER LONG TERM CARE	101 00								21. 00
22. 00	HOME HEALTH AGENCY	101. 00							0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	11/ 00		0		0				23. 00 24. 00
24. 00	HOSPICE	116.00		Ü	1	U				
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30. 00								24. 10 25. 00
26. 00	RURAL HEALTH CLINIC	88. 00							0	26. 00
26. 00	RURAL HEALTH CLINIC	88. 00							0	26. 00
		89. 00							0	
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	89.00		158					۷	26. 25 27. 00
28. 00	Total (sum of lines 14-26) Observation Bed Days			130	1				0	28. 00
29. 00	1								١	29. 00
30.00	Ambulance Trips Employee discount days (see instruction)									30.00
31. 00	Employee discount days (see Histruction)									31. 00
32.00	Labor & delivery days (see instructions)			0		0				31.00
32. 00	Total ancillary labor & delivery room			U	1	U				32. 00
32. UI	outpatient days (see instructions)									JZ. U1
33 00	LTCH non-covered days									33. 00
55.50	12.2	ı			1	1		ı	'	- 5. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150115

Peri od:
From 07/01/2015
Part I
To 06/30/2016
Date/Time Prepared:

11/28/2016 1:02 pm Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 10.00 6.00 7.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 4,660 199 10, 104 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 322 2.203 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 C 0 6.00 7.00 Total Adults and Peds. (exclude observation 4,660 199 10, 104 7.00 beds) (see instructions) INTENSIVE CARE UNIT 99 8.00 2,802 4,690 8.00 CORONARY CARE UNIT 9.00 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 1.931 13.00 14.00 Total (see instructions) 7,462 339 16, 725 0.00 1, 247. 57 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 690 2.943 34.08 16.00 1.651 0.00 16.00 SUBPROVIDER - IRF 17.00 937 76 1, 507 0.00 11.06 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 4,074 216 5, 016 0.00 26.29 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 9,578 1, 917 16, 352 0.00 26.64 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 0.00 24 00 0 0.00 24.00 0 24. 10 HOSPICE (non-distinct part) 0 C 0 24.10 CMHC - CMHC 25.00 25.00 26, 00 RURAL HEALTH CLINIC 1, 488 0 3, 713 0.00 4. 08 26, 00 RURAL HEALTH CLINIC II 26. 01 6, 194 6.84 0.00 1,855 Ω 26.01 26. 25 FEDERALLY QUALIFIED HEALTH CENTER C 0.00 0.00 26. 25 27.00 Total (sum of lines 14-26) 0.00 1, 356. 56 27.00 Observation Bed Days 28.00 339 2, 476 28.00 29 00 Ambul ance Trips 0 29 00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 0 32.00 32.00 184 447 Total ancillary labor & delivery room C 32.01 outpatient days (see instructions) LTCH non-covered days 33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150115 Pe

Peri od: Worksheet S-3 From 07/01/2015 Part I To 06/30/2016 Date/Ti me Prepared:

11/28/2016 1:02 pm Full Time Di scharges Equi val ents Title V Title XVIII Total All Component Nonpai d Title XIX Workers Pati ents 12.00 13.00 11.00 14.00 15.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 2, 258 258 3, 817 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 81 2 00 0 3.00 HMO IPF Subprovider 0 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 6.00 7.00 Total Adults and Peds. (exclude observation 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 3, 817 14.00 Total (see instructions) 0.00 0 2, 258 258 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 0.00 175 462 16.00 129 16.00 SUBPROVIDER - IRF 123 17.00 0.00 76 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 0.00 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 0.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 0 00 24 00 24 00 HOSPICE (non-distinct part) 24. 10 24. 10 25. 00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 0.00 26.00 RURAL HEALTH CLINIC II 26. 01 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 Observation Bed Days 28.00 28.00 29 00 Ambul ance Trips 29 00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) 32.00 32.00 Total ancillary labor & delivery room 32.01 outpatient days (see instructions)

LTCH non-covered days

Provider CCN: 150115

Health Financial Systems

HOSPITAL WAGE INDEX INFORMATION

Peri od: Worksheet S-3 From 07/01/2015 Part II To 06/30/2016 Date/Time Prepared:

In Lieu of Form CMS-2552-10

11/28/2016 1:02 pm Adj usted Worksheet A Amount Recl assi fi cati Paid Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col.2 ± col (from Salaries in col. 5) Worksheet A-6) 3) col. 4 2.00 5.00 6. 00 1.00 3.00 4.00 PART II - WAGE DATA SALARI ES 1.00 Total salaries (see 200. 00 94, 758, 486 94, 758, 486 2, 821, 617. 00 33, 58 1.00 instructions) 2.00 Non-physician anesthetist Part 0 C 0.00 0.00 2.00 2, 494, 619 3.00 Non-physician anesthetist Part 2, 494, 619 24, 003. 00 103.93 3.00 4.00 Physician-Part A -222, 716 867.00 256. 88 222, 716 4.00 Admi ni strati ve Physicians - Part A - Teaching 4.01 0.00 0.00 4.01 5.00 Physician-Part B 8, 794, 605 8, 794, 605 42, 678. 00 206.07 5.00 6.00 Non-physician-Part B 1,050,289 1, 050, 289 22, 707. 00 46. 25 6.00 Interns & residents (in an 21 00 7.00 0.00 0.00 7.00 approved program) 7.01 Contracted interns and 0 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office personnel 0.00 0.00 8.00 SNF 44 00 1 329 370 1, 329, 370 54, 680.00 9 00 24.31 9 00 10.00 Excluded area salaries (see 34, 523, 855 34, 523, 855 873, 284. 00 39.53 10.00 instructions) OTHER WAGES & RELATED COSTS 0 0 0.00 0.00 11.00 Contract labor: Direct Patient 11.00 Care 12.00 Contract Labor: Top Level 0 0 0.00 0.00 12.00 management and other management and administrative servi ces Contract Labor: Physician-Part 13.00 119, 750 0 119, 750 1, 015. 00 117. 98 13.00 A - Administrative 14.00 Home office salaries & 0 0.00 0.00 14.00 0 wage-related costs Home office: Physician Part A 15.00 0 0.00 0.00 15.00 - Administrative 16.00 Home office and Contract 0 0.00 0.00 16.00 Physicians Part A - Teaching WAGE-RELATED COSTS Wage-related costs (core) (see 12, 235, 429 0 12, 235, 429 17.00 17.00 instructions) Wage-related costs (other) Ω 18.00 18.00 (see instructions) 19.00 19 00 Excluded areas 6, 016, 456 6,016,456 20.00 Non-physician anesthetist Part 20.00 21.00 Non-physician anesthetist Part 173, 771 173, 771 21.00 22.00 Physician Part A -0 0 22.00 Administrative 22.01 Physician Part A - Teaching 22.01 23.00 Physician Part B 264, 142 264, 142 23.00 24.00 Wage-related costs (RHC/FQHC) 118.484 118.484 24 00 25.00 Interns & residents (in an 25.00 approved program) OVERHEAD COSTS - DIRECT SALARIES Employee Benefits Department 26.00 4. 00 682, 301 682, 301 20, 490. 00 33. 30 26.00 Administrative & General 8, 129, 496 334, 938. 00 27.00 8, 129, 496 24. 27 27.00 5.00 28.00 Administrative & General under 448, 992 448, 992 1, 862.00 241.13 28.00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 1, 733, 458 1, 733, 458 72, 809. 00 23.81 29.00 Operation of Plant 30 00 30.00 7 00 0 00 റ ററി 31.00 Laundry & Linen Service 8.00 232.984 232.984 19, 047. 00 12. 23 31.00 32.00 Housekeepi ng 9.00 1, 114, 645 1, 114, 645 86, 853.00 12. 83 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 15. 35 34 00 34.00 Di etarv 10.00 1,052,551 -738, 565 313, 986 20, 461, 00 Di etary under contract (see 0.00 35.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 738, 565 48, 129. 00 15. 35 36.00 738, 565 37 00 Maintenance of Personnel 12 00 o ool 37 00 0 00 38.00 Nursing Administration 13.00 810,004 0 810,004 25, 466. 00 31. 81 38.00 257, 926 Central Services and Supply 257, 926 17, 987. 00 14. 34 39.00 39.00 14.00 40.00 Pharmacy 15.00 1, 910, 935 1, 910, 935 50, 892. 00 37. 55 40. 00

Health Financial Systems	MEN	MORIAL HOSP &	HEALTH CARE CTR	?	In Li€	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der	Provider CCN: 150115		Worksheet S-3 Part II	
					From 07/01/2015 To 06/30/2016		
	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 Records Library	16. 00	1, 316, 949	0	1, 316, 94	9 66, 123. 00	19. 92	41. 00
42.00 Social Service	17. 00	C	o		0.00	0.00	42.00
43.00 Other General Service	18. 00	C	0		0.00	0.00	43. 00

32 85

23.12

5.00

6.00

7.00

Health Financial Systems In Lieu of Form CMS-2552-10 MEMORIAL HOSP & HEALTH CARE CTR HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provider CCN: 150115 Peri od: From 07/01/2015 To 06/30/2016 11/28/2016 1: 02 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . 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 82, 867, 965 82, 867, 965 2, 734, 091. 00 30. 31 1.00 instructions) 2.00 Excluded area salaries (see 35, 853, 225 ol 35, 853, 225 927, 964. 00 38. 64 2.00 instructions) 3.00 Subtotal salaries (line 1 47, 014, 740 0 47, 014, 740 1, 806, 127. 00 26.03 3.00 minus line 2) 4.00 Subtotal other wages & related 119, 750 119, 750 1, 015. 00 117. 98 4.00

0

0

12, 235, 429

59, 369, 919

17, 690, 241

0.00

1, 807, 142. 00

765, 057. 00

12, 235, 429

59, 369, 919

17, 690, 241

costs (see inst.)

(see inst.)

instructions)

5.00

6.00

7.00

Subtotal wage-related costs

Total overhead cost (see

Total (sum of lines 3 thru 5)

Health Financial Systems	MEMORIAL HOSP & HEALTH	CARE CTR		In Lieu	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	F	Provider CCN: 1	150115	Peri od:	Worksheet S-3
				From 07/01/2015	Part IV
				To 07 /20 /2017	Data /Tima Dranarad.

	To 06/30/2016	Date/Time Prep 11/28/2016 1:0	
		Amount Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 467, 358	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	-228, 640	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)	10, 817, 847	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)	79, 371	
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
	Disability Insurance (If employee is owner or beneficiary)	238, 773	13. 00
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00		383, 178	
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	5, 721, 499	
	Medicare Taxes - Employers Portion Only	0	18. 00
	Unemployment Insurance	32, 405	
20. 00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))	_	
22. 00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	303, 283	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	18, 815, 074	24. 00
05.60	Part B - Other than Core Related Cost		05.00
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	MEMORIAL HOSP & HEALT	TH CARE CTR	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150115	Peri od:	Worksheet S-3
			From 07/01/2015	
			T 0//00/004/	D 1 /T' D 1

		o 06/30/2016	Date/lime Pre	
			11/28/2016 1:0	J2 pm
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospi tal	0	0	2.00
3.00	Subprovi der - I PF	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
14. 01	Hospital-Based Health Clinic RHC 1	0	0	14. 01
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

	n Financial Systems ME	MORIAL HOSP & F	HEALTH CARE CT	₹	In Lie	u of Form CMS-2	2552-10
HOME	HEALTH AGENCY STATISTICAL DATA		Provi der		Period: From 07/01/2015	Worksheet S-4	
			Component		Го 06/30/2016	Date/Time Prep 11/28/2016 1:0	
					Home Health	PPS	<i>32</i> piii
					Agency I		
					1.	00	
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0. 00
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	Ι ο	5, 003	495	1, 420	6, 918	1. 00
2. 00	Unduplicated Census Count (see instructions)	0. 00		52. 00	149.00	726. 00	2. 00
				Number of Emp	loyees (Full Ti	me Equivalent)	
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal	work week				
				1.00	0.00	2.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	()	1.00	2. 00	3. 00	
3.00	Administrator and Assistant Administrator(s)		0.00	1		0.00	3.00
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			0.00		0. 00 0. 00	4. 00 5. 00
6.00	Direct Nursing Service			0.00		0.00	6. 00
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			0.00		0. 00 0. 00	7. 00 8. 00
9. 00	Physical Therapy Supervisor			0.00		0.00	9. 00
10.00	Occupational Therapy Service			0.00		0.00	10.00
11. 00 12. 00	1 1 1			0.00		0. 00 0. 00	11. 00 12. 00
13. 00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14. 00 15. 00				0.00			14. 00 15. 00
16. 00	· ·			0.00			16. 00
17.00				0.00		0.00	
18. 00	Other (specify) HOME HEALTH AGENCY CBSA CODES			0.00	0.00	0.00	18. 00
19. 00	Enter in column 1 the number of CBSAs where			3	3		19. 00
	you provided services during the cost reporting period.						
20. 00				50031			20. 00
20.00	during this cost reporting period (line 20			50031			20. 00
20. 01	during this cost reporting period (line 20 contains the first code).			50036			20. 01
	during this cost reporting period (line 20 contains the first code).		oi sodes				
20. 01	during this cost reporting period (line 20 contains the first code).	Full Ex		50036	,	Total (cols.	20. 01
20. 01	during this cost reporting period (line 20 contains the first code).	Full Ep		50036 99915	PEP Only Epi sodes 4.00	Total (col s. 1-4) 5.00	20. 01
20. 01 20. 02	during this cost reporting period (line 20 contains the first code). PPS ACTIVITY DATA	Full Ex Without Outliers 1.00	With Outliers 2.00	50036 99915 LUPA Epi sodes 3.00	Epi sodes 4.00	1-4) 5. 00	20. 01 20. 02
20. 01 20. 02 21. 00	during this cost reporting period (line 20 contains the first code). PPS ACTIVITY DATA Skilled Nursing Visits	Full Ex Without Outliers 1.00	2.00 195	50036 99915 LUPA Epi sodes 3.00	Epi sodes 4. 00	1-4) 5. 00 4, 020	20. 01 20. 02 21. 00
20. 01 20. 02	during this cost reporting period (line 20 contains the first code). PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges	Full Ex Without Outliers 1.00	2.00 195 38,414	50036 99915 LUPA Epi sodes 3.00	Epi sodes 4. 00 4 85 7 17, 487	1-4) 5. 00 4, 020 810, 328	20. 01 20. 02 21. 00
20. 01 20. 02 21. 00 22. 00 23. 00 24. 00	during this cost reporting period (line 20 contains the first code). PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Physical Therapy Visit Charges	Full Ex Without Outliers 1.00 3,566 717,510 2,425 508,040	2.00 195 38,414 48 10,080	50036 99915 LUPA Epi sodes 3. 00 174 36, 91 37 6, 500	Epi sodes 4. 00 4. 00 7. 17, 487 1. 39 0. 8, 170	1-4) 5.00 4,020 810,328 2,543 532,790	20. 01 20. 02 21. 00 22. 00 23. 00 24. 00
20. 01 20. 02 21. 00 22. 00 23. 00	during this cost reporting period (line 20 contains the first code). PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visits Physical Therapy Visit Charges Occupational Therapy Visits	Full Ex Without Outliers 1.00 3,566 717,510 2,425 508,040 961	2.00 2.00 195 38,414 48 10,080	50036 99915 LUPA Epi sodes 3. 00 174 36, 915 36, 500	Epi sodes 4. 00 4 85 7 17, 487 39 8, 170 4 22	1-4) 5.00 4,020 810,328 2,543 532,790 1,020	20. 01 20. 02 21. 00 22. 00 23. 00
20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visits	Full Ex Without Outliers 1.00 3,566 717,510 2,425 508,040 961 201,410 52	2.00 2.00 195 38,414 48 10,080 33 6,930	50036 99915 LUPA Epi sodes 3. 00 174 36, 91: 37 6, 500	Epi sodes 4. 00 4. 85 7. 17, 487 9. 8, 170 4. 22 4, 600 1	1-4) 5.00 4,020 810,328 2,543 532,790 1,020 213,780 54	20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00	PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges	Full Ex Without Outliers 1.00 3,566 717,510 2,425 508,040 961 201,410	2.00 195 38,414 48 10,080 33 6,930 1 210	50036 99915 LUPA Epi sodes 3. 00 17/ 36, 91: 3 6, 500 844	Epi sodes 4. 00 4. 85 7. 17, 487 9. 8, 170 4. 22 4, 600 1. 210	1-4) 5.00 4,020 810,328 2,543 532,790 1,020 213,780 54 11,330	20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00
20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 28. 00 29. 00 30. 00	during this cost reporting period (line 20 contains the first code). PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visits Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges	Full Ex Wi thout Outliers 1.00 3,566 717,510 2,425 508,040 961 201,410 52 10,910 1	2.00 2.00 195 38,414 48 10,080 33 6,930 1 210 0	50036 99915 LUPA Epi sodes 3. 00 174 36, 91: 3. 6, 500 4. (0)	Epi sodes 4. 00 4. 00 4. 85 7. 17, 487 8, 170 4. 22 4, 600 1 210 0 0 0	1-4) 5.00 4,020 810,328 2,543 532,790 1,020 213,780 54 11,330 1	20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 28. 00 29. 00 30. 00
20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 28. 00 29. 00 30. 00 31. 00	during this cost reporting period (line 20 contains the first code). PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visits Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visits Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visits	Full Ex Wi thout Outliers 1.00 3,566 717,510 2,425 508,040 961 201,410 52 10,910 1 239 1,823	2.00 195 38,414 48 10,080 33 6,930 1 210 0 64	50036 99915 LUPA Epi sodes 3. 00 174 36, 915 6, 500	Epi sodes 4. 00 4. 85 7. 17, 487 9. 8, 170 4. 22 0. 4, 600 0. 1 210 0. 0 0. 0 1 48	1-4) 5.00 4,020 810,328 2,543 532,790 1,020 213,780 54 11,330 1 239 1,940	20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00
20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 28. 00 29. 00 30. 00	during this cost reporting period (line 20 contains the first code). PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visits Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visit Charges	Full Ex Wi thout Outliers 1.00 3,566 717,510 2,425 508,040 961 201,410 52 10,910 1	2.00 195 38,414 48 10,080 33 6,930 1 210 0 64 5,760	50036 99915 LUPA Epi sodes 3. 00 174 36, 913 6, 500 4	Epi sodes 4. 00 4. 85 7. 17, 487 9. 8, 170 4. 22 9. 4, 600 9. 1 210 9. 0 9. 48 9. 4, 272	1-4) 5.00 4,020 810,328 2,543 532,790 1,020 213,780 54 11,330 1	20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00
20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 31. 00 32. 00 33. 00	during this cost reporting period (line 20 contains the first code). PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visits Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visit Charges Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	Full Ex Wi thout Outliers 1.00 3,566 717,510 2,425 508,040 961 201,410 52 10,910 1 239 1,823 163,650 8,828	2.00 195 38,414 48 10,080 33 6,930 1 210 0 64 5,760	50036 99915 LUPA Epi sodes 3. 00 174 36, 913 6, 500 6, 500 6, 500 6, 500 6, 500 6, 500 6, 500 7, 7, 100 840 7, 100 840 840 840 840 840 840 840 840 840 8	Epi sodes 4. 00 4. 85 7. 17, 487 9. 8, 170 4. 22 9. 4, 600 9. 1 9. 210 9. 0 9. 48 9. 4, 272 4. 195	1-4) 5.00 4,020 810,328 2,543 532,790 1,020 213,780 54 11,330 1 239 1,940 174,132 9,578	20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 33. 00
20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00	during this cost reporting period (line 20 contains the first code). PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges	Full Eq Wi thout Outliers 1.00 3,566 717,510 2,425 508,040 961 201,410 52 10,910 1 239 1,823 163,650 8,828	2.00 195 38,414 48 10,080 33 6,930 1 210 0 64 5,760 341	50036 99915 LUPA Epi sodes 3. 00 174 36, 91: 3 6, 500 6, 600 6,	Epi sodes 4. 00 4. 00 4. 00 4. 00 4. 00 4. 00 5. 17, 487 6. 22 7. 4, 600 8. 170 9. 210 9. 0 9. 0 9. 48 4. 272 4. 195 9. 0	1-4) 5.00 4,020 810,328 2,543 532,790 1,020 213,780 54 11,330 1 239 1,940 174,132 9,578	20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00
20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00	during this cost reporting period (line 20 contains the first code). PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visits Physical Therapy Visit Charges Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	Full Ex Wi thout Outliers 1.00 3,566 717,510 2,425 508,040 961 201,410 52 10,910 1,239 1,823 163,650 8,828	2.00 195 38,414 48 10,080 33 6,930 1 210 0 64 5,760 341	50036 99915 LUPA Epi sodes 3. 00 174 36, 913 6, 500 4840 (0) (1) (2) (1) (2) (4) (4) (4) (4) (4) (4) (4) (4) (4)	Epi sodes 4. 00 4. 00 4. 00 4. 00 4. 00 4. 00 5. 4. 600 6. 0 0 7. 0 0 8. 170 9. 0 0	1-4) 5.00 4,020 810,328 2,543 532,790 1,020 213,780 54 11,330 1 239 1,940 174,132 9,578 0 1,742,599	20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00
20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00	during this cost reporting period (line 20 contains the first code). PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visits Physical Therapy Visits Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visit Charges Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) Total Number of Episodes (standard/non	Full Eq Wi thout Outliers 1.00 3,566 717,510 2,425 508,040 961 201,410 52 10,910 1 239 1,823 163,650 8,828	2.00 195 38,414 48 10,080 33 6,930 1 210 0 64 5,760 341	50036 99915 LUPA Epi sodes 3. 00 174 36, 91: 3 6, 500 6, 600 6,	Epi sodes 4. 00 4. 00 4. 00 4. 00 4. 00 4. 00 5. 4. 600 6. 0 0 7. 0 0 8. 170 9. 0 0	1-4) 5.00 4,020 810,328 2,543 532,790 1,020 213,780 54 11,330 1 239 1,940 174,132 9,578	20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 28. 00 29. 00 30. 00 31. 00 33. 00 34. 00
20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00	during this cost reporting period (line 20 contains the first code). PPS ACTIVITY DATA Skilled Nursing Visits Skilled Nursing Visit Charges Physical Therapy Visits Physical Therapy Visits Occupational Therapy Visit Charges Occupational Therapy Visit Charges Speech Pathology Visit Charges Speech Pathology Visit Charges Medical Social Service Visits Medical Social Service Visit Charges Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) Total Number of Episodes (standard/non outlier)	Full Ex Wi thout Outliers 1.00 3,566 717,510 2,425 508,040 961 201,410 52 10,910 1,239 1,823 163,650 8,828	2.00 195 38,414 48 10,080 33 6,930 1 210 0 64 5,760 341 0 61,394	50036 99915 LUPA Epi sodes 3.00 174 36, 91: 36, 500 6, 500 6, 500 6, 450 214 44, 70:	Epi sodes 4.00 4.00 4.00 4.00 4.00 4.00 4.00 5.00 6.00 7.00 6.00 6.00 6.00 7.	1-4) 5.00 4,020 810,328 2,543 532,790 1,020 213,780 54 11,330 1 239 1,940 174,132 9,578 0 1,742,599 557	20. 01 20. 02 21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00

Health Financial Systems MEMORIAL HOSP &	HEALTH CARE CT	R	In Li€	eu of Form CMS-2	
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provi der	CCN: 150115	Peri od:	Worksheet S-7	
			From 07/01/2015 To 06/30/2016		pared:
				11/28/2016 1:	
	Group	SNF Days	Swing Bed SNF		
	1.00		Days	col . 2 + 3)	
/0.00 l	1.00	2.00	3.00	4. 00	40.00
69. 00 70. 00	PE2 PE1			0	
71. 00	PD2		0 0	0	
72. 00	PD1		14	14	1
73.00	PC2		0 0	0	1
74. 00	PC1		22 0	22	
75. 00	PB2		0 0	0	1
76. 00	PB1		6 0	6	76. 00
77. 00	PA2		0 0	0	77. 00
78. 00	PA1		0 0	0	78. 00
199. 00	AAA		0		199. 00
200. 00 TOTAL		4, 0			200. 00
			CBSA at	CBSA on/after	
			Beginning of Cost Reporting	October 1 of the Cost	
			Peri od	Reporting	
			rerrou	Period (if	
				applicable)	
			1. 00	2.00	
SNF SERVICES					
201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBS			99915	99915	201. 00
in effect at the beginning of the cost reporting period. E					
in effect on or after October 1 of the cost reporting peri	od (if applicat		Domoontogo	Accesi stad	
		Expenses	Percentage	Associated with Direct	
				Patient Care	
				and Related	
				Expenses?	
		1.00	2. 00	3. 00	
A notice published in the Federal Register Volume 68, No.					
payments beginning 10/01/2003. Congress expected this increase					
expenses. For lines 202 through 207: Enter in column 1 the column 2 the percentage of total expenses for each categor					
line 7, column 3. In column 3, enter "Y" for yes or "N" fo					
with direct patient care and related expenses for each cate			is iliciteases assi	oci a teu	
202. 00 Staffing	egory. (See The	1	0 0.00		202. 00
203.00 Recrui tment			0.00		203. 00
204.00 Retention of employees			0.00		204.00
205. 00 Trai ni ng			0.00		205. 00
206. 00 OTHER (SPECIFY)			0.00		206. 00
207.00 Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	1, 435, 7	05		207. 00

	Financial Systems MEI FAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	MORIAL HOSP & HE IED HEALTH CENTE		CCN: 150115	Peri od:	eu of Form CM Worksheet S		
	STICAL DATA			t CCN: 158507	From 07/01/2015 To 06/30/2016	5	rep	
					Rural Health Clinic (RHC) I	Cost		
					1.	. 00		
	Clinic Address and Identification							
00	Street				522 SOUTH MAPL		4	1.
		_		ty	State	ZIP Code	_	
	1014 014 717 014 0			00	2. 00	3.00	_	_
00	City, State, ZIP Code, County	FI	RENCH LICK		11/	47432		2.
						1.00	+	
00	FQHCs ONLY: Designation - Enter "R" for rural	or "U" for urb	an			1.00	0	3.
	<u> </u>				Grant Award	Date		
					1. 00	2.00		
	Source of Federal Funds				<u> </u>	•		
00	Community Health Center (Section 330(d), PHS				C			4
00	Migrant Health Center (Section 329(d), PHS Ac				C			5
00	Health Services for the Homeless (Section 340	O(d), PHS Act)			C			6
00	Appalachian Regional Commission				C)		7
00	Look-Alikes				C			8
00	OTHER (SPECIFY)				C			9
	I=				1. 00	2. 00	_	
. 00	Does this facility operate as other than an F				N		0	10
	no in column 1. If yes, indicate number of ot							
	subscripts of line 11 the type of other opera	Sunda			onday	Tuesday		
		from	to	from	to	from	\dashv	
		1.00	2. 00	3.00	4. 00	5. 00	_	
	Facility hours of operations (1)							
	Clinic			08: 00	17: 00	07: 00		11
. 00								
. 00		<u>'</u>						
					1.00	2. 00		10
2. 00	Have you received an approval for an exception				N	2.00		
2. 00	Have you received an approval for an exception is this a consolidated cost report as defined	d in CMS Pub. 10	0-04, chaptei	9, section		2.00		
. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column in column.	lin CMS Pub. 10 umn 1. If yes, e	0-04, chapteı nter in colur	9, section nn 2 the	N	2.00		
. 00	Have you received an approval for an exception 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	0-04, chapteı nter in colur	9, section nn 2 the	N	2.00		
. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column in column.	lin CMS Pub. 10 umn 1. If yes, e	0-04, chapteı nter in colur	9, section nn 2 the ders and	N	2.00	0	
. 00	Have you received an approval for an exception 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	0-04, chapteı nter in colur	9, section nn 2 the ders and	N N		0	
. 00	Have you received an approval for an exception 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.	d in CMS Pub. 10 umn 1. If yes, e List the names	0-04, chapte nter in colur of all provio	9, section nn 2 the ders and Provi	N N der name	CCN number	0	13
. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columnumber of providers included in this report. numbers below.	d in CMS Pub. 10 Jumn 1. If yes, e List the names	0-04, chapte nter in colur of all provid	9, section nn 2 the ders and Provi	N N N der name 1.00	CCN number 2.00 Total Visit	0	13
. 00	Have you received an approval for an exception and the second of the sec	d in CMS Pub. 10 umn 1. If yes, e List the names	0-04, chapte nter in colur of all provio	9, section nn 2 the ders and Provi	N N der name 1.00	CCN number	0	13
. 00	Have you received an approval for an exception of the second seco	d in CMS Pub. 10 Jumn 1. If yes, e List the names	0-04, chapte nter in colur of all provid	9, section nn 2 the ders and Provi	N N N der name 1.00	CCN number 2.00 Total Visit	0	14
. 00	Have you received an approval for an exception of the state of the sta	d in CMS Pub. 10 Jumn 1. If yes, e List the names	0-04, chapte nter in colur of all provid	9, section nn 2 the ders and Provi	N N N der name 1.00	CCN number 2.00 Total Visit	0	14
. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columnumber of providers included in this report. Including in	d in CMS Pub. 10 Jumn 1. If yes, e List the names	0-04, chapte nter in colur of all provid	9, section nn 2 the ders and Provi	N N N der name 1.00	CCN number 2.00 Total Visit	0	13
. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columnumber of providers included in this report. Including in	d in CMS Pub. 10 Jumn 1. If yes, e List the names	0-04, chapte nter in colur of all provid	9, section nn 2 the ders and Provi	N N N der name 1.00	CCN number 2.00 Total Visit	0	13
. 00	Have you received an approval for an exception of the second seco	d in CMS Pub. 10 Jumn 1. If yes, e List the names	0-04, chapte nter in colur of all provid	9, section nn 2 the ders and Provi	N N N der name 1.00	CCN number 2.00 Total Visit	0	13
. 00	Have you received an approval for an exception and the second of the sec	d in CMS Pub. 10 Jumn 1. If yes, e List the names	0-04, chapte nter in colur of all provid	9, section nn 2 the ders and Provi	N N N der name 1.00	CCN number 2.00 Total Visit	0	13
. 00	Have you received an approval for an exception of the state of the sta	d in CMS Pub. 10 Jumn 1. If yes, e List the names	0-04, chapte nter in colur of all provid	9, section nn 2 the ders and Provi	N N N der name 1.00	CCN number 2.00 Total Visit	0	13
. 00	Have you received an approval for an exception and the second of the sec	d in CMS Pub. 10 Jumn 1. If yes, e List the names	0-04, chapternter in colur of all provid V 2.00	Provi XVIII 3.00	N N N der name 1.00	CCN number 2.00 Total Visit	0	13
. 00	Have you received an approval for an exception of the state of the sta	d in CMS Pub. 10 Jumn 1. If yes, e List the names	0-04, chapter in colur of all provided by V 2.00	9, section nn 2 the ders and Provi	N N N der name 1.00	CCN number 2.00 Total Visit	0	13
. 00	Have you received an approval for an exception of the state of the sta	Y/N 1.00	0-04, chapter in colur of all provided by V 2.00	Provi XVIII 3.00	N N N der name 1.00	CCN number 2.00 Total Visit	0	14
. 00	Have you received an approval for an exception of the state of the sta	Y/N 1.00	O-04, chapter in colur of all provided by V 2.00	Provi XVIII 3.00	N N N N N N N N N N N N N N N N N N N	CCN number 2.00 Total Visit	0	14
2. 00	Have you received an approval for an exception of the state of the sta	Y/N 1.00	O-04, chapter in colur of all provided by V 2.00	Provi XVIII 3.00	N N N N N N N N N N N N N N N N N N N	CCN number 2.00 Total Visit 5.00	0	14.
00	Have you received an approval for an exception of the state of the sta	Y/N 1.00 Tuesday	O-04, chapter in colur of all provided by the column of all provid	Provi XVIII 3.00 esday	N N N N N N N N N N N N N N N N N N N	CCN number 2.00 Total Visit 5.00	0	12. 13.

alth Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu						u of Form CMS-2	2552-10
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALI	FIED HEALTH CEN	TER Pr	rovi der	CCN: 150115	Peri od:	Worksheet S-8	
STATISTICAL DATA		Co	omponent	CCN: 158507	From 07/01/2015 To 06/30/2016		
					Rural Health	Cost	<u> </u>
					Clinic (RHC) I		
	Fri	day		Sa	turday		
	from	t	0	from	to		
	11. 00	12.	. 00	13.00	14.00		
Facility hours of operations (1)							
11. 00 Clinic	06: 00	15: 00					11. 00

	Financial Systems ME FAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	MORIAL HOSP & H LED HEALTH CENT		CCN: 150115	Peri od:	worksheet S-8	
	STI CAL DATA			t CCN: 158508	From 07/01/2015 To 06/30/2016		epared
					Rural Health Clinic (RHC) II	Cost	
					1.	00	
	Clinic Address and Identification					4	
. 00	Street		C	.	105 COOPER STR		1. (
		-		00	State 2.00	ZIP Code 3.00	
. 00	City, State, ZIP Code, County		LOOGOOTEE	. 00		47553	2.
					•		
	T					1. 00	
. 00	FOHCs ONLY: Designation - Enter "R" for rural	or "U" for url	ban			C	3.
					Grant Award	Date	-
	Source of Federal Funds				1. 00	2. 00	
. 00	Community Health Center (Section 330(d), PHS	Act)			0		4.
. 00	Migrant Health Center (Section 329(d), PHS Ad				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.
					1. 00	2.00	
0. 00	Does this facility operate as other than an F	RHC or EOHC? En	ter "Y" for w	es or "N" for	1.00		10.
5. 00	no in column 1. If yes, indicate number of or subscripts of line 11 the type of other opera	ther operations	in column 2.	(Enter in	14		10.
		Suno		-	onday	Tuesday	
		from	to	from	to	from	
	Tarana and a same and	1.00	2. 00	3. 00	4. 00	5. 00	
	Facility hours of operations (1)						
1 00				00.00	10.00	00.00	1,1
1. 00	Clinic			08: 00	18: 00	08: 00	11.
1. 00				08: 00			11.
		on to the produ	ctivity standa		18: 00 1. 00 N	08: 00	
2. 00	Clinic Have you received an approval for an exception	d in CMS Pub. 10 umn 1. If yes, o	00-04, chapte enter in colu	ard? r 9, section mn 2 the	1. 00	2.00	12.
2. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column in column.	d in CMS Pub. 10 umn 1. If yes, o	00-04, chapte enter in colu	ard? r 9, section mn 2 the ders and	1. 00 N N	2.00	12.
2. 00	Have you received an approval for an exception 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.	d in CMS Pub. 10 umn 1. If yes, o	00-04, chapte enter in colu	ard? - 9, section mn 2 the ders and Provi	1.00 N N	2.00	12.
2. 00	Have you received an approval for an exception 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. In numbers below.	d in CMS Pub. 10 umn 1. If yes, o	00-04, chapte enter in colu	ard? - 9, section mn 2 the ders and Provi	1. 00 N N	2.00	12.
2. 00	Have you received an approval for an exception 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.	d in CMS Pub. 10 umn 1. If yes, o	00-04, chapte enter in colu	ard? - 9, section mn 2 the ders and Provi	1.00 N N	2.00 CCN number 2.00	12.
2. 00 3. 00	Have you received an approval for an exception 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. In numbers below.	d in CMS Pub. 10 umn 1. If yes, o List the names	00-04, chapte enter in colu of all provid	ard? r 9, section mn 2 the ders and Provi	1.00 N N N der name	2.00	12.
2. 00 3. 00 4. 00	Have you received an approval for an exception of the state of the sta	d in CMS Pub. 10 umn 1. If yes, List the names Y/N 1.00	00-04, chapte enter in colu of all provid V	ard? r 9, section mn 2 the ders and Provi	1.00 N N der name 1.00	2.00 CCN number 2.00 Total Visits	12. 13. 14.
2. 00 3. 00 4. 00	Have you received an approval for an exception of the state of the sta	d in CMS Pub. 10 umn 1. If yes, List the names Y/N 1.00	00-04, chapte enter in colu of all provid V	ard? r 9, section mn 2 the ders and Provi	1.00 N N der name 1.00	2.00 CCN number 2.00 Total Visits	12. 13. 14.
2. 00 3. 00 4. 00	Have you received an approval for an exception of the state of the sta	d in CMS Pub. 10 umn 1. If yes, List the names Y/N 1.00	00-04, chapterenter in column of all provided V 2.00	ard?	1.00 N N der name 1.00	2.00 CCN number 2.00 Total Visits	12. 13.
2. 00 3. 00 4. 00	Have you received an approval for an exception of the state of the sta	d in CMS Pub. 10 umn 1. If yes, List the names Y/N 1.00	00-04, chapterenter in column of all provided V 2.00	ard? r 9, section mn 2 the ders and Provi	1.00 N N der name 1.00	2.00 CCN number 2.00 Total Visits	12. 13.
22.00 33.00	Have you received an approval for an exception of the state of the sta	y/N 1.00	00-04, chapterenter in column of all provided V 2.00	ard? - 9, section nn 2 the ders and - Provi - XVIII - 3.00	1.00 N N der name 1.00	2.00 CCN number 2.00 Total Visits	12. 13. 13. 15.
2. 00 3. 00 4. 00	Have you received an approval for an exception of the state of the sta	Y/N 1.00 Tuesday	OO-04, chapterenter in column of all provided V 2.00	ard? r 9, section mn 2 the ders and Provi XVIII 3.00 unty 00	1.00 N N der name 1.00 XIX 4.00	2.00 CCN number 2.00 Total Visits 5.00	12. 13.
2. 00	Have you received an approval for an exception of the state of the sta	d in CMS Pub. 10 umn 1. If yes, of List the names Y/N 1.00	OO-04, chapterenter in column of all provided V 2.00	ard? r 9, section mn 2 the ders and Provi XVIII 3.00	1.00 N N der name 1.00 XIX 4.00	2.00 CCN number 2.00 Total Visits 5.00	11. 12. 13. 14.

Health Financial Systems MI	Ith Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu						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 07/01/2015 To 06/30/2016	Date/Time Pre	
					Rural Health	11/28/2016 1:	UZ pm
						Cost	
					Clinic (RHC) II		
	Fr	i day		Sa	turday		
	from		to	from	to		
	11. 00	1	12.00	13. 00	14.00		
Facility hours of operations (1)							
11. 00 Cl i ni c	08: 00	12: 00					11. 00

	Financial Systems MEMORIAL HOSP & HEALTH				eu of Form CMS-2			
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der (CCN: 150115	Peri od:	Worksheet S-10	0		
				From 07/01/2015 To 06/30/2016	Date/Time Pre	nared:		
					11/28/2016 1:			
					1. 00			
	Uncompensated and indigent care cost computation				1.00			
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	led by lir	ne 202 column	1 8)	0. 342177	1.00		
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid				7, 285, 966	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00				
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental p	ayments f	rom Medicaio	l?		4. 00		
5.00	If line 4 is "no", then enter DSH or supplemental payments from N	ledi cai d			0	5. 00		
6.00	Medi cai d charges				41, 700, 416			
7.00	Medicaid cost (line 1 times line 6)				14, 268, 923			
8.00	Difference between net revenue and costs for Medicaid program (li	ne 7 minu	ıs sum of lir	nes 2 and 5; if	6, 982, 957	8. 00		
	<pre>< zero then enter zero) Children Chil</pre>	6	-l- ! \					
0.00	State Children's Health Insurance Program (SCHIP) (see instruction	ons for ea	ich i i ne)		0	0.00		
9. 00 10. 00	Net revenue from stand-alone SCHLP Stand-alone SCHLP charges				0			
11. 00	Stand-alone SCHIP cost (line 1 times line 10)							
12. 00	Difference between net revenue and costs for stand-alone SCHIP (I	ine 11 mi	nus line 9.	if < zero then				
12.00	enter zero)	1116 11 1111	nus i i i c 7,	TT \ ZCTO tHOH		12.00		
	Other state or local government indigent care program (see instru	ctions fo	r each line)			1		
13.00	Net revenue from state or local indigent care program (Not include				0	13.00		
14.00	Charges for patients covered under state or local indigent care p	rogram (N	lot included	in lines 6 or	0	14.00		
	10)							
15. 00	State or local indigent care program cost (line 1 times line 14)				0			
16. 00	Difference between net revenue and costs for state or local indig	gent care	program (lir	ne 15 minus line	0	16. 00		
	13; if < zero then enter zero) Uncompensated care (see instructions for each line)							
17. 00	Private grants, donations, or endowment income restricted to fund	ling chari	ty care		0	17. 00		
18. 00	Government grants, appropriations or transfers for support of hos							
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local			ns (sum of lines	6, 982, 957			
17.00	8, 12 and 16)	rnar gent	care program	is (sum of filles	0, 702, 737	17.00		
	,		Uni nsured	Insured	Total (col. 1			
		L	pati ents	pati ents	+ col . 2)			
			1. 00	2. 00	3. 00			
20. 00	Total initial obligation of patients approved for charity care (a		3, 216, 27	73 0	3, 216, 273	20.00		
21 00	charges excluding non-reimbursable cost centers) for the entire f		1 100 5	35 0	1 100 535	21 00		
21. 00	Cost of initial obligation of patients approved for charity care times line 20)	(Tine I	1, 100, 53	35	1, 100, 535	21. 00		
22. 00	Partial payment by patients approved for charity care			0	0	22. 00		
23. 00			1, 100, 53					
20.00	cost of order ty our of time 21 militas fills 22)		1, 100, 00	,0	1, 100, 000	20.00		
					1. 00			
24. 00	Does the amount in line 20 column 2 include charges for patient of		nd a Length o	of stay limit		24.00		
	imposed on patients covered by Medicaid or other indigent care pr		-	-				
25. 00	If line 24 is "yes," charges for patient days beyond an indigent		gram's Lengt	th of stay limit	0			
26. 00		,			9, 938, 896			
27. 00	Medicare bad debts for the entire hospital complex (see instructi		>		365, 618			
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line			20)	9, 573, 278			
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exper	ise (IIne	i times line	28)	3, 275, 756			
30.00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line	20)			4, 376, 291 11, 359, 248			
31.00	Trotal differinguised and discompensated care cost (Title 19 brus 11fle	30)			11, 339, 248	J 31.00		

	*	MORIAL HOSP & HE				u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	JE EXPENSES	Provi der	F	eriod: rom 07/01/2015 o 06/30/2016	Worksheet A Date/Time Pre	nared·
						11/28/2016 1:	
	Cost Center Description	Sal ari es	0ther		Reclassi fi cati	Reclassi fied	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS		2.00	0.00		0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		7, 831, 353	7, 831, 353	0	7, 831, 353	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		9, 072, 038	9, 072, 038	0	9, 072, 038	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	682, 301	19, 547, 603			20, 229, 904	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	8, 129, 496	16, 239, 087			24, 368, 570	5. 00
6.00	00600 MAI NTENANCE & REPAI RS	1, 733, 458	6, 045, 312		l .	7, 778, 770	
8.00	00800 LAUNDRY & LINEN SERVICE	232, 984	201, 120			434, 104	8.00
9.00	00900 HOUSEKEEPI NG	1, 114, 645	348, 720			1, 463, 365	1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	1, 052, 551	725, 848 0			502, 953 1, 247, 885	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	810, 004	129, 191	1		938, 326	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	257, 926	197, 749			315, 289	1
15. 00	01500 PHARMACY	1, 910, 935	11, 378, 855			13, 289, 790	
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 316, 949	286, 214		I	1, 603, 163	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	6, 045, 096	626, 367		-2, 096, 630	4, 574, 833	
31. 00	03100 I NTENSI VE CARE UNI T	2, 654, 787	359, 683			2, 984, 288	
40. 00	04000 SUBPROVI DER - I PF	2, 078, 915	283, 273			2, 359, 605	ı
41.00	04100 SUBPROVI DER - I RF	620, 749	160, 904			778, 870	
43.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	1 220 270	40.000	1 200 240	/	601, 146	
44. 00	ANCI LLARY SERVICE COST CENTERS	1, 329, 370	68, 890	1, 398, 260	-1, 289	1, 390, 971	44. 00
50. 00	05000 OPERATING ROOM	4, 868, 617	10, 773, 307	15, 641, 924	-2, 601, 082	13, 040, 842	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0,770,007	0,011,721		1, 202, 294	
53. 00	05300 ANESTHESI OLOGY	3, 716, 995	715, 649			4, 088, 737	
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 410, 418	999, 943			6, 229, 647	1
56.00	05600 RADI 0I SOTOPE	211, 920	522, 269	734, 189	-2, 924	731, 265	56.00
60.00	06000 LABORATORY	2, 379, 157	4, 022, 611	6, 401, 768	0	6, 401, 768	
65. 00	06500 RESPI RATORY THERAPY	1, 048, 989	453, 207			1, 193, 879	1
66. 00	06600 PHYSI CAL THERAPY	2, 170, 793	297, 097			2, 398, 522	1
69. 00	06900 ELECTROCARDI OLOGY	2, 596, 932	3, 453, 955	6, 050, 887	-3, 049, 696	3, 001, 191	1
69. 01 69. 02	06901 PULMONARY 06902 CARDI OPULMONARY	104 409	7 107	111 405	2 042	100 443	69. 01 69. 02
69. 02	06903 SLEEP LAB	104, 498 228, 798	7, 107 20, 126			108, 643 241, 154	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	20, 120	240, 724	7,770	241, 134	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	5, 757, 043	5, 757, 043	-1, 626, 385	4, 130, 658	ł
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	0	C		8, 939, 105	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
74. 00	07400 RENAL DI ALYSI S	0	0	C	0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS		100.000		1	204.542	
88. 00	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	281, 631	102, 929			384, 560	
88. 01	08900 FEDERALLY QUALIFIED HEALTH CENTER	495, 482	57, 867 0		I	553, 349 0	
	09000 CLINIC	389, 598	1, 059, 496			1, 418, 480	ı
90. 01	09001 I MED	363, 730	123, 231			486, 961	
90. 02	09002 ONCOLOGY	1, 369, 047	1, 175, 351			2, 513, 159	ı
90. 03	09003 OUTPATIENT CENTER	209, 523	193, 455			402, 978	
91.00	09100 EMERGENCY	7, 118, 001	1, 362, 763	8, 480, 764	-93, 293	8, 387, 471	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS				1		
	09500 AMBULANCE SERVI CES	1, 813, 236	175, 298			1, 957, 541	
	09600 DURABLE MEDICAL EQUIP-RENTED	1 475 202	204 573			1 742 125	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	1, 475, 383	294, 573	1, 769, 956	-26, 831	1, 743, 125	101.00
116 00	11600 HOSPI CE	0	0		O	0	116. 00
118.00		66, 222, 914	105, 069, 484	171, 292, 398		171, 320, 552	
	NONREI MBURSABLE COST CENTERS			, , , , , , , , , , , , , , , , , , , ,		, , , , , , , , , , , , , , , , , , , ,	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	24, 710, 087	4, 278, 797			28, 960, 730	1
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	659, 354	36, 043		l .	695, 397	1
	07950 LODGE	0	462		I		194. 00
	07952 MEMORIAL HOSPITAL FOUNDATION	149, 967	5, 240			155, 207	1
	07953 MKT/PHY SERVICES 07954 COMMUNITY EDUCATION	2, 250, 924	1, 985, 596		I	4, 236, 520 519, 809	
	07954 COMMONTTY EDUCATION 07955 VOLUNTEER	355, 952 158, 560	163, 857 19, 600		I	519, 809 178, 160	
	07955 VOLUNTEER 07956 MAB	130, 300	17, 000	176, 160	l		194. 05
	07958 PUBLIC RELATIONS	250, 728	644, 077			894, 805	
	07959 UNUSED SPACE	0	0	07.1,000	I		194. 09
200.00		94, 758, 486	112, 203, 156	206, 961, 642		206, 961, 642	

 Health Financial
 Systems
 MEMORIAL HOSP

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150115

Peri od: From 07/01/2015 To 06/30/2016 Date/Time Prepared:

				10 00/30/2016 Date/Trille Pre	
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8) 6.00	For Allocation 7.00	<u>1</u>	
	GENERAL SERVICE COST CENTERS	0.00	7.00	<u> </u>	
1.00	00100 CAP REL COSTS-BLDG & FIXT	-2, 762, 236	5, 069, 117		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	32, 529		'	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 915, 260			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-5, 878, 712	18, 489, 858		5. 00
6.00	00600 MAINTENANCE & REPAIRS	-79, 679		l e e e e e e e e e e e e e e e e e e e	6. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	434, 104		8. 00
9.00	00900 HOUSEKEEPI NG	0	1, 463, 365		9. 00
10.00	01000 DI ETARY	-38, 821	464, 132		10.00
11.00	01100 CAFETERI A	-642, 302	605, 583		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-7, 535		l control of the cont	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	315, 289		14. 00
15. 00	01500 PHARMACY	-223, 768			15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	-53, 472	1, 549, 691		16. 00
30. 00	03000 ADULTS & PEDIATRICS	0	4, 574, 833		30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	2, 984, 288		31.00
40. 00	04000 SUBPROVI DER - I PF	-294, 269	2, 065, 336	l e e e e e e e e e e e e e e e e e e e	40.00
41. 00	04100 SUBPROVI DER – I RF	-64, 570	714, 300		41. 00
43. 00	04300 NURSERY	0.,070	601, 146		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0			44. 00
	ANCILLARY SERVICE COST CENTERS			1	
50.00	05000 OPERATING ROOM	-2, 742, 068	10, 298, 774		50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 202, 294		52.00
53.00	05300 ANESTHESI OLOGY	-3, 355, 583	733, 154		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-3, 308, 392	2, 921, 255		54.00
56.00	05600 RADI OI SOTOPE	0	731, 265		56. 00
60.00	06000 LABORATORY	-150, 000			60.00
65. 00	06500 RESPI RATORY THERAPY	-2, 408	1, 191, 471		65. 00
66. 00	06600 PHYSI CAL THERAPY	-555	2, 397, 967		66. 00
69. 00	06900 ELECTROCARDI OLOGY	-397, 470	2, 603, 721		69. 00
69. 01	06901 PULMONARY	0 200	0 242		69. 01
69. 02	06902 CARDI OPULMONARY	-9, 300	99, 343		69. 02
69. 03 70. 00	06903 SLEEP LAB 07000 ELECTROENCEPHALOGRAPHY	-3, 233 0	237, 921 0		69. 03 70. 00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 130, 658		71.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	8, 939, 105	l control of the cont	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0, 737, 103		73. 00
74. 00	07400 RENAL DIALYSIS	0	0	l e e e e e e e e e e e e e e e e e e e	74.00
, ,, ,,	OUTPATIENT SERVICE COST CENTERS			1	1
88. 00	08800 RURAL HEALTH CLINIC	-22, 873	361, 687		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	-5, 501	547, 848	3	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
90.00	09000 CLI NI C	-314, 119	1, 104, 361		90. 00
90. 01	09001 I MED	-183, 019	303, 942		90. 01
90. 02	09002 ONCOLOGY	-3, 041	2, 510, 118		90. 02
90. 03		0	402, 978		90. 03
	09100 EMERGENCY	-4, 043, 397	4, 344, 074		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
05 00	OTHER REIMBURSABLE COST CENTERS	10 (0)	1 027 025	-1	05.00
	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	-19, 606 0	1, 937, 935		95. 00 96. 00
	10100 HOME HEALTH AGENCY	0	1, 743, 125		101. 00
101.00	SPECIAL PURPOSE COST CENTERS	U	1, 743, 123	y	1101.00
116 00	11600 HOSPI CE	0	0		116. 00
118. 00		-26, 488, 660			118. 00
110.00	NONREI MBURSABLE COST CENTERS	20, 100, 000	111,001,072		1110.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	28, 960, 730		192.00
	1 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	695, 397		192. 01
194.00	07950 LODGE	0	462		194. 00
	07952 MEMORIAL HOSPITAL FOUNDATION	0	155, 207		194. 02
	3 07953 MKT/PHY SERVICES	0	4, 236, 520		194. 03
	4 07954 COMMUNITY EDUCATION	0	519, 809		194. 04
	07955 VOLUNTEER	0	178, 160)	194. 05
	07956 MAB	0	0)	194. 06
	07958 PUBLIC RELATIONS	0	894, 805		194. 08
	9 07959 UNUSED SPACE	0	0)	194. 09
200.00	TOTAL (SUM OF LINES 118-199)	-26, 488, 660	180, 472, 982	2	200. 00

Provider CCN: 150115 | Period: | Worksheet A-6 | From 07/01/2015 | To 06/30/2016 | Date/Time Prepared:

					То	06/30/2016	Date/Time Prep 11/28/2016 1:0	pared:
		Increases					111/20/2010 1.0	DZ PIII
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3.00	4.00	5. 00				
	B - LABOR AND DELIVERY	<u> </u>	<u> </u>					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 039, 863	162, 431				1.00
2.00	NURSERY	43.00	519, 931	81, 215			ĺ	2.00
	0 — — — — —		1, 559, 794	243, 646			j	
	C - CAFETERIA							
1.00	CAFETERI A	11. 00	738, 565	509, 320				1.00
	0		738, 565	509, 320				
	D - IMPLANTABLE DEVICES							
1.00	IMPL. DEV. CHARGED TO PATIENTS	72. 00	0	8, 939, 105				1. 00
		+		8, 939, 105				
	E - BILLABLE SUPPLES		٠,	0, 707, 100				
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	7, 312, 720				1. 00
1.00	PATI ENTS	71.00	٩	7,012,720				1. 00
2.00		0.00	o	0				2. 00
3.00		0.00	o	0				3. 00
4.00		0.00	o	0				4. 00
5.00		0.00	o	0				5.00
6.00		0.00	o	0				6.00
7. 00		0.00	o	0				7.00
8.00		0.00	O	0				8. 00
9.00		0.00	O	0				9.00
10.00		0.00	O	0				10.00
11.00		0.00	О	0				11.00
12.00		0.00	o	0				12.00
13.00		0.00	o	0				13.00
14.00		0.00	o	0				14.00
15. 00		0.00	O	0				15.00
16.00		0.00	O	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	O	0			1	21.00
22.00		0.00	O	0			1	22.00
23.00		0.00	O	0			1	23.00
24.00	L	0.00	ol	0			1	24.00
	0		0	7, 312, 720				
500.00	Grand Total: Increases		2, 298, 359	17, 004, 791			[]	500. 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 07/01/2015 To 06/30/2016 Date/Time Prepared:

Cost Center Line # Salary Other Wkst. A-7 Ref.								11/28/2016 1: 02 pm
B - LABOR AND DELIVERY								
B - LABOR AND DELIVERY								
1.00		6. 00	7. 00	8. 00	9. 00	10. 00		
2.00 0 0 0 1,559,794 243,646								
1.00 DIETARY 10.00 738,565 509,320 0 0 0 0 0 0 0 0 0		ADULTS & PEDIATRICS		1, 559, 794	243, 646		l .	
1.00 DIETARY 10.00 738,565 509,320 0 0 0 0 0 738,565 509,320 0 0 0 0 0 0 0 0 0	2.00		0.00	0		<u> </u>		2.00
1.00		0		1, 559, 794	243, 646	o l		
1.00								
D - IMPLANTABLE DEVICES MEDI CAL SUPPLIES CHARGED TO	1.00	DI ETARY	<u>10.</u> 00					1.00
1.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 8,939,105 0		0		738, 565	509, 320)		
PATI ENTS								
D	1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	8, 939, 105	0		1.00
E - BI LLABLE SUPPLES ADMI NI STRATI VE & GENERAL 1. 00 2. 00 1. 00 1. 00 2. 00 3. 00 NURSI NG ADMI NI STRATI ON 1. 00 3. 00 4. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0. 140, 386 0. 4. 00 6. 00 1. 00 9. 00 1. 00 9. 00 1. 00 9. 00 1.		PATI ENTS				<u> </u>		
1. 00		0		0	8, 939, 105	5		
2. 00 DI ETARY 10.00 0 27,561 0 2.00 3. 00 NURSING ADMINISTRATION 13.00 0 869 0 3.00 4. 00 CENTRAL SERVICES & SUPPLY 14.00 0 140,386 0 4.00 5. 00 ADULTS & PEDIATRICS 30.00 0 293,190 0 5.00 6. 00 INTENSIVE CARE UNIT 31.00 0 30.182 0 6.00 7. 00 SUBPROVI DER - I PF 40.00 0 2,583 0 7.00 8. 00 SUBPROVI DER - I RF 41.00 0 2,783 0 8.00 9. 00 SKI LLED NURSING FACI LI TY 44.00 0 7,289 0 9.00 11. 00 OPERATI ING ROOM 50.00 0 2,601,082 0 10.00 11. 00 ANESTHESI OLOGY 53.00 0 343,907 0 11.00 12. 00 RADI OLOGY-DI AGNOSTI C 54.00 0 180,714 0 12.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
3. 00 NURSING ADMINISTRATION 13. 00 0 869 0 4. 00 4. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 140,386 0 4. 00 5. 00 ADULTS & PEDIATRICS 30. 00 0 293,190 0 5. 00 6. 00 INTENSIVE CARE UNIT 31. 00 0 30,182 0 6. 00 7. 00 SUBPROVI DER - IPF 40. 00 0 2,583 0 7. 00 88. 00 SUBPROVI DER - IRF 41. 00 0 7,289 0 7. 00 SKI LLED NURSING FACILITY 44. 00 0 7,289 0 9. 00 SKI LLED NURSING FACILITY 44. 00 0 7,289 0 10. 00 OPERATING ROOM 50. 00 0 2,601,082 0 10. 00 OPERATING ROOM 50. 00 0 343,907 0 11. 00 ANESTHESI OLOGY 53. 00 0 343,907 0 11. 00 13. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 180,714 0 11. 00 13. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 180,714 0 11. 00 RESPI RATORY THERAPY 65. 00 0 308,317 0 14. 00 RESPI RATORY THERAPY 66. 00 0 69,368 0 15. 00 16. 00 17. 00 CARDI OPULMONARY 69. 02 0 2,962 0 17. 00 CARDI OPULMONARY 69. 02 0 2,962 0 17. 00 CARDI OPULMONARY 69. 02 0 2,962 0 17. 00 18. 00 19. 29. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 29. 00 19. 00 19. 00 19. 00 19. 29. 00 19. 00 19. 00 19. 00 19. 29. 00 19. 00 19. 00 19. 29. 00 19. 00 19. 00 19. 29. 00 19. 00 19. 29. 00 19. 00 19. 29. 00 19. 00 19. 29. 00 19. 00 19. 29. 29. 00 19. 00 19. 00 19. 29. 29. 00 19. 00 19. 00 19. 29. 29. 00 19. 00 19. 00 19. 29. 29. 00 19. 00 19. 00 19. 29. 29. 00 19. 00 19. 00 19. 29. 29. 00 19. 00 19. 00 19. 00 19. 29. 29. 00 19. 00 19. 00 19. 29. 29. 00 19. 00 19. 29. 29. 00 19. 00 19. 00 19. 29. 29. 00 19. 00 19. 29. 29. 00 19. 00 19. 29. 29. 00 19. 00 19. 29. 29. 00 19. 00 19. 29. 29. 00 19. 00 19. 29. 29. 00 19. 00 19. 29. 29. 00 19. 00 19. 29. 29. 00 19. 00 19. 29. 29. 00 19. 00 19. 29. 29. 00 19. 00 19. 29. 29. 00 19. 00 19. 29. 29. 00 19. 00 19. 29. 29. 00 19. 00 19. 29. 29. 00 19. 00 19. 29. 29. 00 19. 00 19. 29. 29. 00 19. 00 19. 29. 29. 00 19. 00 19. 29. 00 19. 29. 29. 00 19. 00 19. 29. 29. 00 19. 00 19. 29. 29. 00 19. 29. 29. 00 19. 29. 29. 00 19. 29. 29. 00 19. 29. 29. 00 19. 29.	1.00			0	13	0		1.00
4.00 CENTRAL SERVICES & SUPPLY 14.00 0 140,386 0 5.00 5.00 ADULTS & PEDIATRICS 30.00 0 293,190 0 5.00 6.00 INTENSIVE CARE UNIT 31.00 0 30,182 0 5.00 6.00 SUBPROVIDER - IPF 40.00 0 2,583 0 7.00 8.00 SUBPROVIDER - IPF 440.00 0 2,783 0 8.00 9.00 SKILLED NURSING FACILITY 44.00 0 7,289 0 9.00 SKILLED NURSING FACILITY 44.00 0 7,289 0 9.00 10.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00	DI ETARY	10.00	0	27, 561	0		2.00
5. 00 ADULTS & PEDIATRICS 30. 00 0 293, 190 0 5. 00 6. 00 INTENSI VE CARE UNIT 31. 00 0 30, 182 0 6. 00 7. 00 SUBPROVI DER - I PF 40. 00 0 2, 583 0 7. 00 8. 00 SUBPROVI DER - I RF 41. 00 0 2, 783 0 8. 00 9. 00 SKI LLED NURSI NG FACI LI TY 44. 00 0 7, 289 0 9. 00 10. 00 OPERATI NG ROOM 50. 00 0 2, 601, 082 0 10. 00 11. 00 ANESTHESI OLOGY 53. 00 0 343, 907 0 11. 00 12. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 180, 714 0 12. 00 13. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 180, 714 0 12. 00 14. 00 SESPI RATORY THERAPY 65. 00 0 2, 924 0 13. 00 15. 00 PHYSI CAL THERAPY 66. 00 0 69, 36	3.00	NURSING ADMINISTRATION	13.00	0	869	0		3.00
6. 00 INTENSIVE CARE UNIT 31. 00 0 30, 182 0 6. 00 7. 00 SUBPROVI DER - IPF 40. 00 0 2, 583 0 7. 00 8. 00 SUBPROVI DER - I RF 41. 00 0 2, 783 0 8. 00 9. 00 SKI LLED NURSI NG FACI LI TY 44. 00 0 7, 289 0 9. 00 9. 00 10. 00 0 0 0 0 0 0 0 0	4.00	CENTRAL SERVICES & SUPPLY	14.00	0	140, 386	0		4.00
7. 00 SUBPROVI DER - I PF 40.00 0 2,583 0 7. 00 8. 00 SUBPROVI DER - I RF 41. 00 0 2,783 0 8. 00 9. 00 SKILLED NURSING FACILITY 44. 00 0 7,289 0 9. 00 10. 00 OPERATING ROM 50. 00 0 2,601,082 0 11. 00 11. 00 ANESTHESI OLOGY 53. 00 0 343,907 0 11. 00 12. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 180,714 0 12. 00 13. 00 RADI OLOGY-THERAPY 65. 00 0 2,924 0 13. 00 14. 00 RESPI RATORY THERAPY 65. 00 0 308, 317 0 14. 00 15. 00 PHYSI CAL THERAPY 66. 00 0 69, 368 0 15. 00 16. 00 ELECTROCARDI OLOGY 69. 00 0 3, 049, 696 0 16. 00 17. 00 CARDI OPULMONARY 69. 02 0 2, 962	5.00	ADULTS & PEDIATRICS	30.00	0	293, 190	0		5. 00
8. 00 SUBPROVI DER - I RF	6.00	INTENSIVE CARE UNIT	31.00	0	30, 182	0		6. 00
9. 00 SKI LLED NURSING FACILITY	7.00	SUBPROVI DER - I PF	40.00	0	2, 583	0		7. 00
10. 00 OPERATING ROOM 50. 00 0 2, 601, 082 0 10. 00 11. 00 ANESTHESI OLOGY 53. 00 0 343, 907 0 11. 00 12. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 180, 714 0 12. 00 13. 00 RADI OI SOTOPE 56. 00 0 2, 924 0 13. 00 14. 00 RESPI RATORY THERAPY 65. 00 0 308, 317 0 14. 00 15. 00 PHYSI CAL THERAPY 66. 00 0 69, 368 0 15. 00 16. 00 ELECTROCARDI OLOGY 69. 00 0 3, 049, 696 0 0 17. 00 CARDI OPULMONARY 69. 02 0 2, 962 0 17. 00 18. 00 SLEEP LAB 69. 03 0 7, 770 0 18. 00 19. 00 CLI NI C 90. 00 0 30, 614 0 19. 00 20. 00 ONCOLOGY 90. 02 0 31, 239 0 20. 00 21. 00 EMERGENCY 91. 00 0 30, 993 0 </td <td>8.00</td> <td>SUBPROVI DER - I RF</td> <td>41.00</td> <td>0</td> <td>2, 783</td> <td>0</td> <td></td> <td>8.00</td>	8.00	SUBPROVI DER - I RF	41.00	0	2, 783	0		8.00
11. 00 ANESTHESI OLOGY 53. 00 0 343, 907 0 12. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 180, 714 0 12. 00 13. 00 RADI OLOGY-DI AGNOSTI C 56. 00 0 2, 924 0 13. 00 14. 00 RESPI RATORY THERAPY 65. 00 0 308, 317 0 14. 00 15. 00 PHYSI CAL THERAPY 66. 00 0 69, 368 0 15. 00 16. 00 ELECTROCARDI OLOGY 69. 00 0 3, 049, 696 0 15. 00 17. 00 CARDI OPULMONARY 69. 02 0 2, 962 0 17. 00 18. 00 SLEEP LAB 69. 03 0 7, 770 0 18. 00 19. 00 CLI NI C 90. 00 0 30, 614 0 19. 0	9.00	SKILLED NURSING FACILITY	44.00	o	7, 289	0		9. 00
12. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 180, 714 0 12. 00 13. 00 RADI OI SOTOPE 56. 00 0 2, 924 0 13. 00 14. 00 RESPI RATORY THERAPY 65. 00 0 308, 317 0 14. 00 15. 00 PHYSI CAL THERAPY 66. 00 0 69, 368 0 15. 00 16. 00 ELECTROCARDI OLOGY 69. 00 0 3, 049, 696 0 16. 00 17. 00 CARDI OPULMONARY 69. 02 0 2, 962 0 18. 00 SLEEP LAB 69. 03 0 7, 770 0 18. 00 19. 00 CLI NI C 90. 00 0 30, 614 0 19. 00 20. 00 ONCOLOGY 90. 02 0 31, 239 0 20. 00 21. 00 EMERGENCY 91. 00 0 93, 293 0 21. 00 22. 00 AMBULANCE SERVI CES 95. 00 0 30, 993 0 22. 00 23. 00 HOME HEALTH AGENCY 101. 00 0 26, 831 0 23. 00 0 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 7, 312, 720 0	10.00	OPERATING ROOM	50.00	o	2, 601, 082	0		10.00
13. 00 RADI OI SOTOPE 56. 00 0 2, 924 0 13. 00 14. 00 RESPI RATORY THERAPY 65. 00 0 308, 317 0 14. 00 15. 00 PHYSI CAL THERAPY 66. 00 0 69, 368 0 15. 00 16. 00 ELECTROCARDI OLOGY 69. 00 0 3, 049, 696 0 16. 00 17. 00 CARDI OPULMONARY 69. 02 0 2, 962 0 17. 00 18. 00 SLEEP LAB 69. 03 0 7, 770 0 18. 00 19. 00 CLI NI C 90. 00 0 30, 614 0 19. 00 20. 00 ONCOLOGY 90. 02 0 31, 239 0 20. 00 21. 00 EMERGENCY 91. 00 0 93, 293 0 21. 00 22. 00 AMBULANCE SERVI CES 95. 00 0 30, 993 0 22. 00 23. 00 HOME HEALTH AGENCY 101. 00 0 26, 831 0 23. 00 24. 00 O 7, 312, 720 0 7, 312, 720 0	11.00	ANESTHESI OLOGY	53.00	o	343, 907	0		11.00
14. 00 RESPI RATORY THERAPY 65. 00 0 308, 317 0 14. 00 15. 00 PHYSI CAL THERAPY 66. 00 0 69, 368 0 15. 00 16. 00 ELECTROCARDI OLOGY 69. 00 0 3, 049, 696 0 0 17. 00 CARDI OPULMONARY 69. 02 0 2, 962 0 17. 00 18. 00 SLEEP LAB 69. 03 0 7, 770 0 18. 00 19. 00 CLI NI C 90. 00 0 30, 614 0 19. 00 20. 00 ONCOLOGY 90. 02 0 31, 239 0 20. 00 21. 00 EMERGENCY 91. 00 0 93, 293 0 21. 00 22. 00 AMBULANCE SERVI CES 95. 00 0 30, 993 0 22. 00 23. 00 HOME HEALTH AGENCY 101. 00 0 26, 831 0 23. 00 24. 00 O 0 7, 312, 720 0 7, 312, 720 0	12.00	RADI OLOGY-DI AGNOSTI C	54.00	o	180, 714	0		12. 00
15. 00 PHYSI CAL THERAPY 66. 00 0 69, 368 0 15. 00 16. 00 ELECTROCARDI OLOGY 69. 00 0 3, 049, 696 0 16. 00 17. 00 CARDI OPULMONARY 69. 02 0 2, 962 0 17. 00 18. 00 SLEEP LAB 69. 03 0 7, 770 0 18. 00 19. 00 CLI NI C 90. 00 0 30, 614 0 19. 00 20. 00 ONCOLOGY 90. 02 0 31, 239 0 20. 00 21. 00 EMERGENCY 91. 00 95. 00 93. 293 0 21. 00 22. 00 AMBULANCE SERVI CES 95. 00 0 30, 993 0 22. 00 23. 00 HOME HEALTH AGENCY 101. 00 0 26, 831 0 23. 00 24. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 7, 312, 720	13.00	RADI OI SOTOPE	56.00	o	2, 924	0		13.00
16. 00 ELECTROCARDI OLOGY 69. 00 0 3, 049, 696 0 16. 00 17. 00 CARDI OPULMONARY 69. 02 0 2, 962 0 17. 00 18. 00 18. 00 SLEEP LAB 69. 03 0 7, 770 0 18. 00 19. 00 CLI NI C 90. 00 0 30, 614 0 19. 00 20. 00 ONCOLOGY 90. 02 0 31, 239 0 20. 00 21. 00 EMERGENCY 91. 00 0 93, 293 0 21. 00 22. 00 23. 00 HOME HEALTH AGENCY 101. 00 0 26, 831 0 23. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 7, 312, 720 0 24. 00 24. 00 0 24. 00 0 0 7, 312, 720 0 0 0 24. 00 0 0 0 0 0 0 0 0 0	14.00	RESPIRATORY THERAPY	65.00	o	308, 317	0		14.00
17. 00 CARDI OPULMONARY 69. 02 0 2, 962 0 18. 00 SLEEP LAB 69. 03 0 7, 770 0 19. 00 CLI NI C 90. 00 0 30, 614 0 20. 00 ONCOLOGY 90. 02 0 31, 239 0 21. 00 EMERGENCY 91. 00 0 93, 293 0 22. 00 AMBULANCE SERVI CES 95. 00 0 30, 993 0 23. 00 HOME HEALTH AGENCY 101. 00 0 26, 831 0 24. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 28, 154 0 0 0 7, 312, 720 0	15.00	PHYSI CAL THERAPY	66.00	o	69, 368	0		15. 00
18. 00 SLEEP LAB 69. 03 0 7, 770 0 19. 00 CLI NI C 90. 00 0 30, 614 0 20. 00 ONCOLOGY 90. 02 0 31, 239 0 21. 00 EMERGENCY 91. 00 0 93, 293 0 22. 00 AMBULANCE SERVI CES 95. 00 0 30, 993 0 23. 00 HOME HEALTH AGENCY 101. 00 0 26, 831 0 24. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 28, 154 0 0 0 7, 312, 720 0	16.00	ELECTROCARDI OLOGY	69.00	o	3, 049, 696	0		16. 00
19. 00	17.00	CARDI OPULMONARY	69. 02	o	2, 962	2		17. 00
20. 00 ONCOLOGY 90. 02 0 31, 239 0 20. 00 21. 00 EMERGENCY 91. 00 0 93, 293 0 21. 00 22. 00 AMBULANCE SERVICES 95. 00 0 30, 993 0 22. 00 23. 00 HOME HEALTH AGENCY 101. 00 0 26, 831 0 23. 00 24. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 0 28, 154 0 0 0 0 7, 312, 720 0 24. 00	18.00	SLEEP LAB	69. 03	o	7, 770	0		18. 00
21. 00 EMERGENCY 91. 00 93, 293 0 21. 00 22. 00 AMBULANCE SERVI CES 95. 00 0 30, 993 0 23. 00 HOME HEALTH AGENCY 101. 00 0 26, 831 0 24. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 7, 312, 720 0 24. 00	19.00	CLINIC	90.00	o	30, 614	. 0		19. 00
21. 00 EMERGENCY 91. 00 93, 293 0 21. 00 22. 00 AMBULANCE SERVI CES 95. 00 0 30, 993 0 23. 00 HOME HEALTH AGENCY 101. 00 0 26, 831 0 24. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 7, 312, 720 0 24. 00	20.00	ONCOLOGY	90. 02	ol				20.00
22. 00 AMBULANCE SERVICES 95. 00 0 30, 993 0 22. 00 23. 00 HOME HEALTH AGENCY 101. 00 0 26, 831 0 24. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 0 28, 154 0 0 7, 312, 720		EMERGENCY		o				
23. 00 HOME HEALTH AGENCY 101. 00 0 26, 831 0 23. 00 24. 00 PHYSICIANS PRIVATE OFFICES 192. 00 0 7, 312, 720 24. 00				o				
24. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 0 28, 154 0 24. 00 7, 312, 720				ol				
0 7, 312, 720				ol				
			— — — +					1
	500, 00	Grand Total: Decreases		2, 298, 359				500.00

8.00

9.00

10.00

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 150115 Peri od: Worksheet A-7 From 07/01/2015 Part I Date/Time Prepared: 06/30/2016 11/28/2016 1:02 pm 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 7, 585, 948 1, 579, 813 1, 579, 813 0 1.00 0 2.00 Land Improvements 0 2.00 0 3. 00 3.00 Buildings and Fixtures 109, 931, 972 3, 441, 900 3, 441, 900 0 Building Improvements 4.00 0 4.00 0 5.00 Fixed Equipment 5.00 6.00 Movable Equipment 95, 665, 287 11, 269, 650 0 0 0 11, 269, 650 0 6.00 7.00 HIT designated Assets 7.00 0 8.00 Subtotal (sum of lines 1-7) 213, 183, 207 16, 291, 363 16, 291, 363 0 8.00 9.00 Reconciling Items 0 0 9.00 213, 183, 207 Total (line 8 minus line 9) 16, 291, 363 O 16, 291, 363 10.00 10.00 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 9, 165, 761 1.00 2.00 Land Improvements 0 2.00 3.00 Buildings and Fixtures 113, 373, 872 0 3.00 0) 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 0 6.00 106, 934, 937 6.00

229, 474, 570

229, 474, 570

0

0

7.00

8.00

9.00

HIT designated Assets

10.00 Total (line 8 minus line 9)

Reconciling Items

Subtotal (sum of lines 1-7)

Heal th	Financial Systems ME	MORIAL HOSP & F	HEALTH CARE CTF	2	In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der		Period: From 07/01/2015	Worksheet A-7 Part II		
						Date/Time Pre	pared:	
						11/28/2016 1:		
	SUMMARY OF CAPITAL							
	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						
1.00	CAP REL COSTS-BLDG & FLXT	3, 935, 184		2, 672, 751	167, 623	0	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	9, 072, 038	0	(0	0	2. 00	
3.00	Total (sum of lines 1-2)	13, 007, 222	1, 055, 795	2, 672, 751	167, 623	0	3. 00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description		Total (1) (sum					
		Capi tal -Relate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14. 00	15.00	L				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	(SHEET A, COLUM	· ·					
1. 00	CAP REL COSTS-BLDG & FIXT	0	7, 831, 353	1			1.00	
2. 00	CAP REL COSTS-MVBLE EQUIP	0	9, 072, 038				2. 00	
3.00	Total (sum of lines 1-2)	0	16, 903, 391				3. 00	

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10								
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7		
					From 07/01/2015	Part III		
					To 06/30/2016			
		0011	DUTATION OF DAT	F1.00	ALLOCATION OF	11/28/2016 1:0	J2 pm	
	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL							
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance		
			Leases	for Ratio	instructions)			
				(col. 1 - col				
				2)				
		1.00	2.00	3. 00	4. 00	5. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS						
1.00	CAP REL COSTS-BLDG & FIXT	122, 539, 633	0	122, 539, 63	3 0. 534001	0	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	106, 934, 937	0	106, 934, 93	7 0. 465999	0	2. 00	
3.00	Total (sum of lines 1-2)	229, 474, 570	0	229, 474, 57	0 1.000000	0	3. 00	
		ALLOCA	TION OF OTHER (F CAPITAL		
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
	'		Capi tal -Relate		'			
			d Costs	through 7)				
		6. 00	7. 00	8. 00	9. 00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS		•	<u> </u>			
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 3, 845, 699	1, 055, 795	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 9, 104, 567	0	2. 00	
3.00	Total (sum of lines 1-2)	0	0		0 12, 950, 266	1, 055, 795		
	,		Sl	JMMARY OF CAPI		,		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum		
	P. C. C.		instructions)		Capi tal -Rel ate			
					d Costs (see	through 14)		
					instructions)			

0 0 0 12.00

167, 623

167, 623

13.00

0 0 0 14.00

0 0 0 15.00

5, 069, 117 1. 00 9, 104, 567 2. 00 14, 173, 684 3. 00

11. 00

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

1.00

2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)

| Peri od: | Worksheet A-8 | From 07/01/2015 | To 06/30/2016 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 150115

				To To	06/30/2016	Date/Time Prep 11/28/2016 1:0	
				Expense Classification on		11/28/2016 1:0	JZ pili
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1. 00 B	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 11	1. 00
	COSTS-BLDG & FIXT (chapter 2)		-2,072,731	CAL REE COSTS-BEDG & TTAT	1.00	''	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
4.00	di scounts (chapter 8)		O		0.00		4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5. 00
6.00	Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay	А	-10 791	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
7.00	stations excluded) (chapter		, , , ,		0.00		7.00
8. 00	21) Television and radio service		0		0. 00	0	8. 00
	(chapter 21)						
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-10, 523, 607		0. 00	0	9. 00 10. 00
	adjustment				F 00		
11. 00	Sale of scrap, waste, etc. (chapter 23)	В	-28, 383	ADMINISTRATIVE & GENERAL	5. 00	0	11. 00
12. 00	Related organization	A-8-1	-1, 888, 939			О	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0. 00	o	13. 00
14.00	Cafeteria-employees and guests		-642, 302	CAFETERI A	11. 00	0	14.00
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
	patients						
17. 00	Sale of drugs to other than patients	В	-223, 768	PHARMACY	15. 00	0	17. 00
18. 00	Sale of medical records and	В	-53, 472	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0. 00	0	19. 00
20.00	books, etc.) Vending machines	В	47.2	ADMINISTRATIVE & CENEDAL	5. 00	0	20. 00
20. 00 21. 00	Income from imposition of	Б	-463 0	ADMINISTRATIVE & GENERAL	0.00	0	
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	О	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	0	29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	67. 00		30. 00
00 = "	limitation (chapter 14)			ADUI TO A DEDI ATT. 15			
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 limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
33. 00	TELEPHONE DEPRECIATION	Α		CAP REL COSTS-BLDG & FIXT	1. 00	9	
33. 01	CRNA	A	-844, 129	OPERATING ROOM	50. 00	0	33. 01

Health Financial Systems ADJUSTMENTS TO EXPENSES Provi der CCN: 150115 Peri od: Worksheet A-8 From 07/01/2015
To 06/30/2016 Date/Time Prepared:

				11	0 06/30/2016	11/28/2016 1:0	
				Expense Classification on	Worksheet A	1172072010 1.	JZ piii
				To/From Which the Amount is			
				TOTTION WITCH THE AMOUNT 13	to be Aujusteu		
	Coot Conton Decemention	Pagi a/Cada (2)	Amount	Coot Conton	lino #	Wka+ A 7 Daf	
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
22.00	MI COEL L'ANEQUIC DEVENUE	1.00	2.00	3.00	4. 00	5. 00	00.00
33. 02	MI SCELLANEOUS REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03	ADVERTISING - BENEFITS	A	·	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 03
33. 04	MAI NTENANCE	В		MAINTENANCE & REPAIRS	6. 00	0	33. 04
33. 05	ADVERTISING - FRENCH LICK	A		RURAL HEALTH CLINIC	88. 00	0	33. 05
33. 06	ADVERTISING - LOOGOOTEE	Α		RURAL HEALTH CLINIC II	88. 01	0	33. 06
33. 07	ADVERTISING - AMBULANCE	Α	-4, 396	AMBULANCE SERVICES	95. 00	0	33. 07
33. 08	ADVERTISING - CARING HANDS	A	-1, 273	SUBPROVI DER - I PF	40.00	0	33. 08
33.09	DI ETARY SUPPLEMENTS	В	-36, 695	DI ETARY	10.00	0	33. 09
33. 10	CLINICAL ENGINEERING	В	-1, 051	MAINTENANCE & REPAIRS	6.00	0	33. 10
33. 11	MI SCELLANEOUS - DI ETARY	В	-2, 126	DI ETARY	10.00	0	33. 11
33. 12	ADVERTISING - REHAB	A		SUBPROVI DER - I RF	41.00	0	33. 12
33. 13	MI SCELLANEOUS - FINANCE	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
33. 14	MI SCELLANEOUS - AMBULANCE	В		AMBULANCE SERVICES	95.00	o o	33. 14
33. 15	ACCOUNTS PAYABLE DI SCOUNT	В	·	ADMINISTRATIVE & GENERAL	5. 00	Ő	33. 15
33. 16	MI SCELLANEOUS - SLEEP LAB	В	·	SLEEP LAB	69. 03	0	33. 16
33. 17	ADVERTISING - ADMIN	B		ADMI NI STRATI VE & GENERAL	5.00	10	33. 17
33. 17	MI SCELLANEOUS - CLI NCAL	В		NURSING ADMINISTRATION	13. 00	0	33. 17
33. 19	MISCELLANEOUS - FRENCH LICK	В		RURAL HEALTH CLINIC	88. 00	0	33. 19
33. 19	MI SCELLANEOUS - FRENCH LICK	В		RURAL HEALTH CLINIC	88. 01	0	33. 19
			·	l .		0	
33. 21	MI SCELLANEOUS - CARDI AC REHAB	В		CARDI OPULMONARY	69. 02	0	33. 21
33. 22	ADVERTISING - NURSING ADMIN	В		NURSI NG ADMI NI STRATI ON	13. 00	0	33. 22
33. 23	HOSPITAL ASSESSMENT FEE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 23
33. 24	CRNA EXPENSE	A		ANESTHESI OLOGY	53. 00	0	33. 24
33. 25	MI SC. PROC. CENTER	В	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 25
33. 26	BUSINESS OFFICE EXPENSE -	A	-434, 818	ADMINISTRATIVE & GENERAL	5. 00	0	33. 26
	PHYSI CI AN						
33. 27	AHA & IHA LOBBYING DUES	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 27
33. 28	PHYSICIAN EMPLOYEE BENEFIT	A	-1, 887, 094	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 28
	OFFSET						
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 - ONCOLOGY	A	·	ONCOLOGY	90. 02	o	33. 37
50. 00	TOTAL (sum of lines 1 thru 49)	1	-26, 488, 660	l e e e e e e e e e e e e e e e e e e e			50. 00
55. 55	(Transfer to Worksheet A,		25, 100, 000				55.00
	column 6, line 200.)						
	100. 0 0, 11110 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.

				_	11/28/2016 1:	UZ PIII	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	i	
				Allowable Cost	Included in	i	
					Wks. A, column	i	
					5		
	1. 00	2. 00	3. 00	4. 00	5. 00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED							
	HOME OFFICE COSTS:					ı	
1.00	50. 00	OPERATING ROOM	AMBULATORY SURGERY CENTER	4, 263, 956	6, 152, 895	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).			4, 263, 956	6, 152, 895	5. 00	
	Transfer column 6, line 5 to					I	
	Worksheet A-8, column 2,					I	
	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.

			Related Organization(s) and/	or Home Office			
Symbol (1)	Name	Percentage of	Name	Percentage of			
, , ,		Ownershi p		Ownershi p			
1. 00	2. 00	3. 00	4. 00	5. 00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							
		1.00 2.00	Symbol (1) Name Percentage of Ownership 1.00 2.00 3.00	Symbol (1) Name Percentage of Ownership Name 1.00 2.00 3.00 4.00	Ownershi p Ownershi p 1. 00 2.00 3. 00 4. 00 5. 00		

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.

Health Financial Systems			MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CM				u of Form CMS-	2552-10
		SERVICES FROM	RELATED ORGANIZATIONS	AND HOME	Provider CCN: 150115		Worksheet A-8	3-1
OFFI CE	COSTS					From 07/01/2015 To 06/30/2016	Date/Time Pro	
	Net	Wkst. A-7 Ref.						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6. 00	7. 00						
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RE	SULT OF TRANS	SACTIONS WITH RELATED	ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:						
1.00	-1, 888, 939	0						1.00
2.00	0	0						2.00
3.00	0	0						3.00
4.00	0	0						4.00
5.00	-1, 888, 939							5.00
* The	amounts on line	es 1-4 (and sub	oscripts as appropriate	e) are transf	erred in detail to Wo	rksheet A. column	6. lines as	
			se cost and negative ar					whi ch
			columns 1 and/or 2, th					
	Related Orga	ani zati on(s)						
	and/or Ho	me Office						

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.

	SURGERY CENTER	6. 00
7.00		7. 00
8.00		8. 00
9.00		9. 00
10.00		10.00
9. 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 Peri od: Worksheet A-8-2 From 07/01/2015 To 06/30/2016 Date/Time Prepared: Provider CCN: 150115

							11/28/2016 1:	02 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				'	'		Hours	
	1. 00	2, 00	3.00	4. 00	5. 00	6. 00	7. 00	
1. 00		SUBPROVIDER - IPF	344, 694				0	1. 00
2.00		SUBPROVI DER - I RF	130, 250			_		2. 00
3. 00		OPERATI NG ROOM	9, 000				0	3. 00
4. 00		ANESTHESI OLOGY	1, 705, 093				0	4. 00
5. 00		RADI OLOGY-DI AGNOSTI C	3, 308, 392			1	0	5. 00
		LABORATORY						6. 00
6.00			150, 000				0	
7.00		RESPI RATORY THERAPY	2, 408			_	0	7. 00
8. 00		PHYSI CAL THERAPY	1, 945			1	0	8. 00
9.00		ELECTROCARDI OLOGY	456, 868				867	9. 00
10. 00		CLINIC	314, 119			_	0	10.00
11. 00	90. 01		183, 019			0	0	11. 00
12.00	91. 00	EMERGENCY	4, 046, 754	4, 037, 00	9, 750	142, 500	49	12.00
200.00			10, 652, 542				1, 882	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RO	E Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14.00	
1.00	40. 00	SUBPROVIDER - IPF	0		0 0	0	0	1. 00
2.00	41. 00	SUBPROVIDER - IRF	66, 180	3, 30	09	0	0	2. 00
3.00	50.00	OPERATING ROOM	0		o c	0	0	3. 00
4.00	53.00	ANESTHESI OLOGY	0		o o	0	0	4. 00
5. 00		RADI OLOGY-DI AGNOSTI C	0		0	0	0	5. 00
6. 00		LABORATORY	0		0	_	0	6. 00
7. 00		RESPI RATORY THERAPY	0		0 0	_	o o	7. 00
8. 00		PHYSI CAL THERAPY	0				0	8. 00
9. 00		ELECTROCARDI OLOGY	59, 398	2, 97	٩		0	
10. 00		CLI NI C	J7, J70	2, 7			0	10. 00
11. 00	90.00		0		0 0		0	11. 00
			2 257	1	-	_	_	
12.00	91.00	EMERGENCY	3, 357			_	0	12.00
200.00		0 1 0 1 (5)	128, 935				Ü	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE		Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	4.00	0.00	14	47.00	47.00	40.00		
1 00	1.00	2.00	15. 00	16. 00	17. 00	18.00		1 00
1.00		SUBPROVI DER - I PF	0		0 0	,		1.00
2.00		SUBPROVI DER - I RF	0					2. 00
3.00		OPERATING ROOM	0		0			3. 00
4.00		ANESTHESI OLOGY	0		0			4. 00
5. 00		RADI OLOGY-DI AGNOSTI C	0		0	-,,		5. 00
6.00		LABORATORY	0		0 0	150, 000		6. 00
7.00	65. 00	RESPI RATORY THERAPY	0		0 0	2, 408		7. 00
8.00	66. 00	PHYSI CAL THERAPY	0		0 0	1, 945		8. 00
9.00	69. 00	ELECTROCARDI OLOGY	0	59, 39	163, 318	397, 470		9. 00
10.00		CLINIC	0		0 0			10.00
11. 00	90. 01		Ö		ol o	1		11. 00
12. 00		EMERGENCY	Ö					12. 00
200.00	, 1. 00		l ő					200. 00
200.00		I	١	1 .25, 70	2.0,001	1 .5,525,667	ı	

Provider CCN: 150115

Peri od:

COST ALLOCATION - GENERAL SERVICE COSTS

From 07/01/2015 Part I Date/Time Prepared: 06/30/2016 11/28/2016 1:02 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT All ocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 5, 069, 117 00100 CAP REL COSTS-BLDG & FLXT 5, 069, 117 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 9, 104, 567 9, 104, 567 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 18, 314, 644 28, 669 51, 493 18, 394, 806 4.00 00500 ADMINISTRATIVE & GENERAL 1, 589, 568 23, 103, 993 5 00 18 489 858 1,081,716 1, 942, 851 5 00 6.00 00600 MAINTENANCE & REPAIRS 7, 699, 091 368, 985 662, 729 338, 945 9,069,750 6.00 8.00 00800 LAUNDRY & LINEN SERVICE 434, 104 18, 677 33, 546 45, 556 531, 883 8.00 9.00 00900 HOUSEKEEPI NG 1, 463, 365 16, 087 28, 894 217, 948 1, 726, 294 9.00 01000 DI ETARY 113, 990 702, 982 10.00 63, 466 61, 394 10 00 464, 132 11.00 01100 CAFETERI A 605, 583 12, 801 22, 992 144, 412 785, 788 11.00 01300 NURSING ADMINISTRATION 930, 791 20, 030 158, 381 1, 120, 354 13.00 11, 152 13.00 01400 CENTRAL SERVICES & SUPPLY 315, 289 10, 830 19, 452 50, 433 14.00 396,004 14.00 35, 093 63, 029 15.00 01500 PHARMACY 13, 066, 022 373, 647 13, 537, 791 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1,549,691 29, 391 52, 789 257, 504 1, 889, 375 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4.574.833 329, 692 592, 155 877.016 6, 373, 696 30.00 31.00 03100 INTENSIVE CARE UNIT 2, 984, 288 133, 973 240, 627 519, 093 3.877.981 31 00 40.00 04000 SUBPROVIDER - IPF 2, 065, 336 105, 839 190, 095 406, 492 2, 767, 762 40.00 41.00 04100 SUBPROVIDER - IRF 714, 300 55, 219 99, 179 121, 376 990, 074 41.00 04300 NURSERY 43.00 601.146 41.593 74. 705 101,663 819, 107 43.00 04400 SKILLED NURSING FACILITY 44.00 1, 390, 971 72, 588 130, 375 259, 933 1, 853, 867 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 10, 298, 774 360, 043 951, 966 12, 257, 451 50.00 646, 668 05200 DELIVERY ROOM & LABOR ROOM 52.00 1, 202, 294 136, 913 1, 618, 760 76, 228 203, 325 52.00 53.00 05300 ANESTHESI OLOGY 733, 154 C 726, 788 1, 459, 942 53.00 05400 RADI OLOGY-DI AGNOSTI C 240, 292 1, 057, 904 4, 353, 237 54.00 2, 921, 255 133, 786 54.00 56.00 05600 RADI OI SOTOPE 731, 265 11, 436 20, 539 41, 437 804, 677 56.00 60.00 06000 LABORATORY 6, 251, 768 54, 581 98.033 465, 199 6, 869, 581 60.00 06500 RESPIRATORY THERAPY 1, 191, 471 19, 534 35, 085 205, 110 1, 451, 200 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 2, 397, 967 80, 416 144, 434 424, 457 3, 047, 274 66.00 06900 ELECTROCARDI OLOGY 69 00 2,603,721 145, 067 260, 553 507, 781 3, 517, 122 69.00 69.01 06901 PULMONARY 0 69.01 06902 CARDI OPULMONARY 69.02 99, 343 11, 345 20, 377 20, 433 151, 498 69.02 06903 SLEEP LAB 44, 737 69.03 237, 921 16, 487 29, 611 328, 756 69.03 07000 ELECTROENCEPHALOGRAPHY 70.00 C 0 0 Λ 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 4, 130, 658 C 0 0 4, 130, 658 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 8, 939, 105 0 0 8, 939, 105 72.00 ol 07300 DRUGS CHARGED TO PATIENTS 0 73 00 0 Ω 0 73 00 07400 RENAL DIALYSIS 74.00 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 33, 465 55, 068 468, 852 88.00 361, 687 18, 632 08801 RURAL HEALTH CLINIC LI 88 01 547, 848 42, 701 76, 695 96, 882 88 01 764, 126 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER Ω 89.00 09000 CLI NI C 1, 104, 361 53, 390 95, 892 76, 178 1, 329, 821 90.00 90.00 09001 I MED 394, 662 90.01 303, 942 7,010 12, 590 71. 120 90.01 09002 ONCOLOGY 2, 510, 118 181, 370 90 02 100, 981 267, 691 3, 060, 160 90 02 90.03 09003 OUTPATIENT CENTER 402, 978 40, 968 443, 946 90.03 09100 EMERGENCY 100, 414 91.00 4, 344, 074 180, 352 1, 391, 790 6,016,630 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1, 937, 935 18, 535 354, 544 2, 344, 305 95.00 33, 291 09600 DURABLE MEDICAL EQUIP-RENTED 96 00 96.00 101.00 10100 HOME HEALTH AGENCY 1, 743, 125 29, 843 288, 483 2, 078, 066 101. 00 16, 615 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 116, 00 SUBTOTALS (SUM OF LINES 1-117) 144, 831, 892 3, 682, 972 6, 614, 934 12, 815, 222 135, 376, 530 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9, 593 17, 230 26, 823 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 28, 960, 730 4, 831, 584 752, 627 1, 351, 783 35, 896, 724 192. 00 192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 695, 397 24, 720 44, 399 128, 924 893, 440 192, 01 499, 827 194, 00 07950 LODGE 462 278, 287 778, 576 194. 00 4, 948 194. 02 07952 MEMORIAL HOSPITAL FOUNDATION 155, 207 8,887 29, 323 198, 365 194. 02 194. 03 07953 MKT/PHY SERVICES 4, 236, 520 60, 483 108, 632 440, 125 4, 845, 760 194. 03 194. 04 07954 COMMUNITY EDUCATION 746, 779 194. 04 519.809 56, 282 101.088 69,600 6, 282 194. 05 07955 VOLUNTEER 178, 160 11, 282 31, 003 226, 727 194. 05 0 194.06 194. 06 07956 MAB 194. 08 07958 PUBLIC RELATIONS 894, 805 12, 576 22, 587 49, 025 978, 993 194. 08 194. 09 07959 UNUSED SPACE 504, 265 194. 09 323, 918 0 180, 347 0 200.00 Cross Foot Adjustments 0 200.00

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B		
				From 07/01/2015 To 06/30/2016	Part Date/Time Pre	pared:	
					11/28/2016 1:		
		CAPI TAL REI	LATED COSTS				
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal		
	col . 7)						
	0	1. 00	2.00	4. 00	4A		
201.00 Negative Cost Centers		0		0	0	201. 00	
202.00 TOTAL (sum lines 118-201)	180, 472, 982	5, 069, 117	9, 104, 56	18, 394, 806	180, 472, 982	202. 00	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150115

| Period: | Worksheet B | From 07/01/2015 | Part | To 06/30/2016 | Date/Time Prepared: | 11/28/2016 1:02 pm

				'	0 00/30/2010	11/28/2016 1:	
	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						
	CAP REL COSTS-BLDG & FIXT						1.00
	CAP REL COSTS-MVBLE EQUIP						2.00
	EMPLOYEE BENEFITS DEPARTMENT						4. 00
	ADMINISTRATIVE & GENERAL	23, 103, 993					5. 00
	MAINTENANCE & REPAIRS	1, 331, 566	10, 401, 316	1			6. 00
	LAUNDRY & LINEN SERVICE	78, 088	54, 117	1			8. 00
	HOUSEKEEPI NG	253, 444	46, 612				9. 00
	DI ETARY	103, 208	183, 892	1	,	1, 026, 377	10. 00
	CAFETERI A	115, 365	37, 092		7, 321	0	11. 00
13.00 01300	NURSING ADMINISTRATION	164, 484	32, 313	0	6, 378	0	13. 00
14.00 01400	CENTRAL SERVICES & SUPPLY	58, 139	31, 380	36, 764	6, 193	0	14. 00
15. 00 01500	PHARMACY	1, 987, 537	101, 681	0	20, 069	0	15. 00
16.00 01600	MEDICAL RECORDS & LIBRARY	277, 387	85, 161	0	16, 808	0	16. 00
I NPATI	IENT ROUTINE SERVICE COST CENTERS						
30. 00 03000	ADULTS & PEDIATRICS	935, 748	955, 285	167, 689	188, 546	395, 957	30.00
31.00 03100	INTENSIVE CARE UNIT	569, 342	388, 188	54, 946		183, 792	31.00
	SUBPROVIDER - IPF	406, 346	306, 668	22, 129	60, 528	115, 331	40.00
	SUBPROVI DER - I RF	145, 357	159, 998	1		59, 057	41.00
	NURSERY	120, 256	120, 517			75, 672	
	SKILLED NURSING FACILITY	272, 174	210, 325	1		196, 568	
	LARY SERVICE COST CENTERS	2,2, ., .	2.0,020	0.70.0	11,012	1707000	
	OPERATING ROOM	1, 799, 565	1, 043, 227	120, 118	205, 903	0	50.00
	DELIVERY ROOM & LABOR ROOM	237, 657	220, 872		l '	0	
1	ANESTHESI OLOGY	1	220, 672	1	43, 374	0	53.00
1		214, 340	-	ή	7/ 510		1
	RADI OLOGY-DI AGNOSTI C	639, 116	387, 647			0	54.00
	RADI OI SOTOPE	118, 138	33, 135		-,	0	56. 00
	LABORATORY	1, 008, 551	158, 150	1		0	60.00
65. 00 06500	RESPI RATORY THERAPY	213, 056	56, 600	0	11, 171	0	65. 00
66. 00 06600	PHYSI CAL THERAPY	447, 382	233, 006	12, 466	45, 989	0	66. 00
69.00 06900	ELECTROCARDI OLOGY	516, 363	420, 333	34, 306	82, 962	0	69.00
69. 01 06901	PULMONARY	0	C	0	0	0	69. 01
69. 02 06902	CARDI OPULMONARY	22, 242	32, 873	0	6, 488	0	69. 02
	SLEEP LAB	48, 266	47, 77C	1	l	0	69. 03
	ELECTROENCEPHALOGRAPHY	10, 200	17,770	j ,	7, 120	0	70.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	606, 438	Ċ			0	71.00
					0		
	IMPL. DEV. CHARGED TO PATIENTS	1, 312, 386	C		0	0	72.00
1 1	DRUGS CHARGED TO PATIENTS	0	C	0	0	0	73. 00
	RENAL DI ALYSI S	0	C	0	0	0	74. 00
	TIENT SERVICE COST CENTERS						
1	RURAL HEALTH CLINIC	68, 834	53, 986	1	.,	0	1
	RURAL HEALTH CLINIC II	112, 184	123, 727	' 0	24, 420	0	88. 01
89. 00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	C	0	0	0	89. 00
90.00 09000	CLI NI C	195, 236	154, 697	0	30, 533	0	90.00
90. 01 09001	IMED	57, 942	20, 310	0	4, 009	0	90. 01
90. 02 09002	ONCOLOGY	449, 274	292, 593	8, 449	57, 749	0	90. 02
1 1	OUTPATI ENT CENTER	65, 177		1	ol	0	90. 03
	EMERGENCY	883, 326	290, 950	77, 811	57, 425	0	
	OBSERVATION BEDS (NON-DISTINCT PART)	1 222, 223	,	1		-	92. 00
	REI MBURSABLE COST CENTERS	1					72.00
	AMBULANCE SERVICES	344, 177	53, 706	0	10, 600	0	95. 00
	DURABLE MEDICAL EQUIP-RENTED	344, 177	33, 700		l ' '	0	
	HOME HEALTH AGENCY	305, 089	48, 143		I I		101. 00
	AL PURPOSE COST CENTERS	303,009	40, 143	<u>, </u>	7, 302	0	101.00
				0	Ol		11/ 00
116. 00 11600		0	(224 254	1	·		116. 00
	SUBTOTALS (SUM OF LINES 1-117)	16, 483, 180	6, 384, 954	662, 079	1, 240, 325	1, 026, 377	1118.00
	I MBURSABLE COST CENTERS	0.000	07.70		o./		
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 938	27, 796	1			190. 00
	PHYSICIANS' PRIVATE OFFICES	5, 270, 163	2, 180, 741				192. 00
192. 01 19201	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	131, 170	71, 627	0	14, 137		192. 01
194. 00 07950	LODGE	114, 306	806, 338	0	159, 148	0	194. 00
194. 02 07952	MEMORIAL HOSPITAL FOUNDATION	29, 123	14, 337	' O	2, 830	0	194. 02
	MKT/PHY SERVICES	711, 425	175, 249	1	34, 589	0	194. 03
	COMMUNITY EDUCATION	109, 638	163, 078	1	32, 187		194. 04
194. 05 07955		33, 287	18, 201	1	3, 592		194. 05
194. 06 07956		0	.0, 201		0, 0, 2		194. 06
	PUBLIC RELATIONS	143, 730	36, 439	ή	7, 192		194. 08
	UNUSED SPACE	74, 033	522, 556	1	103, 138		194. 00
		/4, 033	522, 556	, 	103, 138	0	
200.00	Cross Foot Adjustments		_	,		•	200.00
201.00	Negative Cost Centers	0	10 101 01	1	0 000 010		201. 00
202. 00	TOTAL (sum lines 118-201)	23, 103, 993	10, 401, 316	664, 088	2, 033, 043	1, 026, 377	1202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150115

| Period: | Worksheet B | From 07/01/2015 | Part | To 06/30/2016 | Date/Time Prepared: | 11/28/2016 1:02 pm

			10	00/ 30/ 2010	11/28/2016 1:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
OFNEDAL CERVILOR COCT OFNEDO	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.00
						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00 00600 MAI NTENANCE & REPAI RS						6. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	0.45 577					10.00
11. 00 01100 CAFETERI A	945, 566	l .				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	10, 852	1, 334, 381	50/ 445			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	7, 665	0	536, 145	15 //0 7/5		14. 00
15. 00 01500 PHARMACY	21, 687	0	0	15, 668, 765	2 204 000	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	28, 178	0	0	0	2, 296, 909	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	74.040	401 007	1, 593	٥	7/ 707	20.00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT	74, 948			0	76, 737	30.00
	42, 839		1, 667 598	0	47, 055	31.00
40. 00 04000 SUBPROVI DER - I PF	30, 204	194, 210	209	0	21, 628	40.00
41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	9, 800		209	0	10, 239	41.00
	7, 328 23, 302	47, 121 0	700	0	9, 884	43.00
44.00 O4400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	23, 302	l d	700	U	9, 176	44. 00
50. 00 05000 OPERATING ROOM	60, 769		3, 939	0	385, 210	50. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	14, 657	0 94, 242	3, 939	0	20, 772	
		94, 242		0		52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	13, 903	١	30	0	16, 171 283, 026	53. 00 54. 00
	41, 615	١	27	0	•	
56. 00 05600 RADI OI SOTOPE	2, 207	0	25	0	52, 131	56.00
60. 00 06000 LABORATORY	46, 127	0	0	0	206, 077	60.00
65. 00 06500 RESPIRATORY THERAPY	18, 505	0	444	0	36, 031	65. 00
66. 00 06600 PHYSI CAL THERAPY	31, 274	0	829	0	48, 958	66. 00
69. 00 06900 ELECTROCARDI OLOGY	26, 226	0	482	0	164, 524	69. 00
69. 01 06901 PULMONARY	0	0	0	0	0	69. 01
69. 02 06902 CARDI OPULMONARY	1, 730	0	30	0	4, 388	69. 02
69. 03 06903 SLEEP LAB	4, 333	0	47	0	9, 405	69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	234, 665	0	59, 858	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	286, 849	0	91, 533	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	15, 668, 765	450, 528	73. 00
74. 00 07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
OUTPATIENT SERVICE COST CENTERS	T		T	1		
88.00 08800 RURAL HEALTH CLINIC	3, 617	0	0	0	5, 401	88. 00
88.01 08801 RURAL HEALTH CLINIC II	6, 060	0	0	0	0	88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 09000 CLI NI C	6, 557	0	217	0	19, 878	90. 00
90. 01 09001 I MED	5, 118	l	0	0	3, 233	90. 01
90. 02 09002 0NC0L0GY	22, 633		702	0	57, 405	90. 02
90. 03 09003 OUTPATI ENT CENTER	0		0	0	4, 146	
91. 00 09100 EMERGENCY	51, 293	0	1, 277	0	158, 282	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS			[
95. 00 09500 AMBULANCE SERVI CES	37, 800	l I	490	0	25, 730	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
101.00 10100 HOME HEALTH AGENCY	23, 610	0	705	0	14, 858	101. 00
SPECIAL PURPOSE COST CENTERS	_		_	_1		
116. 00 11600 H0SPI CE	0		0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	674, 837	1, 334, 381	535, 525	15, 668, 765	2, 292, 264	118. 00
NONREI MBURSABLE COST CENTERS	i			1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	209, 252	0	620	0		192. 00
192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0		192. 01
194. 00 07950 LODGE	4	0	0	0		194. 00
194. 02 07952 MEMORI AL HOSPI TAL FOUNDATION	2, 627	0	0	O		194. 02
194. 03 07953 MKT/PHY SERVICES	43, 218		0	O		194. 03
194. 04 07954 COMMUNITY EDUCATION	9, 298	1	0	0		194. 04
194. 05 07955 VOLUNTEER	1, 922	i i	0	0		194. 05
194. 06 07956 MAB	0		0	0		194. 06
194. 08 07958 PUBLI C RELATIONS	4, 408	0	0	0		194. 08
194. 09 07959 UNUSED SPACE	0	0	0	O	0	194. 09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	945, 566	1, 334, 381	536, 145	15, 668, 765	2, 296, 909	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

			'	o 06/30/2016 Date/lim	16 1:02 pm
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown Adjustments			
	24. 00	25. 00	26. 00		
GENERAL SERVICE COST CENTERS					
1.00 O0100 CAP REL COSTS-BLDG & FLXT					1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P					2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500 ADMINISTRATIVE & GENERAL 6.00 00600 MAINTENANCE & REPAIRS					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 CAFETERIA					11. 00
13.00 O1300 NURSING ADMINISTRATION					13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY					15. 00 16. 00
INPATIENT ROUTINE SERVICE COST CENTERS					18.00
30. 00 03000 ADULTS & PEDI ATRI CS	9, 652, 106	0	9, 652, 106		30.00
31. 00 03100 INTENSIVE CARE UNIT	5, 517, 877	O	5, 517, 877		31. 00
40. 00 04000 SUBPROVI DER - 1 PF	3, 925, 404	0	3, 925, 404		40. 00
41. 00 04100 SUBPROVI DER - RF	1, 483, 355	0	1, 483, 355		41. 00
43. 00 04300 NURSERY	1, 227, 880	0	1, 227, 880		43. 00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	2, 645, 199	0	2, 645, 199		44. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	15, 876, 182	ol	15, 876, 182	ı	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 250, 554	0	2, 250, 554		52.00
53. 00 05300 ANESTHESI OLOGY	1, 704, 386	0	1, 704, 386		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 843, 927	o	5, 843, 927		54. 00
56. 00 05600 RADI OI SOTOPE	1, 016, 853	0	1, 016, 853		56. 00
60. 00 06000 LABORATORY	8, 321, 847	0	8, 321, 847		60.00
65. 00 06500 RESPI RATORY THERAPY	1, 787, 007	0	1, 787, 007		65. 00
66. 00 06600 PHYSI CAL THERAPY	3, 867, 178	0	3, 867, 178		66.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 PULMONARY	4, 762, 318	0	4, 762, 318		69. 00 69. 01
69. 02 06902 CARDI OPULMONARY	219, 249	0	219, 249		69. 02
69. 03 06903 SLEEP LAB	448, 005	o	448, 005		69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	C		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 031, 619	0	5, 031, 619		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	10, 629, 873	0	10, 629, 873		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	16, 119, 293	0	16, 119, 293		73.00
74. 00 O7400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	0	0	C		74. 00
88. 00 08800 RURAL HEALTH CLINIC	611, 345	o	611, 345		88. 00
88. 01 08801 RURAL HEALTH CLINIC II	1, 030, 517	0	1, 030, 517		88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C		89. 00
90. 00 09000 CLI NI C	1, 736, 939	0	1, 736, 939		90. 00
90. 01 09001 I MED	518, 182	0	518, 182		90. 01
90. 02 09002 0NCOLOGY	4, 094, 495	0	4, 094, 495		90. 02
90. 03 09003 OUTPATI ENT CENTER 91. 00 09100 EMERGENCY	513, 269 7, 536, 994	0	513, 269 7, 536, 994		90. 03 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 550, 994	0	7, 550, 994		92.00
OTHER REIMBURSABLE COST CENTERS		<u> </u>			72.00
95. 00 09500 AMBULANCE SERVICES	2, 816, 808	0	2, 816, 808		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C		96. 00
101.00 10100 HOME HEALTH AGENCY	2, 479, 973	0	2, 479, 973		101. 00
SPECIAL PURPOSE COST CENTERS		ol.		ī	11/ 00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1-117)	123, 668, 634	0	123, 668, 634		116. 00 118. 00
NONREI MBURSABLE COST CENTERS	123, 000, 034	<u> </u>	123, 000, 034		118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	64, 043	0	64, 043		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	43, 989, 288	0	43, 989, 288		192. 00
192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 115, 019	0	1, 115, 019		192. 01
194. 00 07950 LODGE	1, 858, 372	0	1, 858, 372		194. 00
194. 02 07952 MEMORIAL HOSPITAL FOUNDATION	247, 282	0	247, 282		194. 02
194. 03 07953 MKT/PHY SERVICES 194. 04 07954 COMMUNITY EDUCATION	5, 810, 241	O O	5, 810, 241		194. 03 194. 04
194. 05 07955 VOLUNTEER	1, 060, 980 283, 729	0	1, 060, 980 283, 729		194. 04
194. 06 07956 MAB	203, 727	0	200, 727		194. 06
194. 08 07958 PUBLIC RELATIONS	1, 171, 402	ol	1, 171, 402		194. 08
194.09 07959 UNUSED SPACE	1, 203, 992	0	1, 203, 992		194. 09
200.00 Cross Foot Adjustments	0	O	C		200. 00
201.00 Negative Cost Centers	0	0	100 473 003		201. 00
202.00 TOTAL (sum lines 118-201)	180, 472, 982	0	180, 472, 982		202. 00

Provider CCN: 150115

Peri od:

From 07/01/2015

ALLOCATION OF CAPITAL RELATED COSTS

Part II

06/30/2016 Date/Time Prepared: 11/28/2016 1:02 pm 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 28, 669 51, 493 80, 162 80, 162 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 0 0 0 1,081,716 1, 942, 851 3, 024, 567 6, 926 5.00 00600 MAINTENANCE & REPAIRS 1, 031, 714 1, 477 6 00 368, 985 662, 729 6 00 00800 LAUNDRY & LINEN SERVICE 8.00 18, 677 33, 546 52, 223 199 8.00 9.00 00900 HOUSEKEEPI NG 16, 087 28, 894 44, 981 950 9.00 01000 DI ETARY 0000 63.466 113, 990 177, 456 10.00 10 00 268 22, 992 01100 CAFETERI A 11.00 12, 801 35, 793 629 11.00 13.00 01300 NURSING ADMINISTRATION 11, 152 20,030 31, 182 690 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 10,830 19, 452 30, 282 220 14.00 01500 PHARMACY 63 029 15 00 15 00 35, 093 98 122 1 628 16.00 01600 MEDICAL RECORDS & LIBRARY 29, 391 52, 789 82, 180 1, 122 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 0 3, 821 30.00 03000 ADULTS & PEDIATRICS 329, 692 592, 155 921, 847 30.00 31.00 03100 INTENSIVE CARE UNIT 133, 973 240, 627 374,600 2, 262 31 00 40.00 04000 SUBPROVI DER - I PF 0 105, 839 190, 095 295, 934 1,771 40.00 99, 179 04100 SUBPROVI DER - I RF 154, 398 529 41.00 55, 219 41.00 0 04300 NURSERY 41, 593 74, 705 116, 298 443 43.00 43.00 04400 SKILLED NURSING FACILITY 72,588 202, 963 44.00 130, 375 1, 133 44.00 ANCILLARY SERVICE COST CENTERS 0 1, 006, 711 50.00 05000 OPERATING ROOM 360, 043 646, 668 4, 148 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 76, 228 136, 913 213, 141 886 52.00 05300 ANESTHESI OLOGY 53.00 C 3.167 53 00 05400 RADI OLOGY-DI AGNOSTI C 00000000 133, 786 240, 292 374, 078 54.00 4,610 54.00 56.00 05600 RADI OI SOTOPE 11, 436 20, 539 31, 975 181 56.00 06000 LABORATORY 54, 581 98.033 60.00 152, 614 2,027 60.00 06500 RESPIRATORY THERAPY 65.00 19, 534 35, 085 54, 619 894 65.00 06600 PHYSI CAL THERAPY 80, 416 144, 434 224, 850 1,850 66,00 66,00 69.00 06900 ELECTROCARDI OLOGY 145, 067 260, 553 405, 620 2, 213 69.00 69.01 06901 PULMONARY 69.01 Λ 69.02 06902 CARDI OPULMONARY 11, 345 20, 377 31, 722 89 69.02 06903 SLEEP LAB 69.03 0 0 16, 487 29, 611 46, 098 195 69.03 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 C 0 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 Ω 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 18, 632 33, 465 52, 097 240 88.00 08801 RURAL HEALTH CLINIC II 00000 422 88.01 42, 701 76.695 119, 396 88.01 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 \cap Λ 89 00 90.00 09000 CLI NI C 53, 390 95, 892 149, 282 332 90.00 09001 I MED 90. 01 7,010 12, 590 19,600 310 90.01 90 02 09002 ONCOLOGY 100, 981 90 02 181, 370 282, 351 1, 166 90.03 09003 OUTPATIENT CENTER 179 90.03 09100 EMERGENCY 0 100, 414 180, 352 280, 766 6,065 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 18, 535 33, 291 51,826 1, 545 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 101.00 10100 HOME HEALTH AGENCY 1, 257 101. 00 0 16, 615 29, 843 46, 458 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 0 116. 00 SUBTOTALS (SUM OF LINES 1-117) 0 3, 682, 972 6, 614, 934 10, 297, 906 55, 844 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN <u>ក</u>ា190. 00 0 9.593 17, 230 26.823 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 752, 627 1, 351, 783 2, 104, 410 21, 058 192. 00 192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 24, 720 44, 399 69, 119 562 192. 01 194. 00 07950 LODGE 499, 827 0 194.00 278. 287 778, 114 194. 02 07952 MEMORIAL HOSPITAL FOUNDATION 4, 948 8, 887 13, 835 128 194. 02 1, 918 194. 03 194. 03 07953 MKT/PHY SERVICES 60, 483 108, 632 169, 115 0 194. 04 07954 COMMUNITY EDUCATION 56, 282 101, 088 157.370 303 194. 04 194. 05 07955 VOLUNTEER 135 194. 05 6, 282 11, 282 17, 564 194.06 07956 MAB 0 194.06 194. 08 07958 PUBLIC RELATIONS 0 12, 576 22, 587 35, 163 214 194. 08 194.09 07959 UNUSED SPACE 323, 918 0 194, 09 180, 347 504, 265 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00

Health Financial Systems ME	EMORIAL HOSP & HEALTH CARE CTR			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od: From 07/01/2015	Worksheet B Part II		
				To 06/30/2016	Date/Time Pre 11/28/2016 1:		
		CAPI TAL REI	ATED COSTS				
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT		
	0	1.00	2.00	2A	4. 00		
202.00 TOTAL (sum lines 118-201)	0	5, 069, 117	9, 104, 56	7 14, 173, 684	80, 162	202. 00	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				''	0 00/30/2010	11/28/2016 1:	
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	REPAI RS	LINEN SERVICE	0.00	10.00	
	GENERAL SERVICE COST CENTERS	5. 00	6. 00	8.00	9. 00	10. 00	
	00100 CAP REL COSTS-BLDG & FLXT						1. 00
	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	3, 031, 493					5.00
6.00	00600 MAINTENANCE & REPAIRS	174, 720	1, 207, 911				6. 00
	00800 LAUNDRY & LINEN SERVICE	10, 246	6, 285	68, 953			8. 00
	00900 HOUSEKEEPI NG	33, 255	5, 413	1	85, 294		9. 00
	01000 DI ETARY	13, 542	21, 356	1	1, 523	214, 145	10.00
	01100 CAFETERI A	15, 137	4, 308	1	307	0	11. 00
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	21, 582	3, 753		268	0	13.00
	01500 PHARMACY	7, 629 260, 792	3, 644 11, 808		260 842	0	14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	36, 397	9, 890	1	705	0	16. 00
-	INPATIENT ROUTINE SERVICE COST CENTERS	30, 377	7, 070	,, ,	703		10.00
	03000 ADULTS & PEDIATRICS	122, 783	110, 938	17, 413	7, 910	82, 613	30. 00
31. 00	03100 INTENSIVE CARE UNIT	74, 705	45, 081	5, 705	3, 214	38, 347	31. 00
	04000 SUBPROVI DER - I PF	53, 318	35, 614	2, 298	2, 539	24, 063	40.00
	04100 SUBPROVI DER - I RF	19, 073	18, 581	1, 457	1, 325	12, 322	41. 00
	04300 NURSERY	15, 779		1	998	15, 788	43. 00
	04400 SKILLED NURSING FACILITY	35, 713	24, 425	3, 901	1, 742	41, 012	44. 00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	227 120	101 151	10 470	0 (20	0	FO 00
1	05200 DELIVERY ROOM & LABOR ROOM	236, 128 31, 184	121, 151 25, 650	1	8, 638 1, 829	0	50. 00 52. 00
	05300 ANESTHESI OLOGY	28, 124	25, 650		1, 029	0	53. 00
1	05400 RADI OLOGY-DI AGNOSTI C	83, 861	45, 018	_	3, 210	0	54. 00
1	05600 RADI OI SOTOPE	15, 501	3, 848	1	274	0	56. 00
	06000 LABORATORY	132, 336	18, 366	1	1, 310	0	60.00
65.00	06500 RESPI RATORY THERAPY	27, 956	6, 573	1	469	0	65. 00
66.00	06600 PHYSI CAL THERAPY	58, 703	27, 059	1, 294	1, 929	0	66. 00
	06900 ELECTROCARDI OLOGY	67, 754	48, 814	3, 562	3, 481	0	69. 00
1	06901 PULMONARY	0	C	0	0	0	69. 01
	06902 CARDI OPULMONARY	2, 918	3, 818		272	0	69. 02
1	06903 SLEEP LAB	6, 333	5, 548	1	396	0	69. 03
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	79, 573			0	0	70. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	172, 203			0	0	71.00
1	07300 DRUGS CHARGED TO PATIENTS	172, 203			0	0	73. 00
	07400 RENAL DIALYSIS	0	Č		0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS	_			-,		
88. 00	08800 RURAL HEALTH CLINIC	9, 032	6, 269	0	447	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	14, 720	14, 369	0	1, 025	0	88. 01
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	0	0	0	89. 00
	09000 CLI NI C	25, 618	17, 965	1	1, 281	0	90.00
	09001 I MED	7, 603	2, 359		168	0	90. 01
	09002 ONCOLOGY 09003 OUTPATI ENT CENTER	58, 951	33, 979 0		2, 423	0	90. 02 90. 03
1	09100 EMERGENCY	8, 552 115, 904	33, 788	-	2, 409	0	90.03
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	113, 704	33, 700	0,077	2, 407	O	92. 00
	OTHER REIMBURSABLE COST CENTERS				1		72.00
	09500 AMBULANCE SERVICES	45, 161	6, 237	0	445	0	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	C	0	0	0	96. 00
-	10100 HOME HEALTH AGENCY	40, 032	5, 591	0	399	0	101. 00
	SPECIAL PURPOSE COST CENTERS	1 -			ام		
	11600 HOSPI CE	0	741 404				116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	2, 162, 818	741, 494	68, 745	52, 038	214, 145	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	517	3, 228	3 0	230	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	691, 452		1	18, 056		190.00
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	17, 211	8, 318	1	593		192. 01
- 1	07950 LODGE	14, 998			6, 677		194. 00
194. 02	07952 MEMORIAL HOSPITAL FOUNDATION	3, 821	1, 665	1	119	0	194. 02
194. 03	07953 MKT/PHY SERVICES	93, 349	20, 352	0	1, 451	0	194. 03
	07954 COMMUNITY EDUCATION	14, 386	18, 938	0	1, 350		194. 04
	07955 VOLUNTEER	4, 368	2, 114	1	151		194. 05
	07956 MAB	0	0	0	0		194. 06
	07958 PUBLIC RELATIONS	18, 859	4, 232	1	1		194. 08
200.00	07959 UNUSED SPACE	9, 714	60, 685		4, 327	0	194. 09 200. 00
200.00	Cross Foot Adjustments Negative Cost Centers	0	٠		0	Ω	200.00
202.00	TOTAL (sum lines 118-201)	3, 031, 493	1, 207, 911	68, 953	85, 294	214, 145	
1	•						

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150115

				10	00/ 30/ 2010	Date/lime Pre 11/28/2016 1:	
Cost C	Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	<u> </u>
		,	ADMI NI STRATI ON	SERVICES &		RECORDS &	
		11. 00	13.00	SUPPLY 14. 00	15. 00	LI BRARY 16. 00	
GENERAL SERV	/ICE COST CENTERS	11.00	13.00	14.00	15.00	10.00	
	L COSTS-BLDG & FIXT						1. 00
2.00 00200 CAP RE	L COSTS-MVBLE EQUIP						2. 00
4. 00 00400 EMPLOY	EE BENEFITS DEPARTMENT						4. 00
	STRATIVE & GENERAL						5. 00
1	NANCE & REPAIRS						6. 00
	RY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEK							9. 00
10. 00 01000 DI ETAR 11. 00 01100 CAFETE		56, 174					10. 00 11. 00
	IG ADMINISTRATION	645	58, 120				13. 00
1 1	AL SERVICES & SUPPLY	455	0	46, 307			14. 00
15. 00 01500 PHARMA		1, 288	o	0	374, 480		15. 00
	L RECORDS & LIBRARY	1, 674	O	0	0	131, 968	16. 00
I NPATI ENT RO	OUTINE SERVICE COST CENTERS						
	S & PEDIATRICS	4, 452	20, 990	138	0	4, 407	30.00
	SIVE CARE UNIT	2, 545	11, 997	144	0	2, 702	31. 00
40. 00 04000 SUBPRO		1, 794	8, 459	52	0	1, 242	40.00
41. 00 04100 SUBPRO		582	2, 745	18	0	588	41.00
43. 00 04300 NURSER		435	2, 052 0	0	0	568 527	43.00
	ED NURSING FACILITY ERVICE COST CENTERS	1, 384	υ	60	υĮ	527	44. 00
50. 00 05000 OPERAT		3, 610	ol	340	ol	22, 121	50. 00
	RY ROOM & LABOR ROOM	871	4, 105	0.0	o	1, 193	52. 00
53. 00 05300 ANESTH		826	0	3	Ö	929	53. 00
1 1	OGY-DI AGNOSTI C	2, 472	O	2	O	16, 253	54.00
56. 00 05600 RADI 01		131	О	2	О	2, 994	56. 00
60. 00 06000 LABORA	TORY	2, 740	0	0	0	11, 834	60.00
65. 00 06500 RESPI R	RATORY THERAPY	1, 099	0	38	0	2, 069	65.00
66. 00 06600 PHYSI C		1, 858	0	72	0	2, 811	66. 00
69. 00 06900 ELECTR		1, 558	0	42	0	9, 448	69. 00
69. 01 06901 PULMON		0	0	0	0	0	69. 01
69. 02 06902 CARDI 0		103	0	3	0	252	69. 02
69. 03 06903 SLEEP	LAB ROENCEPHALOGRAPHY	257 0	0	4	O O	540	69. 03
1 1	AL SUPPLIES CHARGED TO PATIENTS	0	0	20, 271	0	0 3, 437	70. 00 71. 00
1 1	DEV. CHARGED TO PATTENTS	0	0	24, 771	0	5, 256	71.00
	CHARGED TO PATIENTS		0	24, 771	374, 480	25, 939	73. 00
74. 00 07400 RENAL		o	Ö	0	0, 1, 100	20, 707	74. 00
	SERVICE COST CENTERS	-1		-1			
88. 00 08800 RURAL	HEALTH CLINIC	215	0	0	0	310	88. 00
	HEALTH CLINIC II	360	0	0	0	0	88. 01
	LLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 09000 CLI NI C	,	390	0	19	0	1, 141	90. 00
90. 01 09001 I MED		304	1, 433	0	0	186	90. 01
90. 02 09002 0NCOLO		1, 345	6, 339	61	0	3, 296	
90. 03 09003 OUTPAT		0	0	0	0	238	
91. 00 09100 EMERGE 92. 00 09200 OBSERV	NCY /ATION BEDS (NON-DISTINCT PART)	3, 047	0	110	0	9, 089	91.00
	JRSABLE COST CENTERS						92. 00
	NCE SERVICES	2, 246	ol	42	0	1, 478	95. 00
	E MEDICAL EQUIP-RENTED	2,210	Ö	0	o	0	96. 00
101.00 10100 HOME H		1, 403	Ö	61	Ö		101. 00
	POSE COST CENTERS			<u>'</u>	'		
116. 00 11600 HOSPI C	E	0	0	0	0		116. 00
	TALS (SUM OF LINES 1-117)	40, 089	58, 120	46, 253	374, 480	131, 701	118. 00
	ABLE COST CENTERS						
	FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	CLANS' PRIVATE OFFICES	12, 434	0	54	0		192. 00
	ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0		192. 01
194. 00 07950 LODGE	AL LICCULTAL FOUNDATION	15/	0	0	0		194. 00
194. 02 07952 MEMORI 194. 03 07953 MKT/PH	AL HOSPITAL FOUNDATION	156	U	0	U O		194. 02 194. 03
194. 04 07954 COMMUN		2, 567 552	0	0	0		194. 03
194. 05 07955 VOLUNT		114	0	0	0		194. 04
194. 06 07956 MAB		0	n	0	0		194. 05
194. 08 07958 PUBLI C	RELATIONS	262	ő	Ö	o o		194. 08
194. 09 07959 UNUSED		0	ol	o	ol		194. 09
	Foot Adjustments]	٦				200. 00
	ve Cost Centers	0	o	0	О		201. 00
202. 00 TOTAL	(sum lines 118-201)	56, 174	58, 120	46, 307	374, 480	131, 968	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150115 Period: From 07/01/2

			1		8/2016 1:02 pm
Cost Center Description	Subtotal	Intern &	Total	1172	3, 2010 11 02 piii
		Residents Cost			
		& Post			
		Stepdown			
	24.00	Adjustments 25.00	26. 00		
GENERAL SERVICE COST CENTERS	24.00	25.00	20.00		
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 DEPARTMEN	T				4. 00
5.00 00500 ADMINISTRATIVE & GENERAL					5. 00
6.00 00600 MAINTENANCE & REPAIRS					6. 00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9. 00 00900 HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMINI STRATI ON					11. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00 01500 PHARMACY					15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY					16. 00
I NPATI ENT ROUTI NE SERVI CE COST CE	NTERS				10.00
30. 00 03000 ADULTS & PEDIATRICS	1, 297, 312	0	1, 297, 312		30.00
31.00 03100 INTENSIVE CARE UNIT	561, 302	О	561, 302		31.00
40. 00 04000 SUBPROVI DER - 1 PF	427, 084	0	427, 084		40. 00
41. 00 04100 SUBPROVI DER - I RF	211, 618	0	211, 618		41.00
43. 00 04300 NURSERY	166, 794	0	166, 794		43. 00
44.00 04400 SKILLED NURSING FACILITY	312, 860	0	312, 860		44. 00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	1, 415, 319	0	1, 415, 319		50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	278, 859	0	278, 859		52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	33, 049	0	33, 049		53.00
56. 00 05600 RADI 01 SOTOPE	536, 019 54, 906	0	536, 019 54, 906		54. 00 56. 00
60. 00 06000 LABORATORY	321, 450		321, 450		60.00
65. 00 06500 RESPIRATORY THERAPY	93, 717	o	93, 717		65. 00
66. 00 06600 PHYSI CAL THERAPY	320, 426	o	320, 426		66.00
69. 00 06900 ELECTROCARDI OLOGY	542, 492	0	542, 492		69. 00
69. 01 06901 PULMONARY	0	0	0		69. 01
69. 02 06902 CARDI OPULMONARY	39, 177	0	39, 177		69. 02
69. 03 06903 SLEEP LAB	59, 371	0	59, 371		69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0		70. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO	l	0	103, 281		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIE	l	0	202, 230		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	400, 419	0	400, 419 0		73.00
74. 00 07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS		UU			74. 00
88. 00 08800 RURAL HEALTH CLINIC	68, 610	O	68, 610		88. 00
88. 01 08801 RURAL HEALTH CLINIC II	150, 292	o	150, 292		88. 01
89. 00 08900 FEDERALLY QUALIFIED HEALTH		o	0		89. 00
90. 00 09000 CLI NI C	196, 028	О	196, 028		90.00
90. 01 09001 I MED	31, 963	0	31, 963		90. 01
90. 02 09002 ONCOLOGY	390, 788	0	390, 788		90. 02
90. 03 09003 OUTPATIENT CENTER	8, 969	0	8, 969		90. 03
91. 00 09100 EMERGENCY	459, 257	0	459, 257		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI	NCT PART)	0			92. 00
OTHER REIMBURSABLE COST CENTERS	100,000		100,000		05.00
95. 00 09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTE	108, 980 D 0	0	108, 980		95. 00 96. 00
101.00 10100 HOME HEALTH AGENCY	96, 054	0	96, 054		101. 00
SPECIAL PURPOSE COST CENTERS	70,034	Ų.	70, 034		101.00
116. 00 11600 HOSPI CE	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-1		o	8, 888, 626		118. 00
NONREI MBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,				
190.00 19000 GIFT, FLOWER, COFFEE SHOP &	CANTEEN 30, 798	0	30, 798		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES		0	3, 100, 851		192. 00
192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL S		0	96, 070		192. 01
194. 00 07950 LODGE	893, 429	0	893, 429		194. 00
194. 02 07952 MEMORIAL HOSPITAL FOUNDATIO	l	0	19, 724		194. 02
194. 03 07953 MKT/PHY SERVICES	288, 752		288, 752		194. 03
194. 04 07954 COMMUNITY EDUCATION	192, 899		192, 899		194. 04 194. 05
194. 05 07955 VOLUNTEER 194. 06 07956 MAB	24, 446		24, 446		194. 05
194. 06 07956 MAB 194. 08 07958 PUBLIC RELATIONS	59, 098	0	59, 098		194. 06
194. 08 07958 PUBLIC RELATIONS 194. 09 07959 UNUSED SPACE	578, 991		578, 991		194. 09
200.00 Cross Foot Adjustments	376, 771	0	0		200. 00
201.00 Negative Cost Centers	0	o	0		201. 00
202.00 TOTAL (sum lines 118-201)	14, 173, 684	· · · · · · · · · · · · · · · · · · ·	14, 173, 684		202. 00
· ·		·			

Provi der CCN: 150115 COST ALLOCATION - STATISTICAL BASIS Peri od: Worksheet B-1 From 07/01/2015 06/30/2016 Date/Time Prepared: 11/28/2016 1:02 pm CAPITAL RELATED COSTS Reconciliation ADMINISTRATIVE Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 786 816 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 786, 816 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4, 450 4, 450 94, 076, 185 4.00 00500 ADMINISTRATIVE & GENERAL 167, 901 8, 129, 496 5 00 167, 901 -23, 103, 993 157 368 989 5 00 6.00 00600 MAINTENANCE & REPAIRS 57, 273 57, 273 1, 733, 458 0 9,069,750 6.00 8.00 00800 LAUNDRY & LINEN SERVICE 2,899 2, 899 232, 984 531, 883 8.00 0 9.00 00900 HOUSEKEEPI NG 2, 497 2, 497 1, 114, 645 1, 726, 294 9.00 01000 DI ETARY 702, 982 9,851 313, 986 10.00 9.851 10 00 1, 987 11.00 01100 CAFETERI A 1, 987 738, 565 0 785, 788 11.00 01300 NURSING ADMINISTRATION 1, 731 810, 004 1, 120, 354 13.00 1,731 0 13.00 01400 CENTRAL SERVICES & SUPPLY 257, 926 396, 004 14.00 1.681 1.681 14.00 5, 447 1, 910, 935 15.00 01500 PHARMACY 5, 447 13, 537, 791 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 4,562 4, 562 1, 316, 949 1, 889, 375 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 4, 485, 302 30.00 03000 ADULTS & PEDIATRICS 51. 174 51. 174 0 6, 373, 696 30.00 31.00 03100 INTENSIVE CARE UNIT 20, 795 20.795 2.654.787 0 3.877.981 31 00 40.00 04000 SUBPROVIDER - IPF 16, 428 16, 428 2, 078, 915 0 2, 767, 762 40.00 41.00 04100 SUBPROVIDER - IRF 8, 571 8, 571 620, 749 0 990, 074 41.00 0 04300 NURSERY 43.00 6, 456 6, 456 519.931 819, 107 43.00 04400 SKILLED NURSING FACILITY 44.00 11, 267 11, 267 1, 329, 370 1, 853, 867 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 55, 885 55, 885 4, 868, 617 12, 257, 451 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 11, 832 1, 039, 863 0 1, 618, 760 11, 832 52.00 0 53.00 05300 ANESTHESI OLOGY 3, 716, 995 1, 459, 942 53.00 05400 RADI OLOGY-DI AGNOSTI C 20, 766 20, 766 5, 410, 418 54.00 0 0 4, 353, 237 54.00 56.00 05600 RADI OI SOTOPE 1,775 1, 775 211, 920 804, 677 56.00 60.00 06000 LABORATORY 8, 472 8, 472 2, 379, 157 6, 869, 581 60.00 06500 RESPIRATORY THERAPY 3,032 3, 032 1, 048, 989 0 0 0 1, 451, 200 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 12, 482 12, 482 2, 170, 793 3, 047, 274 66.00 06900 ELECTROCARDI OLOGY 69 00 22, 517 22, 517 2, 596, 932 3, 517, 122 69.00 69.01 06901 PULMONARY Ω 69.01 06902 CARDI OPULMONARY 69.02 1, 761 1,761 104.498 0 0 0 151, 498 69.02 06903 SLEEP LAB 69.03 2.559 2.559 228, 798 328, 756 69.03 07000 ELECTROENCEPHALOGRAPHY 70.00 0 C 0 Ω 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 4, 130, 658 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 8, 939, 105 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73 00 C 0 73 00 07400 RENAL DIALYSIS 74.00 0 0 0 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 2, 892 2, 892 281, 631 0 468, 852 88.00 08801 RURAL HEALTH CLINIC II 0 88 01 6, 628 495, 482 88 01 6,628 764, 126 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 09000 CLI NI C 8, 287 8, 287 389, 598 0 1, 329, 821 90.00 90.00 0 09001 I MED 90.01 1,088 1,088 363, 730 394, 662 90.01 09002 ONCOLOGY 1, 369, 047 90 02 15, 674 15, 674 3, 060, 160 90 02 90.03 09003 OUTPATIENT CENTER 209, 523 0 443, 946 90.03 09100 EMERGENCY 15, 586 7, 118, 001 91.00 15, 586 6,016,630 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 2,877 1, 813, 236 0 2, 344, 305 95.00 2,877 09600 DURABLE MEDICAL EQUIP-RENTED 0 96 00 96.00 101.00 10100 HOME HEALTH AGENCY 2,579 2, 579 1, 475, 383 2, 078, 066 101. 00 0 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 116, 00 571<u>, 662</u> SUBTOTALS (SUM OF LINES 1-117) 65, 540, 613 -23, 103, 993 112, 272, 537 118. 00 118.00 571,662 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 489 1, 489 26, 823 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 24, 710, 087 0 116,821 116, 821 35, 896, 724 192. 00 0 192. 01 19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 3, 837 893, 440 192, 01 3.837 659, 354 0 194, 00 07950 LODGE 43, 195 43, 195 778, 576 194. 00 Γ 194. 02 07952 MEMORIAL HOSPITAL FOUNDATION 768 149, 967 0 198, 365 194. 02 768 194. 03 07953 MKT/PHY SERVICES 9, 388 9, 388 2, 250, 924 0 0 4, 845, 760 194. 03 194. 04 07954 COMMUNITY EDUCATION 746, 779 194. 04 8,736 8, 736 355, 952 194. 05 07955 VOLUNTEER 975 975 158, 560 226, 727 194. 05 0 194.06 194. 06 07956 MAB 0 194. 08 07958 PUBLIC RELATIONS 1, 952 1, 952 250, 728 978, 993 194. 08 194. 09 07959 UNUSED SPACE 27, 993 504, 265 194. 09 27, 993 0 200.00 Cross Foot Adjustments 200.00

Health Fina	ncial Systems ME	MORIAL HOSP & F	HEALTH CARE CTR		In Lie	u of Form CMS-:	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der		Period: From 07/01/2015	Worksheet B-1	
				1	Го 06/30/2016	Date/Time Pre 11/28/2016 1:	
		CAPITAL REL	ATED COSTS				
	Cost Center 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	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	5, 069, 117	9, 104, 567	18, 394, 806	5	23, 103, 993	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	6. 442570	11. 571406	0. 195531	1	0. 146814	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			80, 162	2	3, 031, 493	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000852	2	0. 019264	205. 00

-	LLOCATION - STATISTICAL BASIS	LINIORI AL 11031 &		CCN: 150115 F	Peri od:	Worksheet B-1	
						Date/Time Pre 11/28/2016 1:	pared: 02 pm
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	LAUNDRY & LINEN 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	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-BLDG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 6. 00	OO5OO ADMINISTRATIVE & GENERAL OO6OO MAINTENANCE & REPAIRS	557, 192					5. 00 6. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	2, 899					8.00
9. 00	00900 HOUSEKEEPI NG	2, 497	9, 244	551, 79 <i>6</i>			9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	9, 851 1, 987	l .	9, 851 1, 987		2, 218, 880	10.00
13. 00	01300 NURSING ADMINISTRATION	1, 731	l .	1, 731	1		13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 681	50, 780	1, 681	0	17, 987	14.00
15. 00 16. 00	O1500 PHARMACY O1600 MEDI CAL RECORDS & LI BRARY	5, 447 4, 562		5, 447 4, 562		50, 892	1
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	4, 502	0	4, 562	<u>:</u>	66, 123	1 16.00
	03000 ADULTS & PEDIATRICS	51, 174				175, 874	
31.00	03100 INTENSIVE CARE UNIT 04000 SUBPROVI DER - I PF	20, 795				100, 527	
41. 00	04100 SUBPROVIDER - I RF	16, 428 8, 571				70, 878 22, 997	
43. 00	04300 NURSERY	6, 456				17, 197	1
44. 00	04400 SKILLED NURSING FACILITY	11, 267	51, 900	11, 267	5, 016	54, 680	44. 00
50 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	55, 885	165, 911	55, 885	5 0	142, 602] 50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	11, 832				34, 394	
	05300 ANESTHESI OLOGY	00.774		(32, 624	1
54. 00 56. 00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	20, 766 1, 775	1	20, 766 1, 775		97, 655 5, 179	
60.00	06000 LABORATORY	8, 472				108, 243	1
65. 00	06500 RESPI RATORY THERAPY	3, 032	l .	-,		43, 425	1
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	12, 482 22, 517				73, 388 61, 543	1
69. 01	06901 PULMONARY	0	l ·	22, 31,		01, 313	1
69. 02	06902 CARDI OPULMONARY	1, 761		.,			69. 02
69. 03 70. 00	06903 SLEEP LAB 07000 ELECTROENCEPHALOGRAPHY	2, 559	l .	2, 559		10, 167 0	69. 03 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö			0	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C		0	1
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	_		-	0	
	OUTPATIENT SERVICE COST CENTERS				,] / 1. 00
	08800 RURAL HEALTH CLINIC	2, 892	l .			8, 487	
88. 01 89. 00	08801 RURAL HEALTH CLINIC II 08900 FEDERALLY QUALIFIED HEALTH CENTER	6, 628	l .			14, 220	88. 01 89. 00
	09000 CLI NI C	8, 287		8, 287	0		90.00
	09001 I MED	1, 088		.,			90. 01
90. 02 90. 03	09003 OUTPATI ENT CENTER	15, 674	11, 670 0	15, 674		53, 112 0	
	09100 EMERGENCY	15, 586	107, 475	15, 586		120, 366	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
95. 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVI CES	2, 877	0	2, 877	0	88, 702	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	2,077		0	96.00
101.00	10100 HOME HEALTH AGENCY	2, 579	0	2, 579	0	55, 403	101. 00
116 00	SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE	0	0		0	0] 116. 00
118.00		342, 038				1, 583, 586	
400.00	NONREI MBURSABLE COST CENTERS	1	T	1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	1, 489 116, 821	l .	1, 489 116, 821		491, 031	190.00
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 837	l ·	3, 837			192. 01
	07950 LODGE	43, 195	l .	43, 195	1		194. 00
	07952 MEMORIAL HOSPITAL FOUNDATION 07953 MKT/PHY SERVICES	768 9, 388		768 9, 388		6, 165 101, 416	194. 02
194.04	07954 COMMUNITY EDUCATION	8, 736	l .	8, 736			194. 04
	07955 VOLUNTEER	975	0	975			194. 05
	07956 MAB 07958 PUBLIC RELATIONS	1, 952	0 884	(1, 952	1		194. 06 194. 08
	07959 UNUSED SPACE	27, 993		27, 993			194. 09
200.00							200.00
201. 00 202. 00		10, 401, 316	664, 088	2, 033, 043	1, 026, 377	945, 566	201. 00 202. 00
_52.00	Part I)	.5, 151, 510	554, 666	2, 333, 343	1, 525, 577	, 10, 500	
	· · · · · · · · · · · · · · · · · · ·				•		-

Heal th Fina	ncial Systems ME	EMORIAL HOSP & I	HEALTH CARE CTR	?	In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der		Period: From 07/01/2015	Worksheet B-1	
					To 06/30/2016	Date/Time Pre 11/28/2016 1:	
	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. 667382	0. 723993	3. 68441	1 39. 188156	0. 426146	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	1, 207, 911	68, 953	85, 29	214, 145	56, 174	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	2. 167854	0. 075173	0. 15457	8. 176282	0. 025316	205. 00

	Financial Systems M LLOCATION - STATISTICAL BASIS	EMORIAL HOSP & H		CCN: 150115 P	eri od:	u of Form CMS-2 Worksheet B-1	552-10
				F	rom 07/01/2015 o 06/30/2016	Date/Time Prep 11/28/2016 1:0	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	MEDI CAL RECORDS &		
		(DI RECT NURS.	SUPPLY (COSTED	REQUIS.)	LI BRARY (REVENUE)		
		HRS.) 13. 00	REQUI S.) 14. 00	15. 00	16. 00		
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	10.00		
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 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 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	486, 989					11.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	480, 989	16, 707, 777				13. 00 14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	0	100 0			15. 00 16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		5				
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	175, 874 100, 527	49, 628 51, 945	0			30. 00 31. 00
40.00	04000 SUBPROVI DER - I PF	70, 878	18, 650	0	3, 384, 099		40.00
41. 00 43. 00	04100 SUBPROVI DER - RF 04300 NURSERY	22, 997 17, 197	6, 521 0	0			41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	21, 822	0			44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	122, 760	0	60, 273, 872		50. 00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	34, 394 0	0 931	0	.,		52. 00 53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	841	0	44, 285, 117		54.00
56. 00 60. 00	05600 RADI OI SOTOPE 06000 LABORATORY	0	783 0	0	-,,		56. 00 60. 00
65. 00	06500 RESPI RATORY THERAPY	0	13, 843	0	5, 637, 811		65.00
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0	25, 822 15, 010	0	,		66. 00 69. 00
69. 01	06901 PULMONARY	0	0	0	-		69. 01
69. 02 69. 03	O6902 CARDI OPULMONARY O6903 SLEEP LAB	0	923 1, 478	0			69. 02 69. 03
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0 7, 312, 720	0	9, 365, 920		70. 00 71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	8, 939, 105	0	14, 322, 191		72. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	100 0			73. 00 74. 00
	OUTPATIENT SERVICE COST CENTERS		۰				
	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	0	0	0			88. 00 88. 01
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	l .		89.00
90. 00	09000 CLI NI C 09001 I MED	12, 010	6, 747 0	0	3, 110, 287 505, 833		90. 00 90. 01
90. 02 90. 03	O9002 ONCOLOGY O9003 OUTPATI ENT CENTER	53, 112	21, 879	0	8, 982, 133 648, 747		90. 02 90. 03
91. 00	09100 EMERGENCY	Ö	39, 793	0	l		91.00
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0	15, 279	0			95. 00 96. 00
	10100 HOME HEALTH AGENCY	0	21, 970	0	l .	1	101.00
116 00	SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE	l ol	ol	0	٥	1	116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	486, 989	16, 688, 450	100			118. 00
190.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	ol	0	O	1	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	19, 327	0			192.00
	19201 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 07950 LODGE	0	0	0	726, 732 0		192. 01 194. 00
	07952 MEMORIAL HOSPITAL FOUNDATION 07953 MKT/PHY SERVICES	0	0	0	0		194. 02 194. 03
194.04	07954 COMMUNITY EDUCATION	0	Ö	0	o o	1	194. 04
	07955 VOLUNTEER 07956 MAB	0	0 n	0	0		194. 05 194. 06
194. 08	07958 PUBLIC RELATIONS	0	0	0	o o	1	194. 08
194. 09 200. 00	07959 UNUSED SPACE Cross Foot Adjustments	0	0	0	0		194. 09 200. 00
201.00	1 1						201. 00

Health Financial Systems ME	EMORIAL HOSP & H	IEALTH CARE CTF	₹	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 07/01/2015 To 06/30/2016	Date/Time Pre 11/28/2016 1:	
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,	1, 334, 381	536, 145	15, 668, 76	5 2, 296, 909		202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	2. 740064	0. 032090	156, 687. 65000	0. 006391		203. 00
204.00 Cost to be allocated (per Wkst. B,	58, 120	46, 307	374, 48	0 131, 968		204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 119346	0. 002772	3, 744. 80000	0. 000367		205. 00
	. '		•	,		•

Title XVIII Hospital PPS
Cost Center Description Total Cost (from Wkst. B, Part I, col. 26) INPATIENT ROUTINE SERVICE COST CENTERS Therapy Limit Adj. Total Costs PCE Disallowance 1 Nearpy Limit Adj. Total Costs On Similar Service Cost Centers
(from Wkst. B, Adj. Disallowance Part I, col. 26) 1.00 2.00 3.00 4.00 5.00
Part I, col. 26) 1.00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS
26)
1.00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS
INPATIENT ROUTINE SERVICE COST CENTERS
00 00 000000 ADULTO A DEDIATRICO
30. 00 03000 ADULTS & PEDI ATRI CS 9, 652, 106 9, 652, 106 0 9, 652, 106 30 30 30 30 30 30 30
31. 00 03100 NTENSI VE CARE UNI T 5, 517, 877 5, 517, 877 0 5, 517, 877 31. 00 03100 NTENSI VE CARE UNI T 5, 517, 877 5,
40. 00 04000 SUBPROVI DER - I PF 3, 925, 404 3, 925, 404 0 3, 925, 404 40
41. 00 04100 SUBPROVI DER - I RF 1, 483, 355 1, 483, 355 43, 820 1, 527, 175 4
43. 00 04300 NURSERY 1, 227, 880 1, 227, 880 0 1, 227, 880 43
44. 00 O4400 SKILLED NURSING FACILITY 2, 645, 199 2, 645, 199 0 2, 645, 199 4
ANCI LLARY SERVI CE COST CENTERS
50. 00 05000 0PERATI NG ROOM 15, 876, 182 15, 876, 182 0 15, 876, 182 50 15, 876, 182 50 50 50 50 50 50 50 5
52. 00 05200 DELI VERY ROOM & LABOR ROOM 2, 250, 554 2, 250, 554 0 2, 250, 554 52
53. 00 05300 ANESTHESI OLOGY 1, 704, 386 1, 704, 386 0 1, 704, 386 5:
54. 00 05400 RADI OLOGY-DI AGNOSTI C 5, 843, 927 5, 843, 927 5, 843, 927 5
56. 00 05600 RADI OI SOTOPE 1, 016, 853 1, 016, 853 0 1, 016, 853 50 1, 016, 853 50 50 50 50 50 50 50
60. 00 06000 LABORATORY 8, 321, 847 8, 321, 847 0 8, 321, 847 60
65. 00 06500 RESPI RATORY THERAPY 1, 787, 007 0 1, 787, 007 0 1, 787, 007 65.
66. 00 06600 PHYSI CAL THERAPY 3, 867, 178 0 3, 867, 178 0 3, 867, 178
69. 00 06900 ELECTROCARDI OLOGY 4, 762, 318 4, 762, 318 163, 318 4, 925, 636 64
69. 01 06901 PULMONARY 0 0 0 60
69. 02 06902 CARDI OPULMONARY 219, 249 219, 249 0 219, 249 60
69. 03 06903 SLEEP LAB 448, 005 448, 005 0 448, 005 60
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 5,031,619 5,031,619 0 5,031,619 7.
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 10, 629, 873 10, 629, 873 0 10, 629, 873 72. 00 10, 629, 873 10
73. 00 07300 DRUGS CHARGED TO PATIENTS 16, 119, 293 16, 119, 293 0 16, 119, 293 73. 00 16, 119, 293 73. 00 16, 119, 293 73. 00 16, 119, 293 73. 00
74. 00 07400 RENAL DI ALYSIS 0 0 0 74
OUTPATIENT SERVICE COST CENTERS
88. 00 08800 RURAL HEALTH CLINIC 611, 345 611, 345 0 611, 345 86
88. 01 08801 RURAL HEALTH CLINIC II 1,030, 517 1,030, 517 0 1,030, 517 88
89.00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 80
90. 00 09000 CLI NI C 1, 736, 939 1, 736, 939 0 1, 736, 939 90
90. 01 09001 I MED 518, 182 518, 182 0 518, 182 90
90. 02 09002 0NCOLOGY 4, 094, 495 4, 094, 495 0 4, 094, 495 90
90. 03 09003 0UTPATI ENT CENTER 513, 269 513, 269 90 513, 269 90
91. 00 09100 EMERGENCY 7, 536, 994 7, 536, 994 6, 393 7, 543, 387 9 ⁻¹
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 1,899,736 1,899,736 1,899,736 1,899,736 2,899,736 1,899,736 1,899,736 1,899,736 1,899,736 1,899,736 1,899,736 2,899,736 1,899,736
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVI CES 2, 816, 808 2, 816, 808 0 2, 816, 808 9!
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 96
101. 00 10100 HOME HEALTH AGENCY 2, 479, 973 2, 479, 973 2, 479, 973 2, 479, 973
SPECIAL PURPOSE COST CENTERS
116. 00 11600 HOSPI CE 0 0 116
200.00 Subtotal (see instructions) 125, 568, 370 0 125, 568, 370 213, 531 125, 781, 901 200
201.00 Less Observation Beds 1,899,736 1,899,736 1,899,736 1,899,736 20
202.00 Total (see instructions) 123,668,634 0 123,668,634 213,531 123,882,165 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 150115 Peri od: Worksheet C From 07/01/2015 Part I Date/Time Prepared: 06/30/2016 11/28/2016 1:02 pm Title XVIII Hospi tal **PPS** 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 12, 007, 106 03000 ADULTS & PEDIATRICS 12, 007, 106 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 7, 362, 626 7, 362, 626 31.00 04000 SUBPROVIDER - IPF 40.00 3, 384, 099 3, 384, 099 40.00 41.00 04100 SUBPROVI DER - I RF 1.602.071 1, 602, 071 41.00 04300 NURSERY 43.00 1, 546, 487 1, 546, 487 43.00 44.00 04400 SKILLED NURSING FACILITY 1, 435, 705 1, 435, 705 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 7, 768, 080 52, 505, 792 60, 273, 872 0. 263401 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 3, 249, 956 213 3, 250, 169 0.692442 0.000000 52 00 53.00 05300 ANESTHESI OLOGY 857, 491 1, 672, 851 2, 530, 342 0.673579 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 5, 102, 849 39, 182, 268 44, 285, 117 0.131961 0.000000 54.00 05600 RADI OI SOTOPE 8, 156, 906 0.000000 56,00 430, 729 7, 726, 177 0.124662 56,00 60.00 06000 LABORATORY 7, 120, 540 25, 124, 387 32, 244, 927 0.258082 0.000000 60.00 06500 RESPIRATORY THERAPY 2, 663, 955 2, 973, 856 5, 637, 811 0. 316968 0.000000 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 4, 215, 115 3, 445, 364 7, 660, 479 0.504822 0.000000 66.00 06900 ELECTROCARDI OLOGY 0 184994 69.00 7, 220, 546 18, 522, 504 25, 743, 050 0.000000 69 00 69.01 06901 PULMONARY 0.000000 0.000000 69.01 06902 CARDI OPULMONARY 0. 319315 0.000000 69.02 548 686,076 686, 624 69.02 06903 SLEEP LAB 5, 600 1, 466, 029 1, 471, 629 0.304428 0.000000 69.03 69.03 07000 ELECTROENCEPHALOGRAPHY 70.00 0.000000 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 563, 463 5, 802, 457 9, 365, 920 0.537226 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 8, 461, 320 5, 860, 871 14, 322, 191 0.742196 0.000000 72.00 25, 821, 711 70, 471, 877 73 00 07300 DRUGS CHARGED TO PATIENTS 44, 650, 166 0 228734 0 000000 73 00 07400 RENAL DIALYSIS 74.00 0 0.000000 0.000000 74.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 845, 072 845, 072 88.00 08801 RURAL HEALTH CLINIC II 88.01 0 C 88.01 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLI NI C 54, 157 3, 056, 130 3, 110, 287 0.558450 0.000000 90.00 90 01 09001 I MED 505, 833 505 833 1 024413 0.000000 90 01 09002 ONCOLOGY 90.02 115, 778 8,866,355 8, 982, 133 0.455849 0.000000 90.02 90.03 09003 OUTPATIENT CENTER 648, 747 648, 747 0.791170 0.000000 90.03 91.00 09100 EMERGENCY 4,011,452 20, 754, 951 24, 766, 403 0.304323 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 769, 281 0.000000 92 00 92 00 1,804,515 0.686003 964, 766 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 1, 073, 827 0. 699654 0.000000 95.00 95.00 2, 952, 176 4, 026, 003 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0.000000 96.00 101.00 10100 HOME HEALTH AGENCY 2, 324, 811 0 2, 324, 811 101.00 SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE 116.00 Subtotal (see instructions) 200.00 110, 039, 977 251, 377, 601 361, 417, 578 200. 00 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 110, 039, 977 251, 377, 601 361, 417, 578 202.00

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 07/01/2015	Worksheet C Part I Date/Time Prepared: 11/28/2016 1:02 pm
		Ti +1 o V/// / /	Hospi tal	DDC

		Title XVIII	Hospi tal	PPS	z piii
Cost Center Description	PPS Inpatient	THE ATTE	1103pr tur	110	
oust conton possin per on	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 INTENSIVE CARE UNIT				;	31.00
40. 00 04000 SUBPROVI DER - I PF					40.00
41. 00 04100 SUBPROVI DER - RF					41.00
43. 00 04300 NURSERY					43.00
44.00 04400 SKILLED NURSING FACILITY					44. 00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0. 263401				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 692442			[52. 00
53. 00 05300 ANESTHESI OLOGY	0. 673579			1	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 131961				54.00
56. 00 05600 RADI 01 SOTOPE	0. 124662				56. 00
60. 00 06000 LABORATORY	0. 258082				60.00
65. 00 06500 RESPIRATORY THERAPY	0. 316968				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 504822				66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 191338				69. 00
69. 01 06901 PULMONARY	0. 000000				69. 01
69. 02 06902 CARDI OPULMONARY	0. 319315				69. 02
69. 03 06903 SLEEP LAB	0. 304428				69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 537226				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 742196				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 228734				73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000				74. 00
OUTPATIENT SERVICE COST CENTERS	0. 000000				7 1. 00
88. 00 08800 RURAL HEALTH CLINIC					88. 00
88. 01 08801 RURAL HEALTH CLINIC II					88. 01
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER					89. 00
90. 00 09000 CLINIC	0. 558450			1	90.00
90. 01 09001 I MED	1. 024413				90. 01
90. 02 09002 0NC0L0GY	0. 455849				90. 02
90. 03 09003 0UTPATI ENT CENTER	0. 791170				90. 03
91. 00 09100 EMERGENCY	0. 304581				91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 686003				92. 00
OTHER REIMBURSABLE COST CENTERS	0.00000				, 2. 00
95. 00 09500 AMBULANCE SERVI CES	0. 699654				95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			1	96. 00
101.00 10100 HOME HEALTH AGENCY	0.00000			1	01.00
SPECIAL PURPOSE COST CENTERS					51.00
116. 00 11600 HOSPI CE				11	16. 00
200.00 Subtotal (see instructions)					00.00
201.00 Less Observation Beds					01.00
202.00 Total (see instructions)					02.00
	1			ĮZ,	00

		EWORTAL HUSP & F				u or Form CW3	2332-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150115	Peri od: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Pre 11/28/2016 1:	pared:
			Ti t	le XIX	Hospi tal	Cost	OZ PIII
			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 Owance		
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00	03000 ADULTS & PEDIATRICS	9, 652, 106		9, 652, 10	06 0	9, 652, 106	30.00
31. 00	03100 NTENSI VE CARE UNIT	5, 517, 877		5, 517, 87		5, 517, 877	
40. 00	04000 SUBPROVI DER - I PF	3, 925, 404		3, 925, 40		3, 925, 404	
41. 00	04100 SUBPROVI DER - I RF	1, 483, 355		1, 483, 35		1, 527, 175	
43. 00	04300 NURSERY	1, 483, 333		1, 227, 88		1, 327, 173	
44. 00	04400 SKILLED NURSING FACILITY	2, 645, 199		2, 645, 19		2, 645, 199	
44.00	ANCI LLARY SERVICE COST CENTERS	2,043,199		2,040,19	79 0	2, 043, 199	44.00
EO 00	05000 OPERATING ROOM	15 07/ 100		15 07/ 10	2	15 07/ 100	F0 00
50.00		15, 876, 182		15, 876, 18		15, 876, 182	
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 250, 554		2, 250, 55		2, 250, 554	
53. 00	05300 ANESTHESI OLOGY	1, 704, 386		1, 704, 38		1, 704, 386	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 843, 927		5, 843, 92		5, 843, 927	
56. 00	05600 RADI OI SOTOPE	1, 016, 853		1, 016, 85		1, 016, 853	
60.00	06000 LABORATORY	8, 321, 847	l	8, 321, 84		8, 321, 847	
65. 00	06500 RESPI RATORY THERAPY	1, 787, 007	0	1 ., ,		1, 787, 007	
66. 00	06600 PHYSI CAL THERAPY	3, 867, 178		3, 867, 17		3, 867, 178	
69. 00	06900 ELECTROCARDI OLOGY	4, 762, 318		4, 762, 31	8 163, 318	4, 925, 636	1
69. 01	06901 PULMONARY	0			0	0	69. 01
69. 02	06902 CARDI OPULMONARY	219, 249		219, 24		219, 249	
69. 03	06903 SLEEP LAB	448, 005		448, 00	05	448, 005	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 031, 619		5, 031, 61	9 0	5, 031, 619	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10, 629, 873		10, 629, 87	'3 0	10, 629, 873	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	16, 119, 293		16, 119, 29	0	16, 119, 293	73.00
74.00	07400 RENAL DI ALYSI S	0			0 0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	611, 345		611, 34	.5 0	611, 345	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	1, 030, 517		1, 030, 51	7 0	1, 030, 517	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89. 00
90.00	09000 CLI NI C	1, 736, 939		1, 736, 93	9 0	1, 736, 939	90.00
90. 01	09001 I MED	518, 182		518, 18		518, 182	
90. 02	09002 ONCOLOGY	4, 094, 495		4, 094, 49		4, 094, 495	
90. 03	09003 OUTPATIENT CENTER	513, 269		513, 26		513, 269	
91. 00	09100 EMERGENCY	7, 536, 994	l e	7, 536, 99			
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 899, 736		1, 899, 73		1, 899, 736	
72.00	OTHER REIMBURSABLE COST CENTERS	1,077,700	l	1,077,70	.0	1,077,700	/2.00
95. 00	09500 AMBULANCE SERVICES	2, 816, 808		2, 816, 80	0 8	2, 816, 808	95 00
	09600 DURABLE MEDICAL EQUIP-RENTED	2,010,000		2,010,00	0 0	2, 010, 000	1
	10100 HOME HEALTH AGENCY	2, 479, 973		2, 479, 97	-	2, 479, 973	
101.00	SPECIAL PURPOSE COST CENTERS	2,417,713		2,417,71	J	2,417,713	101.00
116 00	11600 HOSPI CE	0			0	0	116. 00
200.00		125, 568, 370	l	125, 568, 37		125, 781, 901	
200.00	,	1, 899, 736	l .	1, 899, 73		1, 899, 736	
201.00	1	123, 668, 634					201.00
202.00	Total (See Histiactions)	123,000,034	I	y 123,008,03	213, 531	123, 002, 105	1202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 150115 Peri od: Worksheet C From 07/01/2015 Part I Date/Time Prepared: 06/30/2016 11/28/2016 1:02 pm 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 12, 007, 106 03000 ADULTS & PEDIATRICS 12, 007, 106 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 7, 362, 626 7, 362, 626 31.00 04000 SUBPROVIDER - IPF 40.00 3, 384, 099 3, 384, 099 40.00 41.00 04100 SUBPROVI DER - I RF 1.602.071 1, 602, 071 41.00 04300 NURSERY 43.00 1, 546, 487 1, 546, 487 43.00 44.00 04400 SKILLED NURSING FACILITY 1, 435, 705 1, 435, 705 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 7, 768, 080 52, 505, 792 60, 273, 872 0. 263401 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 3, 249, 956 213 3, 250, 169 0.692442 0.000000 52 00 53.00 05300 ANESTHESI OLOGY 857, 491 1, 672, 851 2, 530, 342 0.673579 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 5, 102, 849 39, 182, 268 44, 285, 117 0.131961 0.000000 54.00 05600 RADI OI SOTOPE 8, 156, 906 0.000000 56,00 430, 729 7, 726, 177 0.124662 56,00 60.00 06000 LABORATORY 7, 120, 540 25, 124, 387 32, 244, 927 0.258082 0.000000 60.00 06500 RESPIRATORY THERAPY 2, 663, 955 2, 973, 856 5, 637, 811 0. 316968 0.000000 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 4, 215, 115 3, 445, 364 7, 660, 479 0.504822 0.000000 66.00 06900 ELECTROCARDI OLOGY 0 184994 69.00 7, 220, 546 18, 522, 504 25, 743, 050 0.000000 69 00 69.01 06901 PULMONARY 0.000000 0.000000 69.01 06902 CARDI OPULMONARY 0. 319315 0.000000 69.02 548 686,076 686, 624 69.02 06903 SLEEP LAB 5, 600 1, 466, 029 1, 471, 629 0.304428 0.000000 69.03 69.03 07000 ELECTROENCEPHALOGRAPHY 70.00 0.000000 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 563, 463 5, 802, 457 9, 365, 920 0.537226 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 8, 461, 320 5, 860, 871 14, 322, 191 0.742196 0.000000 72.00 25, 821, 711 70, 471, 877 73 00 07300 DRUGS CHARGED TO PATIENTS 44, 650, 166 0 228734 0.000000 73 00 07400 RENAL DIALYSIS 74.00 0 0.000000 0.000000 74.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 845, 072 845, 072 0. 723424 0.000000 88.00 08801 RURAL HEALTH CLINIC II 0.000000 88.01 0 C 0.000000 88 01 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0.000000 89.00 0.558450 90.00 09000 CLI NI C 54, 157 3, 056, 130 3, 110, 287 0.000000 90.00 90 01 09001 I MED 505, 833 505 833 1 024413 0 000000 90 01 09002 ONCOLOGY 90.02 115, 778 8,866,355 8, 982, 133 0.455849 0.000000 90.02 90.03 09003 OUTPATIENT CENTER 648, 747 648, 747 0.791170 0.000000 90.03 91.00 09100 EMERGENCY 4,011,452 20, 754, 951 24, 766, 403 0.304323 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 769, 281 0.000000 92 00 92 00 1,804,515 0.686003 964, 766 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 1, 073, 827 0. 699654 0.000000 95.00 95.00 2, 952, 176 4, 026, 003 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0.000000 96.00 101.00 10100 HOME HEALTH AGENCY 2, 324, 811 0 2, 324, 811 101.00 SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE 116.00 Subtotal (see instructions) 200.00 110, 039, 977 251, 377, 601 361, 417, 578 200. 00 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 110, 039, 977 251, 377, 601 361, 417, 578 202.00

Health Financial Systems	MEMORIAL HOSP & HEALT	H CARE CTR	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 150115	From 07/01/2015	Worksheet C Part I Date/Time Prepared: 11/28/2016 1:02 pm
		Ti +Lo VIV	Hecni tal	Coct

			Ti +l o VI V	Hospi tal	11/28/2016 1: U.	2 μιιι
	Cost Contor Description	PPS Inpatient	Title XIX	Hospi tal	Cost	
	Cost Center Description	Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00	03000 ADULTS & PEDIATRICS					30. 00
31. 00	03100 NTENSI VE CARE UNI T					31. 00
40. 00	04000 SUBPROVI DER - I PF					40.00
41. 00	04100 SUBPROVI DER - I RF					41. 00
43. 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
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
	05300 ANESTHESI OLOGY	0. 000000				
53.00	1 1				•	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0.000000				54.00
56. 00	05600 RADI OI SOTOPE	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
	06902 CARDI OPULMONARY	0. 000000				69. 02
69. 03	06903 SLEEP LAB	0. 000000				69. 03
	07000 ELECTROENCEPHALOGRAPHY	0. 000000			•	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			•	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			•	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73. 00
74. 00	07400 RENAL DIALYSIS	0. 000000				74. 00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC	0. 000000			•	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0. 000000				88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89. 00
90.00	09000 CLI NI C	0. 000000				90.00
90. 01	09001 I MED	0. 000000				90. 01
	09002 ONCOLOGY	0. 000000				90. 02
	09003 OUTPATI ENT 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
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				96.00
101.00	10100 HOME HEALTH AGENCY				1	101. 00
	SPECIAL PURPOSE COST CENTERS					
116.00	11600 H0SPI CE				1	116. 00
200.00	Subtotal (see instructions)				2	200. 00
201.00	Less Observation Beds				2	201. 00
	Total (see instructions)	1			la la	202. 00

Health Financial Systems	MEMORIAL HOSP &	HEALTH CARE CTF	?	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT.	AL COSTS	Provi der		Period: From 07/01/2015 To 06/30/2016		pared: 02 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	_	Related Cost	•		
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 297, 312	0	1, 297, 31	2 12, 580	103. 12	30.00
31.00 INTENSIVE CARE UNIT	561, 302		561, 30	2 4, 690	119. 68	31. 00
40. 00 SUBPROVI DER - I PF	427, 084	. 0	427, 08	4 2, 943	145. 12	40. 00
41. 00 SUBPROVI DER - I RF	211, 618	0	211, 61	8 1, 507	140. 42	41. 00
43. 00 NURSERY	166, 794		166, 79	4 1, 931	86. 38	43.00
44.00 SKILLED NURSING FACILITY	312, 860)	312, 86	0 5, 016	62. 37	44.00
200.00 Total (lines 30-199)	2, 976, 970		2, 976, 97	0 28, 667		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	4, 660					30.00
31.00 INTENSIVE CARE UNIT	2, 802					31. 00
40. 00 SUBPROVI DER - I PF	1, 651					40. 00
41. 00 SUBPROVI DER - I RF	937	131, 574				41. 00
43. 00 NURSERY	0	0				43. 00
44.00 SKILLED NURSING FACILITY	4, 074	254, 095				44. 00
200.00 Total (lines 30-199)	14, 124	1, 441, 144				200. 00

Health Financial Systems ME	MORIAL HOSP & I	HEALTH CARE CTE	₹	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 150115	Peri od:	Worksheet D	
				From 07/01/2015 To 06/30/2016		nared:
				10 00/30/2010	11/28/2016 1:	02 pm
		Ti tl	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,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1		1			
50. 00 05000 OPERATI NG ROOM	1, 415, 319				101, 317	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	278, 859				0	
53. 00 05300 ANESTHESI OLOGY	33, 049				3, 453	ł
54. 00 05400 RADI OLOGY-DI AGNOSTI C	536, 019					
56. 00 05600 RADI 01 SOTOPE	54, 906					
60. 00 06000 LABORATORY	321, 450					
65. 00 06500 RESPI RATORY THERAPY	93, 717		1			65.00
66. 00 06600 PHYSI CAL THERAPY	320, 426					
69. 00 06900 ELECTROCARDI OLOGY	542, 492				91, 057	69. 00
69. 01 06901 PULMONARY	0	·	0.0000		0	69. 01
69. 02 06902 CARDI OPULMONARY	39, 177					69. 02
69. 03 06903 SLEEP LAB	59, 371	1, 471, 629			1	69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	~			0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	103, 281	9, 365, 920		, , , , , , , , , , , , , , , , , , , ,		71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	202, 230					
73. 00 07300 DRUGS CHARGED TO PATIENTS	400, 419				1	73. 00
74. 00 07400 RENAL DIALYSIS	0	0	0.0000	00 0	0	74. 00
OUTPATIENT SERVICE COST CENTERS	10.440	0.5.070				
88. 00 08800 RURAL HEALTH CLINIC	68, 610				0	
88. 01 08801 RURAL HEALTH CLINIC II	150, 292	1			0	88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	ı			0	89. 00
90. 00 09000 CLI NI C	196, 028				51	90.00
90. 01 09001 MED	31, 963				0	90. 01
90. 02 09002 0NCOLOGY	390, 788				309	90. 02
90. 03 09003 OUTPATIENT CENTER	8, 969				0	
91. 00 09100 EMERGENCY	459, 257					1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	255, 338	2, 769, 281	0. 09220	900, 459	83, 026	92. 00
95. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVICES			I			95. 00
95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		,	0. 00000	0	0	
200. 00 Total (lines 50-199)	5, 961, 960	0 327, 728, 670		41, 548, 311		
200.00 10tal (111es 50-199)	5, 901, 960	321, 128, 6/0	1	41, 548, 311	039, 921	J200. 00

Health Financial Systems	ealth Financial Systems MEMORIAL HOSP & HEALTH CARE CTR				In Lieu of Form CMS-2552-10				
APPORTIONMENT OF INPATIENT	ROUTINE SERVICE	OTHER PASS	THROUGH CO	STS	Provi der	CCN: 150115		Worksheet D	
							From 07/01/2015 To 06/30/2016	Date/Time Pre	pared:
								11/28/2016 1:	
					Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Des	scription	Nu	ırsing Schoo	l Alli	ed Health	All Other	Swi ng-Bed	Total Costs	
					Cost	Medi cal	Adjustment	(sum of cols.	

					Го 06/30/2016	Date/Time Pre 11/28/2016 1:	
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allie	ed Health	All Other	Swi ng-Bed	Total Costs	
			Cost	Medi cal	Adjustment	(sum of cols.	
				Education Cos	t Amount (see	1 through 3,	
					instructions)	minus col. 4)	
	1.00		2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS	0)	0		0	0	
31.00 03100 INTENSIVE CARE UNIT	0)	0			0	31. 00
40. 00 04000 SUBPROVI DER - 1 PF	0)	0		0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0)	0		0	0	41. 00
43. 00 04300 NURSERY	0)	0		D	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0)	0		D	0	44. 00
200.00 Total (lines 30-199)	0)	0	(D	0	200. 00
Cost Center Description	Total Patient		•	I npati ent	I npati ent		
	Days	5 ÷	col. 6)	Program Days			
					Pass-Through		
					Cost (col. 7 x		
					col . 8)		
LAIDATLENT DOUTLAG CEDALICE COCT CENTEDO	6. 00		7. 00	8. 00	9. 00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10.500		0.00	1 4 7 7			00.00
30. 00 03000 ADULTS & PEDI ATRI CS	12, 580	1	0.00				30.00
31. 00 03100 I NTENSI VE CARE UNI T	4, 690		0.00				31.00
40. 00 04000 SUBPROVI DER - PF	2, 943		0.00				40. 00
41. 00 04100 SUBPROVI DER - RF	1, 507		0.00		/	1	41.00
43. 00 04300 NURSERY	1, 931		0.00				43. 00
44. 00 04400 SKILLED NURSING FACILITY	5, 016		0.00				44. 00
200.00 Total (lines 30-199)	28, 667			14, 12	1 0	1	200. 00

Health Financial Systems	MEMORIAL HOSP & HEAD	TH CARE CTR	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150115	From 07/01/2015	Worksheet D Part IV Date/Time Prepared:

				Т	o 06/30/2016	Date/Time Pre 11/28/2016 1:	
_			Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
		Anestheti st			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	1		1	1		
	05000 OPERATING ROOM	0	0	0	0	0	00.00
1	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
1	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
	05600 RADI 0I S0T0PE	0	0	0	0	0	56. 00
1	06000 LABORATORY	0	0	0	0	0	60. 00
	06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
1	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
1	06901 PULMONARY	0	0	0	0	0	69. 01
	06902 CARDI OPULMONARY	0	0	0	0	0	69. 02
	06903 SLEEP LAB	0	0	0	0	0	69. 03
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
1	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	07400 RENAL DI ALYSI S	0	0	0	0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
	08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88. 01
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
	09000 CLI NI C	0	0	0	0	0	90.00
90. 01	09001 I MED	0	0	0	0	0	90. 01
	09002 ONCOLOGY	0	0	0	0	0	90. 02
90. 03	09003 OUTPATIENT CENTER	0	0	0	0	0	90. 03
	09100 EMERGENCY	0	0	0	0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
1	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	1	
200.00	Total (lines 50-199)	0	0	0	0	0	200. 00

Health Financial Systems	MEMORIAL HOSP & HEAL	TH CARE CTR	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	FANCILLARY SERVICE OTHER PASS	Provi der CCN: 150115	From 07/01/2015	Worksheet D Part IV Date/Time Prepared:

						0 06/30/2016	Date/lime Prep 11/28/2016 1:0	
				Ti +I	e XVIII	Hospi tal	PPS	02 piii
	Cost Center Description	Total	Tota		Ratio of Cost	Outpati ent	Inpati ent	
	oust center bescription	Outpatient		Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of		I, col.	(col. 5 ÷ col.	to Charges	Charges	
		col. 2, 3 and		8)	7)	(col . 6 ÷ col .	onal goo	
		4)		-,	.,	7)		
		6.00		7. 00	8. 00	9. 00	10.00	
-	ANCILLARY SERVICE COST CENTERS					· · · · · · · · · · · · · · · · · · ·		
50.00	05000 OPERATI NG ROOM	0	6	0, 273, 872	0.000000	0. 000000	4, 314, 852	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		3, 250, 169	0.000000	0. 000000	0	52.00
53.00	05300 ANESTHESI OLOGY	0		2, 530, 342	0.000000	0. 000000	264, 357	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	4	4, 285, 117	0.000000	0. 000000	3, 106, 759	54.00
56.00	05600 RADI OI SOTOPE	0		8, 156, 906	0.000000	0. 000000	276, 062	56.00
60.00	06000 LABORATORY	0	3	2, 244, 927	0.000000	0. 000000	3, 764, 653	60.00
65.00	06500 RESPI RATORY THERAPY	0		5, 637, 811	0.000000	0.000000	1, 359, 259	65.00
66.00	06600 PHYSI CAL THERAPY	0		7, 660, 479	0.000000	0.000000	1, 226, 409	66.00
69.00	06900 ELECTROCARDI OLOGY	0	2	5, 743, 050	0. 000000	0.000000	4, 321, 007	69.00
69. 01	06901 PULMONARY	0		0	0. 000000	0.000000	0	69. 01
69. 02	06902 CARDI OPULMONARY	0		686, 624	0.000000	0.000000	246	69. 02
69. 03	06903 SLEEP LAB	0		1, 471, 629	0.000000	0.000000	2, 509	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0. 000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		9, 365, 920	0.000000	0. 000000	1, 997, 586	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1	4, 322, 191	0.000000	0.000000	5, 265, 564	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7	0, 471, 877	0.000000	0.000000	12, 441, 290	73.00
74.00	07400 RENAL DIALYSIS	0		0	0. 000000	0. 000000	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
88. 00	08800 RURAL HEALTH CLINIC	0		845, 072			0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0		0	0.00000		0	88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0.000000		0	89. 00
90.00	09000 CLI NI C	0		3, 110, 287		0.000000	814	90.00
90. 01	09001 I MED	0		505, 833	0.000000	0.000000	0	90. 01
90. 02	09002 ONCOLOGY	0		8, 982, 133			7, 091	90. 02
90. 03	09003 OUTPATIENT CENTER	0		648, 747			0	90. 03
91.00	09100 EMERGENCY	0	2	4, 766, 403	0.000000	0. 000000	2, 299, 394	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		2, 769, 281	0.000000	0. 000000	900, 459	92.00
	OTHER REIMBURSABLE COST CENTERS							
95. 00	09500 AMBULANCE SERVICES							95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	l .	0	1 0.00000	0. 000000	0	96. 00
200.00	Total (lines 50-199)	0	32	7, 728, 670	1	[41, 548, 311	200. 00

Health Financial Systems	MEMORIAL HOSP & HEALT	H CARE CTR	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150115	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared:	

				10 06/30/2016	11/28/2016 1:	
		Ti t	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		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	11, 156, 000)	O		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	(52.00
53. 00 05300 ANESTHESI OLOGY	0	806, 672	2			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	13, 932, 82	1			54. 00
56. 00 05600 RADI 0I SOTOPE	0	2, 684, 48	5			56. 00
60. 00 06000 LABORATORY	0	3, 391, 59°	1			60.00
65. 00 06500 RESPIRATORY THERAPY	0	100, 92	7			65.00
66. 00 06600 PHYSI CAL THERAPY	o	41, 17	7			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	6, 416, 390				69.00
69. 01 06901 PULMONARY	0					69. 01
69. 02 06902 CARDI OPULMONARY	0	171, 30	7			69. 02
69. 03 06903 SLEEP LAB	0	366, 05!	5			69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	(70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 748, 12	1			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 264, 85	•			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	20, 996, 92	•			73. 00
74. 00 07400 RENAL DI ALYSI S	0					74. 00
OUTPATIENT SERVICE COST CENTERS			-1	-1		1
88. 00 08800 RURAL HEALTH CLINIC	0	(88. 00
88. 01 08801 RURAL HEALTH CLINIC II	o	(88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(89. 00
90. 00 09000 CLI NI C	0	69, 73	5			90.00
90. 01 09001 MED	0	17, 43	•			90. 01
90. 02 09002 0NCOLOGY	0	633, 20	•			90. 02
90. 03 09003 OUTPATIENT CENTER	0	(90. 03
91. 00 09100 EMERGENCY	0	4, 184, 48	il i			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 959, 550		Ď		92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>	1, 707, 000	·1	-1		72.00
95. 00 09500 AMBULANCE SERVI CES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	(96. 00
200. 00 Total (lines 50-199)	0	70, 941, 748				200.00
	1 9	, , ,	-1 '	-1		1-00.00

Health Financial Systems ME	MORIAL HOSP & I	HEALTH CARE CTF	7	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
				From 07/01/2015	Part V	
			'	To 06/30/2016		pared:
					11/28/2016 1:	02 pm_
		Titl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	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.			
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 263401	11, 156, 000)	0	2, 938, 502	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 692442	0)	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 673579	806, 672		ol ol	543, 357	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 131961	13, 932, 824		ol ol	1, 838, 589	54.00
56. 00 05600 RADI 01 SOTOPE	0. 124662			o	334, 653	56, 00
60. 00 06000 LABORATORY	0. 258082		1		875, 309	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 316968				31, 991	
66. 00 06600 PHYSI CAL THERAPY	0. 504822	· ·	1		20, 787	66.00
	1		1			•
	0. 184994		1	0	1, 186, 994	
69. 01 06901 PULMONARY	0. 000000			0	0	69. 01
69. 02 06902 CARDI OPULMONARY	0. 319315			0	54, 701	
69. 03 06903 SLEEP LAB	0. 304428		1	0 0	111, 437	69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	l e	1	이	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 537226			이	939, 138	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 742196			0 0	1, 680, 966	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 228734		37	0 211, 972	4, 802, 710	73. 00
74.00 07400 RENAL DIALYSIS	0. 000000	0	1	0	0	74. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000				0	88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90. 00 09000 CLI NI C	0. 558450	69, 736	,	ol ol	38, 944	90.00
90. 01 09001 I MED	1. 024413	17, 437		ol ol	17, 863	90. 01
90. 02 09002 ONCOLOGY	0. 455849			o	288, 647	90. 02
90. 03 09003 OUTPATIENT CENTER	0. 791170		1		0	90. 03
91. 00 09100 EMERGENCY	0. 304323			ol ol	1, 273, 434	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 686003				1, 344, 261	92.00
OTHER REIMBURSABLE COST CENTERS	0.000003	1, 737, 330	'	0	1, 344, 201	72.00
95. 00 09500 AMBULANCE SERVI CES	0. 699654			0		95. 00
					0	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			0 0	10, 222, 202	96.00
200.00 Subtotal (see instructions)		70, 941, 748	1		18, 322, 283	
201.00 Less PBP Clinic Lab. Services-Program			1	이		201. 00
Only Charges		70 041 740		011 070	10 222 222	202 00
202.00 Net Charges (line 200 +/- line 201)		70, 941, 748	95	0 211, 972	18, 322, 283	J2U2. UÜ

| Peri od: | Worksheet D | From 07/01/2015 | Part V | To 06/30/2016 | Date/Time Prepared:

				To 06/30/2016	Date/Time Prepared: 11/28/2016 1:02 pm
		Ti tl	e XVIII	Hospi tal	PPS
		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.)			
ANCILLARY SERVICE COST CENTERS	6. 00	7. 00			
50. 00 05000 OPERATING ROOM	1	0			50, 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM					52.00
53. 00 05300 ANESTHESI OLOGY			•		53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0			54.00
56. 00 05600 RADI 01 SOTOPE					56.00
60. 00 06000 LABORATORY	150	0			60.00
65. 00 06500 RESPIRATORY THERAPY	150				65. 00
66. 00 06600 PHYSI CAL THERAPY					66.00
69. 00 06900 ELECTROCARDI OLOGY		0			69.00
69. 01 06901 PULMONARY		0	1		69. 01
69. 02 06902 CARDI OPULMONARY					69. 02
69. 03 06903 SLEEP LAB		0			69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	ł		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	85	48, 485			73. 00
74. 00 07400 RENAL DI ALYSI S	0		i e		74. 00
OUTPATIENT SERVICE COST CENTERS	<u>'</u>				
88. 00 08800 RURAL HEALTH CLINIC	0	0			88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	0			88. 01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			89. 00
90. 00 09000 CLI NI C	0	0			90.00
90. 01 09001 I MED	0	0			90. 01
90. 02 09002 ONCOLOGY	0	0			90. 02
90. 03 09003 OUTPATI ENT CENTER	0	0			90. 03
91. 00 09100 EMERGENCY	0	0			91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92. 00
OTHER REIMBURSABLE COST CENTERS		ı			
95. 00 09500 AMBULANCE SERVI CES	0	•			95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0			96. 00
200.00 Subtotal (see instructions)	235	48, 485			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0				201. 00
Only Charges 202.00 Net Charges (line 200 +/- line 201)	235	48, 485			202. 00
202.00 Net Charges (line 200 +/- line 201)	235	1 40, 483	I		J202. 00

Hoal th	Financial Systems ME	MORIAL HOSP &	JENITU CADE CTE	.	In Lio	u of Form CMS-:	2552 10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA				Peri od:	Worksheet D	2332-10
All Old	TOWNER OF THE ATTENT AND LEARLY SERVICE GATTA	E 00313			From 07/01/2015 To 06/30/2016	Part II Date/Time Pre 11/28/2016 1:	pared: 02 pm
			Ti tl	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Total Charges (from Wkst. C, Part I, col. 8)		Inpatient Program	Capital Costs (column 3 x column 4)	
		26)	ŕ	Í			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	1, 415, 319				0	00.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	278, 859				0	52. 00
53. 00	05300 ANESTHESI OLOGY	33, 049				0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	536, 019		1		921	54.00
56. 00	05600 RADI OI SOTOPE	54, 906	8, 156, 906			0	56.00
60.00	06000 LABORATORY	321, 450				2, 054	
65. 00	06500 RESPIRATORY THERAPY	93, 717	5, 637, 811			262	65. 00
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	320, 426 542, 492				· ·	66. 00 69. 00
69. 00	06901 PULMONARY	542, 492	25, 743, 050	0.02107	·	347 0	69.00
69. 01	06901 POLMONARY	39, 177	686, 624	1		0	1
69. 03	06903 SLEEP LAB	59, 371	1, 471, 629			0	69. 03
70. 00	07000 ELECTROENCEPHALOGRAPHY	39, 371	1,4/1,029	0.00000		0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	103, 281	9, 365, 920			62	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	202, 230		l .		0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	400, 419		l .		2, 158	1
	07400 RENAL DIALYSIS	0	0	0.00000		0	
	OUTPATIENT SERVICE COST CENTERS				-1		1
88. 00	08800 RURAL HEALTH CLINIC	68, 610	845, 072	0. 08118	8 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	150, 292	0	0.00000	o o	0	88. 01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	o	0	89. 00
90.00	09000 CLI NI C	196, 028	3, 110, 287	0.06302	6 0	0	90.00
90. 01	09001 I MED	31, 963	505, 833	0. 06318	9 0	0	90. 01
90. 02	09002 ONCOLOGY	390, 788	8, 982, 133	0. 04350	7 0	0	90. 02
90. 03	09003 OUTPATI ENT CENTER	8, 969	648, 747	0. 01382	5 0	0	90. 03
91. 00	09100 EMERGENCY	459, 257	24, 766, 403	0. 01854	4 161, 205	2, 989	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 769, 281	0.00000	0 345	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	
200.00	Total (lines 50-199)	5, 706, 622	327, 728, 670	11	885, 312	9, 797	200. 00

Health Financial Systems MEMORIAL HOSP & HEAL APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		S Provi der	CCN: 150115 t CCN: 15S115	Peri od: From 07/01/2015 To 06/30/2016	eu of Form CMS-2552-10 Worksheet D Part IV Date/Time Prepared: 11/28/2016 1:02 pm		
			Ti tl	e XVIII	Subprovi der – I PF	PPS	
Cost Center Descri	pti on	Non Physician Anesthetist Cost	Ü		h All Other Medical Education Cost	4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST (CENTERS	_	T	.1		T	
50. 00 05000 OPERATI NG ROOM	DOD DOOM	0		1	0 0		
52. 00 05200 DELI VERY ROOM & LA	ABUR RUUM	0	(0 0	1	1
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOST	1.0	0			0	0	
56. 00 05600 RADI 01 SOTOPE	10	0			0	0	
60. 00 06000 LABORATORY		0				0	
65. 00 06500 RESPIRATORY THERAF	DV	0					
66. 00 06600 PHYSI CAL THERAPY		0				0	
69. 00 06900 ELECTROCARDI OLOGY		0				l ő	1
69. 01 06901 PULMONARY		0		á	0 0	0	
69. 02 06902 CARDI OPULMONARY		0	ĺ		0 0	0	
69. 03 06903 SLEEP LAB		0	ď		0 0	0	69. 03
70. 00 07000 ELECTROENCEPHALOGE	RAPHY	0			0 0	0	70. 00
71.00 07100 MEDICAL SUPPLIES (CHARGED TO PATIENTS	0			0 0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED	TO PATIENTS	0	(0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO F	PATI ENTS	0	(0 0	0	73. 00
74.00 07400 RENAL DIALYSIS		0	(0 0	0	74. 00
OUTPATIENT SERVICE COST		_					
88. 00 08800 RURAL HEALTH CLINI		0	ł	1	0 0	l .	
88. 01 08801 RURAL HEALTH CLINI		0	(0 0	0	
89. 00 08900 FEDERALLY QUALIFIE	D HEALIH CENTER	0	(2	0	0	
90. 00 09000 CLI NI C		0	(0	0	
90. 01 09001 MED		0			0	0	1 ,0.0.
90. 02 09002 0NCOLOGY 90. 03 09003 OUTPATI ENT CENTER		0			0	0	
91. 00 09100 EMERGENCY		0			0 0	0	
92. 00 09200 0BSERVATI ON BEDS (NON_DISTINCT DART)	0			0 0	1	1
OTHER REIMBURSABLE COST				4	0 0		72.00
95. 00 09500 AMBULANCE SERVICES							95. 00
96.00 09600 DURABLE MEDICAL EC		0			0 0	0	96.00
200.00 Total (lines 50-19		0	1	1	0 0	i	200. 00

Heal th	Financial Systems M	EMORIAL HOSP &	HEALTH CARE CT	R	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER				CCN: 150115	Peri od:	Worksheet D	
THROUG	CH COSTS		Componen		From 07/01/2015 To 06/30/2016	Part IV Date/Time Pre 11/28/2016 1:	pared: 02 pm
			Ti tl	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Total Outpati ent	Total Charges (from Wkst. C,	to Charges	Outpatient Ratio of Cost	Inpatient Program	
		Cost (sum of col. 2, 3 and 4)	Part I, col. 8)	(col . 5 ÷ col 7)	to Charges (col. 6 ÷ col. 7)	Charges	
		6, 00	7.00	8.00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	60, 273, 872	0.00000	0. 000000	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3, 250, 169	0. 00000	0. 000000	0	
53.00	05300 ANESTHESI OLOGY	0	2, 530, 342			0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	44, 285, 117			76, 075	
56.00	05600 RADI 0I SOTOPE	0	-, ,	1		0	
60.00	06000 LABORATORY	0	02/2:://2/			206, 067	•
65. 00	06500 RESPI RATORY THERAPY	0	5, 637, 811	1		15, 769	
66. 00	06600 PHYSI CAL THERAPY	0	.,,			24, 012	
69. 00	06900 ELECTROCARDI OLOGY	0	20, , 10, 000			16, 483	
69. 01	06901 PULMONARY	0	0			0	
69. 02	06902 CARDI OPULMONARY	0	000,02			0	
69. 03	06903 SLEEP LAB	0	1, 471, 629			0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0 0/5 000			0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,000,720			5, 622	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		1		0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0				379, 734	
74. 00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	(0.00000	0. 000000	0	74. 00
88. 00	08800 RURAL HEALTH CLINIC	1 0	845, 072	0.00000	0. 000000	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II					0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER					0	
90.00	09000 CLINIC		3, 110, 287			0	
90. 01	09001 I MED		505, 833	1		0	
90. 02	09002 ONCOLOGY	0	8, 982, 133	1		0	
90. 03	09003 OUTPATIENT CENTER	0		1		0	90. 03
91.00	09100 EMERGENCY	0	24, 766, 403	1		161, 205	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0. 000000	345	1
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	_	1	0. 000000	0	
200.00	Total (lines 50-199)	0	327, 728, 670)		885, 312	200.00

Health Financial Systems	MEMORIAL HOSP & HEALT	In Lieu of Form CMS-2552-		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150115 Component CCN: 15S115	From 07/01/2015	
		Title XVIII	Subprovi der -	PPS

			Ti tl	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Inpati ent	Outpati ent	Outpati ent	IPF		
	COST CONTENT DESCRIPTION	Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8	char gcs	Costs (col.			
		x col . 10)		x col . 12)	´		
		11.00	12. 00	13.00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	(0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	(ol	0		52. 00
53.00	05300 ANESTHESI OLOGY	0	(ol	0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	(ol	0		54.00
56.00	05600 RADI OI SOTOPE	0	(ol	0		56. 00
60.00	06000 LABORATORY	0	(ol	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	(ol	0		65. 00
66.00	06600 PHYSI CAL THERAPY	0	(ol	0		66. 00
69.00	06900 ELECTROCARDI OLOGY	0	(ol	0		69. 00
69. 01	06901 PULMONARY	0	(ol	0		69. 01
69. 02	06902 CARDI OPULMONARY	0	(ol	0		69. 02
69. 03	06903 SLEEP LAB	0	(ol	0		69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	(ol	0		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	(0		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	O	(0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	O	50		0		73. 00
74.00	07400 RENAL DIALYSIS	O	(0		74.00
	OUTPATIENT SERVICE COST CENTERS			•			
88. 00	08800 RURAL HEALTH CLINIC	0	(0		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	(0		88. 01
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(0		89. 00
90.00	09000 CLI NI C	0	(0		90.00
90. 01	09001 I MED	0	(0		90. 01
90. 02	09002 ONCOLOGY	0	(0		90. 02
90. 03	09003 OUTPATIENT CENTER	0	(0		90. 03
91.00	09100 EMERGENCY	0	(0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(0		92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	(- 1	0		96. 00
200.00	Total (lines 50-199)	0	50	o	0		200. 00

Health Financial Systems		MEMORIAL HOSP & HEAL	In Lie	u of Form CMS-2552-10		
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE COST		CCN: 150115	From 07/01/2015	
			Component	CCN: 15S115	To 06/30/2016	Date/Time Prepared: 11/28/2016 1:02 pm
			Ti +Lo	VV/1.1.1	Subprovi dor	DDC

			·			11/28/2016 1:	02 pm_
			Ti tl	e XVIII	Subprovi der - I PF	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge PI	PS Reimbursed	Cost	Cost	PPS Services	
		Ratio From S	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
	LLADY OFFICE OF SERVICE	1.00	2. 00	3. 00	4. 00	5. 00	
	LLARY SERVICE COST CENTERS	0.2/2401					
	OO OPERATING ROOM	0. 263401	0		0 0	0	
	DO DELIVERY ROOM & LABOR ROOM	0. 692442	ŭ		٦	0	52.00
•	OO ANESTHESI OLOGY	0. 673579	0		0	0	
	00 RADI OLOGY-DI AGNOSTI C	0. 131961	0		0	0	54.00
1	00 RADI OI SOTOPE	0. 124662	0		0	0	56.00
	OO LABORATORY	0. 258082	0		0	0	60.00
	00 RESPI RATORY THERAPY 00 PHYSI CAL THERAPY	0. 316968	0		0) 0	65.00
	00 ELECTROCARDI OLOGY	0. 504822 0. 184994	0		0	0	66. 00 69. 00
	DOLELECTROCARDI OLOGY DI PULMONARY	0. 184994	0		0	0	69.00
	2 CARDI OPULMONARY	1	0		0	0	
	03 SLEEP LAB	0. 319315 0. 304428	0		0	0	69. 02 69. 03
	00 ELECTROENCEPHALOGRAPHY	0. 304428	0		0	0	70.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 537226	0		0	0	71.00
	00 IMPL. DEV. CHARGED TO PATIENTS	0. 537226	0		0	0	72.00
	DO DRUGS CHARGED TO PATIENTS	0. 742196	50		0 53	_	73.00
	00 RENAL DIALYSIS	0. 000000	0		0 0		1
	PATIENT SERVICE COST CENTERS	0.000000			0 0	0	74.00
	O RURAL HEALTH CLINIC	0. 000000				0	88. 00
	01 RURAL HEALTH CLINIC II	0. 000000				0	1
	O FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				o n	89. 00
	OO CLINIC	0. 558450	0		0	0	90.00
	01 I MED	1. 024413	0		0 0	o n	90. 01
	02 ONCOLOGY	0. 455849	0		0	,	90. 02
	03 OUTPATIENT CENTER	0. 791170	0		0	Ö	90. 03
	OO EMERGENCY	0. 304323	0		0 0	Ö	1
	00 OBSERVATION BEDS (NON-DISTINCT PART)	0. 686003	0		0 0	, O	92.00
	R REIMBURSABLE COST CENTERS	0.000000			<u> </u>		72.00
	OO AMBULANCE SERVICES	0. 699654			0		95. 00
	OO DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		o o	0	1
200.00	Subtotal (see instructions)		50		0 53	_	200.00
201.00	Less PBP Clinic Lab. Services-Program		00		0 0		201. 00
	Only Charges						
202. 00	Net Charges (line 200 +/- line 201)		50		0 53	11	202. 00

Health Financial Systems	Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In					
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVIC	S AND VACCINE COST Provider Co		CCN: 150115	Peri od:	Worksheet D	
		Componer	t CCN: 15S115	From 07/01/2015 To 06/30/2016		pared: 02 pm
		Ti t	le XVIII	Subprovi der - I PF	PPS	
	Co	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				

		Cos	sts	
	Cost Center Description	Cost	Cost	
	·	Reimbursed	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 OPERATI NG 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 RESPI RATORY 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 PATIENTS	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	12	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	0	0	88. 01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89. 00
90.00	09000 CLI NI C	0	0	90. 00
90. 01	09001 I MED	0	0	90. 01
90. 02	09002 ONCOLOGY	0	0	90. 02
90. 03	09003 OUTPATI ENT CENTER	0	0	90. 03
91.00	09100 EMERGENCY	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0		95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00	Subtotal (see instructions)	0	12	200. 00
201.00		0		201. 00
	Only Charges			
202.00	Net Charges (line 200 +/- line 201)	0	12	202. 00

Hoal th	Financial Systems ME	MORIAL HOSP &	HEALTH CADE CT	.	In lie	eu of Form CMS-2	2552_10
	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CCN: 150115	Peri od:	Worksheet D	2332-10
ALTORI	TOTAL OF THE ATTENT ANOTELANT SERVICE GATTA	E 00013		t CCN: 15T115	From 07/01/2015 To 06/30/2016	Part II	pared: 02 pm
			Ti tl	e XVIII	Subprovi der - I RF	PPS	<u> </u>
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	, , , , , , , , , , , , , , , , , , ,		(from Wkst. C,		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, 319	60, 273, 872	0. 02348	1, 700	40	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	278, 859	3, 250, 169	0. 08579	98 0	0	52. 00
53.00	05300 ANESTHESI OLOGY	33, 049	2, 530, 342	0. 01306	51 15	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	536, 019	44, 285, 117	0. 01210	24, 249	294	54.00
56.00	05600 RADI OI SOTOPE	54, 906	8, 156, 906	0.00673	31 0	0	56. 00
60.00	06000 LABORATORY	321, 450	32, 244, 927	0.00996	67, 983	678	60.00
65.00	06500 RESPI RATORY THERAPY	93, 717			23 25, 405	422	65. 00
66.00	06600 PHYSI CAL THERAPY	320, 426	7, 660, 479	0. 04182	28 683, 982	28, 610	66. 00
69.00	06900 ELECTROCARDI OLOGY	542, 492	25, 743, 050	0. 02107	73 2, 656	56	69. 00
69. 01	06901 PULMONARY	0	O	0. 00000	00	0	69. 01
69. 02	06902 CARDI OPULMONARY	39, 177	686, 624	0.05705	57 0	0	69. 02
69. 03	06903 SLEEP LAB	59, 371	1, 471, 629	0. 04034	14 0	0	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	O	0. 00000	00	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	103, 281	9, 365, 920			172	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	202, 230	14, 322, 191	0. 01412	20 374	5	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	400, 419	70, 471, 877	0. 00568	302, 567	1, 719	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0. 00000	00 0	1	1
	OUTPATIENT SERVICE COST CENTERS			•		•	1
88. 00	08800 RURAL HEALTH CLINIC	68, 610	845, 072	0. 08118	38 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	150, 292	0	0. 00000	00	0	88. 01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	O	0. 00000	00	0	89. 00
90.00	09000 CLI NI C	196, 028	3, 110, 287	0. 06302	26 0	0	90.00
90. 01	09001 I MED	31, 963	505, 833	0. 06318	39 0	0	90. 01
90. 02	09002 ONCOLOGY	390, 788	8, 982, 133	0. 04350	07	0	90. 02
90. 03	09003 OUTPATIENT CENTER	8, 969	648, 747	0. 01382	25 0	0	90. 03
91.00	09100 EMERGENCY	459, 257	24, 766, 403	0. 01854	14 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0.00000	10, 609	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0			0	
200.00	Total (lines 50-199)	5, 706, 622	327, 728, 670	1	1, 135, 168	31, 996	200. 00

Health Financial Systems MEN APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERV THROUGH COSTS	MORIAL HOSP & F VICE OTHER PASS	S Provi der	CCN: 150115	Peri od: From 07/01/2015		pared:
		Ti tl	e XVIII	Subprovi der – I RF	PPS	•
Cost Center Description	Anesthetist Cost	Nursing School		h All Other Medical Education Cost	4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0	1	0 0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0 0	0	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 56. 00 05600 RADI OI SOTOPE	0	0		0	0	
60. 00 06000 LABORATORY	0	0		0	0	
65. 00 06500 RESPI RATORY THERAPY	0	0			0	
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	0			0	
69. 01 06901 PULMONARY	0	0		0 0	0	
69. 02 06902 CARDI OPULMONARY	0	0		0 0	0	
69. 03 06903 SLEEP LAB	0	0	,	0 0	Ō	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0)	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	,	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0 0	0	73. 00
74. 00 07400 RENAL DIALYSIS	0	0		0 0	0	74. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	1	0 0	0	
88. 01 08801 RURAL HEALTH CLINIC II	0	0	1	0 0	0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	0	0	
90. 00 09000 CLI NI C	0	0		0	0	
90. 01 09001 MED	0	0		0	0	
90. 02 09002 0NCOLOGY 90. 03 09003 0UTPATI ENT CENTER	0	0		0	0	
91. 00 09100 EMERGENCY	0	0		0 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	
OTHER REIMBURSABLE COST CENTERS			1	<u> </u>	·	/2.00
95. 00 09500 AMBULANCE SERVICES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	
200.00 Total (lines 50-199)	0	0	1	0 0	۱ .	200.00

APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	EMORIAL HOSP & RVICE OTHER PAS			CCN: 150115	Peri od: From 07/01/2015	u of Form CMS-2 Worksheet D Part IV	
THROUG	H COSTS				CCN: 15T115	To 06/30/2016	Date/Time Pre 11/28/2016 1:	
			-	Title	e XVIII	Subprovi der - I RF	PPS	•
	Cost Center Description	Total			Ratio of Cos		I npati ent	
		Outpati ent	(from Wkst.		to Charges	Ratio of Cost	Program	
		Cost (sum of	Part I, co	OI .	(col . 5 ÷ col		Charges	
		col . 2, 3 and	8)		7)	(col. 6 ÷ col. 7)		
		4) 6. 00	7.00		8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS	0.00	7.00		8.00	7.00	10.00	
50. 00	05000 OPERATI NG ROOM	0	60, 273,	872	0.00000	0. 000000	1, 700	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM				0. 00000		0	1
53.00	05300 ANESTHESI OLOGY		1		0. 00000		15	1
54.00	05400 RADI OLOGY-DI AGNOSTI C				0. 00000		24, 249	
56. 00	05600 RADI OI SOTOPE	0			0. 00000		0	1
60.00	06000 LABORATORY	0	1		0. 00000		67, 983	60.00
65.00	06500 RESPIRATORY THERAPY	0			0.00000	0. 000000	25, 405	1
66. 00	06600 PHYSI CAL THERAPY	0	1		0. 00000		683, 982	66.00
69. 00	06900 ELECTROCARDI OLOGY	0	25, 743,	050	0. 00000	0. 000000	2, 656	69.00
69. 01	06901 PULMONARY	0		0	0. 00000	0. 000000	0	69. 01
69. 02	06902 CARDI OPULMONARY	0	686,	624	0. 00000	0. 000000	0	69. 02
69. 03	06903 SLEEP LAB	0	1, 471,	629	0.00000	0. 000000	0	69. 03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1	0	0.00000		0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	.,		0.00000		15, 628	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0.00000		374	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0			0. 00000		302, 567	73.00
74. 00	07400 RENAL DIALYSIS	0		0	0.00000	0. 000000	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
88. 00	08800 RURAL HEALTH CLINIC	0			0.00000		0	
88. 01	08801 RURAL HEALTH CLINIC II	0	l .	0	0.00000		0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	l .	0	0.00000		0	89.00
90.00	09000 CLINIC	0	-,		0.00000		0	
90. 01 90. 02	09001 I MED 09002 ONCOLOGY	0		833	0. 00000 0. 00000		0	90. 01
90. 02	09003 OUTPATIENT CENTER				0.00000		-	90.02
90. 03	1091001 EMERGENCY			747	0.00000		0	90.03
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0. 00000		10, 609	91.00
7Z. UU	OTHER REIMBURSABLE COST CENTERS			, 201	0.00000	0.00000	10, 609	72.00
95. 00	09500 AMBULANCE SERVI CES							95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0. 00000	0. 000000	0	1
200.00	1	0	327, 728,	670			1, 135, 168	200 00

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR				In Lieu of Form CMS-2552-		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHI	ER PASS	Provi der C	CCN: 150115	Peri od: From 07/01/2015	Worksheet D	
THROUGH COSTS			Component	CCN: 15T115		Date/Time Prepared:	
						11/28/2016 1:02 pm	
			Title	XVIII	Subprovi der -	l PPS	

			Ti tl	e XVIII	Subprovi der -	PPS	
	Cost Center Description	Inpatient	Outpati ent	Outpati ent	I RF		
	cost center bescription	Program	Program	Program			
		Pass-Through	Charges	Pass-Through	,		
		Costs (col. 8	onar ges	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		50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	O	(0		52. 00
53.00	05300 ANESTHESI OLOGY	O	(0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	O	(0		54. 00
56.00	05600 RADI OI SOTOPE	0	(0		56. 00
60.00	06000 LABORATORY	0	(0		60.00
65.00	06500 RESPI RATORY 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 PATIENTS	0	(0		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	(0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 250		0		73. 00
74.00	07400 RENAL DIALYSIS	0	(0		74. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	(0		88. 00
	08801 RURAL HEALTH CLINIC II	0	(0		88. 01
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(0		89. 00
90.00	09000 CLI NI C	0	(0		90. 00
90. 01	09001 I MED	0	(0		90. 01
90. 02	09002 ONCOLOGY	0	(0		90. 02
	09003 OUTPATI ENT CENTER	0	(0		90. 03
91.00	09100 EMERGENCY	0	(0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(0		92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	(0		96. 00
200.00	Total (lines 50-199)	0	1, 250)	0		200. 00

Health Financial Systems		MEMORIAL HOSP & HEALT	In Lie	u of Form CMS-2552-10	
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE COST	Provider CCN: 150115 Component CCN: 15T115	From 07/01/2015	
			Title XVIII	Subprovi der -	11/28/2016 1: 02 pm PPS
			II the Aviii	Subprovider -	FF3

			Ti tl	e XVIII	Subprovi der - I RF	PPS	<u>02 piii</u>
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	, ,	
		Part I, col. 9	ĺ	Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 263401	0	(0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 692442	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 673579	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 131961	0		0	0	54.00
56.00	05600 RADI 0I SOTOPE	0. 124662	0		0	0	56.00
60.00	06000 LABORATORY	0. 258082	0		0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0. 316968	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 504822	0		0	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 184994	0		0	0	69. 00
69. 01	06901 PULMONARY	0. 000000	0		0	0	69. 01
69. 02	06902 CARDI OPULMONARY	0. 319315	l 0		0	0	69. 02
	06903 SLEEP LAB	0. 304428			0	0	69. 03
	07000 ELECTROENCEPHALOGRAPHY	0. 000000			0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 537226	l 0		0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 742196			0	0	1
	07300 DRUGS CHARGED TO PATIENTS	0. 228734			5, 444	286	1
	07400 RENAL DIALYSIS	0. 000000			0 0	0	1
	OUTPATIENT SERVICE COST CENTERS		_		-		1
	08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
	08801 RURAL HEALTH CLINIC II	0. 000000				Ō	1
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	
	09000 CLI NI C	0. 558450			0	0	
	09001 I MED	1. 024413			0	Ō	
	09002 ONCOLOGY	0. 455849			0	0	90. 02
	09003 OUTPATIENT CENTER	0. 791170	l .		0	o o	1
	09100 EMERGENCY	0. 304323			o o	o o	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 686003		•	0	_	
	OTHER REIMBURSABLE COST CENTERS	0.00000			<u> </u>		72.00
	09500 AMBULANCE SERVICES	0. 699654					95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			0	0	
200.00	Subtotal (see instructions)	0.00000	1, 250		5, 444	_	200. 00
201.00	Less PBP Clinic Lab. Services-Program		1,250		0 0	200	201. 00
201.00	Only Charges						
202. 00	Net Charges (line 200 +/- line 201)		1, 250		5, 444	286	202. 00
_52. 50	1 2 3 (1.1 200 1. 1.1 201)	I	., 200	'	-1 3,111	200	1=32.00

Health Financial Systems	MEMORIAL HOSP &	HEALTH CARE	CTR	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICE	ES AND VACCINE COST	Compon		Peri od: From 07/01/2015 To 06/30/2016	Date/Time Pre 11/28/2016 1:	
		Ti	tle XVIII	Subprovider - IRF	PPS	
	Co	sts				
Cost Center Description	Cost Reimbursed Services Subject To	Cost Reimbursed Services No Subject To	ot			

					IRF	
		Cos	sts			
	Cost Center Description	Cost	Cost			
	·	Rei mbursed	Rei mbursed			
		Servi ces	Services Not			
		Subject To	Subject To			
			Ded. & Coins.			
		(see inst.)	(see inst.)			
		6.00	7.00	1		
ΔNC	ILLARY SERVICE COST CENTERS	0.00	7.00	l		
	OO OPERATING ROOM	1	0			50.00
	OO DELIVERY ROOM & LABOR ROOM			1		52.00
	00 ANESTHESI OLOGY	0				
		0				53.00
	OO RADI OLOGY-DI AGNOSTI C	0	0			54.00
	00 RADI OI SOTOPE	0	0			56. 00
	00 LABORATORY	0) 0			60.00
	00 RESPI RATORY THERAPY	0	0			65. 00
66. 00 066	00 PHYSI CAL THERAPY	0	0			66. 00
69. 00 069	00 ELECTROCARDI OLOGY	0	0			69. 00
69. 01 069	01 PULMONARY	0	0			69. 01
69. 02 069	02 CARDI OPULMONARY	0	0			69. 02
	03 SLEEP LAB	0	0			69. 03
70. 00 070	OO ELECTROENCEPHALOGRAPHY	0	0			70. 00
	OO MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71. 00
	00 IMPL. DEV. CHARGED TO PATIENTS	0	0			72. 00
	OO DRUGS CHARGED TO PATIENTS	0	1, 245			73. 00
	00 RENAL DIALYSIS	0	0			74. 00
	PATIENT SERVICE COST CENTERS		, <u> </u>			74.00
	OO RURAL HEALTH CLINIC		0			88. 00
	01 RURAL HEALTH CLINIC II	0	j o			88. 01
	OO FEDERALLY QUALIFIED HEALTH CENTER	0				89. 00
	OO CLINIC	0				90.00
	01 I MED					90.00
	02 ONCOLOGY	0				90.01
		0				
	O3 OUTPATIENT CENTER	0				90. 03
	OO EMERGENCY	0	0			91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART)	0) 0			92.00
	ER REIMBURSABLE COST CENTERS		1	1		
	00 AMBULANCE SERVICES	0)			95. 00
	OO DURABLE MEDICAL EQUIP-RENTED	0	0	1		96. 00
200.00	Subtotal (see instructions)	0	1, 245			200. 00
201. 00	Less PBP Clinic Lab. Services-Program	0)			201. 00
	Only Charges					
202. 00	Net Charges (line 200 +/- line 201)	0	1, 245			202. 00

	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER I COSTS	RVICE OTHER PASS			CCN: 150115 CCN: 155305	Period: From 07/01/2015 To 06/30/2016		epared: 02 pm
				Titl	e XVIII	Skilled Nursing Facility	PPS	•
	Cost Center Description	Non Physician Anesthetist Cost				h All Other Medical Education Cost	4)	
		1.00	2.	. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	_		_	Т			l
	05000 OPERATING ROOM	0		0		0	0	1
	05200 DELIVERY ROOM & LABOR ROOM	0		0		0 0	0	1
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0		0		0	0	1
	05600 RADI OLOGY-DI AGNOSTI C	0		0		0	0	
	06000 LABORATORY	0		0		0	0	1
	06500 RESPIRATORY THERAPY			0		0	0	
	06600 PHYSI CAL THERAPY	0		0		0	0	
	06900 ELECTROCARDI OLOGY	0		0		0	0	
	06901 PULMONARY	0		0		0	0	
	06902 CARDI OPULMONARY	0		0		0 0	0	
	06903 SLEEP LAB	0		0		0 0	o o	
	07000 ELECTROENCEPHALOGRAPHY	0		0		0 0	o o	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		0 0	Ō	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0		0 0	0	72.0
3. 00	07300 DRUGS CHARGED TO PATIENTS	0		0		0 0	0	73.0
4. 00	07400 RENAL DIALYSIS	0		0		0 0	0	74. C
	OUTPATIENT SERVICE COST CENTERS			,				1
	08800 RURAL HEALTH CLINIC	0		0		0	0	88. 0
	08801 RURAL HEALTH CLINIC II	0		0		0	0	88. 0
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0		0	0	89.0
0. 00	09000 CLI NI C	0		0		0	0	90.0
	09001 I MED	0		0		0	0	90.0
	09002 ONCOLOGY	0		0		0	0	
	09003 OUTPATI ENT CENTER	0		0		0	0	1
	09100 EMERGENCY	0		0		0	0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1	0		0 0	0	92.0
	OTHER REIMBURSABLE COST CENTERS							١
	09500 AMBULANCE SERVICES	_		_		_	_	95.0
	09600 DURABLE MEDI CAL EQUI P-RENTED	0	l .	0		0	0	
00.00	Total (lines 50-199)	0	1	0	I	0 0	1 0	200.

		EMORIAL HOSP & I				eu of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	RVICE OTHER PAS		CCN: 150115 t CCN: 155305	Peri od: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Pre 11/28/2016 1:	pared: 02 pm
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description	Total	Total Charges	Ratio of Cos	t Outpatient	Inpati ent	
			(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of col. 2, 3 and		(col . 5 ÷ col 7)	to Charges (col. 6 ÷ col.	Charges	
		4)	0)	')	7)		
		6, 00	7.00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	60, 273, 872	0.00000		0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0				0	52. 00
53.00	05300 ANESTHESI OLOGY	0	_, _, _, _,			0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0				18, 330	
56. 00	05600 RADI OI SOTOPE	0	0, .00, ,00			0	
60.00	06000 LABORATORY	0				334, 712	1
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	5, 637, 811	1			1
66. 00 69. 00	06900 ELECTROCARDI OLOGY	0		1		1, 114, 668 5, 606	
69. 01	06901 PULMONARY			1		0 5,000	
69. 02	06902 CARDI OPULMONARY	0	1	1		Ö	
69. 03	06903 SLEEP LAB	Ö		1		Ö	
70.00	07000 ELECTROENCEPHALOGRAPHY	0		1		0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9, 365, 920	0. 00000	0. 000000	70, 517	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	,,			0	
	07300 DRUGS CHARGED TO PATIENTS	0					
74.00	07400 RENAL DIALYSIS	0	C	0.00000	0. 000000	0	74. 00
	OUTPATIENT SERVICE COST CENTERS		1 045 070				
	08800 RURAL HEALTH CLINIC	0				l	
88. 01 89. 00	08801 RURAL HEALTH CLINIC II 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		1		0	88. 01 89. 00
	09000 CLINIC			1		0	90.00
	09001 I MED		-, ,	1		0	
90. 02	09002 ONCOLOGY	0				o o	1
90. 03	09003 OUTPATIENT CENTER	0	648, 747			Ō	90. 03
91.00	09100 EMERGENCY	0	24, 766, 403			0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 769, 281	0.00000	0. 000000	53, 353	92. 00
	OTHER REIMBURSABLE COST CENTERS						1
	09500 AMBULANCE SERVICES						95. 00
	09600 DURABLE MEDI CAL EQUI P-RENTED	0		0.0000	0. 000000	l e	
200.00	Total (lines 50-199)	0	327, 728, 670	1		3, 674, 841	J200. 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	Provider CCN: 150115 Component CCN: 155305	From 07/01/2015	
		Title XVIII	Skilled Nursing	

Title XVIII Skilled Nursing	g PPS
Facility	
Cost Center Description Inpatient Outpatient Outpatient	
Program Program Program	
Pass-Through Charges Pass-Through	
Costs (col. 8 Costs (col. 9	
x col . 10) x col . 12)	
11.00 12.00 13.00	
ANCILLARY SERVICE COST CENTERS	50.00
50. 00 05000 OPERATING ROOM 0 0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0	52. 00
53. 00 05300 ANESTHESI OLOGY 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	56. 00
60. 00 06000 LABORATORY 0 0 0	60. 00
65. 00 06500 RESPI RATORY 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 DI ALYSI S 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	90.00
90. 01 09001 I MED 0 0	90. 01
90. 02 09002 0NCOLOGY 0 0	90. 02
90. 03 09003 0UTPATIENT CENTER 0 0 0	90. 03
91. 00 09100 EMERGENCY 0 0	91.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0	92.00
OTHER REIMBURSABLE COST CENTERS	
95. 00 09500 AMBULANCE SERVI CES	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0	96.00
200.00 Total (lines 50-199) 0 0	200. 00

Health Financial Systems	MEMORIAL HOSP & HEALT	u of Form CMS-2552-10		
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150115 Component CCN: 155305	From 07/01/2015 To 06/30/2016	
-		T' 11 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	CLILL LN I	DDC

						11/28/2016 1:	UZ pm
			Ti tl	e XVIII	Skilled Nursing	PPS	
					Facility		
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	•		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			
				(see inst.)	(see inst.)		
		1. 00	2.00	3.00	4.00	5. 00	
ΔNC	CILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
	DOO OPERATING ROOM	0. 263401	0	1	0 0	0	50.00
	200 DELIVERY ROOM & LABOR ROOM	0. 692442	Ö			Ö	1
	300 ANESTHESI OLOGY	0. 673579	0	1	0	0	
	l e e e e e e e e e e e e e e e e e e e	1	0		0	0	1
	400 RADI OLOGY-DI AGNOSTI C	0. 131961	Ĭ		0	_	
	600 RADI OI SOTOPE	0. 124662	0		0	0	
1	DOO LABORATORY	0. 258082	0		0	0	60.00
	500 RESPI RATORY THERAPY	0. 316968	0		0	0	65. 00
	600 PHYSI CAL THERAPY	0. 504822	0		0	0	66. 00
	900 ELECTROCARDI OLOGY	0. 184994	0	1	0	0	69. 00
	901 PULMONARY	0. 000000	0)	0	0	
	902 CARDI OPULMONARY	0. 319315	0	1	0	0	69. 02
69. 03 069	903 SLEEP LAB	0. 304428	0		0	0	69. 03
70.00 070	DOO ELECTROENCEPHALOGRAPHY	0. 000000	0)	0 0	0	70.00
71. 00 071	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 537226	0)	0	0	71. 00
72. 00 072	200 IMPL. DEV. CHARGED TO PATIENTS	0. 742196	0	1	0 0	0	72. 00
73. 00 073	300 DRUGS CHARGED TO PATIENTS	0. 228734	0)	0 7, 516	0	73.00
74. 00 074	400 RENAL DIALYSIS	0. 000000	0)	0 0	0	74.00
	FPATIENT SERVICE COST CENTERS						
	BOO RURAL HEALTH CLINIC	0. 000000				0	88. 00
	BO1 RURAL HEALTH CLINIC II	0. 000000				0	1
	900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
	DOO CLINIC	0. 558450	0		0	0	1
	001 MED	1. 024413	0			0	1
	OO2 ONCOLOGY	0. 455849			0	0	1
	003 OUTPATIENT CENTER	0. 453649	0		0	0	1
	100 EMERGENCY	1	_	1	0	_	1
	l e e e e e e e e e e e e e e e e e e e	0. 304323	0	l .	0 0	0	
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 686003	0		0 0	0	92. 00
	HER REIMBURSABLE COST CENTERS	0 (00/54		ı			05.00
	500 AMBULANCE SERVI CES	0. 699654	_		0	_	95. 00
	600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	1	0	0	
200.00	Subtotal (see instructions)		0	1	0 7, 516	0	200. 00
201. 00	Less PBP Clinic Lab. Services-Program				0		201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		0	1	0 7, 516	0	202. 00

Health Financial Systems	MEMORIAL HOSP &	HEALTH CARE CT	R	In Lie	u of Form CMS-2	2552-1
PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCI		Provi der	CCN: 150115	Peri od: From 07/01/2015	Worksheet D Part V	
		Componen	t CCN: 155305	To 06/30/2016		pared: 02 pm
		Ti tl	e XVIII	Skilled Nursing Facility		
	Co	sts		•		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subj ect To	Subject To				
	Ded & Coins	Ded & Coins				

		Cos	sts		
	Cost Center Description	Cost	Cost		
		Rei mbursed	Rei mbursed		
		Servi ces	Services Not		
		Subject To	Subject To		
		Ded. & Coins.	Ded. & Coins.		
		(see inst.)	(see inst.)		
		6.00	7. 00		
ANC	ILLARY SERVICE COST CENTERS				
50.00 050	OO OPERATING ROOM	0	0		50.00
52. 00 052	OO DELIVERY ROOM & LABOR ROOM	0	0		52. 00
53.00 053	00 ANESTHESI OLOGY	0	0		53. 00
54. 00 054	OO RADI OLOGY-DI AGNOSTI C	0	0		54.00
56.00 056	00 RADI OI SOTOPE	0	0		56. 00
60.00 060	OO LABORATORY	0	0		60.00
65. 00 065	00 RESPI RATORY THERAPY	0	0		65. 00
66. 00 066	00 PHYSI CAL THERAPY	0	0		66. 00
69. 00 069	00 ELECTROCARDI OLOGY	0	0		69. 00
69. 01 069	01 PULMONARY	0	0		69. 01
69. 02 069	02 CARDI OPULMONARY	0	0		69. 02
69. 03 069	03 SLEEP LAB	0	0		69. 03
70.00 070	OO ELECTROENCEPHALOGRAPHY	0	0		70. 00
71.00 071	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71. 00
72. 00 072	OO IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
	OO DRUGS CHARGED TO PATIENTS	0	1, 719		73. 00
74. 00 074	OO RENAL DIALYSIS	0	0		74. 00
	PATIENT SERVICE COST CENTERS	•	•		
88. 00 088	OO RURAL HEALTH CLINIC	0	0		88. 00
	01 RURAL HEALTH CLINIC II	0	0		88. 01
89. 00 089	OO FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
90.00 090	OO CLINIC	0	0		90.00
90. 01 090	O1 I MED	0	0		90. 01
90. 02 090	02 ONCOLOGY	0	0		90. 02
90. 03 090	03 OUTPATIENT CENTER	0	0		90. 03
91. 00 091	OO EMERGENCY	0	0		91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
	ER REIMBURSABLE COST CENTERS				1
	00 AMBULANCE SERVICES	0			95. 00
	OO DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00	Subtotal (see instructions)	0	1, 719		200.00
201. 00	Less PBP Clinic Lab. Services-Program	0			201. 00
	Only Charges				
202. 00	Net Charges (line 200 +/- line 201)	0	1, 719		202. 00
	•	•		-	•

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Health Financial Systems ME	EMORIAL HOSP &	HEALTH CARE CT	₹	In Lie	u of Form CMS-2	2552-10
Title XIX	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 150115	Peri od:	Worksheet D	
11/28/2016.1.02 pm						Part V	
Cost Center Description					To 06/30/2016	Date/Time Pre	pared:
Cost Center Description			Ti +	lo VIV	Hospi tal		UZ pm
Cost Center Description			111		HOSPI tai		
ANCILLARY SERVICE COST CENTERS	Cost Center Description	Cost to Charge	DDS Daimhursad		Cost		
Norksheet C, Part I, col. 9 Inst.) Services Subject To Ded & Coins. (See Inst.) Subject To Ded & Coi	COST CENTER DESCRIPTION						
Part I						(366 11131.)	
ANCILLARY SERVICE COST CENTERS			,				
NOTE		rart 1, cor. 7					
ANCILLARY SERVICE COST CENTERS							
ANCILLARY SERVICE COST CENTERS SOLOGY O SOLOGO		1 00	2 00			5 00	
50.00 05000 05000 05000 05000 0	ANCILLARY SERVICE COST CENTERS	11.00	2.00	0.00	1. 00	0.00	
52.00 05200 05200 05200 05200 05200 05200 053000 053		0. 263401	0	6, 984, 83	7 0	0	50.00
53.00 05300 AMESTHESI OLOGY 0.673579 0 255.068 0 0 53.00							
54.00 05400 RADI OLOGY-DI AGNOSTIC 0.131961 0 5.420, 258 0 0 54.00				1			
56.00 05600 RADI OI SOTOPE 0. 124662 0 509, 534 0 0 56.00							
60. 00 06000 LABORATORY 0. 258082 0 2. 649, 301 0 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 0. 316968 0 233, 456 0 0 65. 00 66. 00 06500 RESPI RATORY THERAPY 0. 504822 0 539, 323 0 0 66. 00 66. 00 06900 ELECTROCARDI OLOGY 0. 184994 0 1, 701, 920 0 0 0 0 69. 01 06901 PULMONARY 0. 000000 0 0 0 0 0 0 69. 02 06902 CARDI OPULMONARY 0. 319315 0 21, 554 0 0 69, 01 69. 03 06903 SLEEP LAB 0. 304428 0 157, 550 0 0 69, 02 69. 03 06903 SLEEP LAB 0. 304428 0 157, 550 0 0 69, 02 69. 03 07000 ELECTROCNECPHALOGRAPHY 0. 000000 0 0 0 0 71. 00 07000 ELECTRONCEPHALOGRAPHY 0. 000000 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 537226 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 742196 0 0 0 0 0 73. 00 07300 BRUGS CHARGED TO PATI ENTS 0. 228734 0 2, 685, 160 0 0 0 74. 00 07400 RENAL DI ALYSI S 0. 000000 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0. 000000 0 0 0 88. 01 08800 RURAL HEALTH CLINI C 0. 723424 0 88. 01 08800 RURAL HEALTH CLINI C 0. 558450 0 227, 105 0 0 90. 00 90. 01 09000 CLINI C 0. 558450 0 227, 105 0 0 90. 00 90. 02 09000 DEDERALLY QUALI FIED HEALTH CENTER 0. 000000 0 0 0 0 90. 01 09001 IMED 1. 024413 0 853 0 0 90. 01 90. 02 09000 00000 000000 000000 0							
65. 00 06500 RESPIRATORY THERAPY 0. 316968 0 233, 456 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 504822 0 539, 323 0 0 66. 00 69. 01 06901 PULMONARY 0. 000000 0 0 0 0 0 69. 01 06901 PULMONARY 0. 319315 0 21,554 0 0 69. 01 69. 02 06902 CARDI ODULMONARY 0. 319315 0 21,554 0 0 69. 01 69. 03 06903 SLEEP LAB 0. 304428 0 157,550 0 0 69. 03 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 0 0 0 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 537226 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0. 537226 0 0 0 0 0 73. 00 07300 DRIGS CHARGED TO PATIENTS 0. 742196 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0. 000000 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0. 000000 0 0 0 88. 01 08801 RURAL HEALTH CLINIC I 0. 000000 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0. 000000 90. 01 09000 LIME 0. 000000 0 0 0 90. 01 09000 LIME 0. 000000 90. 03 09000 00000 000000 0 0 0 90. 04 09000 0000000 0 0 0 90. 05 09000 0000000 0 0 90. 07 09000 0000000 0 0 90. 01 09001 MED 0. 0000000 0 0 0 90. 02 09000 00000000 0 0 0 90. 03 09000 0000000000 0 0 0 90. 04 09000 000000000000 0 0 0 90. 05 00000000000000000000000000000000				1			1
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SECTION SERVICE COST CENTERS SERVICE SERVICES				2,000,10	0	_	
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96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 0 96. 00 200. 00 201. 00 Uses PBP Clinic Lab. Services-Program 0 0 0 0 201. 00 0 201. 00 0 0 0 201. 00 0 0 0 0 0 0 0 0 0		0.400454		447.20	ol		05 00
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Health Financial Systems	MEMORIAL HOSP & HEALT	H CARE CTR		In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150115	Peri od:	Worksheet D

From 07/01/2015 Part V 06/30/2016 Date/Time Prepared: 11/28/2016 1:02 pm Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 839, 813 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 49 0 52.00 05300 ANESTHESI OLOGY 171.808 0 53 00 53 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 715, 263 54.00 56.00 05600 RADI OI SOTOPE 63, 520 56.00 60.00 06000 LABORATORY 683.737 0 60.00 06500 RESPIRATORY THERAPY 73, 998 0 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 272, 262 0 66.00 06900 ELECTROCARDI OLOGY 0 69.00 314, 845 69.00 06901 PUL MONARY 69 01 69 01 69.02 06902 CARDI OPULMONARY 6,883 0 69.02 69.03 06903 SLEEP LAB 47, 963 0 69.03 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71 00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 614, 187 73.00 07400 RENAL DIALYSIS
OUTPAȚIENT SERVICE COST CENTERS 74.00 0 74.00 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 08801 RURAL HEALTH CLINIC II 0 0 88.01 88. 01 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 0 09000 CLI NI C 90.00 126, 827 90 00 90.01 09001 I MED 874 0 90.01 09002 ONCOLOGY 799, 417 0 90. 02 90.02 09003 OUTPATIENT CENTER 39, 234 0 90.03 90.03 91.00 09100 EMERGENCY 1, 243, 704 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 312, 891 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 200.00 200. 00 Subtotal (see instructions) 7, 327, 275 0 Less PBP Clinic Lab. Services-Program 201.00 201.00

7, 327, 275

0

202.00

Only Charges

202.00

Net Charges (line 200 +/- line 201)

Heal th	Financial Systems MEMORIAL HOSP & HEAL	TH CARE CTR	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provi der CCN: 150115	Peri od:	Worksheet D-1	
			From 07/01/2015 To 06/30/2016	Date/Time Prep 11/28/2016 1:0	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		12, 580	1.00
2.00	Inpatient days (including private room days, excluding swing-be	ed and newborn days)		12, 580	2.00
3. 00	Private room days (excluding swing-bed and observation bed days do not complete this line.	i). If you have only pr	ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	l days)		10, 104	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room reporting period	n days) through Decembe	r 31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00

	reporting period	l	
18. 0	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. (
	reporting period		
19. 0	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. (
	reporting period		
20. 0	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.0
	reporting period		
21. 0	Total general inpatient routine service cost (see instructions)	9, 652, 106	21. (
22. 0	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. (
	5 x line 17)		
23. 0	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	o	23. (
	x line 18)		
24. 0	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	o	24. (
	7 x line 19)		
25. 0	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	o	25. (
	x line 20)		
26. 0	Total swing-bed cost (see instructions)	o	26. (
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9, 652, 106	27. (
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 0	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. (
29. 0		0	29. (
30. 0		ام	30.
31. 0		0. 000000	31.
32. 0	· · · · · · · · · · · · · · · · · · ·	0.00	
33. 0		0.00	
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
	Average per diem private room cost differential (line 34 x line 31)	0.00	
36. 0		0.00	36.
37. 0		9, 652, 106	
37.0	27 minus line 36)	9, 032, 100	37.
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
20.00		7/7 2/	20
38. 0		767. 26	
39. 0		3, 575, 432	
40.0	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)	0 3, 575, 432	

	ATION OF INPATIENT OPERATING COST		HEALTH CARE C	CCN: 150115	Peri od:	worksheet D-1	
					From 07/01/2015 To 06/30/2016		
				le XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Day	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	
42. 00	NURSERY (title V & XIX only)	0		0.0			42.00
	Intensive Care Type Inpatient Hospital Units						
43. 00	INTENSIVE CARE UNIT	5, 517, 877	4, 69	1, 176. 5	52 2, 802	3, 296, 609	
44. 00 45. 00	CORONARY CARE UNIT						44. 00 45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
10.00	10		2 11 222			1.00	10.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			one)		13, 756, 890 20, 628, 931	
19.00	PASS THROUGH COST ADJUSTMENTS	41 till ough 46)	(See Thistructi	UIIS)		20, 020, 931	49.00
50. 00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, sum	of Parts I and	815, 882	50.00
51. 00	Pass through costs applicable to Program inpa	atient ancillar	ry services (f	rom Wkst. D, s	sum of Parts II	639, 921	51.00
52. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)				1, 455, 803	52.00
53. 00	Total Program inpatient operating cost excluding		elated, non-ph	vsician anesth	netist, and	19, 173, 128	•
	medical education costs (line 49 minus line !					,,	
	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00	3					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)		•
58. 00	1	9	g (O	
59. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 1996,	updated and co	ompounded by the	0.00	59.00
	market basket					0.00	
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				the amount by	0.00	60.00
71.00	which operating costs (line 53) are less than					j ŭ	01.00
	amount (line 56), otherwise enter zero (see i				3		
62. 00	, , ,					0	
53. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64.00
	instructions)(title XVIII only)				(
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reporting	ງ period (See	0	65. 00
· · · · · · · ·	instructions)(title XVIII only)	+- (1:	(4 -1 1:	/E) /±: ±1 = \/\/\	L		
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (Title	64 prus rine	os)(title xvii	i oniy). For	0	66.00
67. 00	1 ,	e costs through	n December 31	of the cost re	eporting period	0	67. 00
	(line 12 x line 19)	Ü					
58. 00	Title V or XIX swing-bed NF inpatient routine	e costs after [December 31 of	the cost repo	orting period	0	68.00
60 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs i	(line 67 ± lin	ne 68)			69.00
, , . 00	PART III - SKILLED NURSING FACILITY, OTHER NU		•			0	1 37.00
70. 00	Skilled nursing facility/other nursing facili	ty/ICF/IID rou	utine service	cost (line 37)			70.00
71. 00	Adjusted general inpatient routine service co		line 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		m (line 14 v l	ine 35)			72.00
73. 00 74. 00	Total Program general inpatient routine servi						74.00
75. 00	Capital -related cost allocated to inpatient				Part II, column		75. 00
	26, line 45)						
76. 00	Per diem capital related costs (line 75 ÷ lin						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77.00
79. 00	Aggregate charges to beneficiaries for excess	,	orovi der recor	ds)			79.00
30. 00	Total Program routine service costs for compa	arison to the d		*	nus line 79)		80.00
31. 00	Inpatient routine service cost per diem limi		1)				81.0
32. 00 33. 00	Inpatient routine service cost limitation (li		* .				82. 0
33. 00 34. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		13)				84.0
	Utilization review - physician compensation		ons)				85. 0
JJ. UU	Total Program inpatient operating costs (sum						86.00
							I .
86. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS						
	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions) Adjusted general inpatient routine cost per o)	· Line 2)			2, 476 767. 26	

Health Financial Systems ME	MORIAL HOSP &	HEALTH CARE CTR	2	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 07/01/2015 To 06/30/2016	Date/Time Pre	pared.
					11/28/2016 1:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost		Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	1, 297, 312	9, 652, 106	0. 13440	7 1, 899, 736	255, 338	90.00
91.00 Nursing School cost	0	9, 652, 106	0.00000	0 1, 899, 736	0	91.00
92.00 Allied health cost	0	9, 652, 106	0.00000	0 1, 899, 736	0	92.00
93.00 All other Medical Education	0	9, 652, 106	0. 00000	1, 899, 736	0	93. 00

Health Financial Systems	MEMORIAL HOSP & HEALTH C	CARE CTR	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Pr	rovider CCN: 150115	Peri od: From 07/01/2015	Worksheet D-1
	Co	omponent CCN: 15S115		Date/Time Prepared: 11/28/2016 1:02 pm
		Title XVIII	Subprovi der -	PPS

PART A.L. RROW DER COMPONENTS 1.00			TI LIE AVIII	I PF	FF3	
NAME I - ALL PROVIDER COMPONENTS NAME		Cost Center Description			1.00	
INPATIENT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpatient days (including private room days, excluding swing-bed and nebborn days) 2,943 2,00						
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 Sella-private room days (excluding saing-bed and observation bed days) 1. 10 Ioral saing bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total saing-bed Kippe inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. 00 Total saing-bed Kippe inpatient days (including private room days) becember 31 of the cost reporting period in the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total saing-bed Kippe inpatient days (including private room days) after December 31 of the cost reporting period in the cost reporting period of the cost reporting period on the line) 9. 00 Total saing-bed Kippe inpatient days applicable to the Program (excluding private room days) 10. 00 Saing-bed SW type inpatient days applicable to the program (excluding private room days) 11. 00 Saing-bed SW type inpatient days applicable to the program (excluding private room days) 12. 00 Saing-bed SW type inpatient days applicable to the program (excluding private room days) 13. 00 Saing-bed SW type inpatient days applicable to the program (excluding private room days) 14. 00 Saing-bed SW type inpatient days applicable to the program (excluding private room days) 15. 00 Saing-bed SW type inpatient days applicable to the program (excluding private room days) 16. 00 Saing-bed SW type inpatient days applicable to the program (excluding private room days) 17. 00 Saing-bed SW type inpatient days applicable to the program (excluding private room days) 18. 00 Saing-bed SW type inpatient days applicable to the program (excluding private room days) 18. 00 Saing-bed SW type inpatient days applicable to the program (excluding private room days) 18. 00 Saing-bed SW type inpatient days applicable to the program (excluding private room days) 18. 00 Saing-bed SW type inpatient days applicable to the program (exc				vata raam dava		
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report in period of the cost report in period (if callendar year, enter 0 on this line) 7.00 Total swing-bed SRF type inpatient days (including private room days) after December 31 of the cost 0 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost 0 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 0 8.00 reporting period (if callendar year, enter 0 on this line) 10.00 Sing-bed SRF type inpatient days (including private room days) after December 31 of the cost 1 0.00 Sing-bed SRF type inpatient days applicable to the Program (excluding grivate room days) 10.00 Sing-bed SRF type inpatient days applicable to the Program (excluding private room days) 11.00 Sing-bed SRF type inpatient days applicable to the Program (excluding private room days) after 0 1.00 through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SRF type inpatient days applicable to title SV or XIX only (including private room days) after 0 1.00 through December 31 of the cost reporting period (see instructions) 13.00 Swing-bed SRF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically increasing private room days) 15.00 SRF type bed MF type inpatient days applicable to titles V or XIX only (including private room days) 16.00 SRF type bed NF type inpatient days applicable to titles V or XIX only (including private room days) 17.00 Medically increasing private room days applicable to titles V or XIX only (including private room days) 18.00 Medically increasing private room days applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Medical processory private room days applicable to services after December 31 of the cost reporting period (including private room days) 18.00 Medical processory private room days applicable to services after December 31 of the cost reporting period (line 6 x x line 3) 18.00 Med	4.00		days)		2, 943	4. 00
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x line 18) 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	23. 00	1	of the cost reporting	period (line 6	0	23. 00
7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 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 Ceneral 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) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 925, 404) Private room cost differential adjustment (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) 37. 00 Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem		x line 18)				
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) 0 26.00 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 3, 925, 404 27.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00 29.00 Pri vate room charges (excluding swing-bed charges) 0 29.00 30.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 32.00 Average private room per diem charge (line 29 ÷ line 3) 0.00 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 0.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 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 3, 925, 404) 27 minus line 36) 0.00 38.00 Agusted general inpatient routine service cost per diem (see instructions) 1, 333.81 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 2, 202, 120 39.00 40.00 Medically necessary private room cost diplicable to the Program (line 14 x line 35) 0 40.00	24. 00] 31	31 of the cost reportin	ng period (line	0	24. 00
x line 20) 26. 00 Total swing-bed cost (see instructions) Ceneral 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) Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 30 ÷ line 4) Ceneral inpatient routine service cost differential (line 30 ÷ line 4) Ceneral inpatient routine service cost differential (line 32 minus line 33)(see instructions) Ceneral inpatient routine service cost differential (line 34 x line 31) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 925, 404) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 925, 404) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 925, 404) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 925, 404) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem charges Ceneral inpatient routine	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) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + line 28) 30. 00 32. 00 Average private room per diem charge (line 29 + line 3) Average per diem private room per diem charge (line 30 + line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34. 00 Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 3 x line 35) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37, 925, 404) Adjusted general inpatient routine service cost per diem (see instructions) 1, 333.81 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Q. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) O 40. 00		x line 20)			-	
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28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) O 29. 00 Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + line 28) Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) O 0 0 35. 00 Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 925, 404) The procedure of the private room cost differential (line 3, 925, 404) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) O 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) O 28. 00 O 29. 00 O 30. 00 O 30. 00 O 0 31. 00 O 0 32. 00 O 0 32. 00 O 0 32. 00 O 0 32. 00 O 0 0 33. 00 O 0 0 34. 00 O 0 0 35. 00 O 0 0 36. 00 O 0 0 36. 00 O 0 0 36. 00 O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27.00		ne 21 minus iine 26)		3, 925, 404	27.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 925, 404) 37.00 PART II - HOSPITAL AND 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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) 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, 925, 404) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.0000000000000000000000000000000000						
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Average semi-private room per diem charge (line 30 ÷ line 4) 3.00 3.00 3.00 3.00 3.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 3.00 Average per diem private room cost differential (line 34 x line 31) 3.00 Average per diem private room cost differential (line 3 x line 35) 3.00 Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 925, 404) 2.7 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 3.8.00 3.9.00 Adjusted general inpatient routine service cost (line 9 x line 38) 4.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 3		,	THE 20)			
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, 925, 404) 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 (line 9 x line 38) 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, , , , , , , , , , , , , , , , , , , ,				
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, 925, 404 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 333.81 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 40.00		, , ,	, ,	tions)		
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37. 00 37. 00 37. 00 37. 00 37. 00 37. 00 37. 00 37. 00 38. 00 40. 00		,	31)			
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) 1, 333.81 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 2, 202, 120 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			l private room cost dif	fferential (line	-	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,333.81 38.00 Program general inpatient routine service cost (line 9 x line 38) 2,202,120 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) 1,333.81 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 2,202,120 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			MENTS			
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, 202, 120 39.00 40.00	38. 00				1. 333. 81	38. 00
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 2,202,120 41.00		, , , , , , , , , , , , , , , , , , , ,	,			
	41.00	lotal Program general inpatient routine service cost (line 39 +	iine 40)		2, 202, 120	41.00

	<u> </u>	MORIAL HOSP & F				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 150115	Peri od: From 07/01/2015	Worksheet D-1	
			Componen	t CCN: 15S115			
-			Ti t	le XVIII	Subprovi der -	PPS	OZ PIII
	Cost Center Description	Total	Total	Average Pei	Program Days	Program Cost	
	odst deliter beschiption	Inpatient Cost		sDiem (col. 1		(col. 3 x col.	
		1.00	2. 00	3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0			00 0		42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	<u> </u>	0 0.	00 0	l 0	43.00
44. 00	CORONARY CARE UNIT	0	,	0.		Ĭ	44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	3, line 200)			222, 710	48. 00
49. 00				ons)		2, 424, 830	49. 00
50. 00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, su	m of Parts I and	239, 593	50. 00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	9, 797	51. 00
52. 00	Total Program excludable cost (sum of lines 5					249, 390	1
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5		elated, non-ph	ysician anest	hetist, and	2, 175, 440	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
54. 00 55. 00	Program discharges Target amount per discharge					0 00	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)					0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and ta	arget amount (line 56 minus	line 53)	0	57. 00 58. 00
59. 00	, , , , , , , , , , , , , , , , , , , ,	porting period	endi ng 1996,	updated and c	ompounded by the	-	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year of	rost report ur	ndated by the	market hasket		0.00	60, 00
61. 00	If line 53/54 is less than the lower of lines	s 55, 59 or 60	enter the les	ser of 50% of	the amount by	0.00	1
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% o	f the target		
62. 00	Relief payment (see instructions)						62. 00
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ıctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	ember 31 of th	e cost report	ing period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost</pre>	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line	64 plus line	65)(TITIE XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31	of the cost r	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient r					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili)		70. 00
71.00	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applications)		ı (line 14 x l	ine 35)			72. 00 73. 00
74.00	Total Program general inpatient routine servi	•		•	David III. aaliima		74.00
75. 00	Capital-related cost allocated to inpatient r 26, line 45)	routine service	e costs (from	worksneet B,	Part II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ lir Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00							78.00
79. 00	Aggregate charges to beneficiaries for excess				nuo lino 70)		79.00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		ost iiiii tätlö	II (IIII) II	iius IIIle /9)		80. 00 81. 00
82.00	Inpatient routine service cost limitation (li		* .				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins		15)				83. 00 84. 00
85. 00	Utilization review - physician compensation ((see instructio					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		nrough 85)				86. 00
87. 00	Total observation bed days (see instructions))				0	1
88. 00 89. 00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see		,				88. 00 89. 00
	(300						,

Health Financial Systems ME	MORIAL HOSP &	HEALTH CARE CTF	₹	In Lie	eu of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component	CCN: 15S115	From 07/01/2015 To 06/30/2016		
		Ti tl	e XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	427, 084	3, 925, 404	0. 10880	0 0	0	90.00
91.00 Nursing School cost	C	3, 925, 404	0.00000	0	0	91. 00
92.00 Allied health cost	C	3, 925, 404	0.00000	0	0	92.00
93.00 All other Medical Education	c	3, 925, 404	0. 00000	0 0	0	93. 00

Health Financial Systems	MEMORIAL HOSP & HEALTH	CARE CTR	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	P	Provi der CCN: 150115	Peri od: From 07/01/2015	Worksheet D-1
	C	Component CCN: 15T115		Date/Time Prepared: 11/28/2016 1:02 pm
		Title XVIII	Subprovi der -	PPS

		II the Aviii	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			1, 507	1. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		vata room days	1, 507 0	2. 00 3. 00
3.00	do not complete this line.	i. IT you have only pri	vate room days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		1, 507	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December '	R1 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becomber t	or the cost	· ·	0.00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room of	Mays) after December 2	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	lays) al tel December 3	i oi the cost	O	8.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	937	9. 00
10.00	newborn days)	. (i notudi na naivoto a	nom daya)	0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction)		Joili days)	U	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	(including private ro	oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, ent				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar yea			_	
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed of	days)	0	
16. 00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 of	f the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 31 of i	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
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00
20.00	reporting period	arter becomber or or tr	10 0031	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)			1, 527, 175	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 line 17)	31 of the cost reporti	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 3	of the cost reporting	period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1 = 19$	31 of the cost reportin	ng period (line	0	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 27. 00	Total swing-bed cost (see instructions)	no 21 minus Lino 24)		0 1, 527, 175	
27.00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	THE 21 HILLIUS TITLE 20)		1, 527, 175	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	ino 20)		0. 000000	30.00
31. 00 32. 00	Average private room per diem charge (line 29 ÷ line 3)	THE 20)		0.00000	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 minus	s line 33)(see instruct	tions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x line	31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost an	d nrivate room cost did	fforential (line	0 1, 527, 175	36. 00 37. 00
37.00	27 minus line 36)	a private room cost dri	referrial (TIME	1, 027, 175	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		<u>'</u>		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			1 010 00	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see in Program general inpatient routine service cost (line 9 x line 3)			1, 013. 39 949, 546	
40. 00	Medically necessary private room cost applicable to the Program			949, 540	40.00
	Total Program general inpatient routine service cost (line 39 +			949, 546	

	Financial Systems ME ATION OF INPATIENT OPERATING COST	MORIAL HOSP & H	Provi der	CCN: 150115	Peri od:	worksheet D-1	
			Component	t CCN: 15T115	From 07/01/2015 To 06/30/2016	Date/Time Pre	
			Ti tl	e XVIII	Subprovi der -	11/28/2016 1: PPS	02 pm
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	·	Inpatient Cost	Inpatient Days	Diem (col. 1 col. 2)		(col. 3 x col.	
		1. 00	2.00	3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.	00 0	0	42. 00
43. 00	INTENSIVE CARE UNIT	0	C	0. (00 0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
						1. 00	
48. 00 49. 00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines			ons)		460, 212 1, 409, 758	
	PASS THROUGH COST ADJUSTMENTS	<u> </u>					1
50. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sur	n of Parts I and	131, 574	50.00
51. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	31, 996	51.00
52. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)				163, 570	52.00
53. 00	Total Program inpatient operating cost exclude	ding capital re	lated, non-phy	sician anestl	netist, and	1, 246, 188	53. 00
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	02)					1
	Program discharges Target amount per discharge					0	
56. 00	Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00 58. 00	, , , , , , , , , , , , , , , , , , , ,	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	
59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, ι	pdated and co	ompounded by the		59.00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year of	cost report un	dated by the m	arkat haskat		0.00	60.00
61. 00	If line 53/54 is less than the lower of lines	s 55, 59 or 60	enter the less	er of 50% of		0.00	
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see it		s (lines 54 x	60), or 1% of	f the target		
62. 00	Relief payment (see instructions)	·					62. 00
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of the c	ost reporting	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 nlus line 6	5)(title XVII	II only) For	0	66. 00
	CAH (see instructions)	·		, ,	3,		
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 c	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient (routine costs (line 67 + line	: 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU	IRSING FACILITY	AND ICF/IID	ONLY	<u> </u>		
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	•)		70. 00 71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	•	(line 14 v li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine servi	ce costs (line	72 + line 73)				74.00
75. 00	Capital-related cost allocated to inpatient (26, line 45)	routine service	costs (from W	lorksheet B, I	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus	•					77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess	s costs (from p			753		79. 00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		ost limitation	ı (Iıne 78 mii	nus line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (li	ne 9 x line 81	•				82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		S)				83. 00 84. 00
85. 00	Utilization review - physician compensation	(see instructio					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rougn 85)				86.00
						0	87. 00
87. 00	Adjusted general inpatient routine cost per o		line 2)				88.00

Health Financial Systems ME	MORIAL HOSP &	HEALTH	H CARE CTF	₹	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der		Peri od:	Worksheet D-1	
			Component		From 07/01/2015 To 06/30/2016	Date/Time Pre 11/28/2016 1:	
			Ti tl	e XVIII	Subprovi der -	PPS	
					I RF		
Cost Center Description	Cost	Rout	ine Cost	column 1 ÷	Total	Observation	
		(from	line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
	1.00		2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST						
90.00 Capital -related cost	211, 61	8	1, 527, 175	0. 1385 <i>6</i>	0 8	0	90.00
91.00 Nursing School cost		0	1, 527, 175	0. 00000	0 0	0	91. 00
92.00 Allied health cost		0	1, 527, 175	0.00000	0 0	0	92.00
93.00 All other Medical Education		o	1, 527, 175	0.00000	00 0	0	93. 00

Health Financial Systems	MEMORIAL HOSP & HEALTH	H CARE CTR	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150115	Peri od: From 07/01/2015	Worksheet D-1
		Component CCN: 155305		Date/Time Prepared: 11/28/2016 1:02 pm
		Title XVIII	Skilled Nursing	PPS

		II the Aviii	Facility	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			5, 016	
2.00	Inpatient days (including private room days, excluding swing-bed Private room days (excluding swing-bed and observation bed days)			5, 016	2.00
3. 00	do not complete this line.	i. II you have only pr	ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		5, 016	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becomber	or or the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room o	days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room o	lave) after December 2	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	lays) al tel Decembel 3	i or the cost	O	8.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	4, 074	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only	, (i noludi na privoto r	nom dave)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruction		Joili days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	(including private r	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, ento Swing-bed NF type inpatient days applicable to titles V or XIX of		o room dove)	0	12. 00
12.00	through December 31 of the cost reporting period	only (frictualing privati	e room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX of			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year			0	14. 00
15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed	uays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT		6 11	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 o	r the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	-brough Docombon 21 of	the cost	0.00	10.00
19.00	reporting period	Through becember 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services a	after December 31 of t	he cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			2, 645, 199	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
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December :	31 of the cost reporti	ng period (line	0	24. 00
25 00	7 x line 19)	-£ +L++!		0	25 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 (II	ne 21 minus line 26)		2, 645, 199	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed a	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		9/	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 ÷ 1	i ne 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 minus		tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line	31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and	I private room cost di	fferential (line	0 2, 645, 199	36. 00 37. 00
37.00	27 minus line 36)	a private room cost di	ricientiai (iine	2, 040, 199	37.00
	PART II - HOSPITÁL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST				20.00
38. 00	Adjusted general inpatient routine service cost per diem (see in				38.00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 3: Medically necessary private room cost applicable to the Program				39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 +	•			41. 00
		•	'		•

0 .	ATION OF INPATIENT OPERATING COST		Trovider	CCN: 150115	Peri od: From 07/01/2015	Worksheet D-1	I
			Component	CCN: 155305			
			Ti tl	e XVIII	Skilled Nursing Facility		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units					l	4
00	INTENSIVE CARE UNIT						4
00	CORONARY CARE UNIT						4
00	BURN INTENSIVE CARE UNIT						4
00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						4
<i>.</i>	Cost Center Description						+
	·					1. 00	
00	Program inpatient ancillary service cost (Wk			`			4
00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ns)		l	4
00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sun	n of Parts I and		5
	III)			,			
00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II		5
00	and IV) Total Program excludable cost (sum of lines	50 and 51)					5
00	Total Program inpatient operating cost exclu		lated, non-phy	sician anesth	netist, and		5
	medical education costs (line 49 minus line		1				_ ا
20	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						- 5
00	Target amount per discharge						5
00	Target amount (line 54 x line 55)						5
00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus	line 53)		5
00	Bonus payment (see instructions)						5
00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996, u	pdated and co	ompounded by the		5
00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	arket basket			6
00	If line 53/54 is less than the lower of line						6
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% of	the target		
00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)					6
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)				6
	PROGRAM INPATIENT ROUTINE SWING BED COST						
00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See		6
00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reportino	period (See		6
	instructions)(title XVIII only)				, p (-
00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	I only). For		6
$\cap \cap$	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	f the cost re	norting period		6
00	(line 12 x line 19)	o costs till ough	December of e	1 110 0031 10	ppor tring period		~
00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	orting period		6
00	(line 13 x line 20)	routing costs (line 67 : lima	68)			6
50	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N						۱ ۵
00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	tine service c	ost (line 37)		2, 645, 199	
00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)		527. 35	
00	Program routine service cost (line 9 x line Medically necessary private room cost applic	•	(line 14 x li	ne 35)		2, 148, 424 0	
00	Total Program general inpatient routine serv		•	110 00)		2, 148, 424	
00	Capital-related cost allocated to inpatient			orksheet B, F	Part II, column	0	
00	26, line 45)	no 2)				0.00	, ,
00 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	,				0.00	
	Inpatient routine service cost (line 74 minu						7 7
00	Aggregate charges to beneficiaries for exces	s costs (from p				0	7 0
00	Total Program routine service costs for comp		ost limitation	(line 78 mir	nus line 79)	0	
00 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)			0.00	
00	Reasonable inpatient routine service costs (•			2, 148, 424	
00	Program inpatient ancillary services (see in					1, 212, 412	
00	Utilization review - physician compensation					0	
00	Total Program inpatient operating costs (sum		rough 85)			3, 360, 836	기 8
	PART IV - COMPUTATION OF OBSERVATION BED PASTOTAL observation bed days (see instructions					0	8 (0
00	LIOTAL ODSELVATION DEG DAVS ISEE INSTITUTIONS	.)					

Health Financial Systems ME	MORIAL HOSP &	HEALTH	H CARE CTR	2	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der		Peri od:	Worksheet D-1	
			Component		From 07/01/2015 To 06/30/2016		
			Ti tl	e XVIII	Skilled Nursing	PPS	
					Facility		
Cost Center Description	Cost		ine Cost	column 1 ÷	Total	Observation	
		(from	line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
	1.00		2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST						
90.00 Capital -related cost	(0	0	0.00000	0 0	0	90.00
91.00 Nursing School cost		0	0	0. 00000	0	0	91.00
92.00 Allied health cost		ol	o	0. 00000	0 0	0	92.00
93.00 All other Medical Education		0	o	0. 00000	0 0	0	93. 00

Health Financial Systems	S	MEMORIAL HOSP & HEALT	H CARE CTE	2	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SER				CCN: 150115	Peri od:	Worksheet D-3	
					From 07/01/2015 To 06/30/2016	Date/Time Pre	narod:
					10 00/30/2010	11/28/2016 1:	Dareu. D2 pm
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Center	Description			Ratio of Cos		I npati ent	
				To Charges	Program	Program Costs	
					Charges	(col. 1 x col.	
				4.00	0.00	2)	
LNDATLENT DOUTLNE	CEDVICE COST CENTERS			1. 00	2. 00	3. 00	
30. 00 03000 ADULTS & PE	E SERVICE COST CENTERS				5, 144, 500		30. 00
31. 00 03100 NTENSI VE 0					4, 138, 000		31. 00
40. 00 04000 SUBPROVI DER					4, 130, 000		40. 00
41. 00 04100 SUBPROVI DER					0		41. 00
43. 00 04300 NURSERY							43. 00
ANCI LLARY SERVI CE	COST CENTERS						10.00
50. 00 05000 OPERATING R				0. 26340	1 4, 314, 852	1, 136, 536	50. 00
52. 00 05200 DELIVERY RC	OM & LABOR ROOM			0. 69244		0	52. 00
53. 00 05300 ANESTHESI OL	_OGY			0. 67357	9 264, 357	178, 065	53.00
54. 00 05400 RADI OLOGY-D	I AGNOSTI C			0. 13196	3, 106, 759	409, 971	54.00
56. 00 05600 RADI 0I SOTOF	Έ			0. 12466	276, 062	34, 414	56.00
60. 00 06000 LABORATORY				0. 25808	3, 764, 653	971, 589	60.00
65. 00 06500 RESPI RATORY				0. 31696	8 1, 359, 259	430, 842	65.00
66. 00 06600 PHYSI CAL TH				0. 50482		619, 118	66. 00
69. 00 06900 ELECTROCARD	I OLOGY			0. 19133		826, 773	69. 00
69. 01 06901 PULMONARY				0. 00000		0	69. 01
69. 02 06902 CARDI OPULMO	NARY			0. 31931		79	69. 02
69. 03 06903 SLEEP LAB				0. 30442		764	69. 03
70. 00 07000 ELECTROENCE		_		0. 00000		0	70. 00
	PPLIES CHARGED TO PATIENT	S		0. 53722		1, 073, 155	71. 00
	CHARGED TO PATIENTS			0. 74219		3, 908, 081	72.00
73. 00 07300 DRUGS CHARG				0. 22873		2, 845, 746	73.00
74. 00 07400 RENAL DI ALY				0. 00000	0	0	74. 00
0UTPATIENT SERVIO				0.00000		0	00 00
88. 00 08800 RURAL HEALT 88. 01 08801 RURAL HEALT				0. 00000 0. 00000		0	88. 00 88. 01
	QUALIFIED HEALTH CENTER			0.00000		0	89. 00
90. 00 08900 FEDERALLY C	CALITIED HEALTH CENTER			0. 55845		455	90.00
90. 01 09000 ELTRI C				1. 02441		455	90.00
90. 01 09001 TWLD				1.02441		0 000	90.01

0. 791170

0. 304581

0.686003

0.000000

2, 299, 394

41, 548, 311

41, 548, 311

900, 459

90.02

90. 03

91.00

92.00

95.00

201. 00 202. 00

3, 232

700, 352

617, 718

0

0 96.00

13, 756, 890 200. 00

90. 02 | 09002 | 0NCOLOGY 90. 03 | 09003 | OUTPATIENT CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART)

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)

OTHER REIMBURSABLE COST CENTERS
09500 AMBULANCE SERVICES

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

09100 EMERGENCY

91.00

92.00

95.00

200.00

201. 00 202. 00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150115	Peri od: From 07/01/2015	Worksheet D-3	3
	Component	CCN: 15S115		Date/Time Pre 11/28/2016 1:	
	Ti tl	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description		Ratio of Cos To Charges	st Inpatient Program	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
. 00 03000 ADULTS & PEDIATRICS			0		30.
. 00 03100 INTENSIVE CARE UNIT			0		31.
. 00 04000 SUBPROVI DER - 1 PF			1, 894, 500		40.
. 00 04100 SUBPROVI DER - 1 RF . 00 04300 NURSERY			0		41.
ANCI LLARY SERVI CE COST CENTERS					43
. 00 O5000 OPERATING ROOM		0. 2634	01 0	0	50
. OO O5200 DELI VERY ROOM & LABOR ROOM		0. 6924		0	
. 00 05300 ANESTHESI OLOGY		0. 6735		0	
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1319		10, 039	
. 00 05600 RADI OI SOTOPE		0. 1246		0	
. 00 06000 LABORATORY		0. 2580	82 206, 067	53, 182	60
. 00 06500 RESPI RATORY THERAPY		0. 3169	68 15, 769	4, 998	65
. 00 06600 PHYSI CAL THERAPY		0. 5048	22 24, 012	12, 122	66
. 00 06900 ELECTROCARDI OLOGY		0. 1913		3, 154	69
. 01 06901 PULMONARY		0.0000		0	
. 02 06902 CARDI OPULMONARY		0. 3193		0	
. 03 06903 SLEEP LAB		0. 3044		0	
. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5372		3, 020	
.00 07200 IMPL. DEV. CHARGED TO PATIENTS .00 07300 DRUGS CHARGED TO PATIENTS		0. 7421		0, 050	
. 00 07300 DRUGS CHARGED TO PATIENTS . 00 07400 RENAL DIALYSIS		0. 2287 0. 0000		86, 858 0	
OUTPATIENT SERVICE COST CENTERS		0.0000	00 0		/ 4
. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88
.01 08801 RURAL HEALTH CLINIC II		0.0000		0	
.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	00	0	89
. 00 09000 CLI NI C		0. 5584	50 0	0	90
. 01 09001 I MED		1. 0244	13 0	0	90
. 02 09002 0NC0L0GY		0. 4558		0	
. 03 09003 OUTPATI ENT CENTER		0. 7911		0	
. 00 09100 EMERGENCY		0. 3045		49, 100	
. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)		0. 6860	03 345	237	92
OTHER REIMBURSABLE COST CENTERS		1			٠
. 00 09500 AMBULANCE SERVI CES		0.0000			95
. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 0000		0	
0.00 Total (sum of lines 50-94 and 96-98)	haraas (lina (1)		885, 312	222, 710	
1.00 Less PBP Clinic Laboratory Services-Program only c	narues (Tine 61)	I .	1 01		201

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150115	Peri od: From 07/01/2015	Worksheet D-3	3
	Component	t CCN: 15T115		Date/Time Pre 11/28/2016 1:	
	Ti tI	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	,	Ratio of Cos	t Inpatient	Inpatient	
		To Charges		Program Costs (col. 1 x col.	
			chai ges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00 03000 ADULTS & PEDIATRICS			0		30.
. 00 03100 INTENSIVE CARE UNIT			0		31.
0. 00 04000 SUBPROVI DER - I PF			0		40
. 00 04100 SUBPROVI DER - I RF			983, 220		41.
B. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43
0. 00 05000 0PERATING ROOM		0. 2634	01 1, 700	448	50
2. OO O5200 DELIVERY ROOM & LABOR ROOM		0. 2034		0	1
B. 00 05300 ANESTHESI OLOGY		0. 6735		10	
1. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1319		3, 200	
5. 00 05600 RADI OI SOTOPE		0. 1246		0, 200	
0. 00 06000 LABORATORY		0. 2580		17, 545	
5. 00 06500 RESPIRATORY THERAPY		0. 3169	68 25, 405	8, 053	65
0. 00 06600 PHYSI CAL THERAPY		0. 5048	22 683, 982	345, 289	66
0. 00 06900 ELECTROCARDI OLOGY		0. 1913		508	
0. 01 06901 PULMONARY		0.0000		0	
2. 02 06902 CARDI OPULMONARY		0. 3193		0	1
0. 03 06903 SLEEP LAB		0. 3044		0	
0. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2.00 07200 MPL. DEV. CHARGED TO PATIENTS		0. 5372 0. 7421		8, 396 278	
B. 00 07300 DRUGS CHARGED TO PATIENTS		0. 7421		69, 207	
1. 00 07400 RENAL DI ALYSI S		0.0000		07, 207	
OUTPATIENT SERVICE COST CENTERS		0.0000	00 0		1 ′ ′
8. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88
B. 01 08801 RURAL HEALTH CLINIC II		0.0000	00	0	88
0.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	00	0	89
0. 00 09000 CLI NI C		0. 5584		0	
0. 01 09001 I MED		1. 0244		0	
0. 02 09002 0NCOLOGY		0. 4558		0	
0. 03 09003 OUTPATI ENT CENTER		0. 7911		0	
. 00 09100 EMERGENCY		0. 3045		0	
2. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6860	03 10, 609	7, 278	92
OTHER REIMBURSABLE COST CENTERS		1			95
5. 00 09500 AMBULANCE SERVI CES 5. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0.0000	00	0	
0.00 Total (sum of lines 50-94 and 96-98)		0.0000	1, 135, 168	460, 212	
11.00 Less PBP Clinic Laboratory Services-Program only cl	narges (line 61)		1, 133, 100	400, 212	200
Net Charges (line 200 minus line 201)	.a. gos (11110 01)	1	1, 135, 168		202

I NPATI	Financial Systems MEMORIAL HOSI ENT ANCILLARY SERVICE COST APPORTIONMENT	P & HEALTH CARE CT Provi der	CCN: 150115	Peri od:	u of Form CMS-2 Worksheet D-3	
		Componen	t CCN: 155305	From 07/01/2015 To 06/30/2016	Date/Time Pre	
		Ti tl	e XVIII	Skilled Nursing Facility	PPS	<u> </u>
	Cost Center Description		Ratio of Cos To Charges	Inpatient Program Charges	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		30.0
1. 00	03100 NTENSI VE CARE UNI T			0		31. (
0.00	04000 SUBPROVI DER - I PF			0		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. 26340	01 0	0	50.
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 6924	42 0	0	52.
3. 00	05300 ANESTHESI OLOGY		0. 6735		0	1
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1319		2, 419	
5. 00	05600 RADI OI SOTOPE		0. 1246		0	56.
0.00	06000 LABORATORY		0. 2580		86, 383	
5. 00	06500 RESPI RATORY THERAPY		0. 3169		36, 462	65.
6. 00	06600 PHYSI CAL THERAPY		0. 50482	22 1, 114, 668	562, 709	66.
9. 00	06900 ELECTROCARDI OLOGY		0. 1849		1, 037	
9. 01	06901 PULMONARY		0.0000		0	69.
9. 02	06902 CARDI OPULMONARY		0. 3193 ⁻	15 0	0	69.
9. 03	06903 SLEEP LAB		0. 30442	28 0	0	69.
0.00	07000 ELECTROENCEPHALOGRAPHY		0. 00000	00 0	0	70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5372		37, 884	71.
2. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 74219		0	1
3. 00	07300 DRUGS CHARGED TO PATIENTS		0. 2287:	1, 962, 621	448, 918	73.
4. 00	07400 RENAL DIALYSIS		0.00000	00 0	0	74.
	OUTPATIENT SERVICE COST CENTERS		•	<u>.</u>		
8. 00	08800 RURAL HEALTH CLINIC	<u> </u>	0.0000	00	0	88.
8. 01	08801 RURAL HEALTH CLINIC II		0. 00000	00	0	88.
9. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000	00	0	89.
0. 00	09000 CLI NI C		0. 5584	50 0	0	90.
0. 01	09001 I MED		1. 0244	13 0	0	90.
0. 02	09002 ONCOLOGY		0. 4558	49 0	0	1
0. 03	09003 OUTPATIENT CENTER		0. 7911	70 0	0	90.
1. 00	09100 EMERGENCY		0. 30432		0	91.
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 68600	03 53, 353	36, 600	92.
	OTHER REIMBURSABLE COST CENTERS					
5. 00	09500 AMBULANCE SERVI CES					95.
16 OO	09600 DURABLE MEDICAL FOULP-RENTED		0.0000	nol o	l o	96

3, 674, 841

3, 674, 841

96.00

202.00

1, 212, 412 200. 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)

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTF			eu of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONM	ENT Provi der		Peri od:	Worksheet D-3	
			From 07/01/2015 To 06/30/2016	Date/Time Pre	nared:
			10 00/30/2010	11/28/2016 1:	
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	r r r r r	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTER	S S		0 500 070		
30. 00 03000 ADULTS & PEDI ATRI CS			2, 599, 372		30.00
31. 00 03100 I NTENSI VE CARE UNI T			650, 115		31.00
40. 00 04000 SUBPROVI DER - I PF			944, 740		40.00
41. 00 04100 SUBPROVI DER - RF 43. 00 04300 NURSERY			0		41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43. 00
50. 00 05000 OPERATING ROOM		0. 26340	740, 929	195, 161	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 20340		193, 101	1
53. 00 05300 ANESTHESI OLOGY		0. 67357		1	
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 13196			
56. 00 05600 RADI OI SOTOPE		0. 12466		1	1
60. 00 06000 LABORATORY		0. 25808			
65. 00 06500 RESPIRATORY THERAPY		0. 31696		96, 974	
66. 00 06600 PHYSI CAL THERAPY		0. 50482		1	
69. 00 06900 ELECTROCARDI OLOGY		0. 18499			1
69. 01 06901 PULMONARY		0.00000		0	1
69. 02 06902 CARDI OPULMONARY		0. 31931		0	69. 02
69. 03 06903 SLEEP LAB		0. 30442	28	0	69. 03
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 00000	00	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	I ENTS	0. 53722	26 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 74219	06	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 22873	2, 412, 937	551, 921	73. 00
74. 00 07400 RENAL DIALYSIS		0. 00000	00	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0. 72342		0	88. 00
88.01 08801 RURAL HEALTH CLINIC II		0. 00000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENT	ER	0. 00000		0	89. 00
90. 00 09000 CLI NI C		0. 55845		1	
90. 01 09001 I MED		1. 02441		0	
90. 02 09002 0NC0L0GY		0. 45584		3, 467	
90. 03 09003 OUTPATIENT CENTER		0. 79117		0	
91 00 09100 EMERGENCY		0.30433	742 794	226 049	91 00

0.304323

0.686003

0.000000

226, 049

0 96.00

1, 903, 759 200. 00 201. 00 202. 00

91.00

92.00

95.00

742, 794

6, 846, 051

6, 846, 051

09100 EMERGENCY

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

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)

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

91.00

92.00

95.00

200.00

201. 00 202. 00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150115	Peri od:	Worksheet D-3	3
	Componen	t CCN: 15S115	From 07/01/2015 To 06/30/2016		
	Ti t	le XIX	Subprovider -	11/28/2016 1: Cost	U2 pm
Coot Conton Docomintion		Ratio of Cos	IPF st Inpatient	Innationt	
Cost Center Description		To Charges		Inpatient Program Costs	
		'' '' ''	Charges	(col. 1 x col.	
			,	2)	
INDATI ENT. DOUTING CEDIU OF COCT CENTERS		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 NTENSI VE CARE UNI T			0		31.00
40. 00 04000 SUBPROVI DER - 1 PF			473, 343		40.00
41. 00 04100 SUBPROVI DER - I RF			0		41. 00
43. 00 04300 NURSERY			0		43. 00
ANCILLARY SERVICE COST CENTERS		•	<u>'</u>		
50.00 05000 OPERATING ROOM		0. 2634	01 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 6924	42 0	0	52. 00
53. 00 05300 ANESTHESI OLOGY		0. 6735		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1319		91	
56. 00 05600 RADI 0I SOTOPE		0. 1246		0	
50. 00 06000 LABORATORY		0. 2580		27, 690	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0. 3169 0. 5048	· ·	1, 633	1
69. 00 06000 PHYSI CAL THERAPY		0. 5048		0 1, 026	
69. 01 06901 PULMONARY		0.0000		1,020	
69. 02 06902 CARDI OPULMONARY		0. 3193		ő	
69. 03 06903 SLEEP LAB		0. 3044		0	
70.00 07000 ELECTROENCEPHALOGRAPHY		0.0000	00 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5372	26 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 7421		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2287	· ·	17, 898	
74. 00 07400 RENAL DIALYSIS		0.0000	00 0	0	74. 00
OUTPATIENT SERVICE COST CENTERS		0.7004	24	0	00.00
38.00 08800 RURAL HEALTH CLINIC 38.01 08801 RURAL HEALTH CLINIC II		0. 7234 0. 0000		0	
39. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
90. 00 09000 CLINI C		0. 5584		0	
90. 01 09001 I MED		1. 0244		Ö	1
90. 02 09002 0NCOLOGY		0. 4558		Ö	
90. 03 09003 OUTPATIENT CENTER		0. 7911		0	90. 03
91. 00 09100 EMERGENCY		0. 3043	23 141, 564	43, 081	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6860	03 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES		0.0000	00	_	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.0000		01 410	
Total (sum of lines 50-94 and 96-98) Less PBP Clinic Laboratory Services-Program only	charges (line 41)		338, 496	91, 419	200. 00 201. 00
201.00 Less PBP CITILIC Laboratory services-Program only	charges (Title 61)	1	1		1201.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150115	Peri od:	Worksheet D-3	3
	Componen	t CCN: 15T115	From 07/01/2015 To 06/30/2016	Date/Time Pre 11/28/2016 1:	
	Ti t	le XIX	Subprovi der - I RF	Cost	02 pii
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		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	
D. 00 03000 ADULTS & PEDIATRICS			0		30.
1.00 03100 INTENSIVE CARE UNIT			0		31.
D. 00 04000 SUBPROVI DER - 1 PF			0		40.
1. 00 04100 SUBPROVI DER - I RF			98, 553		41. (
3. 00 04300 NURSERY			0		43.
ANCILLARY SERVICE COST CENTERS			1		١
D. 00 05000 OPERATI NG ROOM		0. 2634		0	1
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 6924		0	
3. 00 05300 ANESTHESI 0LOGY 4. 00 05400 RADI 0LOGY-DI AGNOSTI C		0. 6735 0. 1319		0 690	
6. 00 05600 RADI OI SOTOPE		0. 1319	· ·	090	
0. 00 06000 LABORATORY		0. 1240		1, 181	
5. 00 06500 RESPI RATORY THERAPY		0. 3169	· ·	2, 631	
6. 00 06600 PHYSI CAL THERAPY		0. 5048	· ·	30, 760	
9. 00 06900 ELECTROCARDI OLOGY		0. 1849	94 426	79	69.
9. 01 06901 PULMONARY		0.0000	00 0	0	69.
9. 02 06902 CARDI OPULMONARY		0. 3193		0	
9. 03 06903 SLEEP LAB		0. 3044		0	
D. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	1
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5372		0	
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 7421 0. 2287		5, 979	
4. 00 07400 RENAL DI ALYSI S		0. 2287	· ·	0, 4/4	
OUTPATIENT SERVICE COST CENTERS		0.0000	00 0	0	1 ′ ′′
B. 00 08800 RURAL HEALTH CLINIC		0. 7234	24 0	0	88.
3.01 08801 RURAL HEALTH CLINIC II		0.0000	00 0	0	88.
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	00 0	0	89.
D. 00 09000 CLI NI C		0. 5584	·	2, 074	
D. 01 09001 I MED		1. 0244		0	
0. 02 09002 0NCOLOGY		0. 4558		0	
D. 03 09003 OUTPATI ENT CENTER		0. 7911		0	
1.00 09100 EMERGENCY 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 3043 0. 6860		4	1
2. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS		0. 6860	US U	0	92.
5. 00 09500 AMBULANCE SERVICES					95.
6. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.0000	00	0	1
00.00 Total (sum of lines 50-94 and 96-98)		0.0000	109, 330	43, 398	
11.00 Less PBP Clinic Laboratory Services-Program only ch	arges (line 61)		0	, 0 , 0	201.
O2.00 Net Charges (line 200 minus line 201)	,		109, 330		202.

Health Financial Systems	MEMORIAL HOSP & HEALTH CARE CTR			In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 1	150115	From 07/01/2015	Worksheet E Part A Date/Time Prepared: 11/28/2016 1:02 pm	
•						

PART A IMPATIFIT HIGSPITAL SERVICES UNDITE IPPS 1.00			T		11/28/2016 1:	02 pm
ART A - INPATIENT MOSPITAL SERVICES UNDER IPPS			Title XVIII	Hospi tal	PPS	
DRC Amounts other than outlier payments for discharges occurring prior to October 1 (see			1. 00			
1.00 1.00						
1.02 DRG amounts other than outlier payment for discharges occurring on or after October 1 (see 18,284,531 1.02		DRG amounts other than outlier payments for discharges occurring prior to October 1 (see				•
1.03 1.08 For Federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 0 1.03	1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see				1. 02
1.04 Oktober 1 (see instructions) 1.04 Oktober 1 (see instructions) 1.04 Oktober 1 (see instructions) 1.05 0.00 Oktober 1 (see instructions) 1.05 0.00 0.	1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October				
2.00 OutFier payments for discharges. (see instructions)	1. 04	4 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after				1. 04
Managed Care Simulated Payments 0.3.00		Outlier payments for discharges. (see instructions)				1
Bed days available divided by number of days in the cost reporting period (see instructions) 104.23 4.00		Outlier payment for discharges for Model 4 BPCI (see instruction	ns)		0	2. 02
Indirect Medical Education Adjustment Count for all logathic and ostepathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see Instructions) Count for all logathic and osteopathic programs which meet the criteria for an add-on to the cap of ror new programs in accordance with 42 CFR 413. 79(e) Count for all logathic and osteopathic programs which meet the criteria for an add-on to the cap of ror new programs in accordance with 42 CFR 413. 79(e) Count for all logathic and osteopathic programs which meet the criteria for an add-on to the cap of ror new programs in accordance with 42 CFR 413. 79(e) Count for all logathic programs for one with the cost report straddles July 1. 2011 then see instructions. 8.0 Adjustment (Increase or decrease) to the FTE count for all logathic and osteopathic programs for 1993, and 67 FR 5009 (August 1, 2002). All 3.79(e) (20(1v)), 46 FR 2640 (May 12, 1993), and 67 FR 5009 (August 1, 2002). All 3.79(e) (20(1v)), 46 FR 2640 (May 12, 1993), and 67 FR 5009 (August 1, 2002). All 3.79(e) (20(1v)), 46 FR 2640 (May 12, 1993), and 67 FR 5009 (August 1, 2002). All 3.79(e) (20(1v)), 46 FR 2640 (May 12, 1993), and 67 FR 5009 (August 1, 2002). All 3.79(e) (20(1v)), 46 FR 2640 (May 12, 1993), and 67 FR 5009 (August 1, 2002). All 3.79(e) (20(1v)), 46 FR 2640 (May 12, 1993), and 67 FR 5009 (August 1, 2002). All 3.79(e) (20(1v)), 46 FR 2640 (May 12, 1993), and 67 FR 5009 (August 1, 2002). All 3.79(e) (20(1v)), 46 FR 2640 (May 12, 1993), and 67 FR 5009 (August 1, 2002). All 3.79(e) (20(1v)), 46 FR 2640 (May 12, 1993), and 67 FR 5009 (August 1, 2002). All 3.79(e) (20(1v)), 46 FR 2640 (May 12, 1993), and 67 FR 5009 (August 1, 2002). All 3.79(e) (20(1v)), 46 FR 2640 (May 12, 1993), and 67 FR 5009 (August 1, 2002). All 3.79(e) (All 3.79(e					-	1
or before 12/31/1996, (see instructions) 10		Indirect Medical Education Adjustment				
For new programs in accordance with 42 CFR 413.79(e)		or before 12/31/1996 (see instructions)				
ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(T)(1)(iv)(B)(2) 0.00 7.01		for new programs in accordance with 42 CFR 413.79(e)				
Adjustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.79(c) (2) (iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2)				•
8. 01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report stradides July 1, 2011 was einstructions. 8. 01	8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,				8. 00
under section 5506 of ACA (see instructions)	8. 01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If		0.00	8. 01	
Instructions 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 10.00						
11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 12.00 12.00 13.00 15.00 13.00 15.00 1		instructions)				
13.00 Total all owable FTE count for the prior year. 0.00 13.00 14.00 Total all owable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero. 0.00 14.00 14.00 14.00 14.00 14.00 15.00	11. 00	FTE count for residents in dental and podiatric programs.	t year from your recor	ds	0. 00	11. 00
14.00						•
15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 Adjustment for residents in initial years of the program 0.00 16.00 17.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjusted rolling average FTE count 0.000 18.00 19.00		Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,			•	
17. 00 Adjustment for residents displaced by program or hospital closure 0.00 17. 00 18. 00 Adjusted rolling average FTE count 0.00 18. 00 19. 00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0.000000 20. 00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21. 00 22. 00 IME payment adjustment (see instructions) 0.22. 00 22. 01 IME payment adjustment - Managed Care (see instructions) 0.22. 00 23. 00 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23. 00 Image: Add on adjustment count over Cap (see instructions) 0.00 24. 00 IME FTE Resident Count Over Cap (see instructions) 0.00 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 26. 00 Resident to bed ratio (divide line 25 by line 4) 0.00000000000000000000000000000000000	15. 00				0.00	15. 00
18.00 Adjusted rolling average FTE count 0.00 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.01 IME payment adjustment (see instructions) 0.22.00 1 ME payment adjustment - Managed Care (see instructions) 0.22.01 1 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 0.00 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 0.00 23.00 (f)(1)(iv)(c). 0.1 0.00 24.00 25.00 16 the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.01 IME add-on adjustment amount (see instructions) 0.28.01 29.00 Total IME payment - Managed Care (sum of lines 22 and 28) 0.29.00 29.01 <td></td> <td colspan="2">, ,</td> <td></td> <td></td>		, ,				
19.00 Current year resident to bed ratio (line 18 divided by line 4). 20.00 Prior year resident to bed ratio (see instructions) 21.00 Enter the lesser of lines 19 or 20 (see instructions) 22.00 IME payment adjustment (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 23.00 IME payment adjustment - Managed Care (see instructions) 24.00 IME payment adjustment of the Add-on for Section 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME payments adjustment amount (see instructions) 29.00 IME add-on adjustment amount (see instructions) 29.01 IME add-on adjustment amount (see instructions) 29.01 IME add-on adjustment amount (see instructions) 29.01 IME payment (sum of lines 22 and 28) 29.01 Total IME payment (sum of lines 22 and 28) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Sum of lines 30 and 31 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions) 30.00 Allowable disproportionate share percentage (see instructions)						1
20. 00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22. 01 IME payment adjustment (see instructions) 0.22.00 1ME payment adjustment - Managed Care (see instructions) 0.22.01 1ndirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 0.00 23. 00 1ME FTE Resident Count Over Cap (see instructions) 0.00 24. 00 1ME FTE Resident Count Over Cap (see instructions) 0.00 25. 00 1f the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.00 26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27. 00 1ME payments adjustment factor. (see instructions) 0.000000 28. 01 1ME add-on adjustment amount (see instructions) 0.000000 28. 01 1ME add-on adjustment amount - Managed Care (see instructions) 0.28.00 29. 01 Total IME payment - Managed Care (sum of lines 22 and 28) 0.29.00 20. 02 10 IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.29.00 20. 03 10 Disproportionate Share Adjustment						
21.00 Enter the lesser of lines 19 or 20 (see instructions) 22.00 IME payment adjustment (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 29.00 IME add-on adjustment amount (see instructions) 20.01 IME add-on adjustment amount - Managed Care (see instructions) 20.02 IME add-on adjustment amount - Managed Care (see instructions) 20.03 IME add-on adjustment amount - Managed Care (see instructions) 20.04 IME add-on adjustment amount - Managed Care (see instructions) 20.05 IME add-on adjustment amount - Managed Care (see instructions) 20.06 IME add-on adjustment amount - Managed Care (see instructions) 20.07 Intal IME payment - Managed Care (sum of lines 22.01 and 28.01) 20.08 IME add-on adjustment - Managed Care (sum of lines 22.01 and 28.01) 20.09 Importionate Share Adjustment 20.00 Sum of lines 30 and 31 20.00 Allowable disproportionate share percentage (see instructions) 21.00 IME add-on adjustment days (see instructions) 22.01 IME add-on adjustment amount - Managed Care (sum of lines 22.01 and 28.01) 23.00 Sum of lines 30 and 31 24.01 IME add-on adjustment days (see instructions) 25.00 IME add-on adjustment amount - Managed Care (see instructions) 26.00 IME add-on adjustment amount (see instructions) 27.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.01 IME add-on adjustment amount (see instructions) 20.02						
22.00 IME payment adjustment (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 23.00 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME payments adjustment amount (see instructions) 29.00 IME add-on adjustment amount (see instructions) 20.00 Total IME payment (sum of lines 22 and 28) 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment 20.00 Sum of lines 30 and 31 30.00 Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions) 4.64 33.00		, , ,				
22.01 IME payment adjustment - Managed Care (see instructions) 0 1ndi rect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 0.00 23.00 (f) (1) (iv) (C) . 0 0 0 0 0 0 0 0 0		· · · · · · · · · · · · · · · · · · ·				•
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 0.00 23.00 (f) (1) (iv) (c). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 1F the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 0.000000 26.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount (see instructions) 0.28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 Total IME payment (sum of lines 22 and 28) 0.29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.000000 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 15.87 31.00 Sum of lines 30 and 31 18.29 32.00 33.00 Allowable disproportionate share percentage (see instructions) 4.64 33.00	22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
(f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 1f the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 4.64 33.00	23. 00		0, 00	23. 00		
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 29.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 4.64 33.00		(f)(1)(iv)(C).				
26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0 28.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0 28.01 29.00 Total IME payment (sum of lines 22 and 28) 0 29.00 29.01 Disproportionate Share Adjustment 0 29.01 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 2.42 30.00 31.00 Percentage of Medicaid patient days (see instructions) 15.87 31.00 32.00 Sum of lines 30 and 31 18.29 32.00 33.00 Allowable disproportionate share percentage (see instructions) 4.64 33.00		If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24 (see		24 (see		1
27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 0 29. 00 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29. 01 Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 2. 42 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 15. 87 31. 00 32. 00 Sum of lines 30 and 31 18. 29 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 4. 64 33. 00	26 00			0 000000	26 00	
28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions)		the contract of the contract o				
28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30. 00 Percentage of Medicaid patient days (see instructions) 30. 00 Sum of lines 30 and 31 30. 00 Allowable disproportionate share percentage (see instructions)		, ,				•
29.00 Total IME payment (sum of lines 22 and 28) 0 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 2.42 30.00 Percentage of Medicaid patient days (see instructions) 15.87 31.00 Sum of lines 30 and 31 18.29 32.00 Allowable disproportionate share percentage (see instructions) 4.64 33.00					1	
29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 30.00 Allowable disproportionate share percentage (see instructions)					1	
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 15.87 31.00 18.29 32.00 33.00 Allowable disproportionate share percentage (see instructions) 4.64 33.00		Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment		0	1	
31.00Percentage of Medicaid patient days (see instructions)15.8731.0032.00Sum of lines 30 and 3118.2932.0033.00Allowable disproportionate share percentage (see instructions)4.6433.00	30.00	Percentage of SSI recipient patient days to Medicare Part A pati	ent days (see instruc	tions)	2. 42	30.00
32.00 Sum of Lines 30 and 31 18.29 32.00 33.00 Allowable disproportionate share percentage (see instructions) 4.64 33.00			-		15. 87	1
					18. 29	32.00
34.00 Disproportionate share adjustment (see instructions) 212, 101 34.00						1
	34. 00	. UU DI sproporti onate share adjustment (see instructions)				34.00

CALCUL	Financial Systems MEMORIAL HOSP & HEA ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150115	Peri od:	worksheet E	1
			From 07/01/2015 To 06/30/2016	Date/Time Pre	
		Title XVIII	Hospi tal	11/28/2016 1: 0 PPS	02 pm
		THE AVIII	Pri or to 10/1		
			1. 00	2. 00	
25 00	Uncompensated Care Adjustment		7 (47 (44 005	(40/ 145 524	35 00
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0. 000083671	6, 406, 145, 534 0. 000083685	
35. 02	1	er zero on this line)	639, 948		1
	(see instructions)				
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment amount Total uncompensated care (sum of columns 1 and 2 on line 35.0.	,	161, 302 562, 655	401, 353	35. 03 36. 00
30. 00	Additional payment for high percentage of ESRD beneficiary dis				30.00
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding	discharges for MS-DRGs	0		40.00
41 00	652, 682, 683, 684 and 685 (see instructions)	02 /04 on /05 /000	0		41 00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 66 instructions)	83, 684 an 685. (See	0		41.00
41. 01		DRGs 652, 682, 683, 684	0		41. 01
40.00	an 685. (see instructions)	6. 6	0.00		40.00
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qualitated Medicare ESRD inpatient days excluding MS-DRGs 652, 68.		0.00		42.00
10. 00	instructions)	2, 000, 001 an 000. (300			10.00
44. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.00
45. 00	days) Average weekly cost for dialysis treatments (see instructions)	0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line 41		0.00		46. 00
47. 00	Subtotal (see instructions)	•	19, 172, 313		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, si	mall rural hospitals	0		48. 00
	only. (see instructions)			Amount	
				1. 00	
49. 00	Total payment for inpatient operating costs (see instructions	•		19, 172, 313	
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt.			1, 457, 365 0	1
52. 00	Direct graduate medical education payment (from Wkst. E-4, li			0	ı
53. 00	Nursing and Allied Health Managed Care payment			0	
54.00	Special add-on payments for new technologies	0)		0	
55. 00 56. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6' Cost of physicians' services in a teaching hospital (see intro	•		0	
57. 00	Routine service other pass through costs (from Wkst. D, Pt. I	•	nrough 35).	0	ı
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0	
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			20, 629, 678 5, 270	
61. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		20, 624, 408	1
62. 00	Deductibles billed to program beneficiaries	•		2, 253, 776	62.00
63.00	Coinsurance billed to program beneficiaries			8, 911	
64. 00 65. 00				67, 362 43, 785	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		27, 574	
	Subtotal (line 61 plus line 65 minus lines 62 and 63)			18, 405, 506	
68. 00	Credits received from manufacturers for replaced devices for			0	
69. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(FOI SUM See INSTRUCTIONS	>)	0	1
70. 50	RURAL DEMONSTRATION PROJECT			Ö	1
70. 88	SCH or MDH volume decrease adjustment			0	
	Pioneer ACO demonstration payment adjustment amount (see instructions)	ructions)		0	
				0	l l
70. 90	THSP DONUS DAVMENT HRR AGLUSTMENT AMOUNT (See INSTRUCTIONS)			. 0	
	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70. 92
70. 90 70. 91 70. 92 70. 93				0 107, 709 0	70. 93

CALCIII	Financial Systems MEMORIAL HOSP & HEALT ATION OF REIMBURSEMENT SETTLEMENT	H CARE CTF	CCN: 150115	Peri od:	u of Form CMS-2 Worksheet E	
CALCUL	ATTON OF RETWOORSEMENT SETTLEMENT	Provider	CCN. 130113	From 07/01/2015	Part A	
				To 06/30/2016	Date/Time Pre	
					11/28/2016 1:	02 pm
		Ti tl	e XVIII	Hospi tal	PPS	
			FFY	' (yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)			_	_	
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	0	70. 97
	the corresponding federal year for the period ending on or after	r 10/1)				
70. 98	Low Volume Payment-3				0	
70. 99	HAC adjustment amount (see instructions)	. 70)			205, 761	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69	& 70)			18, 307, 454	1
71. 01	Sequestration adjustment (see instructions)				366, 149	
72. 00	Interim payments				17, 805, 487	
	Tentative settlement (for contractor use only)				0	
74. 00					135, 818	
75. 00	Protested amounts (nonallowable cost report items) in accordance	e with			134, 295	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
00.00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					00.00
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instr	uctions)			0	
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	
92.00	Operating outlier reconciliation adjustment amount (see instruc				0	
93.00	Capital outlier reconciliation adjustment amount (see instructi				0 0. 00	
	The rate used to calculate the time value of money (see instructions)	tions)				
95.00	· · · · · · · · · · · · · · · · · · ·	>			0	
96. 00	Time value of money for capital related expenses (see instructi	OHS)		Prior to 10/1		96.00
				1.00	2.00	
	USD Panus Payment Amount			1.00	2.00	
100 00	HSP Bonus Payment Amount HSP bonus amount (see instructions)			O	0	100.00
100.00	HVBP Adjustment for HSP Bonus Payment			U	U	100.00
101 00	HVBP adjustment factor (see instructions)			0.0000000000	0. 0000000000	101 00
	HVBP adjustment amount for HSP bonus payment (see instructions)			0.000000000		101.00
102.00	HRR Adjustment for HSP Bonus Payment			U U	0	102.00
	HRR adjustment factor (see instructions)			0.0000	0. 0000	102 00
102 OC						

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4

				Ti +l e	e XVIII	Hospi tal	11/28/2016 1: PPS	02 pm
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
1. 00	DRG amounts other than outlier		1.00	2.00	3.00	4.00	5.00	1.00
1. 01	payments DRG amounts other than outlier	1. 01	0	0	0		0	1. 01
1. 02	payments for discharges occurring prior to October 1 DRG amounts other than outlier	1. 02	18, 284, 531	0		18, 284, 531	18, 284, 531	1. 02
	payments for discharges occurring on or after October							
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	O	0		0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2. 00	113, 026	0	0	113, 026	113, 026	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4.00	Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
5.00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
6. 01	instructions) IME payment adjustment for managed care (see	22. 01	0	0	0	0	0	6. 01
	instructions)							
7. 00	Indirect Medical Education Adju IME payment adjustment factor	ustment for the	e Add-on for Se 0.000000	ction 422 of tl 0.000000	0.000000	0. 000000		7. 00
7.00	(see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8. 00	IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	0	0	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	O	0	0	0	9. 01
	Disproportionate Share Adjustmo							
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 0464	0. 0464	0. 0464	0. 0464		10.00
11. 00		34.00	212, 101	0	0	212, 101	212, 101	11. 00
11. 01	Uncompensated care payments	36.00	562, 655		675, 373	0	675, 373	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	rcentage of ESF 46.00	D beneficiary 0	di scharges 0	0	0	0	12. 00
13.00	(see instructions) Subtotal (see instructions)	47. 00	19, 172, 313	0	675, 373	18, 496, 940		
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	O	O	0	0	0	14. 00
15. 00	Total payment for inpatient operating costs (see	49. 00	19, 172, 313	0	675, 373	18, 496, 940	19, 172, 313	15. 00
16. 00	instructions) Payment for inpatient program capital	50. 00	1, 457, 365	0	0	1, 457, 365	1, 457, 365	16. 00
17. 00	Special add-on payments for new technologies	54. 00	0	0	0	0	0	17. 00
17. 01 17. 02	Net organ aquisition cost	55. 00 68. 00	0	0	0	0 0	0 0	17. 01 17. 02
18. 00	devices for applicable MS-DRGs		0	0	0	0	0	18. 00
	instructions)							

Peri od: Worksheet E
From 07/01/2015 Part A Exhi bit 4
To 04/20/2014 Part A Exhi bit 4

					Т	o 06/30/2016	Date/Time Pre 11/28/2016 1:	
				Ti tl	e XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1. 00	2.00	3.00	4. 00	5. 00	
19.00	SUBTOTAL			0	675, 373	19, 954, 305	20, 629, 678	19. 00
		W/S L, line	(Amounts from					
			L)					
		0	1. 00	2. 00	3.00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	1, 449, 783	0	C	1, 449, 783	1, 449, 783	20.00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	C	0	0	20. 01
	than outlier							
21.00	Capital DRG outlier payments	2. 00	7, 582	0	C	7, 582	7, 582	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	C	0	0	21. 01
	outlier payments							
22.00	Indirect medical education	5. 00	0. 0000	0.0000	0.0000	0.0000		22. 00
	percentage (see instructions)							
23.00	Indirect medical education	6. 00	0	0	C	0	0	23. 00
	adjustment (see instructions)							
24.00	Allowable disproportionate	10.00	0. 0000	0.0000	0.0000	0.0000		24. 00
	share percentage (see							
	instructions)							
25.00	Disproportionate share	11. 00	0	0	C	0	0	25. 00
	adjustment (see instructions)							
26.00	Total prospective capital	12.00	1, 457, 365	0	C	1, 457, 365	1, 457, 365	26. 00
	payments (see instructions)							
		W/S E, Part A						
		line	Part A)					
		0	1.00	2. 00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0.000000	0. 000000		27. 00
28.00	Low volume adjustment	70. 96			0		0	28. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
29. 00	Low volume adjustment	70. 97				0	0	29. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
100.00	Transfer low volume		Υ					100. 00
	adjustments to Wkst. E, Pt. A.							

Provider CCN: 150115

Peri od:

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

From 07/01/2015 Part A Exhibit 5 Date/Time Prepared: 06/30/2016 11/28/2016 1:02 pm Title XVIII Hospi tal Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 2.00 3. 00 4. 00 0 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 0 0 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 18, 284, 531 18, 284, 531 18, 284, 531 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 2.00 113, 026 113, 026 113,026 2.00 0 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 C 0 2.01 0 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 22.01 0 0 6.01 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 0 8.01 28.01 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 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage 10.00 33.00 0.0464 0.0464 0.0464 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 212, 101 0 212, 101 212, 101 11.00 instructions) 11.01 Uncompensated care payments 36.00 562, 655 161, 302 401, 353 562, 655 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12 00 Total ESRD additional payment (see 12 00 46 00 0 0 0 instructions) 13.00 Subtotal (see instructions) 47.00 19, 172, 313 161, 302 19, 011, 011 19, 172, 313 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 15.00 49.00 19, 172, 313 161, 302 19, 011, 011 19, 172, 313 15.00 (see instructions) 16.00 Payment for inpatient program capital 50.00 1, 457, 365 1, 457, 365 1, 457, 365 16.00 Special add-on payments for new technologies 17.00 54.00 0 17.00 Net organ aquisition cost 55.00 0 17.01 17.01 C 0 0 17.02 Credits received from manufacturers for 68.00 0 0 0 17.02 C replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment 18.00 93.00 0 18.00 amount (see instructions) SUBTOTAL 161, 302 19 00 20 468 376 20, 629, 678 19. 00

Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR In Lieu of Form CMS-2552-10 HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 150115 Peri od: Worksheet E From 07/01/2015 Part A Exhibit 5 06/30/2016 Date/Time Prepared: 11/28/2016 1:02 pm Title XVIII Hospi tal PPS Wkst. L, line (Amt. from L) Wkst. 2.00 3. 00 4.00 n 1 00 20.00 Capital DRG other than outlier 1.00 1, 449, 783 0 1, 449, 783 1, 449, 783 20.00 20. 01 Model 4 BPCI Capital DRG other than outlier 1.01 0 20.01 21.00 Capital DRG outlier payments 2.00 7, 582 0 7.582 7.582 21.00 21.01 Model 4 BPCI Capital DRG outlier payments 2.01 0 21.01 0 22.00 Indirect medical education percentage (see 5.00 0.0000 0.0000 0.0000 22.00 instructions) 23.00 Indirect medical education adjustment (see 6.00 23.00 instructions) 0.0000 0.0000 24.00 Allowable disproportionate share percentage 10 00 0 0000 24 00 (see instructions) 25.00 Disproportionate share adjustment (see 11.00 0 0 25.00 instructions) Total prospective capital payments (see 12.00 1, 457, 365 1, 457, 365 0 1, 457, 365 26.00 instructions) Wkst. E. Pt. (Amt. from A, line Wkst. E, Pt. 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 0 28.00 29.00 Low volume adjustment on or after October 1 70.97 0 29.00 HVBP payment adjustment (see instructions) 70. 93 107, 709 0 107, 709 107, 709 30.00 30.00 HVBP payment adjustment for HSP bonus 30.01 70.90 0 30.01 payment (see instructions) 31.00 HRR adjustment (see instructions) 70.94 C 0 0 0 31.00 HRR adjustment for HSP bonus payment (see 70. 91 0 0 31.01 31.01 instructions) (Amt. to Wkst. Pt. A) 0 1.00 2.00 3.00 4.00 32.00 HAC Reduction Program adjustment (see 70.99 O 205, 761 205, 761 32.00 instructions) 100.00 Transfer HAC Reduction Program adjustment to Υ 100.00 Wkst. E, Pt. A.

Health Financial Systems	MEMORIAL HOSP & HEALT	H CARE CTR	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150115	From 07/01/2015	Worksheet E Part B Date/Time Prepared: 11/28/2016 1:02 pm
		T: +1 - \0/// 1.1	11: 4-1	DDC

			To 06/30/2016	Date/Time Pre	
		Title XVIII	Hospi tal	PPS	<u></u>
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			48, 720	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)				2. 00
3.00	PPS payments			19, 420, 347	3.00
4. 00 5. 00	Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instruct	i one)		20, 672	4. 00 5. 00
6. 00	Line 2 times line 5	1 0113)		0.000	6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		0	9.00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 48, 720	10. 00 11. 00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			40, 720	11.00
	Reasonable charges				
12. 00	Ancillary service charges	>		212, 922	ł
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) Customary charges			212, 922	14. 00
15. 00	Aggregate amount actually collected from patients liable for pa	yment for services on	a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for			0	16. 00
47.00	had such payment been made in accordance with 42 CFR §413.13(e)				47.00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 212, 922	17. 00 18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	164, 202	1
.,. 00	instructions)		, ,	10.7202	17.00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
21 00	instructions)	i notruoti ono)		40.720	21 00
21. 00 22. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see Interns and residents (see instructions)	Thistructions)		48, 720 0	21. 00 22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ıctions)		ĺ	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			19, 441, 019	24. 00
	COMPUTATION OF REIMBÛRSEMENT SETTLEMENT				
25. 00 26. 00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	CAU coo instructions)		126 3, 858, 138	ı
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			15, 631, 475	
27.00	instructions)	45 1110 54 51 111105 22	a.i.a 20] (000	10,001,170	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	29. 00
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			15, 631, 475 7, 060	ł
32. 00	Subtotal (line 30 minus line 31)			15, 624, 415	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34. 00	Allowable bad debts (see instructions)			477, 660	1
35. 00 36. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	ictions)		310, 479 411, 556	1
37. 00	Subtotal (see instructions)	10113)		15, 934, 894	
38. 00				225	
39. 00	OTHER ADJUSTMENT			26, 225	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		+!>	0	39. 50 39. 98
39. 98 39. 99	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	ed devices (see instruc	tions)	0	39. 98
40. 00	Subtotal (see instructions)			15, 960, 894	40.00
40. 01	Sequestration adjustment (see instructions)			319, 218	1
41. 00	O Interim payments			15, 518, 948	1
42.00	, , , , , , , , , , , , , , , , , , , ,			0	42.00
43. 00 44. 00	, , ,			122, 728 0	43. 00 44. 00
44.00	§115. 2	e with two Pub. 15-2,	спартег т,		44.00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)	<u> </u>		0	90. 00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92. 00 93. 00
	Total (sum of lines 91 and 93)				94. 00
				,	,

Health Financial Systems	MEMORIAL HOSP & HEALT	H CARE CTR	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150115		Worksheet E
			From 07/01/2015	Part B
		Component CCN: 15S115	To 06/30/2016	Date/Time Prepared:
				11/28/2016 1:02 pm
		Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der - I PF	PPS		
				1. 00		
	PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			12	1. 00	
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		11	2. 00	
3. 00 4. 00	PPS payments Outlier payment (see instructions)			28 0	3. 00 4. 00	
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	5. 00	
6.00	Line 2 times line 5	,		0	6. 00	
7.00	Sum of line 3 plus line 4 divided by line 6			0. 00	7. 00	
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV	col 13 line 200		0	8. 00 9. 00	
10.00	Organ acquisitions	, cor. 13, 11110 200		0	10. 00	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			12	11. 00	
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges					
12. 00	Ancillary service charges			53	12. 00	
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	13.00	
14. 00	Total reasonable charges (sum of lines 12 and 13)			53	14. 00	
15. 00	Customary charges Aggregate amount actually collected from patients liable for pa	vment for services on	a charge basis	0	15. 00	
16. 00	Amounts that would have been realized from patients liable for			0		
47.00	had such payment been made in accordance with 42 CFR §413.13(e)		-		47.00	
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 53		
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	41		
	instructions)			_		
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	if line 11 exceeds li	ne 18) (see	0	20. 00	
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		12	21. 00	
22. 00	Interns and residents (see instructions)			0	22. 00	
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instru Total prospective payment (sum of lines 3, 4, 8 and 9)	ctions)		0 28	23. 00 24. 00	
21.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			20	21.00	
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0		
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			0 40	26. 00 27. 00	
27.00	instructions)	us the sum of filles 22	unu 20] (300	40	27.00	
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00	
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 40		
31. 00	Primary payer payments			0		
32. 00	Subtotal (line 30 minus line 31)			40	32. 00	
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE: Composite rate ESRD (from Wkst. I-5, line 11)	S)		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 instru Subtotal (see instructions)	ctions)		0 40	36. 00 37. 00	
37. 00 38. 00	MSP-LCC reconciliation amount from PS&R			0		
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0		
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50	
39. 98 39. 99	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	d devices (see instruc	tions)	0	39. 98 39. 99	
40. 00	Subtotal (see instructions)			40		
40. 01	Sequestration adjustment (see instructions)			1	40. 01	
41.00	Interim payments			37	41. 00	
42. 00 43. 00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0	42. 00 43. 00	
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	44. 00	
	\$115. 2					
90. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90. 00	
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91. 00	
92. 00	The rate used to calculate the Time Value of Money				92.00	
93.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93. 00 94. 00	
, 1. 00	Tiotal Country Tribos 71 and 70)		I	O ₁	71.00	

Health Financial Systems	MEMORIAL HOSP & HEALTH	H CARE CTR	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150115	Peri od: From 07/01/2015	Worksheet E
		Component CCN: 15T115		
		Title XVIII	Subprovi der -	PPS

	THE WITH		I RF	FF3	
				·	
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			1, 245	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)			286	
3.00	PPS payments			960	
4.00	Outlier payment (see instructions)			0	4. 00
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5			0. 000	
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 20	00		0	9. 00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			1, 245	11. 00
	Reasonable charges				
12.00	Ancillary service charges			5, 444	12. 00
13.00				0	
14. 00				5, 444	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for payment for services	s on a	charge hasis	0	15. 00
16. 00				0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)				
17. 00	· · · · · · · · · · · · · · · · · · ·			0. 000000	
18.00	,		- 11) (5, 444	
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceed instructions)	as iin	e II) (see	4, 199	19. 00
20.00		ds lin	e 18) (see	0	20. 00
	instructions)				
21. 00	, ,				21. 00
22. 00 23. 00	· · · · · · · · · · · · · · · · · · ·			0	
24. 00				960	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	· · · · · · · · · · · · · · · · · · ·			0	25. 00
26. 00	· ·	-		0	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of line instructions)	es 22	and 23] (see	2, 205	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28. 00
29. 00				0	29. 00
30. 00	· · · · · · · · · · · · · · · · · · ·			2, 205	1
31. 00				0	31. 00
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			2, 205	32. 00
33. 00	·			0	33. 00
34.00				0	
35. 00	, , , , , , , , , , , , , , , , , , ,			0	35. 00
36.00	· · · · · · · · · · · · · · · · · · ·			0	36.00
37. 00 38. 00				2, 205 0	•
				0	
39. 50				0	•
39. 98	Partial or full credits received from manufacturers for replaced devices (see ins	struct	i ons)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	· · · · · · · · · · · · · · · · · · ·			2, 205	
40. 01 41. 00	Sequestration adjustment (see instructions) Interim payments			44 2, 112	
42. 00				2, 112	42. 00
43. 00	·			49	
44. 00	· · · · · · · · · · · · · · · · · · ·	5-2, c	hapter 1,	0	44. 00
	§115. 2				
90. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90. 00
90.00	, ,			0	90.00
92. 00	· · · · · · · · · · · · · · · · · · ·			0.00	
93. 00				0	•
94. 00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems	MEMORIAL HOSP & HEALTH	H CARE CTR	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150115		Worksheet E
			From 07/01/2015	Part B
		Component CCN: 155305	To 06/30/2016	Date/Time Prepared:
		•		11/28/2016 1:02 pm
		Title XVIII	Skilled Nursing	PPS

	Facility	PPS	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00	Medical and other services (see instructions)	1, 719	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instructions) PPS payments	0	2. 00 3. 00
4.00	Outlier payment (see instructions)		4. 00
5. 00	Enter the hospital specific payment to cost ratio (see instructions)		5. 00
6.00	Line 2 times line 5	0	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7. 00
8.00	Transitional corridor payment (see instructions)	0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9. 00
10.00	Organ acquisitions	1 710	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES	1, 719	11. 00
	Reasonable charges		
12.00	Ancillary service charges	7, 516	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)	7, 516	14.00
45.00	Customary charges		45.00
15. 00 16. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15. 00 16. 00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	U	16.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17. 00
18. 00	Total customary charges (see instructions)	7, 516	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	5, 797	19.00
00.00	instructions)		00.00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20. 00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	1, 719	21. 00
22. 00	Interns and residents (see instructions)	0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25. 00	Deductibles and coinsurance (for CAH, see instructions)	0	25. 00
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	1, 719	26. 00 27. 00
27.00	instructions)	1, 717	27.00
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	Subtotal (sum of lines 27 through 29)	1, 719	
31. 00	Primary payer payments	0	31.00
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	1, 719	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	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	Subtotal (see instructions)	1, 719	
38. 00	MSP-LCC reconciliation amount from PS&R		38. 00
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	0	39. 00 39. 50
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	Ö	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
40.00	Subtotal (see instructions)	1, 719	40.00
40. 01	Sequestration adjustment (see instructions)	34	40. 01
41.00	Interim payments	1, 694	41.00
42.00	Tentative settlement (for contractors use only)	0 -9	42.00
43. 00 44. 00	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	-9	43. 00 44. 00
r -1 . 00	\$115. 2		1 7. 00
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)		92.00
93. 00 94. 00	Total (sum of lines 91 and 93)		93. 00 94. 00
, 55	1 (cam 2. 1.100), and 30)	ı	, 00

Health Financial Systems MEMORIA
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 150115

					11/28/2016 1:0	
		Ti t	le XVIII	Hospi tal	PPS	
		Inpatie	nt 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		17, 805, 48	37	15, 518, 948	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		_			
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
	Provi der to Program		1			
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	0	3. 51
3. 52 3. 53				0		3. 52 3. 53
3. 54				0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		3. 99
J. 77	3. 50-3. 98)					3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		17, 805, 48	37	15, 518, 948	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		1	_1	_	
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02
5. 03	Provider to Program			0	U	5. 03
5. 50	TENTATI VE TO PROGRAM		T	0	0	5. 50
5. 51	TENTATIVE TO PROGRAW			0		5. 51
5. 52				0		5. 52
5. 99	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 the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		135, 8	18	122, 728	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		17, 941, 30	05	15, 641, 676	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1. 00	2.00	
8. 00	Name of Contractor		-		2.00	8. 00
2.00	1			1		2.00

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

		Ti tl	e XVIII	Subprovi der - I PF	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, 385, 424		37	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,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	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	Describes to Describe		0		0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	ADDUSTIMENTS TO FROGRAM		0			3. 51
3. 52			0		l ől	3. 52
3. 53			0		l ol	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, 385, 424		37	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
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 50	TENTATIVE TO PROGRAM		0			5. 50
5. 52			0			5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		Ö	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		9, 062		2	6. 01
6. 02	SETTLEMENT TO PROGRAM		1 204 404		0 39	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 394, 486	Contractor	NPR Date	7. 00
				Number	(Mo/Day/Yr)	
		()	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	rt B	
		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,		1, 466, 157 0		2, 112 0	1. 00 2. 00
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 01	ADJUSTIMENTS TO PROVIDER		0			3. 01
3. 02			0		0	3. 02
3. 04			0		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
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		1, 466, 157		2, 112	4. 00
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR					F 00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Dravi dan ta Draggam		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 51	TENTATI VE TO TROGRAM		0		l ol	5. 51
5. 52			0		l ol	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		Ö	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		12, 246		49	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 478, 403		2, 161	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	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	Skilled Nursing Facility	PPS	
		Inpatien	t Part A		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, 305, 321		1, 694	1.00
2.00	Interim payments payable on individual bills, either		(0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	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		(D	0	3. 01
3. 02			(0	3. 02
3. 03					0	3. 03
3.04			(0	3. 04
3. 05	Durani dana da Duranyan		()	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		(1	0	3. 50
3. 50	ADJUSTIMENTS TO FROGRAM		(3. 50
3. 52					Ö	3. 52
3. 53					o o	3. 53
3. 54			(ol	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 305, 32	1	1, 694	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	5. 01
5. 02				D	0	5. 02
5. 03			(<u> </u>	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		(0	5. 50
5. 50 5. 51	TENTATIVE TO PROGRAM		(-	0	5. 50 5. 51
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					5. 99
	5. 50-5. 98)				-	
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVI DER		2, 096	5	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		1 207 11)	9	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 307, 417		1,685 NPR Date	7. 00
				Contractor Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor				2.00	8. 00
	•			•		

Heal th	Financial Systems MEMORIAL HOSP & HEAL	TH CARE CTR	In Lie	u of Form CMS-2	2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 150115 Period: From 07/01/2015 Part II To 06/30/2016 Part II Date/Time 11/28/201						
		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	00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00	00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
3.00	00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-1	2		14, 794	4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			361, 417, 578	5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lin	e 20		3, 216, 273	6. 00	
7. 00	.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168					
8.00	Calculation of the HIT incentive payment (see instructions)			672, 544	8. 00	
9.00	0 Sequestration adjustment amount (see instructions)					
10.00	Calculation of the HIT incentive payment after sequestration (s	ee instructions)		659, 093	10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			803, 522	30.00	
31.00	Other Adjustment (specify)			0	31.00	
22 00	00 Release due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)					

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

803, 522 30. 00 0 31. 00 -144, 429 32. 00

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

	IPF		
		1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1, 570, 440	1.00
2.00	Net IPF PPS Outlier Payments	12, 670	2. 00
3.00	Net IPF PPS ECT Payments	0	3. 00
4. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4. 00
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4. 01
5.00	New Teaching program adjustment. (see instructions)	0.00	5. 00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6. 00
7. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7. 00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8. 00
9.00	Average Daily Census (see instructions)	8. 040984	9. 00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11. 00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1, 583, 110	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	15. 00
16. 00	Subtotal (see instructions)	1, 583, 110	16. 00
17. 00	Pri mary payer payments	0	17. 00
18. 00	Subtotal (line 16 less line 17).	1, 583, 110	
19. 00	Deducti bl es	140, 028	19. 00
20. 00	Subtotal (line 18 minus line 19)	1, 443, 082	
21. 00	Coi nsurance	29, 351	21. 00
22. 00	Subtotal (line 20 minus line 21)	1, 413, 731	22. 00
23. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	14, 175	23. 00
24. 00	Adjusted reimbursable bad debts (see instructions)	9, 214	24. 00
25. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	10, 462	25. 00
26. 00	Subtotal (sum of lines 22 and 24)	1, 422, 945	26. 00
27. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27. 00
28. 00	Other pass through costs (see instructions)	0	28. 00
29. 00	Outlier payments reconciliation	0	29. 00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30. 50
30. 99	Recovery of Accelerated Depreciation	0	30. 99
31.00	Total amount payable to the provider (see instructions)	1, 422, 945	31.00
31. 01	Sequestration adjustment (see instructions)	28, 459	31. 01
32.00	Interim payments	1, 385, 424	32. 00
33.00	Tentative settlement (for contractor use only)	0	33. 00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	9, 062	34.00
35. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35. 00
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount from Worksheet E-3, Part II, line 2	12, 670	
	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52. 00	The rate used to calculate the Time Value of Money	0.00	52. 00
53 00	Time Value of Money (see instructions)	0	53.00

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	Peri od: From 07/01/2015	Worksheet E-3 Part III
		Component CCN: 15T115		
		Title XVIII	Subprovi der -	PPS

		II LIE AVIII	I RF	PPS	
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			1, 464, 440	
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0000	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			23, 138	3. 00
4.00	Outlier Payments			28, 612	4. 00
5.00	Unweighted intern and resident FTE count in the most recent cos	t reporting period er	nding on or prior	0. 00	5. 00
5. 01	to November 15, 2004 (see instructions) Cap increases for the unweighted intern and resident FTE count	for residents that wer	re displaced by	0. 00	5. 01
5.01	program or hospital closure, that would not be counted without			0.00	3.01
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	a comportary cap day as	cinorit direct 12		
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 th	e new program growth p	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	e new program growth p	period of a "new	0.00	8. 00
	teaching program" (see instructions)				
9.00	Intern and resident count for IRF PPS medical education adjustm	ent (see instructions))	0. 00	
10. 00	Average Daily Census (see instructions)			4. 117486	
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, 516, 190	
14. 00	Nursing and Allied Health Managed Care payments (see instructio	٦)		0	
15. 00	Organ acquisition (DO NOT USE THIS LINE)				15. 00
16.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	
17. 00	Subtotal (see instructions)			1, 516, 190	
18. 00 19. 00	Primary payer payments			1 514 100	
20. 00	Subtotal (line 17 less line 18). Deductibles			1, 516, 190	
21. 00	Subtotal (line 19 minus line 20)			7, 616 1, 508, 574	
22. 00	Coi nsurance			1, 508, 574	22. 00
23. 00	Subtotal (line 21 minus line 22)			1, 508, 574	
24. 00	Allowable bad debts (exclude bad debts for professional service	s) (see instructions)		1, 300, 374	
25. 00	Adjusted reimbursable bad debts (see instructions)	s) (see mistractions)		0	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instru	rtions)		0	26. 00
27. 00	Subtotal (sum of lines 23 and 25)	strons)		1, 508, 574	
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	9 49)		0	28. 00
29. 00	Other pass through costs (see instructions)			0	29. 00
30. 00	Outlier payments reconciliation			0	
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	31. 50
31. 99	Recovery of Accelerated Depreciation			0	31. 99
32.00	Total amount payable to the provider (see instructions)			1, 508, 574	32.00
32. 01	Sequestration adjustment (see instructions)			30, 171	32. 01
33.00	Interim payments			1, 466, 157	
34.00	Tentative settlement (for contractor use only)			0	34.00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 33, an	,		12, 246	
36. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	36. 00
	§115. 2				
50. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt. III, line 4			28, 612	50 00
51. 00	Outlier reconciliation adjustment amount (see instructions)			20, 012	51. 00
	The rate used to calculate the Time Value of Money			0. 00	
	Time Value of Money (see instructions)				53. 00
50.00	1 12. 22. 2		ļ	٥١	-0.00

	Financial Systems MEMORIAL HOSP & HEA		•	u of Form CMS-1	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150115	Peri od: From 07/01/2015	Worksheet E-3 Part VI	
		Component CCN: 155305		Date/Time Pre	pared:
		·		11/28/2016 1:	02 pm_
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHE	ED HEALTH SEDVICES FOR T	ITIE YVIII DADT A		
	SERVICES	IN HEALTH SERVICES TOR T	IILL AVIII IAKI A	VIII S SIVI	
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			1, 500, 586	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)				4. 00
	COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine co	osts 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			168, 627	7. 00
8.00	Allowable bad debts (see instructions)			3, 292	1
9.00	Reimbursable bad debts for dual eligible beneficiaries (see in	nstructions)		682	1
10.00	Adjusted reimbursable bad debts (see instructions)			2, 140	
11. 00	Utilization review	0 11) (! + !	>	1 224 222	
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10	and II)(see Instruction	ns)	1, 334, 099	
13.00	Inpatient primary payer payments OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions)	e)		0	1
	Recovery of Accel erated Depreciation	3)		0	
	Subtotal (see instructions			1, 334, 099	
	Sequestration adjustment (see instructions)			26, 682	
	Interim payments			1, 305, 321	1
	Tentative settlement (for contractor use only)				17 00

17.00 Tentative settlement (for contractor use only)
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

2, 096

17.00

18.00 19. 00 BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 150115 Perio

Dispert ASSETS				To	06/30/2016	Date/Time Pre 11/28/2016 1:	
Output Assert A			General Fund		Endowment Fund		, , , , , , , , , , , , , , , , , , ,
Direct Asserts			1 00		3 00	4 00	
Temporary investments		CURRENT ASSETS	1.00	2.00	0. 00	1. 00	
Mortes receivable					_		
Accounts receivable			938, 748	i i			
Other receivable			25 077 696	_	0		
All Oxeneos For uncollect bile notes and accounts receivable 0 0 0 0 0 0 0 0 0			25,077,070	0	0	•	
Propose of expenses			0	o	0		
9.00 Other current assets 9,171,904 0 0 0 9,00 11.00 Dut from other funds 0 0 0 10.00 11.00 Dut from other funds 0 0 0 11.00 11.00 Dut from other funds 0 0 0 11.00 12.00 Land 0 0 0 0 0 0 13.00 Land 0 0 0 0 0 0 13.00 Land 0 0 0 0 0 0 0 13.00 Land 0 0 0 0 0 0 0 13.00 Dut fund is teld depreciation 0 0 0 0 0 0 15.00 Buildings 113, 373, 872 0 0 0 15.00 17.00 Lossehold improvements 0 0 0 0 15.00 17.00 Lossehold improvements 0 0 0 0 17.00 17.00 Lossehold improvements 0 0 0 0 17.00 17.00 Lossehold improvements 0 0 0 0 17.00 17.00 Lossehold improvements 0 0 0 0 0 18.00 17.00 Lossehold improvements 0 0 0 0 0 18.00 17.00 Lossehold improvements 0 0 0 0 0 18.00 17.00 Lossehold improvements 0 0 0 0 0 19.00 17.00 Lossehold improvements 0 0 0 0 0 19.00 17.00 Lossehold improvements 0 0 0 0 0 19.00 17.00 Lossehold improvements 0 0 0 0 0 19.00 17.00 Lossehold improvements 0 0 0 0 0 19.00 17.00 Lossehold improvements 0 0 0 0 0 0 19.00 17.00 Lossehold improvements 0 0 0 0 0 0 0 19.00 17.00 Lossehold improvements 0 0 0 0 0 0 0 0 0 17.00 Lossehold improvements 0 0 0 0 0 0 0 0 0			0	0	0		
10.00 Due From other Funds			0	0	0		
11.00 Total current assets (sum of lines 1-10) 81,021,682 0 0 11.00			9, 171, 904		0		
			81 021 682	_	0	l .	
13.00 Land improvements	11.00		01,021,002		<u> </u>		11.00
14.00 Accumulated depreciation 0 0 0 14.00	12.00		9, 165, 761	0	0	0	12. 00
15.00 Buildings 113,373,872 0 0 15.00		1	0	_	0		
16.00 Accumul ated depreciation -61, 120, 571 0 0 0 16.00 0 0 17.00 17.00 Lasehold improvements 0 0 0 0 0 17.00 17.00 18.00 Accumul ated depreciation 0 0 0 0 18.00 0 19.00			112 272 072	_	0	l	1
17.00 Leasehold Limprovements			1	1	0	l	
18.00 Accumul ated depreciation 0 0 0 0 18.00			01, 120, 371	1	0	l	
20.00 Accumulated depreciation -70, 473, 156 0 0 0 0 20, 00		· '	0	o	0	l e	1
21.00 Automobiles and trucks 0 0 0 0 0 21.00	19. 00		106, 934, 937	0	0	l	
22.00 Accumulated depreciation 0 0 0 0 22.00 23.00 Major movable equijment 0 0 0 0 0 23.00 24.00 Accumulated depreciation 0 0 0 0 0 24.00 25.00 Minor equijment depreciable 0 0 0 0 0 25.00 26.00 Accumulated depreciation 0 0 0 0 0 0 25.00 26.00 Accumulated depreciation 0 0 0 0 0 25.00 27.00 HIT designated Assets 0 0 0 0 0 0 28.00 28.00 Accumulated depreciation 0 0 0 0 0 0 28.00 28.00 Accumulated depreciation 0 0 0 0 0 28.00 28.00 Accumulated depreciation 0 0 0 0 0 28.00 29.00 Minor equijment-nondepreciable 0 0 0 0 0 28.00 29.00 Direct Assets 0 0 0 0 0 0 0 0 20.00 Deposits on leases 56.534,750 0 0 0 31.00 20.00 Deposits on leases 56.534,750 0 0 0 32.00 20.00 Deposits on leases 56.534,750 0 0 0 32.00 20.00 Deposits on marris/officers 8 0.06,407 0 0 33.00 20.00 Total other assets (sum of lines 31-34) 64.585,217 0 0 35.00 20.00 Total other assets (sum of lines 31-34) 64.585,217 0 0 35.00 20.00 Total other assets (sum of lines 31-34) 64.585,217 0 0 35.00 20.00 Total other assets (sum of lines 31-34) 64.585,217 0 0 0 35.00 20.00 Total other assets (sum of lines 31-34) 64.585,217 0 0 0 35.00 20.00 Total other assets (sum of lines 31-34) 64.585,217 0 0 0 0 35.00 20.00 Total other assets (sum of lines 31-34) 64.585,217 0 0 0 0 35.00 20.00 Total other assets (sum of lines 31-34) 64.585,217 0 0 0 0 0 0 0 20.00 Total other assets (sum of lines 31-34) 64.585,217 0 0 0 0 0 0 0 0 0 20.00 Total other assets (sum of lines 31-34) 64.585,217 0 0 0 0 0 0 0 0 0			-70, 473, 156	0	0		
23.00 Major movable equipment 0 0 0 0 23.00		1	0	0	0		
24.00 Accumulated depreciation 0 0 0 0 24.00				0	0		
25.00		, ,		Ö	0		
17.00 HT designated Assets 0 0 0 0 27.00		•	0	0	0	•	1
28. 00 Accumulated depreciation 0 0 0 0 28. 00 0 0 0 29. 00 0 0 0 0 0 29. 00 0 0 0 0 0 29. 00 0 0 0 0 0 29. 00 0 0 0 0 0 29. 00 0 0 0 0 0 0 0 0 0			0	0	0	•	1
29. 00			0	0	0		
Total fixed assets (sum of lines 12-29) 97,880,843 0 0 0 30.00		•		0	0	•	
OTHER ASSETS			97 880 843	1	0		
32.00 Deposits on Leases 0 0 0 0 32.00 33.00 Due from owners/officers 0 0 0 0 0 33.00 34.00 Other assets 8,050,467 0 0 0 34.00 35.00 Total other assets (sum of lines 31-34) 64,585,217 0 0 0 35.00 50.00 Total assets (sum of lines 11, 30, and 35) 243,487,742 0 0 0 36.00 50.00 CURRENT LIABILITIES	00.00		7.70007010				00.00
33.00 Due from owners/officers 0 0 0 0 0 0 0 33.00	31.00	Investments	56, 534, 750	0	0	l .	
34.00 Other assets 8,050,467 0 0 0 34.00		1 .	0	_	0	l .	1
35.00 Total other assets (sum of lines 31-34) 64,585,217 0 0 0 35.00			0.050.4/3	_	0		
36.00 Total assets (sum of lines 11, 30, and 35) 243, 487, 742 0 0 0 36.00			1	1	0	l	1
CURRENT LIABILITIES		,	1	1	0		
38.00 Salaries, wages, and fees payable 12,028,505 0 0 0 0 38.00 39.00 Payroll taxes payable 0 0 0 0 39.00 40.00 Notes and loans payable (short term) 1,782,965 0 0 0 0 40.00 41.00 Deferred income 0 0 0 0 0 0 41.00 42.00 Accelerated payments 3,828,518 0 0 0 0 0 43.00 43.00 Due to other funds 0 0 0 0 0 0 0 43.00 44.00 Other current liabilities 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
39.00 Payroll taxes payable 0			1	1	0	l	1
40. 00 Notes and Loans payable (short term)			12, 028, 505	0	0	l	
41. 00 Deferred income		, ,	1 702 065	0	0	l	
42. 00			1, 782, 903	0	0	l e	1
44.00 Other current liabilities		1	3, 828, 518		9		
Total current liabilities (sum of lines 37 thru 44) 20,621,000 0 0 0 45.00			0	0	0		
LONG TERM LIABILITIES			0	0	0		
Mortgage payable 0 0 0 0 0 0 0 0 0	45. 00	·	20, 621, 000	0	0	0	45.00
47. 00 Notes payable	46 00			0	0	0	46 00
48.00 Unsecured Loans 49.00 Other Long term Liabilities 50.00 Total long term Liabilities (sum of Lines 46 thru 49) 51.00 Total Liabilities (sum of Lines 45 and 50) 52.00 Total Liabilities (sum of Lines 45 and 50) 52.00 Total Liabilities (sum of Lines 45 and 50) 52.00 Total Liabilities (sum of Lines 45 and 50) 52.00 Total Liabilities (sum of Lines 45 and 50) 52.00 Total Liabilities (sum of Lines 45 and 50) 52.00 Total Liabilities (sum of Lines 45 and 50) 52.00 Total Liabilities (sum of Lines 45 and 50) 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total Liabilities and fund balances (sum of Lines 51 and 243, 487, 742) 50 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			52, 997, 234	1	0	1	
Total long term liabilities (sum of lines 46 thru 49) 52,997,234 0 0 0 0 50.00			0	i	0	l	1
Total liabilities (sum of lines 45 and 50) 73,618,234 0 0 0 0 51.00	49. 00	Other long term liabilities	0	_	0	•	
CAPITAL ACCOUNTS 52.00 General fund balance 169,869,508 52.00 53.00 Specific purpose fund 0 53.00 54.00 Donor created - endowment fund balance - restricted 0 54.00 55.00 Governing body created - endowment fund balance unrestricted 0 55.00 Governing body created - endowment fund balance 56.00 Flant fund balance - invested in plant 0 57.00 Flant fund balance - reserve for plant improvement, replacement, and expansion 169,869,508 0 0 0 59.00 0 0 59.00 0 Total fund balances (sum of lines 51 and 243,487,742 0 0 0 0 60.00 0 0 0 0 0 0 0 0 0						•	
52.00 General fund balance 169,869,508 52.00 53.00 53.00 54.00 Donor created - endowment fund balance - restricted 0 54.00 55.00 Donor created - endowment fund balance - unrestricted 0 55.00 Governing body created - endowment fund balance 56.00 Flant fund balance - invested in plant 0 57.00 Flant fund balance - reserve for plant improvement, replacement, and expansion Total fund balances (sum of lines 52 thru 58) 169,869,508 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 243,487,742 0 0 0 60.00	51.00		/3, 618, 234	. 0	0	0	51.00
53.00 Specific purpose fund 0 53.00 54.00 Donor created - endowment fund balance - restricted 0 54.00 55.00 Donor created - endowment fund balance - unrestricted 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 57.00 Plant fund balance - invested in plant 0 57.00 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 0 58.00 59.00 Total fund balances (sum of lines 52 thru 58) 169,869,508 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 243,487,742 0 0 0 60.00	52 00		169 869 508				52 00
54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 243, 487, 742 54.00 55.00 55.00 56.00 56.00 56.00 56.00 57.00 58.00 57.00 58.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00			107,007,000	1			•
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 243, 487, 742 0 0 0 60.00		1			0		•
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 243,487,742 0 0 0 60.00					0		1
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 243,487,742 0 0 0 60.00					0		1
replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 243,487,742 0 0 0 60.00							
59.00 Total fund balances (sum of lines 52 thru 58) 169,869,508 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 243,487,742 243,487,742 0 0 0 60.00	აი. 00						30.00
60.00 Total liabilities and fund balances (sum of lines 51 and 243,487,742 0 0 0 0 60.00	59. 00		169, 869, 508	o	0	0	59.00
[59]	60.00	Total liabilities and fund balances (sum of lines 51 and	1	i	0	0	60.00
		[59]	1				I

In Lieu of Form CMS-2552-10 Health Financial Systems MEMORIAL HOSP & HEALTH CARE CTR STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 150115 Peri od: Worksheet G-1 From 07/01/2015 06/30/2016 Date/Time Prepared: 11/28/2016 1:02 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 169, 830, 977 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 6, 274, 509 2.00 3.00 Total (sum of line 1 and line 2) 176, 105, 486 0 3.00 4.00 FOUNDATION EXPENSE 1, 163, 499 0 0 4.00 5.00 NET ASSETS RELEASED 203, 264 0 5.00 6.00 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, 366, 763 10.00 Subtotal (line 3 plus line 10) 11.00 177, 472, 249 0 11.00 12.00 7, 602, 741 0 12.00 13.00 13.00 14.00 0 0 14.00 0 15.00 15.00 0 0 16.00 0 16.00 17.00 17.00 7, 602, 741 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 169, 869, 508 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 NET ASSETS RELEASED 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 AFS 0 12.00

0

0

0

0

0

13.00

14.00

15.00

16.00

17.00

18.00

19.00

13.00

14.00

15.00

16.00

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

				From 07/01/2015 To 06/30/2016		
	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		18, 893, 15	9	18, 893, 159	1.00
2.00	SUBPROVI DER - I PF		3, 991, 84	7	3, 991, 847	2.00
3.00	SUBPROVI DER - I RF		1, 645, 40	5	1, 645, 405	3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			O	0	5. 00
6.00	Swing bed - NF			O	0	6.00
7.00	SKILLED NURSING FACILITY		1, 435, 70	5	1, 435, 705	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)		25, 966, 11	6	25, 966, 116	10.00
	Intensive Care Type Inpatient Hospital Services			_		
11. 00	INTENSIVE CARE UNIT		8, 248, 27	1	8, 248, 271	11. 00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of I	i nes	8, 248, 27	1	8, 248, 271	16.00
	11-15)					
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		34, 214, 38	7	34, 214, 387	17. 00
18.00	Ancillary services		85, 719, 88	5 286, 495, 623	372, 215, 508	18.00
19. 00	Outpati ent services		(0	0	19. 00
20.00	RURAL HEALTH CLINIC		(845, 072	845, 072	20.00
20. 01	RURAL HEALTH CLINIC II			0	0	20. 01
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	21.00
22.00	HOME HEALTH AGENCY			2, 324, 811	2, 324, 811	22. 00
23.00	AMBULANCE SERVICES		1, 073, 82	7 2, 952, 176	4, 026, 003	23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26.00	HOSPI CE		(0	0	26.00
27.00	PHYSI CI ANS			52, 390, 690	52, 390, 690	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	o Wkst.	121, 008, 09	9 345, 008, 372	466, 016, 471	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			206, 961, 642		29. 00
30.00	ADD (SPECIFY)			O		30.00
31.00				O		31. 00
32.00				O		32.00
33.00				O		33.00
34.00				O		34.00
35.00				O		35. 00
36.00	Total additions (sum of lines 30-35)			0		36. 00
37.00	DEDUCT (SPECIFY)			O		37.00
38. 00				O		38. 00
39. 00				0		39. 00
40.00				O		40.00
41. 00				O		41. 00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		206, 961, 642		43.00
	to Wkst. G-3, line 4)		I	1		

Heal th	Financial Systems MEMORIAL HOSP & HEALTH CA	RF CTR	In Lie	u of Form CMS-2	2552-10
		vi der CCN: 15011		Worksheet G-3	
			From 07/01/2015 To 06/30/2016		pared:
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			466, 016, 471	1, 00
2. 00	Less contractual allowances and discounts on patients' accounts			253, 362, 742	2.00
3. 00	Net patient revenues (line 1 minus line 2)			212, 653, 729	3. 00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			206, 961, 642	
5.00	Net income from service to patients (line 3 minus line 4)			5, 692, 087	5. 00
0.00	OTHER I NCOME			0,072,007	0.00
6.00	Contributions, donations, bequests, etc			0	6.00
7. 00	Income from investments			18, 113	7. 00
8. 00	Revenues from telephone and other miscellaneous communication service	ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			681, 101	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other than pat	tients		0	16. 00
17.00	Revenue from sale of drugs to other than patients			223, 768	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			463	21. 00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	MI SCELLANEOUS			-341, 023	24. 00
25. 00	Total other income (sum of lines 6-24)			582, 422	25. 00
26. 00	Total (line 5 plus line 25)			6, 274, 509	26. 00
	OTHER EVENISES (SDECLEY)				27 00

0 27.00

6, 274, 509 29. 00

28.00

27. 00 OTHER EXPENSES (SPECIFY)

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

Health Financial Systems	MEMORIAL HOSP & HEALT	H CARE CIR			in Lieu	u of form CMS-2552-10	,
ANALYSIS OF PROVIDER-BASED HOME HEALTH AGE	ICY COSTS	Provi der C	CN: 150115	Peri c	od:	Worksheet H	
				From	07/01/2015		
		HHA CCN:	157222	To	06/30/2016	Date/Time Prepared:	
				1		11/28/2016 1:02 pm	
				Hor	ne Health	PPS	
				1			

				HHA CCN:	15/222 1	0 06/30/2016	11/28/2016 1:	
						Home Health	PPS	<u></u>
		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)	
	I	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
1 00	GENERAL SERVICE COST CENTERS				N.	0	I 0	1 00
1. 00	Capital Related - Bldg. & Fixtures				'	0	0	1.00
2.00	Capital Related - Movable			C		0	0	2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	C) c	0	0	3. 00
4.00	Transportation	0	C	1	0	0	0	4.00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	346, 951	C)	46, 720	93, 508	487, 179	5.00
6. 00	Skilled Nursing Care	702, 443	C	69, 989		0	772, 432	6.00
7. 00	Physical Therapy	209, 803	C	1	1	o o	245, 265	1
8.00	Occupational Therapy	107, 892	C	13, 875	5 C	0	121, 767	8. 00
9.00	Speech Pathology	6, 633	C	1	1	0	7, 303	
10.00	Medical Social Services	3, 115	C	1		0	3, 209	1
11. 00 12. 00	Home Health Aide Supplies (see instructions)	98, 546	C			0	132, 801 0	1
13. 00	Drugs		C	_		0		
14. 00	DME	0	C			_	0	1
	HHA NONREIMBURSABLE SERVICES						· · · · · ·	1
15. 00	Home Dialysis Aide Services	0	C	C	C	0	0	
16. 00	Respiratory Therapy	0	C	-) C	0	0	16. 00
17. 00	Private Duty Nursing	0	C			0	0	17. 00
18. 00 19. 00	Clinic Health Promotion Activities	0				0	0	18. 00 19. 00
20. 00	Day Care Program	0				0	0	20.00
21. 00	Home Delivered Meals Program	0	C	o c		Ö	Ö	21. 00
22.00	Homemaker Service	0	C) c) c	0	0	22. 00
23. 00	All Others (specify)	0	C	C) C	0	0	23. 00
24. 00	Total (sum of lines 1-23)	1, 475, 383	Dool oooi fi od	154, 345		93, 508	1, 769, 956	24. 00
		Recl assi fi cati on	Reclassified Trial Balance	Adjustments	Net Expenses for Allocation			
			(col . 6 +		(col. 8 + col.			
			col . 7)		9)			
	OFNEDAL CEDIU OF COCT OFNITEDS	7. 00	8. 00	9. 00	10.00			
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	C	N C) (1		1.00
1.00	Fixtures		C	,	΄]			1.00
2.00	Capital Related - Movable	0	C	o c) c			2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	C	C	0			3. 00
4. 00 5. 00	Transportation Administrative and General	0	460, 348		140 249			4. 00 5. 00
5.00	HHA REIMBURSABLE SERVICES	-26, 831	400, 340	1	460, 348	1		3.00
6.00	Skilled Nursing Care	0	772, 432	· C	772, 432			6.00
7.00	Physical Therapy	0	245, 265	c	245, 265	i		7. 00
8.00	Occupational Therapy	0	121, 767	1	1			8. 00
9.00	Speech Pathology	0	7, 303		1 .,			9. 00
10.00	Medical Social Services	0	3, 209	1	3, 209			10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	0	132, 801 C	l	132, 801			11. 00 12. 00
13. 00	Drugs	0	C					13.00
14. 00	DME	0	C					14. 00
	HHA NONREIMBURSABLE SERVICES							
15. 00	Home Dialysis Aide Services	0	C					15. 00
16.00	Respiratory Therapy	0	C	1				16.00
17. 00 18. 00	Private Duty Nursing Clinic	0	C	-				17. 00 18. 00
19. 00	Health Promotion Activities		C	1				19.00
20. 00	Day Care Program	0	C	-				20.00
21. 00	Home Delivered Meals Program	0	C) c) c			21. 00
22. 00	Homemaker Service	0	C) c) c)		22. 00
23.00	All Others (specify)	0	C) C	0			23. 00
24.00	Total (sum of lines 1-23)	-26, 831	1, 743, 125	6 C	1, 743, 125	1		24. 00

COST ALLOCATION - HHA GENERAL SERVICE COST Provider CCN: 150115 Peri od: Worksheet H-1 From 07/01/2015 Part I 157222 Date/Time Prepared: HHA CCN: 06/30/2016 11/28/2016 1:02 pm Home Health **PPS** Agency I Capital Related Costs Bldgs & Subtotal Net Expenses Movable PI ant Transportati on for Cost Fi xtures Equi pment Operation & (cols. 0-4)Allocation Mai ntenance from Wkst. H, 10) col. 1.00 2.00 3.00 4.00 4A. 00 0 GENERAL SERVICE COST CENTERS 1.00 Capital Related - Bldg. & 0 0 1.00 Fi xtures 2.00 Capital Related - Movable 0 2.00 Equi pment 3 00 Plant Operation & Maintenance 0 0 0 0 3 00 4.00 Transportati on 0 0 0 0 4.00 5.00 0 0 Administrative and General 460, 348 0 0 460, 348 5.00 HHA REIMBURSABLE SERVICES 6.00 6.00 Skilled Nursing Care 772.432 0 0 0 0 772, 432 Physical Therapy 7.00 245, 265 0 0 0 245, 265 7.00 0 0 0 0 121, 767 0 121, 767 8.00 Occupational Therapy 8.00 Speech Pathology 7, 303 7, 303 0 9.00 0 9.00 0 0 10.00 Medical Social Services 3.209 0 3.209 10 00 0 Home Heal th Aide 132, 801 0 0 0 132, 801 11.00 11.00 0 0 0 0 12.00 Supplies (see instructions) 0 12.00 0 0 13.00 Drugs Ω 13.00 14.00 DME 14.00 HHA NONREIMBURSABLE SERVICES 0 0 15.00 Home Dialysis Aide Services 0 15.00 0 0 16.00 Respiratory Therapy Ω O 16.00 17.00 Private Duty Nursing 0 0 0 17.00 00000 0 0 0 0 18.00 Clinic 0 18.00 0 Health Promotion Activities 0 19.00 0 19.00 0 20.00 Day Care Program 0 20.00 21.00 21.00 Home Delivered Meals Program 0 0 0 0 22.00 Homemaker Service 0 0 0 22.00 0 All Others (specify) 0 23.00 C 23.00 Total (sum of lines 1-23) 1, 743, 125 1, 743, 125 24.00 Admi ni strati ve Total (cols. & General 4A + 56.00 5.00 GENERAL SERVICE COST CENTERS Capital Related - Bldg. & 1.00 1.00 Fixtures 2.00 Capital Related - Movable 2.00 Equi pment 3.00 Plant Operation & Maintenance 3.00 4.00 Transportation 4.00 5.00 Administrative and General 5.00 460, 348 HHA REIMBURSABLE SERVICES 6.00 Skilled Nursing Care 277, 201 1,049,633 6.00 7.00 Physical Therapy 88, 018 333, 283 7.00 8.00 Occupational Therapy 43, 698 165, 465 8.00 Speech Pathology 2, 621 9, 924 9 00 9 00 10.00 Medical Social Services 1, 152 4, 361 10.00 Home Heal th Aide 47, 658 180, 459 11.00 11.00 12.00 Supplies (see instructions) 0 12.00 0 0 13.00 Drugs 0 13.00 14.00 DMF 0 14.00 HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services 15.00 0 15.00 0 0 16.00 Respiratory Therapy 16.00 17.00 Private Duty Nursing 0 0 17.00 0 18.00 Clinic 0 18.00 0 Health Promotion Activities 19.00 19.00 0 20.00 Day Care Program 0 20.00 Home Delivered Meals Program 0 0 21.00 21.00 0 0 22.00 22.00 Homemaker Service 23 00 All Others (specify) O 23 00

1, 743, 125

24.00

24.00 Total (sum of lines 1-23)

							11/28/2016 1:	02 pm_
						Home Health	PPS	
						Agency I		
		Capital Rel	ated Costs					
		Bl dgs &	Movabl e	PI ant	Transportati o	nReconciliation	Admi ni strati ve	
		Fi xtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Mai ntenance	, ,		(ACCUM. COST)	
		(()	(SQUARE FEET)			(
		1. 00	2.00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	•						
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2.00	Capital Related - Movable		0			0		2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	1 0	0	r		0		3.00
4. 00	Transportation (see	0	0	Ċ		0		4.00
	instructions)	Ĭ	J		1			
5.00	Administrative and General	0	0	C		-460, 348	1, 282, 777	5. 00
0.00	HHA REIMBURSABLE SERVICES		<u></u>		1	1007010	1,202,777	0.00
6. 00	Skilled Nursing Care	0	0	(nl .	0	772, 432	6.00
7. 00	Physical Therapy	0	0			0 0	245, 265	
8. 00	Occupational Therapy		0		1		121, 767	
9. 00	Speech Pathology		0			0	7, 303	
10. 00	Medical Social Services		0			0		
		0	0			0	3, 209	
11.00	Home Heal th Aide	0	0	(0	132, 801	
12.00	Supplies (see instructions)	0	0	()	0	0	
13. 00	Drugs	0	0	C	1	0	0	13. 00
14. 00	DME	0	0	C)	0 0	0	14. 00
	HHA NONREI MBURSABLE SERVI CES	_	_	_	.1		_	
15. 00	Home Dialysis Aide Services	0	0	C	1	0	0	
16. 00	Respiratory Therapy	0	0	C)	0	0	16. 00
17. 00	Private Duty Nursing	0	0	C		0	0	17. 00
18. 00	Clinic	0	0	C)	0	0	18. 00
19. 00	Health Promotion Activities	0	0	C)	0	0	19. 00
20.00	Day Care Program	0	0	C		0	0	20. 00
21.00	Home Delivered Meals Program	0	0	C		0	0	21. 00
22.00	Homemaker Service	0	0	C		0 0	0	22. 00
23.00	All Others (specify)	0	0	C		0 0	0	23. 00
24.00	Total (sum of lines 1-23)	l o	0	C		-460, 348	1, 282, 777	24.00
25. 00	Cost To Be Allocated (per	0	o o	Ċ		ol	460, 348	
	Worksheet H-1, Part I)]						
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 00000	o	0. 358868	26, 00
20.00	12 2 220 t mai ti pi i oi		3. 333000	0.00000	3. 55000	-1		0. 00

Health Financial Systems MEMORIA ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 11/28/2016 1:02 pm Provi der CCN: 150115 Peri od: From 07/01/2015 To 06/30/2016 HHA CCN: 157222 Home Health PPS

						Agency I		
			CAPITAL REL	LATED COSTS				
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
		0	1.00	2. 00	4. 00	4A	5. 00	
2. 00 S 3. 00 F 4. 00 C 5. 00 S 6. 00 M 7. 00 E 10. 00 E 11. 00 F 12. 00 F 14. 00 E 15. 00 F 16. 00 E 17. 00 F 18. 00 F 19. 00 E 20. 00 T 21. 00 E	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Orugs OME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Home Delivered Meals Program Home Delivered Meals Program Home Mail (sum of lines 1-19) (2) Jnit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 20 minus	0 1, 049, 633 333, 283 165, 465 9, 924 4, 361 180, 459 0 0 0 0 0 0 0 0 0 0 0 0	16, 615 16, 615 0 0 0 0 0 0 0 0 0 0 0 0 0	29, 843 0 0 0 0 0 0 0 0 0 0 0 0 0 0	67, 840 137, 349 41, 023 21, 096 1, 297 609 19, 269 0 0 0 0 0 0	114, 298 1, 186, 982 374, 306 186, 561 11, 221 4, 970 199, 728 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	16, 781 174, 265 54, 953 27, 390 1, 647 730 29, 323 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 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
	6 decimal places. Cost Center Description	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	
		6. 00	8. 00	9. 00	10.00	11. 00	13. 00	
2. 00 S 3. 00 F 4. 00 C 5. 00 S 6. 00 M 7. 00 H 8. 00 S 9. 00 C 11. 00 H 12. 00 F 13. 00 F 14. 00 C 15. 00 H 16. 00 C 17. 00 H 18. 00 H 19. 00 A 20. 00 T 21. 00 C	Administrative and General Skilled Nursing Care Physical Therapy Decupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Home Delivered Meals Program Home Melivered Meals Program Home Service All Others (specify) Total (sum of lines 1-19) (2) Jnit Cost Multiplier: column 26, line 1 divided by the sum Decolumn 26, line 20 minus Column 26, line 1, rounded to Decolumn 26, line 20 minus Decolumn 26, line 1, rounded to Decolumn 26, line 20 minus Decolumn 26, line 20 minus Decolumn 26, line 1, rounded to Decolumn 26, line 20 minus	48, 143 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 0	9, 502 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	5, 218 10, 855 3, 050 1, 348 80 69 2, 990 0 0 0 0 0 0 0 0 23, 610	0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 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.

From 07/01/2015 Part I 157222 06/30/2016 Date/Time Prepared: HHA CCN: To 11/28/2016 1:02 pm Home Health **PPS** Agency I Cost Center Description CENTRAL **PHARMACY** MEDI CAL Subtotal Intern & Subtotal SERVICES & Residents Cost RECORDS & LIBRARY **SUPPLY** & Post Stepdown Adjustments 14. 00 15. 00 16. 00 24.00 25. 00 26.00 1.00 Administrative and General 705 0 194, 647 194, 647 1.00 0 6, 756 0 O 1, 378, 858 1, 378, 858 2 00 2 00 Skilled Nursing Care 3.00 Physical Therapy 0 3, 406 435, 715 0 435, 715 3.00 00000000000000000 4.00 Occupational Therapy 0 1, 333 216, 632 0 0 0 0 0 0 0 0 0 0 0 0 0 216, 632 4.00 Speech Pathology 0 13, 012 13, 012 5.00 5 00 64 6.00 Medical Social Services 5, 778 5, 778 6.00 0 7.00 Home Heal th Aide 3, 290 235, 331 235, 331 7.00 0 8.00 Supplies (see instructions) 8.00 C 0 0 0 9.00 9 00 Drugs Ω 10.00 DMF C 10.00 Home Dialysis Aide Services 0 0 11.00 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 Day Care Program 0 0 0 16.00 16, 00 17.00 Home Delivered Meals Program 0 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) 705 14,858 2, 479, 973 2, 479, 973 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 Total HHA Cost Center Description A&G (see Part Costs 27. 00 28. 00 1.00 Administrative and General 1.00 1, 496, 299 2.00 Skilled Nursing Care 117, 441 2.00 3.00 Physical Therapy 37, 111 472, 826 3.00 Occupational Therapy 4.00 18, 451 235, 083 4.00 1, 108 Speech Pathology 5 00 14, 120 5 00 6.00 Medical Social Services 492 6, 270 6.00 7.00 Home Heal th Aide 20,044 255, 375 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 Respiratory Therapy 0 0 0 12.00 12.00 0 Private Duty Nursing 13.00 13.00 0 14.00 Clinic 14.00 Health Promotion Activities 0 15.00 15.00 0 0 16.00 16.00 Day Care Program 0 Home Delivered Meals Program 17.00 17 00 Homemaker Service 0 0 18.00 All Others (specify) 19.00 0 19.00 Total (sum of lines 1-19) (2) 194,647 2, 479, 973 20.00 20.00 21.00 Unit Cost Multiplier: column 0.085173 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

Provider CCN: 150115

Peri od:

⁽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 STATISTICAL Provider CCN: 150115	Peri od: Worksheet H-2

150115 | Peri od: | Worksheet ... | From 07/01/2015 | Part II | Date/Time Prepared: | 11/28/2016 | 1:02 pm | PPS BASIS HHA CCN:

						Agency I		
		CAPITAL REL	ATED COSTS	·				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAI NTENANCE & REPAI RS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5. 00	6. 00	
1. 00	Administrative and General	2, 579	2, 579	346, 951	0		2, 579	1. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME 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) Total (sum of lines 1-19)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 579 0 0 0 0 0 0 0 0 0 0 0 0 0	702, 443 209, 803 107, 892 6, 633 3, 115 98, 546 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1, 186, 982 374, 306 186, 561 11, 221 4, 970 199, 728 0 0 0	0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 15. 00 16. 00 17. 00 18. 00 19. 00
21. 00	Total cost to be allocated	16, 615	29, 843	288, 483		305, 089		21. 00
22. 00	Unit cost multiplier	6. 442420	11. 571539	0. 195531		0. 146814	18. 667313	
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	,	DIETARY (PATIENT DAYS)	CAFETERI A (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	SUPPLY (COSTED REQUIS.)	
		8. 00	9. 00	10.00	11. 00	13. 00	14. 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 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME 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) Total (sum of lines 1-19) Total cost to be allocated Unit cost multiplier	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 579 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		25, 470 7, 157 3, 164 188 162 7, 017 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	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00

Health Financial Systems	MEMORIAL HOSP & HEALT	H CARE CTR	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO BASIS	O HHA COST CENTERS STATISTICAL	Provi der CCN: 150115 HHA CCN: 157222	From 07/01/2015	Worksheet H-2 Part II Date/Time Prepared: 11/28/2016 1:02 pm
			Home Health	PPS

				Home Health	PPS	
				Agency I		
	Cost Center Description	PHARMACY	MEDI CAL			
		(COSTED	RECORDS &			
		REQUIS.)	LI BRARY			
			(REVENUE)			
		15. 00	16. 00			
1.00	Administrative and General	0	0			1.00
2.00	Skilled Nursing Care	0	1, 057, 003			2.00
3.00	Physi cal Therapy	0	532, 970			3.00
4.00	Occupati onal Therapy	0	208, 535			4.00
5.00	Speech Pathology	0	10, 072			5.00
6.00	Medical Social Services	0	1, 419			6.00
7.00	Home Health Aide	0	514, 812			7.00
8.00	Supplies (see instructions)	0	0			8.00
9.00	Drugs	0	0			9.00
10.00	DME	0	0		-	10. 00
11.00	Home Dialysis Aide Services	0	O		'	11. 00
12.00	Respiratory Therapy	0	O		'	12. 00
13.00	Private Duty Nursing	0	O		'	13. 00
14.00	Clinic	O	O		'	14. 00
15.00	Health Promotion Activities	o	O		'	15. 00
16.00	Day Care Program	o	O		'	16. 00
17.00	Home Delivered Meals Program	o	O		'	17. 00
18.00	Homemaker Service	o	o		-	18. 00
19.00	All Others (specify)	o	o		-	19. 00
20.00	Total (sum of lines 1-19)	O	2, 324, 811		2	20. 00
21.00	Total cost to be allocated	0	14, 858		2	21. 00
22. 00	Unit cost multiplier	0. 000000			2	22. 00
	'		1		'	

Heal th	Financial Systems	ME	MORIAL HOSP & F	HEALTH CARE CT	R	In lie	eu of Form CMS-2	2552-10
	TIONMENT OF PATIENT SERVICE COST					Peri od:	Worksheet H-3	
				HHA CCN:	157222	From 07/01/2015 To 06/30/2016	Date/Time Prep	
				Ti tl	e XVIII	Home Health Agency I	11/28/2016 1: 0 PPS	02 pm
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.		Per Visit	
		col. 28, line	H-2, Part I)	Costs (from	+ 2)		(col . 3 ÷ col .	
		0	1.00	Part II) 2.00	3.00	4. 00	4) 5. 00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION	OF MOOREONIE I	1100101011 00017 71	OCKEONIE OF T	ie i koolo iii ei ii	117111011 0001, 01	`	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00			1, 496, 29			1.00
2. 00 3. 00	Physical Therapy Occupational Therapy	3. 00 4. 00			1			
4. 00	Speech Pathology	5. 00						
5. 00	Medical Social Services	6. 00			6, 27			
6.00	Home Health Aide	7. 00	255, 375		255, 37	3, 629	70. 37	6. 00
7. 00	Total (sum of lines 1-6)		2, 479, 973	С				7. 00
			l		Program Visit	s ırt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject 1			
	dest content beschiption	0000 21 1111 10	05071 1101 (1)		Deducti bl es			
					Coi nsurance			
		0	1.00	2. 00	3.00	4. 00	5. 00	
8. 00	Limitation Cost Computation Skilled Nursing Care	I	50031	C	7	0		8. 00
8. 01	Skilled Nursing Care		50031			0		8. 01
8. 02	Skilled Nursing Care		99915	Ċ	1			8. 02
9.00	Physical Therapy		50031	C	1	0		9. 00
9. 01	Physi cal Therapy		50036	C	1	0		9. 01
9. 02	Physical Therapy		99915 50031		2, 54	0		9. 02 10. 00
10. 00 10. 01	Occupational Therapy Occupational Therapy		50036			0		10.00
10. 02	Occupational Therapy		99915		1, 02			10. 02
11. 00	Speech Pathology		50031	C		0		11. 00
11. 01	Speech Pathology		50036	C	1	0		11. 01
11. 02	Speech Pathology		99915	C		4		11. 02
12. 00 12. 01	Medical Social Services Medical Social Services		50031 50036			0		12. 00 12. 01
12. 01			99915			1		12. 01
13. 00	Home Health Aide		50031	C		0		13. 00
13. 01	Home Health Aide		50036	C		0		13. 01
13. 02			99915	C				13. 02
14. 00	Total (sum of lines 8-13)	From Wko+ II 2	Facility Coata	Charad	., ., .,		Ratio (col. 3	14. 00
	Cost Center Description	Part I, col.	Facility Costs (from Wkst.	Shared Ancillary	Total HHA Costs (cols.		÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)		
				Part II)				
	Constitution and Davis Cont Constitution	0	1.00	2. 00	3.00	4. 00	5. 00	
15. 00	Supplies and Drugs Cost Computation Cost of Medical Supplies	8. 00	0	C	7	0 0	0. 000000	15. 00
16. 00		9. 00			•	0 0		
	,		Program Visits		Cost of		3.33333	
			_		Servi ces			
	Cook Cooker Dooreitstine	D A		t B	D+ A	Part B	Cubi+ +-	
	Cost Center Description	Part A	Not Subject to Deductibles &		Part A	Not Subject to Deductibles &	Subject to Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	HE PROGRAM LIN	ITATION COST, OF	?	
4 00	Cost Per Visit Computation	T -				0 044 553		4
1. 00 2. 00	Skilled Nursing Care Physical Therapy	0				0 811, 196 0 320, 037		1. 00 2. 00
3.00	Occupati onal Therapy					0 163, 118		3. 00
4. 00	Speech Pathology	Ö				0 10, 739		4. 00
5.00	Medical Social Services	0	1			0 627		5. 00
6.00	Home Heal th Ai de	0				0 136, 518		6. 00
7. 00	Total (sum of lines 1-6)	0	9, 578		I	0 1, 442, 235	l l	7. 00

	Financial Systems TONMENT OF PATIENT SERVICE COST Cost Center Description		MORIAL HOSP & F	Provi der HHA CCN:	CCN: 150115 157222 e XVIII	Peri od: From 07/01/2015 To 06/30/2016 Home Heal th Agency I	w of Form CMS- Worksheet H-3 Part I Date/Time Pre 11/28/2016 1: PPS	epared:
	cost center bescription	6. 00	7. 00	8. 00	9. 00	10.00	11.00	
	Limitation Cost Computation	Γ	T		Г			
8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 14. 00	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Health Aide Home Health Aide Total (sum of lines 8-13)	Dogo						8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 14. 00
		Prog	ram Covered Cha	arges	Cost of Services			
	Cost Center Description	Part A	Par Not Subject to Deductibles & Coinsurance 7.00	Subj ect to	Part A	Part B Not Subject to Deductibles & Coinsurance 10.00	Subject to Deductibles & Coinsurance 11.00	
	Supplies and Drugs Cost Computa		7.00	0.00	7.00	10.00	11.00	
15. 00 16. 00	Cost of Medical Supplies Cost of Drugs	0	65, 226 5, 204			0 0	0	
10.00	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00	3, 204	· ·				10.00
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	?	
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	811, 196 320, 037 163, 118 10, 739 627 136, 518 1, 442, 235						1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
7.00	Total (sum of lines 1-6) Cost Center Description	1, 442, 235						7. 00
	Limitation Cost Cost	12. 00						
12. 01 12. 02 13. 00 13. 01 13. 02	Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Health Aide							8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 14. 00

Health Financial Systems	ME	MORIAL HOSP & F	HEALTH CARE CT	R	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 150115	Peri od:	Worksheet H-3	
			HHA CCN:	157222	From 07/01/2015 To 06/30/2016		
			Ti t	le XVIII	Home Health	PPS	
					Agency I		
Cost Center Description	From Wkst. C,	Cost to Charge		HHA Shared	Transfer to		
	Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1. 00	2. 00	3.00	4. 00		
PART II - APPORTIONMENT OF COS	T OF HHA SERVIC	CES FURNI SHED B	Y SHARED HOSP	ITAL DEPARTME	NTS		
1.00 Physical Therapy	66. 00	0. 504822)	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. 537226		ol	0 col. 2, line 1	5. 00	4.00
5.00 Cost of Drugs	73. 00	0. 228734			0 col. 2, line 1	6. 00	5. 00

CIII	Financial Systems MEMORIAL HOSP & HEAL ATION OF HHA REIMBURSEMENT SETTLEMENT		CCN: 150115	Por	ri od:	u of Form CMS-2 Worksheet H-4	
LCUL	ATION OF HEA REIMBURSEMENT SETTLEMENT			Fro	om 07/01/2015	Part I-II	
		HHA CCN:	157222	То	06/30/2016	Date/Time Prep 11/28/2016 1:0	
		Ti tl	e XVIII	ŀ	Home Health Agency I	PPS	
		,			Par	t B	
			Part A		ot Subject to	Subject to	
						Deductibles &	
			1.00		Coi nsurance	Coi nsurance	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	MADV CHADCE	1.00		2. 00	3. 00	
	Reasonable Cost of Part A & Part B Services	WART CHARGE	3				1
00	Reasonable cost of services (see instructions)			0	o	0	1
00	Total charges			0	5, 204	0	
	Customary Charges						
00	Amount actually collected from patients liable for payment for	servi ces		0	0	0	3
00	on a charge basis (from your records)						١.,
00	Amount that would have been realized from patients liable for			0	0	0	4
	for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)	ccoi udilce					
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	00	0. 000000	0. 000000	5
00	Total customary charges (see instructions)			0	5, 204	0	
00	Excess of total customary charges over total reasonable cost (complete		0	5, 204	0	7
	only if line 6 exceeds line 1)						_ ا
00	Excess of reasonable cost over customary charges (complete onl. 1 exceeds line 6)	yifline		O	O	0	8
00	Primary payer amounts			0	0	0	9
	payer amounts			_	Part A	Part B	
					Servi ces 1.00	Servi ces 2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				1.00	2.00	
00	Total reasonable cost (see instructions)				0	0	10
~~					0	4 004 750	1 1 -
00	Total PPS Reimbursement - Full Episodes without Outliers				Ч	1, 321, 759	ļ '
00	Total PPS Reimbursement - Full Episodes with Outliers				0	24, 103	12
00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes				0	24, 103 29, 678	12 13
00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes				0 0	24, 103 29, 678 13, 577	1: 1: 1:
00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers				0 0 0	24, 103 29, 678 13, 577 2, 760	1: 1: 1: 1:
00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes				0 0 0	24, 103 29, 678 13, 577 2, 760 0	1: 1: 1: 1: 1: 1:
00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments				0 0 0	24, 103 29, 678 13, 577 2, 760 0 0	1: 1: 1: 1: 1: 1:
00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24, 103 29, 678 13, 577 2, 760 0	1. 1. 1. 1. 1. 1.
00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments				000000000000000000000000000000000000000	24, 103 29, 678 13, 577 2, 760 0 0	1: 1: 1: 1: 1: 1: 1:
00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments	rance)			0 0 0 0 0 0 0	24, 103 29, 678 13, 577 2, 760 0 0 0	1. 1. 1. 1. 1. 1. 1. 1. 2.
00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments	rance)			0 0 0 0 0 0 0	24, 103 29, 678 13, 577 2, 760 0 0 0	1. 1. 1. 1. 1. 1. 1. 2. 2.
00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsu Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)	rance)			0 0 0 0 0 0 0	24, 103 29, 678 13, 577 2, 760 0 0 0 0 0 0 1, 391, 877	11: 14: 14: 14: 14: 14: 14: 14: 20: 21: 22: 22: 22:
00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsu Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)	rance)			0 0 0 0 0 0 0	24, 103 29, 678 13, 577 2, 760 0 0 0 0 0 0 1, 391, 877	12 14 14 16 16 17 18 19 20 22 22 22 22 24
00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsu Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)	rance)			0 0 0 0 0 0 0	24, 103 29, 678 13, 577 2, 760 0 0 0 0 0 1, 391, 877 0	12 13 14 15 16 17 18 19 20 21 22 22 24 25
00 00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsu Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)	rance)			0 0 0 0 0 0 0	24, 103 29, 678 13, 577 2, 760 0 0 0 0 0 0 1, 391, 877	12 13 14 18 16 15 18 19 20 22 22 23 24 28 26 26
00 00 00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsu Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)	·			0 0 0 0 0 0 0	24, 103 29, 678 13, 577 2, 760 0 0 0 0 0 1, 391, 877 0	12 13 14 15 16 17 18 19 20 22 22 22 24 25 26 27
00 00 00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsu Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in	structi ons)			000000000000000000000000000000000000000	24, 103 29, 678 13, 577 2, 760 0 0 0 0 1, 391, 877 0 1, 391, 877 0 1, 391, 877	12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28
00 00 00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsu Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)	structi ons)			0 0 0 0 0 0 0	24, 103 29, 678 13, 577 2, 760 0 0 0 0 0 1, 391, 877 0	122 133 144 155 166 177 188 199 202 212 222 232 242 255 262 272 282 292 293 293 294 295 295 295 295 295 295 295 295 295 295
00 00 00 00 00 00 00 00 00 00 00 00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsu Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line	structions) 27)			000000000000000000000000000000000000000	24, 103 29, 678 13, 577 2, 760 0 0 0 0 1, 391, 877 0 1, 391, 877 0 1, 391, 877	122 133 144 155 166 177 188 199 200 212 223 244 255 266 277 288 299 300
. 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsu Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	structions) 27)			000000000000000000000000000000000000000	24, 103 29, 678 13, 577 2, 760 0 0 0 0 1, 391, 877 0 1, 391, 877 0 1, 391, 877	112 133 14 155 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 30 30 30 30 30 30 30 30 30 30 30 30
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsu Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	structions) 27)			000000000000000000000000000000000000000	24, 103 29, 678 13, 577 2, 760 0 0 0 0 1, 391, 877 0 1, 391, 877 0 1, 391, 877	122 133 144 155 166 177 188 199 200 211 222 233 244 255 267 277 288 299 300 301 311
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsu Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Subtotal (see instructions) Interim payments (see instructions)	structions) 27)			000000000000000000000000000000000000000	24, 103 29, 678 13, 577 2, 760 0 0 0 0 1, 391, 877 0 1, 391, 877 0 1, 391, 877 0 1, 391, 877 27, 838 1, 364, 039	122 133 144 155 177 188 199 200 211 222 232 244 255 266 277 288 299 300 311 311 312
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsu Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions) Tentative settlement (for contractor use only)	structions) 27)			000000000000000000000000000000000000000	24, 103 29, 678 13, 577 2, 760 0 0 0 0 1, 391, 877 0 1, 391, 877 0 1, 391, 877 0 1, 391, 877 7 0 1, 391, 877 0 1, 391, 877 0 0 1, 391, 877 0 0 1, 391, 877 0 0 1, 391, 877	122 133 144 155 177 188 199 200 211 222 232 244 255 266 277 288 299 300 311 311 312 313 313 313 313 313 314 315 315 315 315 315 315 315 315 315 315
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsu Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Subtotal (see instructions) Interim payments (see instructions)	structions) 27)) nd 33)			000000000000000000000000000000000000000	24, 103 29, 678 13, 577 2, 760 0 0 0 0 1, 391, 877 0 1, 391, 877 0 1, 391, 877 0 1, 391, 877 27, 838 1, 364, 039	122 133 144 155 166 177 188 199 200 211 222 232 244 255 299 300 311 313 323 334

PROGRAM BENEFICIARIES

HHA CCN: 157222

				Home Health	PPS	
		I nnati on	nt Part A	Agency I	-+ D	
		Inpatren	L Part A	Pal	-t B	
		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, 364, 039 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					0	3. 01
3.02			1 0		0	3. 02
3.03					0	3. 03
3.04			1 0		0	3. 04
3.05			l c		0	3. 05
	Provider to Program					
3.50	<u>.</u>		C		0	3.50
3.51)	0	3. 51
3. 52			C)	0	3. 52
3.53			(c)	0	3. 53
3.54			(c		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		C)	0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		C)	1, 364, 039	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01			C		0	5. 01
5. 02			C		0	5. 02
5.03			<u> </u>)	0	5. 03
г го	Provider to Program	I		<u></u>		F F0
5. 50 5. 51					0 0	5. 50 5. 51
5. 51						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 the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER				0	6. 01
6.02	SETTLEMENT TO PROGRAM		d		0	6. 02
7.00	Total Medicare program liability (see instructions)		d		1, 364, 039	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1. 00	2.00	

	Financial Systems MEMORIAL HOSP & HEAL	TH CARE CTR	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 150115	Peri od: From 07/01/2015 To 06/30/2016		
		Title XVIII	Hospi tal	PPS	02 piii
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPI TAL FEDERAL AMOUNT			4 440 700	
1.00	Capital DRG other than outlier			1, 449, 783	
1. 01 2. 00	Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments			0 7, 582	
2.00	Model 4 BPCI Capital DRG outlier payments			7, 362	1
3.00	Total inpatient days divided by number of days in the cost rep	orting period (see inst	ructions)	41.64	1
4. 00	Number of interns & residents (see instructions)	or tring period (see this	1 40 (1 0113)	0.00	
5. 00	Indirect medical education percentage (see instructions)			0.00	
6.00	Indirect medical education adjustment (multiply line 5 by the	sum of lines 1 and 1.01	, columns 1 and	0	1
	1.01) (see instructions)				
7.00	Percentage of SSI recipient patient days to Medicare Part A pa	tient days (Worksheet E	, part A line	0.00	7. 00
	30) (see instructions)				
8.00	Percentage of Medicaid patient days to total days (see instruc	tions)		0.00	
9.00	Sum of lines 7 and 8			0.00	
10. 00 11. 00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			0.00	10.00
12. 00	Total prospective capital payments (see instructions)			1, 457, 365	
12.00	Total prospective capital payments (see Instructions)			1, 457, 305	12.00
	DADT II. DAVMENT UNDED DEACONADLE COCT			1. 00	
1. 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			Ö	
4. 00	Capital cost payment factor (see instructions)			0	
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		<u> </u>	1.00	
1.00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumstance	s (see instructions)		0	2. 00
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3. 00
4.00	Applicable exception percentage (see instructions)			0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	
6. 00	Percentage adjustment for extraordinary circumstances (see ins			0.00	
7.00	Adjustment to capital minimum payment level for extraordinary	circumstances (line 2 x	: line 6)	0	
8. 00 9. 00	Capital minimum payment level (line 5 plus line 7)	abl a)		0	
10.00	Current year capital payments (from Part I, line 12, as applic Current year comparison of capital minimum payment level to ca		Loss Lino ()	0	
11. 00	Carryover of accumulated capital minimum payment level over ca		,	0	
11.00	Worksheet L, Part III, line 14)	pricar payment (110m pri	o. you		11.00
12.00	Net comparison of capital minimum payment level to capital pay			0	
13.00	Current year exception payment (if line 12 is positive, enter		•	0	
14. 00	Carryover of accumulated capital minimum payment level over ca	pital payment for the f	following period	0	14. 00
15. 00	(if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see inst	ructions)		0	15. 00
16. 00		i ucti ulis)		0	
	Current year exception offset amount (see instructions)			0	
. , . 50	Jan. 1911 Joan Shooper on or root amount (300 rinstructions)			۰	1 17.00

Health Financial Systems MEMORIAL HOSP & HEALT			R	In Lieu of Form CMS-2552-10		
ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/F	EDERALLY QUALIFIED	Provi der	CCN: 150115	Peri od:	Worksheet M-1	
HEALTH CENTER COSTS				From 07/01/2015		
		Component	t CCN: 158507	To 06/30/2016		
					11/28/2016 1:0	02 pm_
				Rural Health	Cost	
				Clinic (RHC) I		
	Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Recl assi fi ed	
			+ col . 2)	ons	Trial Balance	

				(Clinic (RHC) I		
		Compensation	Other Costs		Reclassi 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	49, 822	0	49, 822	0	49, 822	1. 00
2.00	Physician Assistant	0	0	0	0	0	2. 00
3.00	Nurse Practitioner	151, 441	0	151, 441	0	151, 441	3. 00
4.00	Visiting Nurse	0	0	0	0	0	4. 00
5.00	Other Nurse	0	0	0	0	0	5. 00
6.00	Clinical Psychologist	0	0	0	0	0	6. 00
7.00	Clinical Social Worker	0	0	0	0	0	7. 00
8.00	Laboratory Techni ci an	0	0	0	0	0	8. 00
9.00	Other Facility Health Care Staff Costs	53, 722	0	53, 722	0	53, 722	9. 00
10.00	Subtotal (sum of lines 1 through 9)	254, 985	0	254, 985	0	254, 985	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11. 00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	27, 371	27, 371	0	27, 371	15. 00
16.00	Transportation (Health Care Staff)	0	O	0	0	0	16. 00
17.00	Depreciation-Medical Equipment	0	Ö	0	0	0	17. 00
18.00	Professional Liability Insurance	0	Ö	0	0	0	18. 00
19.00	Other Health Care Costs	26, 646	75, 558	102, 204	0	102, 204	19. 00
20.00	Allowable GME Costs	0	O	0	0	0	20. 00
21.00	Subtotal (sum of lines 15 through 20)	26, 646	102, 929	129, 575	0	129, 575	21. 00
22.00	Total Cost of Health Care Services (sum of	281, 631	102, 929	384, 560	0	384, 560	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23. 00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25. 00
26.00	All other nonreimbursable costs	0	0	0	0	0	26. 00
27.00	Nonallowable GME costs	0	0	0	0	0	27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0	0	0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	C	0	0	0	29. 00
30.00	Administrative Costs	0	0	0	0	0	30. 00
31.00	Total Facility Overhead (sum of lines 29 and	0	0	0	0	0	31. 00
	30)						
32. 00	Total facility costs (sum of lines 22, 28	281, 631	102, 929	384, 560	0	384, 560	32. 00
	and 31)						

Health Financial Systems	MEMORIAL HOSP & HEALT	H CARE CTR	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RUR HEALTH CENTER COSTS	RAL HEALTH CLINIC/FEDERALLY QUALIFIED	Provi der CCN: 150115 Component CCN: 158507	From 07/01/2015	
			Rural Health	Cost

				Clinic (RHC) I	L
		Adjustments	Net Expenses	CITIIC (KIIC) I	
			for Allocation		
			(col. 5 + col.		
			6)		
		6. 00	7.00		
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00		
1.00	Physi ci an	0	49, 822		1, 00
2.00	Physician Assistant	0	0	1	2.00
3.00	Nurse Practitioner	0	151, 441	1	3. 00
4.00	Visiting Nurse	0	131, 441		4.00
5.00	Other Nurse	0	0		5. 00
6. 00	Clinical Psychologist	0			6.00
		0	0		7.00
7.00	Clinical Social Worker	0	1	1	
8.00	Laboratory Techni ci an	0	0	l .	8. 00
9.00	Other Facility Health Care Staff Costs	0	53, 722		9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	254, 985	l .	10. 00
11. 00	Physician Services Under Agreement	0	0	•	11. 00
12. 00	Physician Supervision Under Agreement	0	0	l .	12. 00
13. 00	Other Costs Under Agreement	0	0	l .	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0	1	14. 00
15. 00	Medical Supplies	0	27, 371		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	-22, 873	79, 331		19. 00
20.00	Allowable GME Costs	0	0		20. 00
21.00	Subtotal (sum of lines 15 through 20)	-22, 873	106, 702		21. 00
22.00	Total Cost of Health Care Services (sum of	-22, 873	361, 687		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)				
	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)				
32.00	Total facility costs (sum of lines 22, 28	-22, 873	361, 687		32. 00
	and 31)	•			
	•			•	•

Health Financial Systems	MEMORIAL HOSP & HEAL	TH CARE CTR	In Lie	u of Form CMS-2552-10
	JRAL HEALTH CLINIC/FEDERALLY QUALIFIED	Provi der CCN: 150115	Peri od: From 07/01/2015	Worksheet M-1
HEALTH CENTER COSTS		Component CCN: 158508		
			Rural Health	Cost

						11/20/2010 1.	uz piii
					Rural Health Clinic (RHC) II	Cost	
		Compensation	Other Costs		Reclassi fi cati	Reclassi fi ed	
		compensation	011101 00313	+ col . 2)	ons	Trial Balance	
				1 (01. 2)	0113	(col. 3 + col.	
						4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	187, 354	0	187, 354	4 O	187, 354	1. 00
2.00	Physician Assistant	0	0) (0	0	2. 00
3.00	Nurse Practitioner	140, 577	0	140, 57	7 0	140, 577	3. 00
4.00	Visiting Nurse	0	0) (0	0	4. 00
5.00	Other Nurse	0	0) (0	0	5. 00
6.00	Clinical Psychologist	0	0) (0	0	6.00
7.00	Clinical Social Worker	0	0) (0	0	7. 00
8.00	Laboratory Techni ci an	0	0		0	0	8. 00
9.00	Other Facility Health Care Staff Costs	100, 258	0	100, 258	3 0	100, 258	1
10.00	Subtotal (sum of lines 1 through 9)	428, 189	Ö	428, 189		428, 189	10.00
11. 00	Physician Services Under Agreement	,	0	,	0	0	11. 00
12. 00	Physician Supervision Under Agreement	0	0		0	0	12. 00
13. 00	Other Costs Under Agreement	0	Ô		0	0	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	Ö		0	0	14. 00
15. 00	Medical Supplies	0	24, 798	24, 798	3 0	24, 798	
16. 00	Transportation (Health Care Staff)	0	24,770	27,770) 0	24,770	16.00
17. 00	Depreciation-Medical Equipment	0	0			0	17. 00
18. 00	Professional Liability Insurance	0	0)		0	18.00
19. 00	Other Health Care Costs	67, 293	33, 069	100, 362		100, 362	19. 00
20. 00	Allowable GME Costs	07, 293	33,007	100, 30,	2 0	100, 302	20.00
21. 00	Subtotal (sum of lines 15 through 20)	67, 293	57, 867	125, 160	0	125, 160	21. 00
							1
22. 00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	495, 482	57, 867	553, 349	9	553, 349	22. 00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23. 00		0	0		0 0	0	23. 00
24. 00	Dental	0		1		0	24.00
25. 00	Optometry	0			0		25. 00
	All other nonreimbursable costs	0	0) 0	0	•
26. 00	1	0	0		0		26. 00
27. 00	Nonallowable GME costs	0	U) 0	0	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	U	') 0	0	28. 00
	through 27)						
20.00	FACILITY OVERHEAD	0	0	ı ,		0	20.00
29. 00	Facility Costs	0	0		0	1	29. 00
30.00	Administrative Costs	0	0	1	0	0	30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	0	'	0	0	31. 00
22.00	30)	405 400	F7 0/7	FE2 24		FF0 040	22.00
32. 00	Total facility costs (sum of lines 22, 28	495, 482	57, 867	553, 349	9	553, 349	32. 00
	and 31)			1		l	I

Health Financial Systems	MEMORI A	L HOSP & HEALT	H CARE CTR		In Lie	eu of Form CN	/IS-2552-10
ANALYSIS OF HOSPITAL-BASED RURAL	HEALTH CLINIC/FEDERALLY	QUALI FI ED	Provi der CCN:	150115		Worksheet M	VI – 1
HEALTH CENTER COSTS					From 07/01/2015		
			Component CCN:	: 158508	To 06/30/2016		
						11/28/2016	1:02 pm
					Rural Health	Cos	t

				Clinic (RHC) II	
		Adjustments	Net Expenses	of the (Mie) II	
			for Allocation		
			(col. 5 + col.		
			6)		
		6. 00	7. 00		
	FACILITY HEALTH CARE STAFF COSTS			·	
1.00	Physi ci an	0	187, 354		1. 00
2.00	Physician Assistant	0	0		2. 00
3.00	Nurse Practitioner	0	140, 577		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	100, 258		9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	428, 189		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	24, 798		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	-5, 501	94, 861		19. 00
20.00	Allowable GME Costs	0	0		20. 00
21.00	Subtotal (sum of lines 15 through 20)	-5, 501	119, 659		21.00
22.00	Total Cost of Health Care Services (sum of	-5, 501	547, 848		22. 00
	lines 10, 14, and 21)				
	COSTS OTHER THAN RHC/FQHC SERVICS				
23. 00	Pharmacy	0		l .	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		_		00.00
29. 00	Facility Costs	0		l .	29. 00
30.00	Administrative Costs	0	0	l .	30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	0		31. 00
22.00	30)	E E01	E 47 040		22.00
32. 00	Total facility costs (sum of lines 22, 28	-5, 501	547, 848		32. 00
	and 31)			I	1

		MORIAL HOSP & I					eu of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO RHC/FQHC SERVICES		P	rovi der	CCN: 150115	Peri od:	Worksheet M-2	
			C	omnonent	CCN: 158507	From 07/01/2015 To 06/30/2016	Date/Time Pre	nared:
				omporterre			11/28/2016 1:	
						Rural Health	Cost	
						Clinic (RHC) I		
		Number of FTE	Total	Vi si ts		y 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		00	3.00	4.00	5.00	
	Posi ti ons							
1. 00	Physi ci an	0. 12		551	4, 20	00 504		1.00
2. 00	Physician Assistant	0.00		0				2.00
3. 00	Nurse Practitioner	1. 03		3, 162				3.00
4.00	Subtotal (sum of lines 1 through 3)	1. 15		3, 713		2, 667	3, 713	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	0. 00		0			0	7. 02
	onl y)							
8. 00	Total FTEs and Visits (sum of lines 4	1. 15		3, 713			3, 713	8.00
9. 00	through 7)			0			0	9.00
9.00	Physician Services Under Agreements			- 0			U	9.00
							1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O RHC/FQHC SERV	/I CES				11.00	
10. 00				22)			361, 687	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)	,			0	11. 00
12. 00	Cost of all services (excluding overhead) (se	um of lines 10	and 11)			361, 687	12.00
13. 00	Ratio of RHC/FQHC services (line 10 divided						1. 000000	13.00
14. 00	Total facility overhead - (from Wkst. M-1, co						0	14.00
15. 00	Parent provider overhead allocated to facili	ty (see instruc	ctions)				249, 658	
16. 00	,						249, 658	
17. 00	Allowable GME overhead (see instructions)						0	17. 00
18.00		40 11 15					249, 658	
	Overhead applicable to RHC/FQHC services (li						249, 658	
20. 00	Total allowable cost of RHC/FQHC services (s	um of lines 10	and 19)			611, 345	20.00

		MORIAL HOSP & F				u of Form CMS-2	
ALLOCA	ATION OF OVERHEAD TO RHC/FQHC SERVICES		Provi der		Peri od:	Worksheet M-2	
			Componen	t CCN: 158508	From 07/01/2015 To 06/30/2016	Date/Time Pre	
					Rural Health	Cost	•
					Clinic (RHC) II		
		Number of FTE	Total Visits		/ Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col. 3)	4	
		1.00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	1					
1. 00	Physi ci an	1. 00					1.00
2. 00	Physici an Assistant	0.00		_,			2.00
3.00	Nurse Practitioner	1. 19					3.00
4. 00	Subtotal (sum of lines 1 through 3)	2. 19			6, 699	6, 699	4.00
5. 00	Visiting Nurse	0.00)		0	5.00
5. 00	Clinical Psychologist	0.00)		0	6.00
7. 00	Clinical Social Worker	0.00)		0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0. 00)		0	7.0
7. 02	Diabetes Self Management Training (FQHC	0.00	C			0	7. 02
8. 00	only) Total FTEs and Visits (sum of lines 4	2. 19	6, 194			6, 699	8.00
0.00	through 7)	2. 17	0, 174			0, 077	0.00
9. 00	Physician Services Under Agreements		1			0	9.00
7. 00	The second contract right contents					9	71.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	RHC/FQHC SERV	/I CES				
10. 00	Total costs of health care services (from Wk	st. M-1, col. 7	7, line 22)			547, 848	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			547, 848	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided	by line 12)				1. 000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, c	ol. 7, line 31)				0	14.00
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			482, 669	15.00
16. 00	Total overhead (sum of lines 14 and 15)					482, 669	16.00
17. 00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					482, 669	18.00
	Overhead applicable to RHC/FQHC services (li					482, 669	19.00
	Total allowable cost of RHC/FQHC services (s	um of lines 10	and 10)			1, 030, 517	1 20 00

Heal th	Financial Systems MEMORIAL HOSP & HEAL	TH CADE CTD	Inlie	u of Form CMS-2	2552_10
	ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provi der CCN: 150115	Peri od:	Worksheet M-3	
0/12002	ATTOM OF RETIRESTREET SETTEMENT FOR KITO/T GITO SERVINGES	Component CCN: 158507	From 07/01/2015 To 06/30/2016	Date/Time Prep	pared:
		Title XVIII	Rural Health Clinic (RHC) I	Cost	<u> </u>
			1 0111110 (11110)		
				1. 00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1. 00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, lin			611, 345	1. 00
2. 00	Cost of vaccines and their administration (from Wkst. M-4, lin	e 15)		5, 946	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			605, 399	3.00
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5, l	ino (l)		3, 713 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	THE 9)		3, 713	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			163. 05	7. 00
7.00	This district cost per visit (Title 6 divided by Title 6)		Cal cul ati on		7.00
			Prior to	On on After	
			January 1	January 1	
	I		1. 00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	80. 44	81. 32	8. 00
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		80. 44	81. 32	9. 00
10. 00	Program covered visits excluding mental health services (from	contractor records)	ol	1, 488	10. 00
11. 00	Program cost excluding costs for mental health services (line		Ö	121, 004	
12. 00	,		o	0	•
13.00	,		o	0	
14.00	Limit adjustment for mental health services (see instructions)		o	0	14. 00
15. 00	Graduate Medical Education Pass Through Cost (see instructions			0	
16. 00		,		121, 004	
16. 01	Total program charges (see instructions)(from contractor's rec			317, 679	
16. 02	Total program preventive charges (see instructions) (from provi				16. 02
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.03)			2, 843 76, 134	16. 03 16. 04
10.04	(Titles V and XIX see instructions.)	and 18) trilles . 60)		70, 134	10.04
16. 05	Total program cost (see instructions)			78, 977	16. 05
17. 00	Primary payer amounts			190	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		22, 994	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	s) (from contractor		57, 444	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			78. 787	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		5, 035	
22. 00	Total reimbursable Program cost (line 20 plus line 21)			83, 822	22. 00
23. 00	Allowable bad debts (see instructions)			0	
23. 01	Adjusted reimbursable bad debts (see instructions)			-	23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		0	
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`			25. 00
25. 50 26. 00	Pioneer ACO demonstration payment adjustment (see instructions Net reimbursable amount (see instructions))		0 83, 822	
26. 00	Sequestration adjustment (see instructions)				26. 00
27. 00				74, 440	
28. 00				0	
29. 00	7	and 28)			29. 00
30. 00		ce with CMS Pub. 15-II,		0	30. 00
	chapter I, §115.2			I	

Heal th	Financial Systems MEMORIAL HOSP & HEAL	TH CARE CTR	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 150115	Peri od:	Worksheet M-3	
		Component CCN: 158508	From 07/01/2015 To 06/30/2016	Date/Time Pre 11/28/2016 1:	
		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, line	e 20)		1, 030, 517	1. 00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line	e 15)		10, 933	2. 00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1, 019, 584	3. 00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6, 699	4. 00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, li	ne 9)		0	5. 00
6.00	Total adjusted visits (line 4 plus line 5)			6, 699	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	152. 20	7. 00
			Carcuration	OI LIIII (I)	
			Prior to	On on After	
			January 1	January 1	
			1. 00	2. 00	0.00
8. 00 9. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 Rate for Program covered visits (see instructions)	or your contractor)	80. 44 80. 44	81. 32 81. 32	8. 00 9. 00
9.00	CALCULATION OF SETTLEMENT		80. 44	81.32	9.00
10. 00	Program covered visits excluding mental health services (from o	contractor records)	0	1, 855	10.00
11. 00	Program cost excluding costs for mental health services (line		o	150, 849	
12.00	Program covered visits for mental health services (from contract	•	0	0	12. 00
13.00	Program covered cost from mental health services (line 9 x line	e 12)	0	0	13. 00
14. 00	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 a			150, 849	
16. 01 16. 02	Total program charges (see instructions)(from contractor's reconstructions) (from preventive charges (see instructions)(from provides)	-		301, 810 872	
16. 02	Total program preventive costs ((line 16.02/line 16.01) times I	,		436	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03 (Titles V and XIX see instructions.)			92, 706	
16. 05	Total program cost (see instructions)			93, 142	16. 05
17. 00	Primary payer amounts			157	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	•		34, 530	
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instructions records)	s) (from contractor		53, 282	
20.00	Net Medicare cost excluding vaccines (see instructions)	4.11.40		92, 985	
21. 00 22. 00	Program cost of vaccines and their administration (from Wkst. Motal reimbursable Program cost (line 20 plus line 21)	W-4, II ne 16)		8, 504 101, 489	
22. 00	Allowable bad debts (see instructions)			101, 489	23. 00
23. 00	Adjusted reimbursable bad debts (see instructions)			0	
24. 00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		0	24. 00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	•		0	25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instructions))		0	25. 50
26. 00	Net reimbursable amount (see instructions)			101, 489	
26. 01	Sequestration adjustment (see instructions)			2, 030	
27. 00 28. 00	Interim payments			87, 734	27. 00 28. 00
28.00	Tentative settlement (for contractor use only) Balance due component/program (line 26 minus lines 26.01, 27, a	and 28)		0 11, 725	
30. 00	Protested amounts (nonallowable cost report items) in accordance chapter I, §115.2			0	
			ı		1

Heal th	Financial Systems MEMORIAL HOSP & HEAL	TH CARE CTR		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provi der CCN: 150115		eri od:	Worksheet M-4	
		0 1 001 450507		om 07/01/2015	D 1 (T' D	
		Component CCN: 158507	IC	06/30/2016	Date/Time Prep 11/28/2016 1:0	
		Title XVIII		Rural Health	Cost	JZ PIII
		THE XVIII	1	linic (RHC) I	0031	
			Ť	Pneumococcal	I nfl uenza	
				1. 00	2. 00	
1. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)			254, 985	254, 985	1. 00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total	health care staff time	е	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 (fro	m your records)		1, 382	2, 136	4. 00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	line 4)		1, 382	2, 136	5. 00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line	22)		361, 687	361, 687	6. 00
7.00	Total overhead (from Wkst. M-2, line 16)			249, 658	249, 658	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total	l direct cost (line 5		0. 003821	0. 005906	8. 00
	divided by line 6)					
9. 00	Overhead cost - pneumococcal and influenza vaccine (line 7 x li			954	1, 474	
10. 00	Total pneumococcal and influenza vaccine cost and its (their) a	idministration (sum of		2, 336	3, 610	10. 00
	lines 5 and 9)					
	Total number of pneumococcal and influenza vaccine injections (12		
12. 00	1 · · · · · · · · · · · · · · · · · · ·	,		194. 67	47. 50	
13. 00	Number of pneumococcal and influenza vaccine injections adminis	tered to Program		10	65	13. 00
	beneficiaries					
14.00	Program cost of pneumococcal and influenza vaccine and its (the	eir) administration		1, 947	3, 088	14. 00
15 00	(line 12 x line 13)				F 04/	15 00

15.00 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)

16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)

5, 946 15. 00

5, 035 16. 00

Health Financial Systems	MEMORIAL HOSP & HEALT	TH CARE CTR	In Lie	u of Form CMS-2	552-10
COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCIN	IE COST	Provi der CCN: 150115	Peri od:	Worksheet M-4	
			From 07/01/2015		
		Component CCN: 158508	To 06/30/2016		
		·		11/28/2016 1:0	02 pm_
		Title XVIII	Rural Health	Cost	
			Clinic (RHC) II		
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1 00 Health care staff cost (from Wkst M-1 c	ol 7 line 10)		428 189	428 189	1 00

		Pneumococcal	Infl uenza	
		1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	428, 189	428, 189	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, 036	4, 776	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1, 036	4, 776	5. 00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	547, 848	547, 848	6. 00
7.00	Total overhead (from Wkst. M-2, line 16)	482, 669	482, 669	7. 00
8. 00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0. 001891	0. 008718	8. 00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	913	4, 208	9. 00
10. 00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1, 949		10. 00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	9	171	11. 00
	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	216. 56	52. 54	12.00
	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	7	133	13. 00
14. 00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1, 516	6, 988	14. 00
15. 00	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)		10, 933	15. 00
16. 00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		8, 504	16. 00

Health Financial Systems	MEMORIAL HOSP & HEALT	H CARE CTR	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED	RHC/FQHC PROVIDER FOR SERVICES	Provi der CCN: 150115	Peri od: From 07/01/2015	Worksheet M-5
RENDERED TO PROGRAM BENEFICIARIES		Component CCN: 158507		
			Rural Health	Cost

			Rural Health	Cost	
			Clinic (RHC) I		
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to provider			74, 440	1.00
2.00	Interim payments payable on individual bills, either submitt			0	2. 00
	the contractor for services rendered in the cost reporting p	berroa. It none, write			
3.00	"NONE" or enter a zero List separately each retroactive lump sum adjustment amount	based 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)	Also show date of each			
	Program to Provider				
3. 01	rrogram to rrovider			0	3. 01
3. 02				l ol	3. 02
3. 03				l ol	3. 03
3. 04				l ol	3. 04
3. 05				l ol	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		74, 440	4. 00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after deskeach payment. If none, write "NONE" or enter a zero. (1)	c review. Also show date of			5. 00
	Program to Provider				
5. 01	Flogram to Flovider			0	5. 01
5. 01					5. 02
5. 02				0	5. 02
5.05	Provider to Program				3.03
5. 50	110vider to 110gram			0	5. 50
5. 51				0	5. 51
5. 52				l ol	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9	98)		o	5. 99
6.00	Determined net settlement amount (balance due) based on the				6. 00
6. 01	SETTLEMENT TO PROVIDER			7, 706	6. 01
6.02	SETTLEMENT TO PROGRAM			0	6. 02
7.00	Total Medicare program liability (see instructions)			82, 146	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 & HE	ALTH CARE CTR	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RENDERED TO PROGRAM BENEFICIARIES	RHC/FQHC PROVIDER FOR SERVIO	ES Provi der CCN: 150115	Peri od: From 07/01/2015	Worksheet M-5
RENDERED TO TROOKAM DENETTOTANTES		Component CCN: 158508	To 06/30/2016	Date/Time Prepared: 11/28/2016 1:02 pm
			Rural Health	Cost

			Rural Health	Cost	
			Clinic (RHC) II		
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to provider			87, 734	1.00
2.00	Interim payments payable on individual bills, either submitt			0	2. 00
	the contractor for services rendered in the cost reporting p	period. If none, write			
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount	based on subsequent			3. 00
	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. 02				0	3. 02
3. 03				0	3. 03
3.04				0	3. 04
3.05				0	3. 05
	Provider to Program				
3. 50				0	3. 50
3. 51				0	3. 51
3. 52				0	3. 52
3.53				0	3. 53
3. 54				0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9			0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transf	fer to Worksheet M-3, line		87, 734	4. 00
	27)				
	TO BE COMPLETED BY CONTRACTOR		, 1		
5.00	List separately each tentative settlement payment after desk each payment. If none, write "NONE" or enter a zero. (1)	c review. Also show date of			5. 00
	Program to Provider				
5. 01	Program to Provider			0	5. 01
5. 01					5. 02
5. 02					5. 02
5.05	Provider to Program			U	3.03
5. 50	Frovider to Frogram			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	20)		0	5. 99
6.00	Determined net settlement amount (balance due) based on the			U	6.00
6. 01	SETTLEMENT TO PROVIDER	cost report. (1)		11, 725	
6. 02	SETTLEMENT TO PROVIDER			11, 725	6.02
7. 00	Total Medicare program liability (see instructions)			99, 459	
7.00	Tiotal medicale program Habitity (see Histructions)		Contractor	NPR Date	7.00
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
8. 00	Name of Contractor	U	1.00	2.00	8. 00
0.00	maine of contractor		T	1	1 0.00