roar tri i rinarior	a. cycrome	memorrate moor rate	200/11/01 01/11	111 210	G OI TOTH ONE LOOL TO
This report is	required by law (42 USC 1395	g; 42 CFR 413.20(b)). Fai	Ture to report can	result in all interio	m FORM APPROVED
payments made	since the beginning of the co	st reporting period being	g deemed overpayment	ts (42 USC 1395g).	OMB NO. 0938-0050
					EXPIRES 05-31-2019
HOSPITAL AND H	OSPITAL HEALTH CARE COMPLEX C	OST REPORT CERTIFICATION	Provider CCN: 15-00		Worksheet S
AND SETTLEMENT	SUMMARY			From 01/01/2018	
				To 12/31/2018	Date/Time Prepared:
					4/1/2019 4: 24 pm
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically filed	cost report		Date: 4/1/201	19 Time: 4:24 pm
use only	2. [] Manually submitted co	st report			
	3. [0] If this is an amended			der resubmitted this	cost report
	4. [F] Medicare Utilization.	Enter "F" for full or "l	L" for low.		•
Contractor	5. [1]Cost Report Status	6. Date Received:		10. NPR Date:	
use only	(1) Ås Submitted	7. Contractor No.		11. Contractor's Vend	lor Code: 4
,	(2) Settled without Audit	8. [N] Initial Report for	or this Provider CCN	12.[0]If line 5, c	olumn 1 is 4: Enter
	(3) Settled with Audit	9. [N] Final Report for	this Provider CCN		mes reopened = 0-9.
	(4) Reopened				•

PART II - CERTIFICATION

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL LOGANSPORT (15-0072) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 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.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned)	
	Officer or Administrator of Provider(s)
Title	
-	
Date	

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	15, 771	60, 802	0	-89, 735	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4. 00 SUBPROVI DER I						4. 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	0	0		0	7. 00
200. 00 Total	0	15, 771			-89, 735	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-MEDICARE.

Health Financial Systems MEMORIAL HOSPITAL LOGANSPORT In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0072 Period: Worksheet S-2

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DA				N: 15-0072	Period: From 01/0		Worksh Part I Date/	neet S-2	pared:
	1. 00	2. (00		3.00			4. 00			•
4 00	Hospital and Hospital Health Care Co										
1. 00 2. 00	Street: 1101 MICHIGAN AVENUE City: LOGANSPORT	PO Box: State: II	\I 7	ip Code	o: 460	47 COLL	nty: CASS				1.00 2.00
2.00	CITY. LOGANSPORT	Component Na		CCN	CBS			Pavme	ent Svs	stem (P,	2.00
		Oumporterre was		umber	Numb		Certifie		0, 0		
								V	XVII	I XIX	
		1. 00		2.00	3.0	00 4.00	5. 00	6. 00	7.00	8.00	
0.00	Hospital and Hospital-Based Componer			F0070	000	45 4	07 (04 (40)	N			0.00
3. 00	Hospi tal	MEMORIAL HOSPITAL LOGANSPORT	. '	50072	999	15 1	07/01/196	66 N	P	0	3.00
4. 00	Subprovi der – IPF	LOGANSI OKT									4.00
5. 00	Subprovi der - IRF										5.00
6.00	Subprovider - (Other)										6.00
7. 00	Swing Beds - SNF	SWING BED - SNF	1	50072	999	15	05/14/200	08 N	P	P	7.00
8.00	Swing Beds - NF										8.00
9. 00 10. 00	Hospi tal -Based SNF Hospi tal -Based NF										9.00
11.00	Hospi tal -Based OLTC										11.00
12.00	Hospital -Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital -Based Hospice										14.00
15.00	Hospital -Based Health Clinic - RHC										15.00
16. 00 17. 00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16. 00 17. 00
	Renal Dialysis										18. 00
19. 00											19.00
							Fro	om:	T	0:	
							1. (. 00	
	Cost Reporting Period (mm/dd/yyyy)						01/01/		12/3	1/2018	20.00
21.00	Type of Control (see instructions)						9	,			21. 00
					-	1. 00	2. (00	3.	. 00	
	Inpatient PPS Information										
22.00	Does this facility qualify and is it					Υ	N	ı			22. 00
	disproportionate share hospital adju				R						
	§412.106? In column 1, enter "Y" for facility subject to 42 CFR Section §										
	hospital?) In column 2, enter "Y" fo			illei i t							
22. 01	Did this hospital receive interim un			for th	is	Υ	Y	<i>'</i>			22. 01
	cost reporting period? Enter in colu										
	the portion of the cost reporting pe										
	Enter in column 2, "Y" for yes or "N reporting period occurring on or aft				cost						
22. 02	Is this a newly merged hospital that				re	N	l N	.			22. 02
	payments to be determined at cost re	•	•					-			
	Enter in column 1, "Y" for yes or "N										
	cost reporting period prior to Octob										
	or "N" for no, for the portion of th October 1.	ne cost reporting	perioa on	or ar	ter						
22. 03	Did this hospital receive a geograph	nic reclassificati	on from u	rban to	o	N	l N	.		N	22. 03
22.00	rural as a result of the OMB standar							-			22.00
	adopted by CMS in FY2015? Enter in c										
	for the portion of the cost reporting	ng period prior to	October	1. Ent	er						
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft										
	Does this hospital contain at least				as						
	counted in accordance with 42 CFR 41										
	yes or "N" for no.										
23. 00	Which method is used to determine Me						3 N	1			23. 00
	below? In column 1, enter 1 if date if date of discharge. Is the method										
	reporting period different from the	, ,	,		2051						
	reporting period? In column 2, ente										
			In-State	In-S	tate	Out-of	Out-of	Medi ca	i d	0ther	
			Medi cai d	Medi	- 1	State	State	HMO da	ys Me	edi cai d	
			pai d days			Medicaid	Medicaid			days	
				unpa	- 1	paid days	el i gi bl e unpai d				
			1. 00	2.0	_	3. 00	4. 00	5. 00		6. 00	
24. 00	If this provider is an IPPS hospital	, enter the	182		0	0.00	0		333		24.00
	in-state Medicaid paid days in colum	nn 1, in-state									
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in										
		<u> </u>									

Health Financial Systems MEMORIAL HOSPIT.	AL LOGANSPORT			n Lieu	ı of Form	n CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CCN: 15-0072	Peri od:		Workshe		
			From 01/01 To 12/31	/2018 /2018	Part I Date/Ti		
In-Sta	ate In-State	Out-of	Out-of	Medi ca	4/1/201 id 0t	9 4: 24 her	pm
Medi ca	aid Medicaid	State	State	HMO da	ys Medi	cai d	
pai d d	ays el i gi bl e unpai d		Medicaid eligible		da	ays	
	days	para days	unpai d				
1.00		3.00	4. 00	5. 00		00	05.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state	0	0 0	0		0		25. 00
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.							
			Urban/Ru		Date of 2.0		
26.00 Enter your standard geographic classification (not wage) st		eginning of t		2	2.0	0	26. 00
cost reporting period. Enter "1" for urban or "2" for rural 27.00 Enter your standard geographic classification (not wage) st		nd of the cos	+	2			27. 00
reporting period. Enter in column 1, "1" for urban or "2" f				2			27.00
enter the effective date of the geographic reclassification		CCII ototuo in		1			25 00
35.00 If this is a sole community hospital (SCH), enter the numbe effect in the cost reporting period.	er or periods	SCH Status in		"			35. 00
			Begi nn		Endi r		
36.00 Enter applicable beginning and ending dates of SCH status.	Subscript lin	e 36 for numb	1.0 er 01/01/		2. 0 12/31/		36. 00
of periods in excess of one and enter subsequent dates.					12,01,		
37.00 If this is a Medicare dependent hospital (MDH), enter the r is in effect in the cost reporting period.	umber of peri	ods MDH statu	S	0			37. 00
37.01 Is this hospital a former MDH that is eligible for the MDH							37. 01
accordance with FY 2016 OPPS final rule? Enter "Y" for yes instructions)	or "N" for no	. (see					
38.00 If line 37 is 1, enter the beginning and ending dates of MD	H status. If	line 37 is					38. 00
greater than 1, subscript this line for the number of period	ds in excess	of one and					
enter subsequent dates.			Y/N	J	Y/N	l	
			1.0	0	2. 0	0	
39.00 Does this facility qualify for the inpatient hospital payme hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii)					Υ		39. 00
1 "Y" for yes or "N" for no. Does the facility meet the mil	eage requirem	ents in					
accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? En or "N" for no. (see instructions)	ter in column	2 "Y" for ye	S				
40.00 Is this hospital subject to the HAC program reduction adjus					N		40. 00
"N" for no in column 1, for discharges prior to October 1. no in column 2, for discharges on or after October 1. (see		yes or "N" f	or				
ino tri coi unii 2, Toi di scriai ges on oi ai tei october 1. (see	rnstructions)			V	XVIII	XIX	
Description Descript Control (DDC) Control				1. 00	2. 00	3. 00	
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for	di sproporti on	ate share in	accordance	N	N	N	45. 00
with 42 CFR Section §412.320? (see instructions)							47.00
46.00 Is this facility eligible for additional payment exception pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, F				N	N	N	46. 00
Pt. III.			3		l		
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital 48.00 Is the facility electing full federal capital payment? Ent				N N	N N	N N	47. 00 48. 00
Teaching Hospitals	7					.,	10.00
56.00 Is this a hospital involved in training residents in approvor "N" for no.	ed GME progra	ms? Enter "Y	" for yes	N			56. 00
57.00 If line 56 is yes, is this the first cost reporting period							57.00
GME programs trained at this facility? Enter "Y" for yes of is "Y" did residents start training in the first month of t							
for yes or "N" for no in column 2. If column 2 is "Y", com							
"N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if a	ppl i cabl e.			NI NI			E0 00
58.00 If line 56 is yes, did this facility elect cost reimburseme defined in CMS Pub. 15-1, chapter 21, §2148? If yes, comple		rans service	5 d5	N			58. 00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, comp			- 1 11/	N			59.00
		NAHE 413. 8! Y/N	5 Workshe Li ne		Pass-Th Qual i fi d		
		.,	20		Cri ter	i on	
		1.00	2. 0	0	Cod 3. 0		
60.00 Are you claiming nursing and allied health education (NAHE)		N N	2.0	J	3. 0		60.00
any programs that meet the criteria under §413.85? (see in	structions)						

			L LOGANSPORT			u of Form CMS-2	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der (Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Pre 4/1/2019 4:24	pared:
		Y/N	IME	Direct GME	I ME	Direct GME	
		1.00	2. 00	3.00	4. 00	5. 00	
61. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
	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)						61.01
	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)						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						61. 03
	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61. 04
	current cost reporting period. (see instructions). 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)						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)						61.06
		Pro	gram Name	Program Code	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. 00	2. 00	3. 00	4. 00	
	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. Enter in column 4, the direct GME FTE unweighted count.				0.00	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. Enter in column 4, the direct GME FTE unweighted count.				0.00	0. 00	61. 20

				1.00	
	ACA Provisions Affecting the Health Resources and Services Administration	(HRSA)			
62.00	Enter the number of FTE residents that your hospital trained in this cost	reporting per	iod for which	0. 00	62.00
	your hospital received HRSA PCRE funding (see instructions)				
62. 01	Enter the number of FTE residents that rotated from a Teaching Health Cen		your hospital	0. 00	62. 01
	during in this cost reporting period of HRSA THC program. (see instruction	ns)			
	Teaching Hospitals that Claim Residents in Nonprovider Settings				
63.00	Has your facility trained residents in nonprovider settings during this c			N	63.00
	"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through				
		Unweighted	Unwei ghted	Ratio (col.	
		FTEs	FTEs in	1/ (col. 1 +	
		Nonprovi der	Hospi tal	col. 2))	
		Si te			
		1. 00	2. 00	3. 00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings	This base year	is your cost	reporti ng	
	period that begins on or after July 1, 2009 and before June 30, 2010.				
64. 00	Enter in column 1, if line 63 is yes, or your facility trained residents	0. 00	0. 00	0. 000000	64.00
	in the base year period, 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)				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0072 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 4/1/2019 4:24 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ (col. 3 + FTEs FTEs in col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if li is yes, or your facility 0.000000 65.00 0.00 0. 00 if line 63 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col . 1 + col . 2)) FTEs in FTFs Hospi tal Nonprovi der Si te 2. 00 3. 00 1 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in 3/(col. 3 +col. 4)) Nonprovi der Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5. 00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 70.00 N Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF Ν 75.00 subprovider? Enter "Y" for yes and "N"

MEMORIAL LICENSTALL COMMODET	1		-6	- CNC C	NEEO 10
	 Period: From 01/01/2 To 12/31/2	2018 2018	of Form Workshe Part I Date/Ti	et S-2 me Pre	pared:
		1. 00	2.00	3. 00	pili
76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes no. Column 2: Did this facility train residents in a new teaching program in accordanc CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is indicate which program year began during this cost reporting period. (see instructions	or "N" for e with 42 Y,	1.00	2.00	0	76. 00
		-	1. 0	ın.	
Long Term Care Hospital PPS		_	1.0	.0	
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reportin "Y" for yes and "N" for no. TEFRA Providers	g period? E	nter	N N		80. 00 81. 00
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Secti		no.	N		85. 00 86. 00
\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N		87. 00
	V		XI X		
THE WALL WAS COLUMN	1.00		2. 0	0	
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "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 the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		91. 00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.0		95. 00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	0. 00 Y		0. 0 Y		97. 00 98. 00
98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Υ		98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column for title V, and in column 2 for title XIX.			N		98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N		98. 04
98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and i	n Y		Υ		98. 05

98.06

105.00

106.00

107.00

108.00

N

Ν

Ν

Ν

column 2 for title XIX.

column 2 for title XIX. Rural Providers

105.00 Does this hospital qualify as a CAH?

98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,

Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in

106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)

training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.

108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.

107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R

Health Financial Systems MEMORIAL HOSPITA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	AL LOGANSPORT Provider C		eri od:		Worksheet	MS-2552-1 S-2
			rom 01/01/ o 12/31/		Part I Date/Time	Prepared:
	Physi cal	Occupati onal	Speech	2	4/1/2019 4 Respi rato	
	1. 00	2. 00	3. 00		4. 00	
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.	N	N	N		N	109.00
				-	1. 00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	"Y" for yes o	r "N" for no.	f yes,	i	N	110. 00
			1.00		2. 00	
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compared by the FCHIP demonstration for the FCHIP demonstration prongular particles and the FCHIP demonstration prongular particles and the FCHIP demonstration for the FCHIP demonstration prongular particles.	ost reporting olumn 1 is Y, rticipating i	period? Enter enter the n column 2.	N			111.00
			_	1. 00	2.00 3.	00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y"	. If column 2 nt for long to rs) based on for yes or "l	is "E", enter erm care (inclu the definition N" for no.	in column udes in CMS	N N		115.00
117.00 s this facility legally-required to carry malpractice insur	rance? Enter	"Y" for yes or	"N" for	Υ		117. 0
l18.00 is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1			1		118. 0
		Premi ums	Losses	٤	Insurance	9
		1. 00	2. 00		3. 00	\dashv
118.01 List amounts of malpractice premiums and paid losses:		633, 27	5	0		0 118. 0
			1.00		2. 00	
18.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. 19.00 DO NOT USE THIS LINE			N			118. 0
20.00 s this a SCH or EACH that qualifies for the Outpatient Hold			N		Υ	120. 0
§3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2. "Y" for yes or "N" for no.	ualifies for					
"N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impla	ualifies for nts? (see ins	tructions)	Y			121.0
"N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.	ualifies for nts? (see ins antable devic fined in §190	tructions) es charged to 3(w)(3) of the	Y			
"N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implayatients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information	ualifies for nts? (see ins antable device fined in §190 1 is "Y", ent	tructions) es charged to 3(w)(3) of the er in column 2				122. 0
"N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	ualifies for ants? (see instantable device fined in §1901 is "Y", ento	tructions) es charged to 3(w)(3) of the er in column 2 " for no. If	N			122. 0
"N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2	ualifies for ants? (see instantable device fined in §190.1 is "Y", entour yes and "Nor yes and "Nor the cert 2.	tructions) es charged to 3(w)(3) of the er in column 2 "for no. If ification date	N			122. C
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Health Financial Systems MEMORIAL HOSP	PITAL LOGANSPORT			In Lieu	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	N: 15-0072		od: 01/01/2018	Worksheet S- Part I Date/Time Pr	2 epared:
					4/1/2019 4: 2	4 pili
140.00 Are there any related organization or home office costs a chapter 10? Enter "Y" for yes or "N" for no in column 1. are claimed, enter in column 2 the home office chain number 1.	If yes, and home	office cos		1. 00 N	2.00	140. 00
1.00	2. 00		<u>'</u>	3. 00		
If this facility is part of a chain organization, enter of office and enter the home office contractor name and con		ugh 143 the	e name a	and address	of the home	
141.00 Name: Contractor's Name: 142.00 Street: PO Box:			ctor's	Number:		141. 00 142. 00
143. 00 Ci ty: State:		Zi p Coo	de:			143. 00
					1. 00	
144.00 Are provider based physicians' costs included in Workshee	et A?				Y	144. 00
				1. 00	2. 00	-
145.00 If costs for renal services are claimed on Wkst. A, line inpatient services only? Enter "Y" for yes or "N" for no no, does the dialysis facility include Medicare utilizati period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the preventer "Y" for yes or "N" for no in column 1. (See CMS Put yes, enter the approval date (mm/dd/yyyy) in column 2.	in column 1. If on for this cost viously filed cos	column 1 is reporting t report?		N		145. 00
147.00 Was there a change in the statistical basis? Enter "Y" for	or ves or "N" for	no			1. 00 N	147. 00
148.00 Was there a change in the order of allocation? Enter "Y"					N	148. 00
149.00 Was there a change to the simplified cost finding method?				T: 11	N	149. 00
	Part A 1.00	Part B 2.00		Title V 3.00	Title XIX 4.00	
Does this facility contain a provider that qualifies for	an exemption fro	m the appli		of the low	er of costs	
or charges? Enter "Y" for yes or "N" for no for each com	N N	N N	B. (See	42 CFR 941	3. 13) N	155. 00
156.00 Subprovi der - IPF	N	N		N	N	156. 00
157.00 Subprovi der - I RF 158.00 SUBPROVI DER	N	N		N	N	157. 00 158. 00
159. 00 SNF	N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY	N	N		N	N	160.00
161. 00 CMHC		N		N	N	161. 00
					1. 00	
Multicampus 165.00 s this hospital part of a Multicampus hospital that has Enter "Y" for yes or "N" for no.	one or more camp	uses in dif	ferent	CBSAs?	N	165. 00
Name	County		Zip Code		FTE/Campus	
166.00 f line 165 is yes, for each	1. 00	2. 00	3. 00	4. 00	5. 00	0166.00
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					3.3	9100.00
					1. 00	
Health Information Technology (HIT) incentive in the Amer 167.00 st this provider a meaningful user under §1886(n)? Enter 168.00 ft this provider is a CAH (line 105 is "Y") and is a mean	r "Y" for yes or	"N" for no.			Υ	167. 00 0168. 00
reasonable cost incurred for the HIT assets (see instruct	tions)					
168.01 If this provider is a CAH and is not a meaningful user, exception under §413.70(a)(6)(ii)? Enter "Y" for yes or '169.00 If this provider is a meaningful user (line 167 is "Y") a	'N" for no. (see	instruction	ns)		9. 9	168. 01 9169. 00
transition factor. (see instructions)			F	Begi nni ng	Endi ng	
				1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning date and endir period respectively (mm/dd/yyyy)	ng date for the r	eporti ng	0	1/01/2018	12/31/2018	170. 00

Health Financial Systems	MEMORIAL HOSPITAL	LOGANSPORT	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	ENTIFICATION DATA		Peri od:	Worksheet S-2	
			From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
				4/1/2019 4: 24	
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provider			N	0	171. 00
section 1876 Medicare cost plans report					
"Y" for yes and "N" for no in column 1.		nter the number of section	on		
1876 Medicare days in column 2. (see in	nstructions)				

Heal th	Financial Systems MEMORIAL HOSPIT	AL LOGANSPORT		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od:	Worksheet S-2	
				From 01/01/2018 o 12/31/2018	Date/Time Pre	
				V /N	4/1/2019 4: 24	1 pm
				Y/N 1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter 1	N for all NO re	esponses. Ente			
	mm/dd/yyyy format.					1
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					+
1. 00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in		instructions)			
			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare	Program2 If	1. 00 N	2. 00	3. 00	2.00
2.00	yes, enter in column 2 the date of termination and in column					2.00
	voluntary or "I" for involuntary.					
3. 00	Is the provider involved in business transactions, including		N			3.00
	contracts, with individuals or entities (e.g., chain home 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 other					
	relationships? (see instructions)		Y/N	Typo	Date	
			1.00	7ype 2. 00	3. 00	
	Financial Data and Reports					
4. 00	Column 1: Were the financial statements prepared by a Cer		Y	Α		4. 00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date available.	for Compiled,				
	column 3. (see instructions) If no, see instructions.	arrabre in				
5. 00	Are the cost report total expenses and total revenues diffe	erent from	N			5. 00
	those on the filed financial statements? If yes, submit re	conciliation.		\/ /N	1 1 . 0	
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
6. 00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is t	he provider is	N		6. 00
7 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	netrueti one		N		7. 00
7. 00 8. 00	Were nursing school and/or allied health programs approved		d during the	N N		8.00
0.00	cost reporting period? If yes, see instructions.	and or renewe	a dui i iig tiic	114		0.00
9. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. 00
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated		the current	N		10.00
10.00	cost reporting period? If yes, see instructions.	Di l'enewed in	the current	IN .		10.00
11.00	Are GME cost directly assigned to cost centers other than	I & Rin an App	proved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.				\/ /NI	
					Y/N 1. 00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes				Y	12.00
13. 00	If line 12 is yes, did the provider's bad debt collection	policy change of	during this co	st reporting	N	13.00
14 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paym	ents waived? L	fves seeins	tructions	N	14. 00
	Bed Complement		, , , , , , , , , , , , , , , , , , , ,			1
15. 00	Did total beds available change from the prior cost report				N	15. 00
		Y/N	t A Date	Y/N	t B Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data					
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	03/04/2019	Υ	03/04/2019	16.00
	date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	N		N		17. 00
	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	,	N		N		18.00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.00
17.00	Report data for corrections of other PS&R Report			14		'
	information? If yes, see instructions.					

Heal th	Financial Systems MEMORIAL HOSPIT	TAL LOGANSPORT		In Lie	u of Form CMS-	2552-10	
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der (CCN: 15-0072	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II	epared:	
			iption	Y/N	Y/N		
	I. a. i		0	1.00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
	•	Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)	<u></u>	1.00		
	Capital Related Cost	ELL CHI EDICENS	11031 1 TALS)			1	
22. 00	Have assets been relifed for Medicare purposes? If yes, se	e instructions	<u> </u>		N	22. 00	
23. 00	Have changes occurred in the Medicare depreciation expense			ring the cost	N	23.00	
20.00	reporting period? If yes, see instructions.	ado to app. a.	oaro mado da	ing the eest		20.00	
24. 00	Were new leases and/or amendments to existing leases enter	ed into during	g this cost r	eporting period?	N	24. 00	
05.00	If yes, see instructions			2.16	.,	05.00	
25. 00	Have there been new capitalized leases entered into during	ine cost repo	nting period	r it yes, see	N	25. 00	
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ing period?	If was saa	N	26. 00	
20.00	instructions.	ne cost report	ing perrou:	ii yes, see	IN.	20.00	
27. 00	Has the provider's capitalization policy changed during th	e cost reporti	na period? I	f ves. submit	N	27.00	
	copy.	'	3 1	3 .			
	Interest Expense						
28. 00	Were new Loans, mortgage agreements or letters of credit e	t reporting	N	28. 00			
29. 00	period? If yes, see instructions. 9.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)						
27.00	treated as a funded depreciation account? If yes, see instructions						
30.00	30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see						
	instructions.						
31.00	31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see						
i nstructi ons. Purchased Servi ces							
32. 00	Have changes or new agreements occurred in patient care se		ned through c	ontractual	N	32.00	
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		na to compet	itive biddina? If	N N	33.00	
	no, see instructions.	p p	9				
	Provi der-Based Physi ci ans						
34.00	Are services furnished at the provider facility under an a	rrangement wit	th provider-b	ased physicians?	N	34.00	
	If yes, see instructions.						
35. 00	If line 34 is yes, were there new agreements or amended ex		ents with the	provi der-based	N	35. 00	
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date		
				1.00	2. 00		
	Home Office Costs			1.00	2.00		
36 00	Were home office costs claimed on the cost report?			N		36.00	
	If line 36 is yes, has a home office cost statement been p	repared by the	e home office			37.00	
	If yes, see instructions.	p. 1 . 2 . 2					
38. 00	If line 36 is yes , was the fiscal year end of the home of			f N		38. 00	
00	the provider? If yes, enter in column 2 the fiscal year en					00	
39. 00		ier chain compo	onents? If ye	s, N		39.00	
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes soo	N		40.00	
40.00	instructions.	. Home office!	ii yes, see	IN		40.00	
		1.	. 00	2.	00		
	Cost Report Preparer Contact Information	L.,		1			
41. 00	Enter the first name, last name and the title/position	MI CHAEL		ALESSANDRI NI		41.00	
	held by the cost report preparer in columns 1, 2, and 3,						
42. 00	respectively. Enter the employer/company name of the cost report	BLUE & CO., LI	I C			42.00	
72.00	preparer.	DEUL & CO., LI				72.00	
43.00		317-713-7959		MALESSANDRI NI @	BLUEANDCO. COM	43.00	
	report preparer in columns 1 and 2, respectively.						

Heal th	Financial Systems MEMORIAL HOS	PI TAI	L LOGANSPORT	In Lie	u of Form CMS-2	2552-10
HOSPI 7	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0072	Peri od: From 01/01/2018	Worksheet S-2 Part II	
				To 12/31/2018		pared: _pm
			3. 00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	DI	I RECTOR			41.00
	held by the cost report preparer in columns 1, 2, and 3,					
	respecti vel y.					
42.00	Enter the employer/company name of the cost report					42.00
	preparer.					
43.00	Enter the telephone number and email address of the cos	:				43.00
	report preparer in columns 1 and 2, respectively.					

 Heal th Fi nancial
 Systems
 MEMORIAL I

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 | Peri od: | Worksheet S-3 | From 01/01/2018 | Part | | To | 12/31/2018 | Date/Time | Prepared: Provi der CCN: 15-0072

					T	o 12/31/2018	Date/Time Pre 4/1/2019 4:24	
							I/P Days /	
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00		2. 00	Available 3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and			39				1.00
1.00	8 exclude Swing Bed, Observation Bed and	00.00		0,	12, 707	0.00	Ĭ	1.00
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)		İ					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			39	12, 959	0. 00	0	7. 00
	beds) (see instructions)			_			_	
8. 00	INTENSIVE CARE UNIT	31.00		5	1, 825	0. 00	0	8. 00
9.00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)							11. 00 12. 00
13. 00	NURSERY	43.00					0	13.00
14. 00	Total (see instructions)	43.00		44	14, 784	0.00	_	14.00
15. 00	CAH visits			44	14, 704	0.00	0	15.00
16. 00	SUBPROVI DER - I PF							16.00
17. 00	SUBPROVI DER - I RF	41.00		0			0	17.00
18. 00	SUBPROVI DER	42. 00		0	l c		0	18. 00
19. 00	SKILLED NURSING FACILITY	44.00		0	C		0	19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
22.00	HOME HEALTH AGENCY							22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24.00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC						_	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			44			_	27.00
28. 00 29. 00	Observation Bed Days						0	28. 00 29. 00
30.00	Ambulance Trips Employee discount days (see instruction)							30.00
31.00	Employee discount days (see Instruction)							31.00
32. 00	Labor & delivery days (see instructions)			5	1, 825			32.00
32. 00	Total ancillary labor & delivery room			3	1,025			32.00
02.01	outpatient days (see instructions)] 52.01
33.00	1 '							33.00
33. 01	LTCH site neutral days and discharges							33. 01

 Heal th Fi nancial
 Systems
 MEMORIAL I

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 15-0072

Peri od: Peri od: Worksheet S-3 From 01/01/2018 Part I To 12/31/2018 Date/Ti me Prepared:

				'		4/1/2019 4: 24	pm
	<u> </u>	I/P Davs	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	'			Pati ents	& Residents	Payrol I	
		6. 00	7.00	8.00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 668	182	3, 777	•		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)	16	1, 333				2.00
3.00	HMO IPF Subprovider	ol	0				3.00
4.00	HMO IRF Subprovider	o	0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	l c			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	Ĭ	0	Č			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 668	182	3, 777	,		7.00
7.00	beds) (see instructions)	1,000	102	0, , , ,			7.00
8. 00	INTENSIVE CARE UNIT	220	0	435			8. 00
9. 00	CORONARY CARE UNIT	220	J	100			9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		0	1, 044			13.00
14. 00	Total (see instructions)	1, 888	182	5, 256		496. 31	
15. 00	CAH visits	1,000	102	5, 250		490.31	15.00
	1	٥	U	_	,		•
16.00	SUBPROVIDER - I PF		0	_	0.00	0.00	16.00
17. 00	SUBPROVIDER - IRF	0	0	C		0.00	
18.00	SUBPROVI DER		0	C			
19.00	SKILLED NURSING FACILITY	0	0	(0. 00	0. 00	•
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			C			24. 10
25.00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	496. 31	27.00
28.00	Observation Bed Days		14	1, 059			28. 00
29.00	Ambul ance Trips	1					29. 00
30.00	Employee discount days (see instruction)			C)		30.00
31.00	Employee discount days - IRF			C)		31.00
32.00	Labor & delivery days (see instructions)	o	0	262			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	o					33.00
	LTCH site neutral days and discharges	o					33. 01
	1	-1	ļ	Į.	į.	1	

Provider CCN: 15-0072 | Period: | Worksheet S-3 | Part | To | 12/31/2018 | Date/Time Prepared:

					12/31/2010	4/1/2019 4: 24	
	·	Full Time	<u> </u>	Di sch	arges		
		Equi val ents			•		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	664	79	1, 659	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			5	574		2.00
3. 00	HMO IPF Subprovider				0		3.00
4. 00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	I NTENSI VE CARE UNI T						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	664	79	1, 659	1
15.00	CAH visits						15.00
16. 00	SUBPROVIDER - I PF		_	_	_	_	16.00
17. 00	SUBPROVIDER - IRF	0.00	0		0	0	17.00
18.00	SUBPROVI DER	0.00	0		O	0	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						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC	0.00					26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27.00
28. 00	Observation Bed Days						28.00
29. 00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0	l		33. 01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0072

					1	o 12/31/2018		
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	pili
		1. 00	2. 00	A-6) 3. 00	4.00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200.00	32, 606, 351	0	32, 606, 351	1, 024, 316. 00	31. 83	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
	A		O					
3. 00	Non-physician anesthetist Part B		0	0	0	0. 00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		0	0	0	0. 00	0. 00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0 3, 883, 917	0	1	0. 00 44, 030. 00		4. 01 5. 00
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0. 00	0. 00	6. 00
7. 00	services Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	0	0	0. 00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see instructions)	44. 00	0 4, 679, 287	0 2, 537, 099	7, 216, 386	0. 00 155, 474. 00		
	OTHER WAGES & RELATED COSTS				<u> </u>			
11. 00	Contract Labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12. 00	Contract labor: Top level management and other management and administrative		0	0	0	0.00	0.00	12.00
13. 00	services Contract Labor: Physician-Part A - Administrative		314, 684	0	314, 684	3, 216. 00	97. 85	13. 00
14. 00	Home office and/or related organization salaries and		0	0	0	0.00	0. 00	14. 00
14. 01	wage-related costs Home office salaries		0	0	0	0. 00	0. 00	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00	0.00	
16. 00	- Administrative Home office and Contract		0	0	0	0. 00	0. 00	16. 00
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		8, 210, 495	0	8, 210, 495			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		1, 823, 769 0	0	1, 823, 769 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	B Physician Part A - Administrative		0	0	0			22. 00
22. 01	Physician Part A - Teaching		0	О	0			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		598, 407 0	0	598, 407 0			23. 00 24. 00
25. 00	Interns & residents (in an		0	0	o o			25. 00
25. 50	approved program) Home office wage-related (core)		0	0	0			25. 50
25. 51	Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	0	О			25. 52
25. 53	wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25. 53
	wage-related (cole)	l		I	I	I	I	l

Health Financial Systems

MEMORIAL HOSPITAL LOGANSPORT

In Lieu of Form CMS-2552-10

Provider CCN: 15-0072

Period: From 01/01/2018 To 12/31/2018

Part II Date/Time Prepared: 4/1/2019 4: 24 pm

Wkst. A Line Amount Reclassificat Adjusted Indicate Reported Form CMS-2552-10

Provider CCN: 15-0072

Period: Worksheet S-3

Part II Date/Time Prepared: 4/1/2019 4: 24 pm

Average Related to Hourly Wage

Windle								4/1/2019 4: 24	pm
Sal ari es (from Wist. A-6) Sal ari es in col. 4 col. 5)			Wkst. A Line	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
OVERHEAD COSTS - DIRECT SALARIES 26.00 3.00 4.00 5.00 6.00			Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
1.00 2.00 3.00 4.00 5.00 6.00					Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
1.00 2.00 3.00 4.00 5.00 6.00					(from Wkst.	3)	col. 4	col. 5)	
OVERHEAD COSTS - DI RECT SALARI ES 26.00 Employee Benefit to Department 4.00 309,030 0 309,030 10,365.00 29.81 26.00 27.00 Administrative & General 5.00 3,573,780 0 3,573,780 149,811.00 23.86 27.00 28.00 Administrative & General under contract (see inst.) 319,644 0 319,644 1,567.00 203.98 28.00 29.00 200					A-6)				
26. 00 Employee Benefits Department 4. 00 309, 030 0 309, 030 10, 365. 00 29. 81 26. 00 27. 00 Administrative & General 5. 00 3, 573, 780 0 3, 573, 780 149, 811. 00 23. 86 27. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 29. 27 30. 00 29. 27 29.			1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
27. 00 Administrative & General 28.00 5.00 3,573,780 0 3,573,780 149,811.00 23.86 27.00 28. 00 Administrative & General under contract (see inst.) 319,644 0 319,644 1,567.00 203.98 28.00 29. 00 Maintenance & Repairs 6.00 0 0 0 0.00 0.00 29.27 30.00 30. 00 Operation of Plant 7.00 639,692 0 639,692 21,856.00 29.27 30.00 31. 00 Laundry & Linen Service 8.00 0 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 31.00 0.00		OVERHEAD COSTS - DIRECT SALARI	ES						
28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 319,644 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26.00	Employee Benefits Department	4.00	309, 030	0	309, 030	10, 365. 00		
Contract (see inst.) 27.00	Administrative & General	5. 00	3, 573, 780	0	3, 573, 780	149, 811. 00	23. 86	27.00	
29.00 Maintenance & Repairs 6.00 0 0 0 0 0 0.00 29.00 30.00 Operation of Plant 7.00 639,692 0 639,692 21,856.00 29.27 30.00 31.00 Laundry & Linen Service 8.00 0 0 0 0 0.00 31.00 32.00 Housekeeping under contract (see instructions) 10.00 453,299 -340,560 112,739 8,401.00 13.42 34.00 13.00 Cafeteria 11.00 0 340,560 340,560 26,246.00 12.98 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28.00	Administrative & General under	1	319, 644	0	319, 644	1, 567. 00	203. 98	28. 00
30.00 Operation of Plant 7.00 639,692 0 639,692 21,856.00 29.27 30.00 31.00 Laundry & Linen Service 8.00 0 0 0 0 0 0.00 31.00 32.00 Housekeeping 9.00 528,712 0 528,712 40,383.00 13.09 32.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									
31.00 Laundry & Linen Service	29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00	0. 00	
32. 00 Housekeeping Housekeeping under contract (see instructions) 34. 00 Di etary under contract (see instructions) 36. 00 Cafeteria 11. 00	30.00	Operation of Plant	7. 00	639, 692	0	639, 692	21, 856. 00	29. 27	30.00
33. 00 Housekeeping under contract (see instructions) 34. 00 Di etary under contract (see instructions) 35. 00 Di etary under contract (see instructions) 36. 00 Cafeteria 11. 00 0 340, 560 340, 560 26, 246. 00 12. 98 36. 00 37. 00 Maintenance of Personnel 12. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00			0	0	0			
(see instructions) 34.00 Di etary 35.00 Di etary under contract (see instructions) 36.00 Cafeteria 37.00 Maintenance of Personnel 38.00 Nursi ng Administrati on 39.00 Central Services and Supply 40.00 Pharmacy 42.00 Social Service 10.00 453, 299 -340, 560 112, 739 8, 401.00 13.42 34.00 453, 299 -340, 560 0 0 0 0 0.00 12.98 36.00 36.00 37.00 340, 560 26, 246.00 12.98 36.00 38.40 0 0 0 0 0 0 0 0 0 0.00 37.00 38.00 Nursi ng Administrati on 13.00 609, 609 0 609, 609 15, 035.00 40.55 38.00 39.00 Central Services and Supply 14.00 230, 992 0 230, 992 14, 632.00 15.79 39.00 40.00 Pharmacy 15.00 509, 667 0 509, 667 14, 893.00 34.22 40.00 41.00 Social Service 17.00 315, 832 0 315, 832 11, 472.00 27.53 42.00	32.00	Housekeepi ng	9. 00	528, 712	0	528, 712	40, 383. 00	13. 09	32.00
34. 00 Di etary Di etary under contract (see instructions) 36. 00 Cafeteria 11. 00 0 340, 560 0 0 0 0 0.00 35. 00 38. 00 Mai ntenance of Personnel 12. 00 0 0 0 0.00 37. 00 38. 00 Nursi ng Administrati on 13. 00 609, 609 0 609, 609 15, 035. 00 40. 55 38. 00 39. 00 Central Services and Supply 14. 00 230, 992 0 230, 992 14, 632. 00 15. 79 39. 00 40. 00 Pharmacy 15. 00 509, 667 0 509, 667 14, 893. 00 34. 22 40. 00 41. 00 Medi cal Records & Medi cal Records & Medi cal Records Li brary 17. 00 Soci al Service 17. 00 315, 832 0 315, 832 11, 472. 00 27. 53 42. 00	33.00	Housekeeping under contract		0	0	0	0. 00	0. 00	33.00
35. 00 Di etary under contract (see i nstructions) 36. 00 Cafeteria 11. 00 0 340, 560 26, 246. 00 12. 98 36. 00 37. 00 Mai ntenance of Personnel 12. 00 0 0 0 0 0. 00 37. 00 38. 00 Nursi ng Administrati on 13. 00 609, 609 0 609, 609 15, 035. 00 40. 55 38. 00 39. 00 Central Services and Supply 14. 00 230, 992 0 230, 992 14, 632. 00 15. 79 39. 00 40. 00 Pharmacy 15. 00 509, 667 0 509, 667 14, 893. 00 34. 22 40. 00 41. 00 Medi cal Records & Medi cal Records & Medi cal Records Li brary 17. 00 Soci al Service 17. 00 315, 832 0 315, 832 11, 472. 00 27. 53 42. 00		(see instructions)							
instructions) 36. 00 Cafeteria	34.00	Di etary	10.00	453, 299	-340, 560	112, 739	8, 401. 00	13. 42	34.00
36. 00 Cafeteria 11. 00 0 340, 560 340, 560 26, 246. 00 12. 98 36. 00 37. 00 Maintenance of Personnel 12. 00 0 0 0 0 0. 00 37. 00 38. 00 Nursi ng Administrati on 13. 00 609, 609 0 609, 609 15, 035. 00 40. 55 38. 00 39. 00 Central Services and Supply 14. 00 230, 992 0 230, 992 14, 632. 00 15. 79 39. 00 40. 00 Pharmacy 15. 00 509, 667 0 509, 667 14, 893. 00 34. 22 40. 00 41. 00 Medical Records & Medical 16. 00 696, 528 0 696, 528 32, 777. 00 27. 53 42. 00 42. 00 Social Service 17. 00 315, 832 0 315, 832 11, 472. 00 27. 53 42. 00	35.00	Dietary under contract (see		0	0	0	0. 00	0. 00	35.00
37. 00 Maintenance of Personnel 12. 00 0 0 0 0. 00 37. 00 38. 00 Nursing Administration 13. 00 609, 609 0 609, 609 15, 035. 00 40. 55 38. 00 39. 00 Central Services and Supply 14. 00 230, 992 0 230, 992 14, 632. 00 15. 79 39. 00 40. 00 Pharmacy 15. 00 509, 667 0 509, 667 14, 893. 00 34. 22 40. 00 41. 00 Medical Records & Medical Records & Medical Records Library 17. 00 Social Service 17. 00 315, 832 0 315, 832 11, 472. 00 27. 53 42. 00		instructions)							
38.00 Nursi ng Admini strati on 13.00 609, 609 0 609, 609 15, 035.00 40.55 38.00 230, 992 14, 632.00 15.79 39.00 40.00 Pharmacy 15.00 509, 667 0 509, 667 14, 893.00 34.22 40.00 Medi cal Records & Medi cal Records & Medi cal Records Li brary Soci al Servi ce 17.00 315, 832 0 315, 832 11, 472.00 27.53 42.00	36.00	Cafeteri a	11. 00	0	340, 560	340, 560	26, 246. 00	12. 98	36.00
39. 00 Central Services and Supply 14. 00 230, 992 0 230, 992 14, 632. 00 15. 79 39. 00 40. 00 Pharmacy 15. 00 509, 667 0 509, 667 14, 893. 00 34. 22 40. 00 41. 00 Medi cal Records & Medi cal Records & Medi cal Records Li brary 42. 00 Soci al Service 17. 00 315, 832 0 315, 832 11, 472. 00 27. 53 42. 00	37.00	Maintenance of Personnel	12. 00	0	0	0	0. 00	0. 00	37.00
40. 00 Pharmacy Pharmacy 15. 00 509, 667 0 509, 667 14, 893. 00 34. 22 40. 00 41. 00 Medi cal Records & Medi cal Records Li brary 16. 00 696, 528 0 696, 528 32, 777. 00 21. 25 41. 00 42. 00 Soci al Servi ce 17. 00 315, 832 0 315, 832 11, 472. 00 27. 53 42. 00	38.00	Nursing Administration	13.00	609, 609	0	609, 609	15, 035. 00	40. 55	38. 00
41. 00 Medi cal Records & Medi cal 16. 00 696, 528 0 696, 528 32, 777. 00 21. 25 41. 00 42. 00 Soci al Servi ce 17. 00 315, 832 0 315, 832 11, 472. 00 27. 53 42. 00	39.00	Central Services and Supply	14. 00	230, 992	0	230, 992	14, 632. 00	15. 79	39.00
Records Li brary 42. 00 Soci al Servi ce 17. 00 315, 832 0 315, 832 11, 472. 00 27. 53 42. 00	40.00	Pharmacy	15. 00	509, 667	0	509, 667	14, 893. 00	34. 22	40.00
42. 00 Soci al Servi ce	41.00	Medical Records & Medical	16.00	696, 528	0	696, 528	32, 777. 00	21. 25	41.00
		Records Library							
43.00 Other General Service 18.00 0 0 0 0 0.00 43.00	42.00	Social Service	17.00	315, 832	0	315, 832	11, 472. 00	27. 53	42.00
	43.00	Other General Service	18. 00	0	0	0	0. 00	0. 00	43.00

Health Financial Systems MEMORIAL HOSPITAL		Τ	In Lieu	In Lieu of Form CMS-2552-10	
HOSPITAL WAGE INDEX INFORMATION	Provi der	CCN: 15-0072	Peri od:	Worksheet S-3	

110311	THE WAGE TRUES THE ORIGINATION			. Trovider c		From 01/01/2018 To 12/31/2018		
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col	. Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		29, 042, 078	0	29, 042, 07	78 981, 853. 00	29. 58	1.00
	instructions)							
2.00	Excluded area salaries (see		4, 679, 287	2, 537, 099	7, 216, 38	155, 474. 00	46. 42	2.00
	instructions)							
3.00	Subtotal salaries (line 1		24, 362, 791	-2, 537, 099	21, 825, 69	826, 379. 00	26. 41	3.00
	minus line 2)							
4.00	Subtotal other wages & related		314, 684	0	314, 68	3, 216. 00	97. 85	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		8, 210, 495	0	8, 210, 49	0.00	37. 62	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		32, 887, 970	-2, 537, 099	30, 350, 87	1 829, 595. 00	36. 59	6.00
7.00	Total overhead cost (see		8, 186, 785	0	8, 186, 78	347, 438. 00	23. 56	7.00
	instructions)							

Health Financial Systems	MEMORIAL HOSPITAL LOGANSPORT	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0072	Peri od: Worksheet S-3 From 01/01/2018 Part IV To 12/31/2018 Date/Time Prepared:

	To 12/31/2018	Date/Time Pre 4/1/2019 4:24	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		1
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	267, 427	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8. 03	Health Insurance (Purchased)	7, 313, 594	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	159, 797	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	47, 867	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	317, 165	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	340, 189	15.00
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	2, 135, 661	17. 00
	Medicare Taxes - Employers Portion Only	0	
	Unempl oyment Insurance	12, 089	19.00
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 instructions))	0	21.00
22. 00	Day Care Cost and Allowances	0	22.00
	Tui ti on Rei mbursement	38, 881	23. 00
	Total Wage Related cost (Sum of lines 1 -23)	10, 632, 670	1
	Part B - Other than Core Related Cost	., , ,	
25. 00	OTHER	0	25. 00

Health Financial Systems	MEMORIAL HOSPITAL LOGANSPORT	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0072	Period: Worksheet S-3 From 01/01/2018 Part V

		To	12/31/2018	Date/Time Pre	
		Щ,		4/1/2019 4: 24	pm
	Cost Center Description		Contract	Benefit Cost	
			Labor		
			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	10, 632, 670	1.00
2.00	Hospi tal		0	10, 632, 670	2.00
3.00	Subprovi der - IPF				3.00
4.00	Subprovi der - I RF		0	0	4.00
5.00	Subprovi der - (0ther)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7. 00	Swing Beds - NF		0	0	7.00
8.00	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				11.00
12.00	Separately Certified ASC				12.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospi tal -Based-CMHC				16.00
17.00	Renal Dialysis				17.00
18.00	Other Other		0	0	18. 00

	Financial Systems MEMORIAL HOSPITAL L			u of Form CMS-2				
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0072	Peri od: From 01/01/2018		0			
			To 12/31/2018		pared:			
				1. 00				
	Uncompensated and indigent care cost computation							
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di Medicaid (see instructions for each line)	vided by line 202 colu	ımn 8)	0. 291857	1.00			
2.00	Net revenue from Medicaid			7, 501, 881	2.00			
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00				
4. 00 5. 00	If line 3 is yes, does line 2 include all DSH and/or supplemen If line 4 is no, then enter DSH and/or supplemental payments f		cai d?	o	4. 00 5. 00			
6. 00	Medicaid charges	olli wedi card		25, 543, 150				
7. 00	Medicaid cost (line 1 times line 6)			7, 454, 947				
8.00	Difference between net revenue and costs for Medicaid program	(line 7 minus sum of I	ines 2 and 5; if	0	8. 00			
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for</pre>	or each line)						
9. 00	Net revenue from stand-alone CHIP	or each title)		0	9.00			
10.00	Stand-alone CHIP charges			0				
11.00	Stand-alone CHIP cost (line 1 times line 10)			0				
12. 00	Difference between net revenue and costs for stand-alone CHIP enter zero)	(line 11 minus line 9;	if < zero then	0	12.00			
	Other state or local government indigent care program (see ins	tructions for each lin	ne)		-			
13.00	Net revenue from state or local indigent care program (Not inc			0	13.00			
14.00	Charges for patients covered under state or local indigent car	e program (Not include	ed in lines 6 or	0	14.00			
15. 00	10) State or local indigent care program cost (line 1 times line 1	1)		0	15.00			
16. 00	Difference between net revenue and costs for state or local in	ine 15 minus line						
	13; if < zero then enter zero)							
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)							
17. 00	Private grants, donations, or endowment income restricted to f	3		0				
18. 00 19. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and Loca	ome (sum of lines	0					
17.00	8, 12 and 16)	Thurgent care progra	illis (sulli or rifles		17.00			
		Uni nsured		Total (col. 1				
		patients 1.00	pati ents 2.00	+ col . 2) 3.00				
	Uncompensated Care (see instructions for each line)	1.00	2.00	3.00				
20. 00	Charity care charges and uninsured discounts for the entire fa (see instructions)	cility 808,	964 675, 412	1, 484, 376	20.00			
21. 00	Cost of patients approved for charity care and uninsured discoinstructions)	unts (see 236,	102 675, 412	911, 514	21.00			
22. 00	Payments received from patients for amounts previously written charity care	off as	0 0	0	22. 00			
23. 00	Cost of charity care (line 21 minus line 22)	236,	102 675, 412	911, 514	23. 00			
				1. 00				
24. 00	Does the amount on line 20 column 2, include charges for patie	nt davs bevond a Lengt	th of stav limit	N N	24.00			
25. 00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t	program?	,	0				
	stay limit		3					
26. 00 27. 00	Total bad debt expense for the entire hospital complex (see in Medicare reimbursable bad debts for the entire hospital comple	•		10, 015, 631 92, 503				
27. 00	Medicare allowable bad debts for the entire hospital complex (•		142, 311				
	1							
28. 00								
28. 00 29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	oense (see instruction	ns)	2, 931, 406	29. 00			
28. 00 29. 00 30. 00	1 , , , , , , , , , , , , , , , , , , ,	·	ns)		29. 00 30. 00			

32, 606, 351

50, 114, 890

82, 721, 241

0

82, 721, 241 200. 00

200.00

TOTAL (SUM OF LINES 118 through 199)

Health FinancialSystemsMEMORIAL HOSRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0072

| Period: | Worksheet A | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: 4/1/2019 4: 24 pm

				4/1/2019 4: 24	4 pm
	Cost Center Description	Adjustments	Net Expenses		
	·	(See A-8)	For		
			Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT	-19, 677			1.00
1. 01	00101 MOB	0		i de la companya del companya de la companya de la companya del companya de la co	1. 01
1. 02	00102 OPS	0	,		1. 02
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2, 838			4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	-3, 375, 853			5. 00
7. 00	00700 OPERATION OF PLANT	-11, 994			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	169, 210		8.00
9. 00	00900 HOUSEKEEPI NG	0	745, 245		9. 00
10.00	01000 DI ETARY	-41, 654			10.00
11.00	01100 CAFETERI A	-315, 471	571, 185		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-2, 333			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-73, 748			14.00
15. 00	01500 PHARMACY	0	,	l control of the cont	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-29, 424			16.00
17. 00	01700 SOCI AL SERVI CE	0	335, 405	j	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-1, 105, 285			30.00
31.00	03100 I NTENSI VE CARE UNI T	0	612, 015	l e e e e e e e e e e e e e e e e e e e	31.00
41.00	04100 SUBPROVI DER – I RF	0	0		41.00
42.00	04200 SUBPROVI DER	0	0		42.00
43.00	04300 NURSERY	0			43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0)	44. 00
FO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		2 241 454	ı	
50.00	· ·	0			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		•	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	-878, 972		i de la companya del companya de la companya de la companya del companya de la co	53.00
	· ·	0	, , , , , , , , , , , , , , , , , , , ,	l e e e e e e e e e e e e e e e e e e e	54.00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		_		59.00
60.00	06000 LABORATORY	0	ŀ		60.00
60. 00	06001 BLOOD LABORATORY	0	2, 760, 076 0	1	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	124, 887		63.00
65. 00	06500 RESPIRATORY THERAPY	0	753, 370		65.00
66. 00	06600 PHYSI CAL THERAPY	0	925, 558		66.00
69. 00	06900 ELECTROCARDI OLOGY	0	471, 860		69.00
69. 01	06901 CARDI AC REHAB	-1, 500			69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 203, 340		71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1	l control of the cont	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7, 014, 435		73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0	410, 383		76.00
76. 01	03040 RADI ATI ON ONCOLOGY	-1, 382, 740			76.00
70.01	OUTPATIENT SERVICE COST CENTERS	1,002,710	701,002		70.01
90.00	09000 CLINIC	-4, 626, 794	3, 173, 653		90.00
	09001 WOUND CARE	-497, 213			90. 01
	09100 EMERGENCY	-762, 639	l '		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		.,,		92.00
	OTHER REIMBURSABLE COST CENTERS	L	L		1
95.00		0	0		95.00
	SPECIAL PURPOSE COST CENTERS		-	1	1
118.00		-13, 128, 135	61, 003, 582		118.00
	NONREI MBURSABLE COST CENTERS			1	
194.00	07950 FOUNDATI ON	0	2, 276		194. 00
194.01	1 07951 MOB	0			194. 01
194. 02	07952 NONREI MBURSABLE OTHER	0	0		194. 02
194. 03	3 07953 PI H	0	0		194. 03
194. 04	1 07954 HEALTH COMPANIES	0	711, 132		194.04
194.05	07955 PHYSICIANS OFFICE	0	7, 258, 583		194. 05
	07956 THE ARBORS	0	0		194.06
194.07	7 07957 PAIN MANAGEMENT	0	235, 016		194.07
	3 07958 OPS	0	0		194. 08
194.09	07959 MHL ROCHESTER HEALTH CENTER	0	113, 026	b	194. 09
	07961 RHEUMATOLOGY	0	138, 144		194. 10
	07960 SPORTS HEALTH	0	1		194. 11
200.00		-13, 128, 135			200.00
	- '				

Health Financial Systems	MEMORIAL HOSPITAL LOGANSPORT	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 15-0072	Period: Worksheet A-6 From 01/01/2018

					To 12/31/2018 Date/Time Pr 4/1/2019 4:2	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - CAFETERIA RECLASS					
1.00	CAFETERI A	1100	34 <u>0, 5</u> 60	54 <u>6, 0</u> 96		1.00
	0		340, 560	546, 096		
	B - OB RECLASS					
1.00	NURSERY	43.00	282, 271	44, 682		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	659, 131	104, 081		2.00
	0		941, 402	148, 763		
	C - MALPRACTICE INS. RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	458, 437		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		0.00	0	0		5. 00
	0		0	458, 437		
	D - IMPLANT EXPENSE RECLASS					
1.00	IMPL. DEV. CHARGED TO	72. 00	0	1, 489, 183		1.00
	PATI ENT					
	0		0	1, 489, 183]
	E - SURGICAL SERVICES RECLASS	<u> </u>				
1.00	PHYSICIANS OFFICE	194. 05	<u>2, 537, 0</u> 99	43 <u>3, 9</u> 12		1.00
	TOTALS		2, 537, 099	433, 912]
	F - UTILITIES RECLASS					
1.00	OPERATION OF PLANT		0	1 <u>9, 8</u> 76		1. 00
	TOTALS		0	19, 876		
500.00	Grand Total: Increases		3, 819, 061	3, 096, 267		500.00

Health Financial Systems MEMORIAL HOSPITAL LOGANSPORT In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0072 Period: From 01/01/2018 To 12/31/2018 Date/Time Prepared:

					To	o 12/31/2018	Date/Time Prepared: 4/1/2019 4:24 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - CAFETERIA RECLASS						
1.00	DI ETARY	1000	34 <u>0, 5</u> 60	54 <u>6, 0</u> 96			1.00
	0		340, 560	546, 096			
	B - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30. 00	941, 402	148, 763	0		1.00
2.00		000	0_	0	0		2.00
	0		941, 402	148, 763			
	C - MALPRACTICE INS. RECLASS						
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	309, 575	12		1.00
	FIXT						
2.00	HEALTH COMPANIES	194. 04	0	60	1		2.00
3.00	PHYSI CI ANS OFFI CE	194. 05	0	144, 126			3.00
4.00	PAIN MANAGEMENT	194. 07	0	3, 318			4.00
5. 00	RHEUMATOLOGY	1 <u>94.</u> 10	0_	<u>1, 3</u> 58			5. 00
	0		0	458, 437			
	D - IMPLANT EXPENSE RECLASS						
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 489, 183	0		1.00
	PATI ENTS	+	+				
	0		0	1, 489, 183			
	E - SURGI CAL SERVI CES RECLASS						
1. 00	OPERATI NG ROOM	5000	2, 537, 099	433, 912			1.00
	TOTALS		2, 537, 099	433, 912			
	F - UTILITIES RECLASS						
1. 00	RADI ATI ON ONCOLOGY	<u> </u>		19, 876			1.00
	TOTALS		0	19, 876			
500. 00	Grand Total: Decreases		3, 819, 061	3, 096, 267			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0072

				1	0 12/31/2018	4/1/2019 4: 24	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	205, 783	0	0	0	0	1.00
2.00	Land Improvements	692, 370	177, 329	0	177, 329	0	2.00
3.00	Buildings and Fixtures	60, 823, 505	5, 871, 694	0	5, 871, 694	0	3.00
4.00	Building Improvements	6, 044, 627	4, 629, 549	0	4, 629, 549	9, 030, 066	4.00
5.00	Fixed Equipment	42, 498, 651	3, 972, 180	0	3, 972, 180	4, 400	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	110, 264, 936	14, 650, 752	0	14, 650, 752	9, 034, 466	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	110, 264, 936	14, 650, 752	0	14, 650, 752	9, 034, 466	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	205, 783	0				1. 00
2.00	Land Improvements	869, 699	0				2.00
3.00	Buildings and Fixtures	66, 695, 199	0				3.00
4.00	Building Improvements	1, 644, 110	0				4. 00
5.00	Fi xed Equi pment	46, 466, 431	0				5.00
6.00	Movable Equipment	0	0				6.00
7. 00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	115, 881, 222	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	115, 881, 222	0				10.00

Health Financial Systems M	IEMORIAL HOSPITAL	LOGANSPORT		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od: From 01/01/2018 To 12/31/2018	Worksheet A-7 Part II Date/Time Pre 4/1/2019 4:24	pared:
		Sl	JMMARY OF CAP	ITAL		
Cost Center Description	Depreciation	Lease	Interest	I nsurance (see	Taxes (see	

				'	0 12/31/2010	4/1/2019 4: 24	
			SU	IMMARY OF CAPIT	AL		
	Cook Cooker December 1	Depreciation	1	1	1	T (
	Cost Center Description		Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)		
		9. 00	10. 00	11. 00	12. 00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1 a	and 2	,		
1.00	NEW CAP REL COSTS-BLDG & FIXT	4, 293, 287	0	463, 455	391, 526	0	1.00
1.01	MOB	225, 503	0	0	0	0	1.01
1.02	OPS	147, 326	0	0	0	0	1.02
3.00	Total (sum of lines 1-2)	4, 666, 116	0	463, 455	391, 526	0	3.00
		SUMMARY 0	F CAPITAL		,		
	Cost Center Description	Other	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	5, 148, 268				1.00
1.01	MOB	0	225, 503				1.01
1.02	OPS	0	147, 326				1.02
3.00	Total (sum of lines 1-2)	0	5, 521, 097				3.00

Health Financial Systems	MEMORIAL HOSPIT	TAL LOGANSPORT		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
				T	4/1/2019 4: 24	pm
	COM	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tali zed	Gross Assets	Ratio (see	Insurance	
cost center bescription	GLOSS ASSELS	Leases	for Ratio	instructions)	i iisui aiice	
		Leases	(col. 1 -	Thisti detrois)		
			col . 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FLXT	108, 055, 987	0	108, 055, 98	7 0. 932472	0	1.00
1. 01 MOB	4, 733, 038	0	4, 733, 03	0. 040844	0	1.01
1. 02 OPS	3, 092, 197	0	3, 092, 19	7 0. 026684	0	1.02
3.00 Total (sum of lines 1-2)	115, 881, 222		115, 881, 22			3.00
	ALLOCA:	TION OF OTHER (CAPITAL	SUMMARY (F CAPITAL	
			I=			
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at				
	6, 00	ed Costs	through 7)	9, 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS		7. 00	8. 00	9.00	10.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	CENTERS) 0	N.	4, 273, 628	0	1. 00
1. 01 MOB		_		225, 503		1.00
1. 02 OPS				147, 326		1. 02
3.00 Total (sum of lines 1-2)				0 4, 646, 457		3.00
0.00 10tal (3am 01 11163 1 2)		SI	JMMARY OF CAPI		Ü	0.00
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
·		(see	instructions)			
		instructions)			9 through 14)	
				instructions)		
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS				_	1 010 511	4.00
1.00 NEW CAP REL COSTS-BLDG & FIXT	463, 455	81, 933	1	0	4, 819, 016	1.00
1. 01 MOB				0	225, 503	1.01
1.02 OPS	442 455	01 022		0	,	1.02
3.00 Total (sum of lines 1-2)	463, 455	81, 933	1	0	5, 191, 845	3. 00

In Lieu of Form CMS-2552-10 Provi der CCN: 15-0072 ADJUSTMENTS TO EXPENSES Peri od: Worksheet A-8 From 01/01/2018 12/31/2018 Date/Time Prepared: 4/1/2019 4:24 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Cost Center Description Amount Wkst. A-7 (2) Ref. 1. 00 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP ONEW CAP REL COSTS-BLDG & 1.00 1.00 REL COSTS-BLDG & FIXT (chapter lfi xt OMOB 1.01 Investment income - MOB 1.01 1.01 (chapter 2) 0 OPS 1.02 Investment income - OPS 1.02 1.02 (chapter 2) Investment income - CAP REL 0 *** Cost Center Deleted *** 2.00 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 discounts (chapter 8) 0.00 5.00 Refunds and rebates of 5.00 expenses (chapter 8) 6.00 Rental of provider space by 0.00 6.00 suppliers (chapter 8) 7.00 Tel ephone services (pay 0.00 7.00 stations excluded) (chapter 8.00 Tel evi si on and radi o servi ce 0.00 8.00 (chapter 21) 9 00 Parking lot (chapter 21) 0.00 9.00 10.00 -8, 842, 665 Provi der-based physici an A-8-2 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 0 (chapter 23) 12.00 Related organization A-8-1 12.00 0 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 Cafeteria-employees and guests -315, 471 CAFETERI A 11.00 14.00 14.00 Α 15.00 Rental of quarters to employee 0.00 15.00 and others 16, 00 Sale of medical and surgical 0 16.00 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than 17.00 0.00 0 pati ents 18.00 Sale of medical records and 0.00 18 00 abstracts Nursing and allied health 0.00 19.00 education (tuition, fees, books, etc.) 20.00 Vending machines 0.0020.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0 22.00 0.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) Adjustment for physical OPHYSICAL THERAPY 24.00 A - 8 - 366,00 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) Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 26.00 1.00 26.00 COSTS-BLDG & FLXT FLXT омов 26, 01 Depreciation - MOB 1.01 26.01 Depreciation - OPS OOPS 26.02 26. 02 1.02 Depreciation - CAP REL 0 *** Cost Center Deleted *** 27.00 2.00 27.00 COSTS-MVBLE EQUIP

0 *** Cost Center Deleted ***

19.00

0.00

28.00

0 29.00

Non-physician Anesthetist

29.00 Physicians' assistant

From 01/01/2018
To 12/31/2018 Date/Time Prepared:

					12/31/2010	4/1/2019 4: 24	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					•		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	5651 561161 56561 Pt. 611	(2)	7 1110 4111 6	0001 0010.	20 "	Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
30. 00	Adjustment for occupational	A-8-3		*** Cost Center Deleted ***	67. 00	0.00	30.00
30.00	therapy costs in excess of	7, 0, 3	0	Cost center bereted	07.00		30.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
30. 77	instructions)		0	ADDETS & FEDIATRICS	30.00		30. 77
31. 00	Adjustment for speech	A-8-3	_	*** Cost Center Deleted ***	68. 00		31.00
31.00	pathology costs in excess of	A-0-3	0	Cost Center Dereteu	00.00		31.00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32. 00
32.00	Depreciation and Interest		0		0.00	0	32.00
33. 00	OTHER REVENUE - MI SCELLANEOUS	В	4 020	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
34.00	1	В		ADMINISTRATIVE & GENERAL	5. 00	0	34. 00
	OTHER REVENUE - BAD DEBT			1			
35.00	OTHER REVENUE - MEDI CARE	В		ADMINISTRATIVE & GENERAL	5. 00	0	35.00
37. 00	OTHER REVENUE - BLUE CROSS	В		ADMINISTRATIVE & GENERAL	5. 00	0	37.00
38. 00	OTHER REVENUE - MEDICALD	В		ADMINISTRATIVE & GENERAL	5. 00	0	38. 00
39. 00	OTHER REVENUE - SCRAP SAL	В		ADMINISTRATIVE & GENERAL	5. 00	0	39. 00
40. 00	OTHER REVENUE - CASH OVER	В		ADMINISTRATIVE & GENERAL	5. 00	0	40.00
41. 00	MHL A/P DISCOUNTS	В		ADMINISTRATIVE & GENERAL	5. 00	0	41.00
44. 00	MHL TELEPHONE SERVICE	В	,	ADMINISTRATIVE & GENERAL	5. 00	0	44.00
45. 00	OTHER REVENUE - VENDING	В	-7, 782	DI ETARY	10. 00	0	45.00
	COMMI SSI ON	_					
45. 01	OTHER REVENUE - CASH	В	76	DI ETARY	10. 00	0	45. 01
	OVER/SHORT						
45. 02	MEALS ON WHEELS	В		DI ETARY	10. 00	0	45. 02
45. 03	DI ETARY REVENUE	В	-13, 526	DI ETARY	10. 00	0	45.03
45. 05	OTHER REVENUE - ACLS REVENUE	В	-140	NURSING ADMINISTRATION	13. 00	0	45. 05
45.06	OTHER REVENUE - CPR TRAINING	В	-2, 193	NURSING ADMINISTRATION	13. 00	0	45.06
45. 07	OTHER REVENUE - REBATES MMT	В	-73, 748	CENTRAL SERVICES & SUPPLY	14. 00	0	45.07
45.08	HIM MEDICAL RECORDS FEES	В	-29, 424	MEDICAL RECORDS & LIBRARY	16. 00	0	45.08
45.09	INTEREST INCOME	В	-18	NEW CAP REL COSTS-BLDG &	1. 00	12	45.09
				FIXT			
45. 10	PATIENT TELEVISIONS	Α	-543	OPERATION OF PLANT	7. 00	0	45. 10
45. 12	PATI ENT TELEPHONES	Α	-2, 838	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	45. 12
45. 13	PATIENT TELEPHONES	Α	-2, 438	NEW CAP REL COSTS-BLDG &	1. 00	9	45. 13
				FIXT			
45. 14	PATI ENT TELEPHONES	Α	-1, 904	ADMINISTRATIVE & GENERAL	5. 00	0	45. 14
45. 15	IHA & AHA LOBBYING FEES	Α	-1, 666	ADMINISTRATIVE & GENERAL	5. 00	0	45. 15
45. 16	GIFT SHOP	Α	-14, 288	NEW CAP REL COSTS-BLDG &	1. 00	9	45. 16
				FIXT			
45. 17	GIFT SHOP	Α	-9, 501	OPERATION OF PLANT	7. 00	0	45. 17
45. 18	ADVERTI SI NG	Α	-863, 180	ADMINISTRATIVE & GENERAL	5. 00	0	45. 18
	TAXES	А		ADMINISTRATIVE & GENERAL	5. 00	0	
45. 20	DONATI ON EXPENSE	А		ADMINISTRATIVE & GENERAL	5. 00	0	
45. 21	PHYSI CI AN RECRUI TMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	
45. 23	VENDI NG	A		NEW CAP REL COSTS-BLDG &	1. 00	9	45. 23
		.,		FLXT	00	,	
45. 24	VENDI NG	Α		OPERATION OF PLANT	7. 00	0	45. 24
45. 25	HOSPITAL ASSESSMENT FEE OFFSET	A		ADMINISTRATIVE & GENERAL	5. 00	n	45. 25
45. 26	HOSPITALIST OFFSET	A		ADULTS & PEDIATRICS	30. 00	0	45. 26
	TOTAL (sum of lines 1 thru 49)		-13, 128, 135	1	33.00	O	50.00
55. 55	(Transfer to Worksheet A,		10, 120, 100				55.00
	column 6, line 200.)						
(4) 0	200. 3 0, 11110 200.)			0110 D L 45 4			

⁽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.

Provider CCN: 15-0072

Peri od: Worksheet A-8-2 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

West. A Line # Cost Center/Physician Identifier Remuneration Provider Component Component Component Component RCE Amount Physician Provider Component Remuneration Component Remuneration Component Remuneration Remuneration Component Remuneration Remuneration Component Remuneration Remunerat								4/1/2019 4: 24	4 pm
1.00		Wkst. A Line #	Cost Center/Physician	Total	Professi ona	Provi der	RCE Amount		
1.00			l denti fi er	Remuneration	Component	Component		ider Component	
1.00 30. OQADULTS & PEDIATRICS 692, 807 692, 807 0 237, 100 0 1.00								Hours	
2.00		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
3.00	1. 00	30.00	ADULTS & PEDIATRICS	692, 807	692, 8	D7 C	237, 100	0	1.00
4. 00 90. 00 CLINIC 4.708, 020 4. 602, 075 105, 945 179, 000 884 4. 00 6. 00 99. 01 MOUND CARE 497, 213 4	2.00	53.00	ANESTHESI OLOGY	878, 972	878, 9	72 C	239, 400	0	2.00
S	3.00	69. 01	CARDI AC REHAB	1, 500	1, 50	00	179, 000	0	3.00
6.00	4.00	90.00	CLINIC	4, 708, 020	4, 602, 0	75 105, 945	179, 000	884	4.00
7. 00	5.00	90. 01	WOUND CARE	497, 213	497, 2	13 C	179, 000	0	5.00
8.00	6.00	91.00	EMERGENCY	762, 639	762, 6	39 C	246, 400	0	6.00
0	7.00	76. 01	RADIATION ONCOLOGY	1, 382, 740	1, 382, 7	40 C	179, 000	0	7.00
10.00	8.00	0.00		0		0 0	0	0	8. 00
Number N	9. 00	0.00		0		0 0	0	0	9. 00
Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit Cost of Identifier Unadjusted RCE Limit Cost of Identifier Cost of Identifier Unadjusted RCE Limit Cost of Share of col. Provider Component Share of col. Cost of Malpractice Insurance Cost of Malpractice Cos	10.00	0.00		0		0	0	0	10.00
Identifier	200.00			8, 923, 891	8, 817, 9	105, 945		884	200.00
1.00		Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent o	f Cost of	Provi der	Physician Cost	
1.00			l denti fi er	Limit	Unadjusted R	CE Memberships &	Component	of Mal practice	
1.00					Limit	Conti nui ng	Share of col.	Insurance	
1.00									
2. 00				-	9. 00				
3. 00 69. 01 CARDI AC REHAB 0 0 0 0 0 0 0 3. 00 4. 00 90. 00 CLI NI C 76, 075 3, 804 52, 707 1, 186 176, 196 4. 00 5. 00 90. 01 WOUND CARE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0				7, 654	
4.00				0		0	0	0	
S. 00				0		0	0	0	
6. 00 91. 00 EMERGENCY 0 0 0 0 0 0 0 0 0 7. 00 8. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				76, 075	3, 80	52, 707	1, 186	176, 196	
7. 00				0		0	0	0	
8. 00				0		0	0	0	
9.00				0		0	0	0	1
10.00				0		0	0	0	
Next				0		0	0	0	1
Wkst. A Line # Cost Center/Physician I dentifier Provider Component Share of col. 14 I mit Share of col. 14 I mit Di sal I owance Di sal I owance Adj ustment Di sal I owance		0.00		0		0	0	0	
Identifier Component Share of col. 14					3, 80		1, 186	183, 850	200.00
Share of col. 14		Wkst. A Line #					Adjustment		
1.00			l denti fi er		Limit	Di sal I owance			
1. 00 2. 00 15. 00 16. 00 17. 00 18. 00 1. 00 30. 00 ADULTS & PEDI ATRI CS 0 0 0 692, 807 1. 00 2. 00 53. 00 ANESTHESI OLOGY 0 0 0 878, 972 2. 00 3. 00 69. 01 CARDI AC REHAB 0 0 0 1,500 3. 00 4. 00 90. 00 CLI NI C 3, 965 81, 226 24, 719 4, 626, 794 4. 00 5. 00 90. 01 WOUND CARE 0 0 497, 213 5. 00 6. 00 91. 00 EMERGENCY 0 0 0 762, 639 6. 00 7. 00 76. 01 RADI ATI ON ONCOLOGY 0 0 0 0 1, 382, 740 7. 00 8. 00 0. 00 0 0 0 0 0 9. 00 10. 00 0 0 0 0 0 0 9. 00									
1. 00 30. 00 ADULTS & PEDI ATRI CS 0 0 692,807 1. 00 2. 00 53. 00 ANESTHESI OLOGY 0 0 0 878, 972 2. 00 3. 00 69. 01 CARDI AC REHAB 0 0 0 1,500 3. 00 4. 00 90. 00 CLI NI C 3, 965 81, 226 24, 719 4, 626, 794 4. 00 5. 00 90. 01 WOUND CARE 0 0 497, 213 5. 00 6. 00 91. 00 EMERGENCY 0 0 0 762, 639 6. 00 7. 00 76. 01 RADI ATI ON ONCOLOGY 0 0 0 1, 382, 740 7. 00 8. 00 0. 00 0 0 0 0 9. 00 9. 00 0. 00 0 0 0 0 9. 00 10. 00 0 0 0 0 0 9. 00									
2. 00 53. 00 ANESTHESI OLOGY 0 0 0 878, 972 2. 00 3. 00 69. 01 CARDI AC REHAB 0 0 0 1,500 3. 00 4. 00 90. 00 CLI NI C 3,965 81,226 24,719 4,626,794 4. 00 5. 00 90. 01 WOUND CARE 0 0 497,213 5. 00 6. 00 91. 00 EMERGENCY 0 0 0 762,639 6. 00 7. 00 76. 01 RADI ATI ON ONCOLOGY 0 0 0 1,382,740 7. 00 8. 00 0. 00 0 0 0 0 8. 00 9. 00 0. 00 0 0 0 0 9. 00 10. 00 0 0 0 0 0 9. 00 10. 00 0 0 0 0 0 0 0									
3. 00 69. 01 CARDI AC REHAB 0 0 0 1,500 3.00 4. 00 90. 00 CLI NI C 3,965 81,226 24,719 4,626,794 4.00 5. 00 90. 01 WOUND CARE 0 0 0 497,213 5.00 6. 00 91. 00 EMERGENCY 0 0 0 762,639 6.00 7. 00 76. 01 RADI ATI ON ONCOLOGY 0 0 0 1,382,740 7.00 8. 00 0. 00 0 0 0 0 0 9.00 9. 00 0. 00 0 0 0 0 9.00 10.00 10. 00 0 0 0 0 0 0 0 10.00				0		-			
4. 00 90. 00 CLINIC 3, 965 81, 226 24, 719 4, 626, 794 4. 00 5. 00 90. 01 WOUND CARE 0 0 497, 213 5. 00 6. 00 91. 00 EMERGENCY 0 0 0 762, 639 6. 00 7. 00 76. 01 RADI ATI ON ONCOLOGY 0 0 0 1, 382, 740 7. 00 8. 00 0. 00 0 0 0 0 9. 00 9. 00 0. 00 0 0 0 0 9. 00 10. 00 0 0 0 0 0 0 10. 00				0		0			4
5. 00 90. 01 WOUND CARE 0 0 497, 213 5. 00 6. 00 91. 00 EMERGENCY 0 0 0 762, 639 6. 00 7. 00 76. 01 RADI ATI ON ONCOLOGY 0 0 0 1, 382, 740 7. 00 8. 00 0. 00 0 0 0 0 8. 00 9. 00 0. 00 0 0 0 0 9. 00 10. 00 0 0 0 0 0 0 10. 00				0		0 0			
6. 00 91. 00 EMERGENCY 0 0 762, 639 6. 00 7. 00 7. 00 7. 00 7. 00 7. 00 7. 00 9. 00				3, 965	81, 2	26 24, 719			
7. 00				0		0			
8. 00 0. 00 9. 00 0. 00 10. 00 0. 00				0		0			4
9. 00 0. 00 0 0 0 9. 00 10. 00 0 0 10. 00				0			1, 382, 740		
10.00 0.00 10.00				0			0		1
				0			0		
200. 00 3, 965 81, 226 24, 719 8, 842, 665 200. 00				0		υ	0 0 0 0 0 0		
	200.00			3, 965	81, 2	26 24, 719	8, 842, 665	l	200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0072

			To	12/31/2018		
		CAPI	CAPITAL RELATED COSTS		4/1/2019 4: 24	pili
Cost Center Description	Net Expenses	NEW BLDG &	MOB	0PS	EMPLOYEE	
	for Cost Allocation	FLXT			BENEFITS DEPARTMENT	
	(from Wkst A				DEFARTMENT	
	col . 7)					
	0	1. 00	1. 01	1. 02	4. 00	
GENERAL SERVICE COST CENTERS	4 040 044	4 040 047	I	1		4 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 MOB	Г 4, 819, 016 225, 503	4, 819, 016 0	1			1. 00 1. 01
1. 02 00102 0PS	147, 326	0	223, 303	147, 326		1.01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	11, 664, 383	42, 664	0	0	11, 707, 047	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	6, 894, 662	367, 004	21, 160	o	1, 295, 413	5.00
7. 00 00700 OPERATION OF PLANT	2, 798, 215	903, 715		11, 704	231, 874	7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	169, 210 745, 245	15, 970 35, 753		0 432	0 191, 646	8. 00 9. 00
10. 00 01000 DI ETARY	251, 864	146, 674	732	432	40, 865	
11. 00 01100 CAFETERI A	571, 185	73, 145	·	o	123, 445	11.00
13.00 01300 NURSING ADMINISTRATION	618, 016	56, 740		o	220, 969	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	403, 347	105, 622	0	0	83, 729	14. 00
15. 00 01500 PHARMACY	921, 643	53, 822	0	0	184, 743	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	1, 197, 140 335, 405	190, 540 36, 444	0	0	252, 475 114, 482	16. 00 17. 00
INPATIENT ROUTINE SERVICE COST CEN		30, 444		<u> </u>	114, 402	17.00
30. 00 03000 ADULTS & PEDIATRICS	1, 908, 857	756, 070	0	0	948, 982	30.00
31.00 03100 INTENSIVE CARE UNIT	612, 015	135, 208	0	O	207, 338	
41. 00 04100 SUBPROVI DER - RF	0	0	1	0	0	41.00
42. 00 04200 SUBPROVI DER	0	0	0	0	102 217	42.00
43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY	327, 219 0	23, 085 0		ol Ol	102, 317 0	43. 00 44. 00
ANCI LLARY SERVICE COST CENTERS	<u> </u>	0	<u> </u>	<u> </u>	0	44.00
50. 00 05000 OPERATING ROOM	2, 341, 454	498, 732	0	2, 798	631, 298	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	764, 089	126, 660	0	o	238, 920	52.00
53. 00 05300 ANESTHESI OLOGY	85, 789	45, 121	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 910, 884	231, 054	0	8, 309	382, 003	54.00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE I MAGING (N	MRL)	0	0	0	0	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	Ö	o	0	59.00
60. 00 06000 LABORATORY	2, 760, 076	123, 794	6, 930	3, 875	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63. 00 06300 BLOOD STORING, PROCESSING & T		0	0	0	0	63.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	753, 370 925, 558	8, 804 97, 765	0	0	213, 178 62, 204	65. 00 66. 00
69. 00 06900 ELECTROCARDI OLOGY	471, 860	12, 259		0	128, 548	69.00
69. 01 06901 CARDI AC REHAB	345, 165	142, 374	0	Ö	117, 923	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO F		0	0	O	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT		0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 NUCLEAR MEDICINE-DIAGNOSTIC	7, 014, 435	19 740	0	0	0 77, 544	73.00
76. 00 03020 NUCLEAR MEDICINE-DI AGNOSTIC 76. 01 03040 RADIATION ONCOLOGY	410, 383 754, 562	18, 760	_	48 216		
OUTPATIENT SERVICE COST CENTERS	734, 302	0	0	48, 216	212, 454	76. 01
90. 00 09000 CLI NI C	3, 173, 653	5, 375	87, 349	0	2, 446, 442	90.00
90. 01 09001 WOUND CARE	197, 575	0	14, 106	0	44, 510	90. 01
91. 00 09100 EMERGENCY	1, 667, 068	392, 111	0	0	537, 972	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTING	CI PARI)					92.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	ol	0	95.00
SPECIAL PURPOSE COST CENTERS		<u> </u>	<u> </u>	<u> </u>		75.00
118.00 SUBTOTALS (SUM OF LINES 1 the	ough 117) 61,003,582	4, 645, 265	146, 227	75, 334	9, 091, 274	118. 00
NONREI MBURSABLE COST CENTERS						
194. 00 07950 FOUNDATI ON	2, 276	0		0		194.00
194. 01 07951 MOB 194. 02 07952 NONREI MBURSABLE OTHER	721 0	0	38, 285	0		194. 01 194. 02
194. 02 07952 NONRET MBURSABLE OTHER 194. 03 07953 PI H		0	0	0		194. 02
194. 04 07954 HEALTH COMPANIES	711, 132	58, 480		ől	190, 736	
194. 05 07955 PHYSICIANS OFFICE	7, 258, 583	115, 271	18, 414	30, 762	2, 327, 812	
194. 06 07956 THE ARBORS	0	0	0	o		194. 06
194. 07 07957 PAIN MANAGEMENT	235, 016	0	0	0		194. 07
194.08 07958 0PS 194.09 07959 MHL ROCHESTER HEALTH CENTER	0 113, 026	0	0	41, 230	0 17, 588	194.08
194. 10 07961 RHEUMATOLOGY	138, 144	0	22, 577	0	49, 009	
194. 11 07960 SPORTS HEALTH	130, 626	0	0	o	30, 155	
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0	0		201.00
202.00 TOTAL (sum lines 118 through	201) 69, 593, 106	4, 819, 016	225, 503	147, 326	11, 707, 047	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-0072

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Ti me Prepared:

						4/1/2019 4: 24	
	Cost Center Description	Subtotal	ADMI NI STRATI V		LAUNDRY &	HOUSEKEEPI NG	
	•	4A	E & GENERAL 5.00	PLANT 7. 00	LINEN SERVICE 8.00	9.00	
	GENERAL SERVICE COST CENTERS	4A	5.00	7.00	0.00	9.00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
1. 01	00101 M0B						1. 01
1. 02	00102 OPS						1. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	8, 578, 239	8, 578, 239	·			5.00
7. 00	00700 OPERATION OF PLANT	3, 946, 878	554, 903				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	185, 180	•				8.00
9.00	00900 HOUSEKEEPI NG	973, 808	136, 911	1		.,	
10. 00 11. 00	01000 DI ETARY	439, 403	61, 777		0	0	
13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	767, 775 895, 725	107, 944 125, 933		0	3, 046	
	01400 CENTRAL SERVICES & SUPPLY	592, 698	83, 329	1		56, 041	1
	01500 PHARMACY	1, 160, 208	163, 117			6, 091	1
	01600 MEDICAL RECORDS & LIBRARY	1, 640, 155					
	01700 SOCIAL SERVICE	486, 331	68, 375				
	INPATIENT ROUTINE SERVICE COST CENTERS				<u>'</u>	•	
30.00	03000 ADULTS & PEDIATRICS	3, 613, 909	508, 090	658, 964	56, 172	396, 092	30.00
31. 00	03100 NTENSIVE CARE UNIT	954, 561	134, 205	117, 843	6, 501	60, 914	31.00
41. 00	04100 SUBPROVI DER - I RF	0	0	0	0		1
42. 00	04200 SUBPROVI DER	0	0	0	0	0	
	04300 NURSERY	452, 621	63, 635		15, 526		
	04400 SKILLED NURSING FACILITY	0	0) 0	0	0	44.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	3, 474, 282	488, 460	446, 388	74, 232	137, 056	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 474, 262 1, 129, 669	158, 824				1
53. 00	05300 ANESTHESI OLOGY	1, 129, 009				20, 400	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 532, 250	356, 017				
57. 00	05700 CT SCAN	0	0		0	0	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY	2, 894, 675	406, 971	154, 112	0	21, 320	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	124, 887	17, 558	1	0	0	
65. 00	06500 RESPI RATORY THERAPY	975, 352	137, 128			27, 411	
66. 00	06600 PHYSI CAL THERAPY	1, 085, 527	152, 617		1, 264		
69. 00	06900 ELECTROCARDI OLOGY	627, 247	88, 187	1	0	27, 411	1
	06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	605, 462	85, 124		0	0	
	07200 IMPL. DEV. CHARGED TO PATIENT	1, 203, 340 1, 489, 183	169, 181 209, 369		0		
	07300 DRUGS CHARGED TO PATIENTS	7, 014, 435	986, 180		0		1
	03020 NUCLEAR MEDICINE-DIAGNOSTIC	506, 687	71, 237	•	0	1	
	03040 RADI ATI ON ONCOLOGY	1, 015, 232	142, 735	1			
	OUTPATIENT SERVICE COST CENTERS		,				
90. 00	09000 CLI NI C	5, 712, 819	803, 182	382, 861	0	36, 548	90.00
90. 01	09001 WOUND CARE	256, 191	36, 019	61, 074	0	15, 228	90. 01
	09100 EMERGENCY	2, 597, 151	365, 141	341, 751	55, 855	97, 462	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		<u> </u>			92.00
	OTHER REIMBURSABLE COST CENTERS	_			_	_	
	09500 AMBULANCE SERVI CES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS	E0 0/0 700	/ 057 400	0.705.040	005 404	1 007 4/0	110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	58, 062, 790	6, 957, 183	3, 705, 813	225, 134	1, 027, 463]118.00
104 00	07950 FOUNDATION	2, 276	320	0	0	0.746	194. 00
	07950 POUNDATTON 07951 MOB	39, 006					194.00
	07952 NONREI MBURSABLE OTHER	37, 000 0	5, 464 0	105, 750	0		194. 01
	07953 PI H	0	0		0		194. 03
	07954 HEALTH COMPANIES	960, 348	135, 018	50, 969	0		194.04
	07955 PHYSI CI ANS OFFI CE	9, 750, 842	1, 370, 874				194.05
194. 06	07956 THE ARBORS	0	0	0	0	0	194.06
	07957 PAIN MANAGEMENT	235, 489	33, 108	0	0	0	194. 07
	07958 OPS	41, 230	5, 797	172, 559	0		194. 08
	07959 MHL ROCHESTER HEALTH CENTER	130, 614	18, 363		0		194. 09
	07961 RHEUMATOLOGY	209, 730			0		194. 10
	07960 SPORTS HEALTH	160, 781	22, 605	0	0	0	194. 11
200.00		0	_		_		200.00
201. 00 202. 00		0 60 503 106	8, 578, 239	0 4 501 701	225 124		201.00
202.00		69, 593, 106	0,070,239	4, 501, 781	225, 134	1, 140, 655	1202.00

Provider CCN: 15-0072

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

					12/31/2016	4/1/2019 4: 24	
Cost Center Descrip	oti on	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY	•
				N	SUPPLY		
	TED0	10. 00	11. 00	13. 00	14. 00	15. 00	
GENERAL SERVICE COST CENT 1. 00 00100 NEW CAP REL COSTS-E							1 00
1. 00 00100 NEW CAP REL COSTS-E 1. 01 00101 MOB	SLUG & FIXI						1. 00 1. 01
1. 02 00102 OPS							1.01
4. 00 00400 EMPLOYEE BENEFITS [DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GE	1						5.00
7.00 00700 OPERATION OF PLANT							7. 00
8.00 00800 LAUNDRY & LINEN SEF	RVICE						8. 00
9. 00 00900 HOUSEKEEPI NG							9. 00
10. 00 01000 DI ETARY		629, 016	000 470				10.00
11. 00 01100 CAFETERI A	TI ON	0	939, 470				11.00
13. 00 01300 NURSI NG ADMI NI STRAT 14. 00 01400 CENTRAL SERVI CES &		0	20, 638 20, 085		844, 210		13. 00 14. 00
15. 00 01500 PHARMACY	SUFFEI	0	31, 423		044, 210	1, 407, 749	15.00
16. 00 01600 MEDI CAL RECORDS & I	IBRARY	Ö	44, 992		0	0	16. 00
17. 00 01700 SOCIAL SERVICE		o	15, 747	Ö	Ö	0	17. 00
INPATIENT ROUTINE SERVIC	E COST CENTERS		·				
30. 00 03000 ADULTS & PEDI ATRI CS	S	516, 253	111, 172	369, 260	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	Г	59, 457	27, 581	91, 610	0	0	31.00
41. 00 04100 SUBPROVI DER - I RF		0	0	0	0	0	41.00
42. 00 04200 SUBPROVI DER		0	0	0	0	0	42.00
43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FAC	CLLLTV	0	12, 677 0		0	0	43. 00 44. 00
ANCI LLARY SERVI CE COST C		<u> </u>	0	l o	<u>U</u>	U	44.00
50. 00 05000 OPERATING ROOM	ENTERS	0	72, 373	257, 128	0	0	50.00
52. 00 05200 DELI VERY ROOM & LAE	BOR ROOM	o	29, 600		o	0	52.00
53. 00 05300 ANESTHESI OLOGY		О	0	0	o	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI	C	0	52, 367	0	0	0	54.00
57.00 05700 CT SCAN		0	0	0	0	0	57.00
58. 00 05800 MAGNETI C RESONANCE		0	0	0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZA 60. 00 06000 LABORATORY	ATTON	0	0	0	0	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY		0	0	0	0	0	60. 00 60. 01
63. 00 06300 BLOOD STORING, PROC	CESSING & TRANS	0	0	0	0	0	63. 00
65. 00 06500 RESPIRATORY THERAPY		o	27, 880	l o	o	0	65. 00
66. 00 06600 PHYSI CAL THERAPY		0	9, 414	0	O	0	66.00
69. 00 06900 ELECTROCARDI OLOGY		0	20, 361	0	o	0	69. 00
69. 01 06901 CARDI AC REHAB		0	17, 212	0	0	0	69. 01
71. 00 07100 MEDI CAL SUPPLIES CH		0	0	0	844, 210	0	71.00
72. 00 07200 I MPL. DEV. CHARGED		0	0	0	0	1 407 740	72.00
73. 00 07300 DRUGS CHARGED TO PA 76. 00 03020 NUCLEAR MEDICINE-DI		0	8, 674	0	0	1, 407, 749 0	73. 00 76. 00
76. 01 03040 RADI ATI ON ONCOLOGY	AGNOSTIC	0	28, 899		0	0	76.00
OUTPATIENT SERVICE COST	CENTERS	<u> </u>	20,077	١	<u> </u>		70.01
90. 00 09000 CLINIC	SENT ENG	0	219, 600	0	0	0	90.00
90. 01 09001 WOUND CARE		О	3, 853	0	О	0	90. 01
91.00 09100 EMERGENCY		0	71, 165	236, 374	0	0	91.00
92. 00 09200 OBSERVATION BEDS (N							92.00
OTHER REIMBURSABLE COST	CENTERS	al					
95. 00 09500 AMBULANCE SERVICES	TEDE	0	0	0	0	0	95. 00
SPECIAL PURPOSE COST CEN 118.00 SUBTOTALS (SUM OF L	INES 1 through 117)	575, 710	845, 713	1, 094, 794	844, 210	1, 407, 749	118 00
NONREI MBURSABLE COST CEN		575, 710	045, 713	1,074,774	044, 210	1,407,749	110.00
194. 00 07950 FOUNDATION	TERS	0	0	0	O	0	194. 00
194. 01 07951 MOB		o	0		o		194. 01
194. 02 07952 NONREI MBURSABLE OTH	HER	0	0	0	o		194. 02
194. 03 07953 PIH		0	0	0	o	0	194. 03
194.04 07954 HEALTH COMPANIES		0	25, 687		0		194. 04
194. 05 07955 PHYSI CLANS OFFI CE		0	64, 006		0		194. 05
194. 06 07956 THE ARBORS		53, 306	0	0	0		194. 06
194. 07 07957 PAIN MANAGEMENT		0	848	0	0		194.07
194. 08 07958 OPS	TH CENTED	0	0	0	0		194. 08
194.09 07959 MHL ROCHESTER HEALT	IN CENTER	0	2 214		0		194. 09 194. 10
194. 10 07961 RHEUMATOLOGY 194. 11 07960 SPORTS HEALTH			3, 216		0		194. 10
200.00 Cross Foot Adjustme	ents	٥	U		U U	U	200.00
201.00 Negative Cost Center		o	0	0	O	0	201.00
202.00 TOTAL (sum lines 1		629, 016	939, 470	1, 094, 794	844, 210	1, 407, 749	
•		. !	•	. '			•

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0072 Peri od: Worksheet B From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 4/1/2019 4:24 pm Cost Center Description MEDI CAL SOCI AL Subtotal Intern & Total RECORDS & SERVI CE Resi dents LI BRARY Cost & Post Stepdown Adjustments 16. 00 17.00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 1.01 00101 MOB 1 01 1.02 00102 OPS 1.02 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 2,090,946 16.00 01700 SOCIAL SERVICE 17.00 602, 217 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 122, 514 288.813 6, 641, 239 6, 641, 239 30.00 03100 INTENSIVE CARE UNIT 0 31.00 22, 137 52, 329 1, 527, 138 1, 527, 138 31.00 o 04100 SUBPROVI DER - I RF 41.00 41.00 C 04200 SUBPROVI DER 42.00 \cap 0 Λ 42.00 43.00 04300 NURSERY 17, 568 82,640 710, 547 0 710, 547 43.00 04400 SKILLED NURSING FACILITY 44.00 0 44.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 397, 349 5, 347, 268 5, 347, 268 50.00 05200 DELIVERY ROOM & LABOR ROOM 41, 023 1, 588, 232 0 1, 588, 232 52.00 52.00 53.00 05300 ANESTHESI OLOGY 31, 360 0 220,001 0 0 220,001 53.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 169, 146 0 3, 410, 249 3, 410, 249 54 00 05700 CT SCAN 57.00 0 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 58.00 58.00 0 0 0 05900 CARDI AC CATHETERI ZATI ON 59.00 0 0 \cap 0 59.00 60.00 06000 LABORATORY 3, 727, 020 249.942 0 3, 727, 020 60 00 o 60.01 06001 BLOOD LABORATORY 60.01 0 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 15, 214 157, 659 157, 659 63.00 82, 274 65.00 06500 RESPIRATORY THERAPY 1, 257, 718 0 0 1, 257, 718 65.00 06600 PHYSI CAL THERAPY 1, 394, 497 1, 394, 497 66.00 48, 283 66.00 69.00 06900 ELECTROCARDI OLOGY 44, 808 881, 825 881, 825 69.00 69 01 06901 CARDI AC REHAB 7,839 839, 725 0 0 839, 725 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 2, 216, 731 2, 216, 731 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENT 72 00 0 Ω 1, 698, 552 1, 698, 552 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 9, 408, 364 0 9, 408, 364 73.00 03020 NUCLEAR MEDICINE-DIAGNOSTIC o 76.00 134, 101 0 737.049 737.049 76.00 03040 RADIATION ONCOLOGY 76.01 105, 240 1, 542, 640 1, 542, 640 76.01 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 183, 013 25, 164 7, 363, 187 0 7, 363, 187 90.00 09001 WOUND CARE 37, 402 409, 767 409, 767 90.01 0 90.01 153, 271 91.00 09100 EMERGENCY 202.772 4, 120, 942 0 4, 120, 942 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 95.00 95.00 0 0 0 SPECIAL PURPOSE COST CENTERS | SUBTOTALS (SUM OF LINES 1 through 117) | NONREIMBURSABLE COST CENTERS 1, 911, 985 602, 217 55, 200, 350 0 55, 200, 350 118. 00 194. 00 07950 FOUNDATION 12.342 0 12, 342 194.00 194. 01 07951 MOB 0 0 210, 246 0 210, 246 194. 01 0 194.02 194. 02 07952 NONREI MBURSABLE OTHER 0 0 o 194. 03 07953 PIH 0 0 194.03 0 0 0 194. 04 07954 HEALTH COMPANIES 1, 184, 205 1, 184, 205 194. 04 0 C 0 194. 05 07955 PHYSI CLANS OFFI CE 173,002 11, 740, 760 11, 740, 760 194. 05 194.06 07956 THE ARBORS 53, 306 194. 06 53, 306 0 0 194. 07 07957 PAIN MANAGEMENT 5 129 0 274 574 274, 574 194. 07 243, 952 194. 08 194. 08 07958 OPS C 243, 952 194. 09 07959 MHL ROCHESTER HEALTH CENTER 148, 977 0 148, 977 194. 09 0 0 194. 10 07961 RHEUMATOLOGY 830 0 341,008 341, 008 194. 10 0 183, 386 194. 11 194. 11 07960 SPORTS HEALTH 183, 386 0 200.00 Cross Foot Adjustments 0 0 200.00 0 201.00 Negative Cost Centers 0 201.00 69, 593, 106 202. 00 202 00 TOTAL (sum lines 118 through 201) 2, 090, 946 602 217 69, 593, 106

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0072

				То	12/31/2018	Date/Time Pre 4/1/2019 4:24	
			CAP	TAL RELATED COS	STS		
	Cost Center Description	Di rectly	NEW BLDG &	MOB	0PS	Subtotal	
	·	Assi gned New	FLXT				
		Capi tal Rel ated Costs					
		0	1. 00	1. 01	1. 02	2A	
	ENERAL SERVICE COST CENTERS 0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1	0102 OPS						1. 02
	0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL	0	42, 664 367, 004	1	0	42, 664 388, 164	1
	0700 OPERATION OF PLANT	0	903, 715	1	11, 704	916, 789	1
8. 00 0	0800 LAUNDRY & LINEN SERVICE	0	15, 970	0	0	15, 970	8. 00
	0900 HOUSEKEEPI NG 1000 DI ETARY	0	35, 753	1	432	36, 917	9.00
	1100 CAFETERI A	0	146, 674 73, 145	1	0	146, 674 73, 145	1
	1300 NURSING ADMINISTRATION	O	56, 740		ō	56, 740	1
	1400 CENTRAL SERVICES & SUPPLY	0	105, 622	1	0	105, 622	1
	1500 PHARMACY 1600 MEDICAL RECORDS & LIBRARY	0	53, 822 190, 540		0	53, 822 190, 540	1
	1700 SOCIAL SERVICE	0	36, 444	1	ō	36, 444	1
	NPATIENT ROUTINE SERVICE COST CENTERS		754 070	0	٥١	757 070	30.00
	3000 ADULTS & PEDIATRICS 3100 INTENSIVE CARE UNIT	0	756, 070 135, 208		0	756, 070 135, 208	
	4100 SUBPROVI DER – I RF	O	0	1	ō	0	1
	4200 SUBPROVI DER	0	0	1	0	0	
	4300 NURSERY 4400 SKILLED NURSING FACILITY	0	23, 085 0		0	23, 085 0	1
A	NCILLARY SERVICE COST CENTERS	<u> </u>		,	- '		11.00
	5000 OPERATING ROOM	0	498, 732	1	2, 798	501, 530	1
	5200 DELIVERY ROOM & LABOR ROOM 5300 ANESTHESIOLOGY	0	126, 660 45, 121	1	0	126, 660 45, 121	52. 00 53. 00
	5400 RADI OLOGY-DI AGNOSTI C	0	231, 054	1	8, 309	239, 363	1
	5700 CT SCAN	0	0	_	0	0	1
	5800 MAGNETIC RESONANCE IMAGING (MRI) 5900 CARDIAC CATHETERIZATION	0	0	0	0	0	
	6000 LABORATORY	0	123, 794	-	3, 875	134, 599	1
	6001 BLOOD LABORATORY	0	0	1 1	0	0	1
	6300 BLOOD STORING, PROCESSING & TRANS. 6500 RESPIRATORY THERAPY	0	0 8, 804	0	0	0 8, 804	63. 00 65. 00
	6600 PHYSI CAL THERAPY	o o	97, 765		Ö	97, 765	1
1	6900 ELECTROCARDI OLOGY	0	12, 259	1	0	26, 839	1
	6901 CARDI AC REHAB 7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	142, 374 0		0	142, 374 0	1
	7200 I MPL. DEV. CHARGED TO PATIENT	o o	0	Ö	Ö	0	1
	7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	3020 NUCLEAR MEDICINE-DIAGNOSTIC 3040 RADIATION ONCOLOGY	0	18, 760 0	1	0 48, 216	18, 760 48, 216	1
	UTPATIENT SERVICE COST CENTERS	<u> </u>		<u> </u>	40, 210	40, 210	70.01
90.00	9000 CLI NI C	0	5, 375		0	92, 724	1
	9001 WOUND CARE 9100 EMERGENCY	0	0 392, 111	,	0	14, 106 392, 111	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)		372, 111		Ĭ	0	
	THER REIMBURSABLE COST CENTERS				ما		05.00
	9500 AMBULANCE SERVICES PECIAL PURPOSE COST CENTERS	0	0	0	0	0	95.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	4, 645, 265	146, 227	75, 334	4, 866, 826	118. 00
_	ONREI MBURSABLE COST CENTERS				ما		101.00
	17950 FOUNDATI ON 17951 MOB	0	0		0		194. 00 194. 01
	7952 NONREI MBURSABLE OTHER	0	0	0	Ö		194. 02
	7953 PI H	0	0	0	0		194. 03
	17954 HEALTH COMPANIES 17955 PHYSICIANS OFFICE	0	58, 480 115, 271	1	0 30, 762	58, 480 164, 447	194.04
	7956 THE ARBORS		115, 2/1	0	0		194.05
194. 07 0	7957 PAIN MANAGEMENT	0	0	0	0		194. 07
	17958 OPS 17959 MHL ROCHESTER HEALTH CENTER	0	0	0	41, 230 0		194. 08 194. 09
	7961 RHEUMATOLOGY		0	22, 577	o		194. 09
194. 11 0	7960 SPORTS HEALTH	0	0	O	o	0	194. 11
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers		0				200. 00 201. 00
202.00	TOTAL (sum lines 118 through 201)	0	4, 819, 016	225, 503	147, 326	5, 191, 845	
1		· '					-

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0072

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared:
4/1/2019 4:24 pm

				''	0 12/31/2016	4/1/2019 4: 24	
	Cost Center Description	EMPLOYEE BENEFITS	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		DEPARTMENT	E & GENERAL	PLANT	LINEN SERVICE		
		4. 00	5. 00	7. 00	8. 00	9. 00	
_	GENERAL SERVICE COST CENTERS			I		I	1 00
	DO100 NEW CAP REL COSTS-BLDG & FLXT						1.00 1.01
	00102 OPS						1.01
	00400 EMPLOYEE BENEFITS DEPARTMENT	42, 664					4.00
5.00	DO500 ADMINISTRATIVE & GENERAL	4, 721	392, 885				5. 00
	00700 OPERATION OF PLANT	845	25, 414				7.00
	00800 LAUNDRY & LINEN SERVICE	0	1, 192		20, 078	l	8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY	698 149	6, 270 2, 829		0	1	1
	01100 CAFETERI A	450	4, 944		0	Ö	11.00
	01300 NURSING ADMINISTRATION	805	5, 768		0	137	13.00
	01400 CENTRAL SERVICES & SUPPLY	305	3, 816		0	2, 514	
	01500 PHARMACY	673	7, 471	9, 827	0	273	1
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	920 417	10, 561 3, 131	34, 789 6, 654	0	410 0	1
_	NPATIENT ROUTINE SERVICE COST CENTERS	417	3, 131	0,034	U		17.00
	03000 ADULTS & PEDIATRICS	3, 458	23, 270	138, 045	5, 010	17, 770	30.00
	D3100 INTENSIVE CARE UNIT	756	6, 146	24, 686	580	2, 733	31.00
1	04100 SUBPROVI DER - I RF	0	0	0	0	0	
	04200 SUBPROVI DER	0	0	0	1 205	0	42.00
	04300 NURSERY 04400 SKILLED NURSING FACILITY	373 0	2, 914 0	4, 215 0	1, 385 0	164	1
-	ANCILLARY SERVICE COST CENTERS		0	<u> </u>	9		1 44.00
	05000 OPERATING ROOM	2, 301	22, 371	93, 511	6, 619	6, 149	50.00
	D5200 DELIVERY ROOM & LABOR ROOM	871	7, 274	23, 125	0	916	1
	05300 ANESTHESI OLOGY	0	843		0	0	53.00
	D5400 RADI OLOGY-DI AGNOSTI C D5700 CT SCAN	1, 392	16, 305 0	49, 470	1, 390	2, 186	54.00 57.00
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
	05900 CARDI AC CATHETERI ZATI ON	o	Ö	Ö	0	Ö	59.00
60.00	06000 LABORATORY	o	18, 639	32, 284	0	957	60.00
	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY	0 777	804 6, 280	0	0	1 220	63.00
	06600 PHYSI CAL THERAPY	227	6, 280 6, 990		113	., ===	65. 00 66. 00
	06900 ELECTROCARDI OLOGY	468	4, 039		0	1	1
	D6901 CARDI AC REHAB	430	3, 899		0	0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7, 748	0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	9, 589	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 03020 NUCLEAR MEDICINE-DIAGNOSTIC	0 283	45, 166 3, 263		0	0	73. 00 76. 00
1	03040 RADI ATI ON ONCOLOGY	774	6, 537		0		1
	DUTPATIENT SERVICE COST CENTERS		2, 33.	,			
90.00	09000 CLI NI C	8, 915	36, 785		0	1, 640	
	09001 WOUND CARE	162	1, 650		0		
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 961	16, 723	71, 591	4, 981	4, 3/3	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS						92.00
	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
5	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	33, 131	318, 631	776, 307	20, 078	46, 098	118. 00
104 00	NONREIMBURSABLE COST CENTERS 07950 FOUNDATION	ا	15		0	427	194. 00
	07950 FOUNDATION 07951 MOB	0	15 251		0	•	194. 00
	07952 NONREI MBURSABLE OTHER	o	0		0		194. 02
	07953 PI H	o	0	0	0	0	194. 03
	07954 HEALTH COMPANIES	695	6, 184		0		194. 04
	07955 PHYSI CI ANS OFFI CE	8, 483	62, 797		0		194. 05
	07956 THE ARBORS 07957 PAIN MANAGEMENT	0	0 1, 516		0	l	194. 06 194. 07
	07957 PATIN WANAGEMENT	0	265		0		194.07
	07959 MHL ROCHESTER HEALTH CENTER	64	841	0	0		194. 09
	07961 RHEUMATOLOGY	179	1, 350		0	l	194. 10
	07960 SPORTS HEALTH	110	1, 035	0	0	l	194. 11
200.00	Cross Foot Adjustments		_	_			200. 00 201. 00
201. 00 202. 00	Negative Cost Centers TOTAL (sum lines 118 through 201)	42, 664	392, 885	943, 048	0 20, 078		201.00
202.00	1.37712 (34m 111103 110 till bugil 201)	1 42, 504	572,000	1 775, 040	20,070	1 31, 433	1-02.00

Provider CCN: 15-0072

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared:
4/1/2019 4:24 pm

					12/31/2016	4/1/2019 4: 24	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVI CES &	PHARMACY	
		10. 00	11. 00	N 13. 00	SUPPLY 14. 00	15. 00	
GEN	NERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	13.00	
1. 00 001 1. 01 001 1. 02 001 4. 00 002 5. 00 005 7. 00 007 8. 00 008 9. 00 001 11. 00 011 13. 00 013 14. 00 014	100 NEW CAP REL COSTS-BLDG & FIXT 101 MOB 102 OPS 400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL 700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE 900 HOUSEKEEPING 900 DIETARY 100 CAFETERIA 300 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 PHARMACY	176, 431 0 0 0 0	91, 894 2, 019 1, 965 3, 074	75, 828 0 0	133, 506 0	75, 140	1. 00 1. 01 1. 02 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
	600 MEDICAL RECORDS & LIBRARY	0	4, 401	0	0	0	16. 00
	700 SOCIAL SERVICE	0	1, 540	0	0	0	17. 00
30. 00 030 31. 00 031 41. 00 041 42. 00 042 43. 00 043 44. 00 044	PATIENT ROUTINE SERVICE COST CENTERS DOO ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT 100 SUBPROVIDER - IRF 200 SUBPROVIDER 300 NURSERY 400 SKILLED NURSING FACILITY CILLARY SERVICE COST CENTERS	144, 802 16, 677 0 0 0	10, 874 2, 698 0 0 1, 240	0	0 0 0 0 0	0 0 0 0 0	30. 00 31. 00 41. 00 42. 00 43. 00 44. 00
	OOO OPERATI NG ROOM	0	7, 079	17, 809	0	0	50.00
	200 DELIVERY ROOM & LABOR ROOM	0	2, 895	6, 810	0	0	52.00
	300 ANESTHESI OLOGY	0	0 F 122	0	0	0	53.00
	400 RADI OLOGY-DI AGNOSTI C 700 CT SCAN	0	5, 122 0	0	0	0	54. 00 57. 00
	BOO MAGNETIC RESONANCE IMAGING (MRI)	o	0	Ö	Ö	0	58.00
	900 CARDI AC CATHETERI ZATI ON	0	0	0	o	0	59. 00
	DOO LABORATORY	0	0	0	0	0	60.00
	DO1 BLOOD LABORATORY	0	0	0	0	0	60.01
	300 BLOOD STORING, PROCESSING & TRANS. 500 RESPIRATORY THERAPY	0	0 2, 727	0	0	0	63. 00 65. 00
	600 PHYSI CAL THERAPY		921	0	0	0	66.00
	900 ELECTROCARDI OLOGY	ő	1, 992	o o	o	0	69.00
	901 CARDI AC REHAB	0	1, 684	0	О	0	69. 01
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	133, 506	0	71. 00
	200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
	300 DRUGS CHARGED TO PATIENTS D20 NUCLEAR MEDICINE-DIAGNOSTIC		0 848	0	0	75, 140 0	73. 00 76. 00
	040 RADI ATI ON ONCOLOGY		2, 827	0	0	0	76. 00
	FPATIENT SERVICE COST CENTERS		_,	_	-		
	DOO CLI NI C	0	21, 478	0	0	0	90.00
	001 WOUND CARE	0	377		0	0	90. 01
	100 EMERGENCY 200 OBSERVATION BEDS (NON-DISTINCT PART)		6, 961	16, 372	U U	U	91. 00 92. 00
	HER REIMBURSABLE COST CENTERS	<u> </u>					72.00
95.00 095	500 AMBULANCE SERVICES	0	0	0	0	0	95.00
	ECIAL PURPOSE COST CENTERS	4/4 470	00.700	75 000	400 50/	75 440	110 00
118. 00 NON	SUBTOTALS (SUM OF LINES 1 through 117) NREIMBURSABLE COST CENTERS	161, 479	82, 722	75, 828	133, 506	75, 140	118.00
	950 FOUNDATION	O	0	O	ol	0	194. 00
194. 01 079		o	0		ō		194. 01
	952 NONREI MBURSABLE OTHER	0	0	0	0		194. 02
194. 03 079		0	0	0	0		194. 03
	954 HEALTH COMPANIES 955 PHYSICIANS OFFICE	0	2, 513 6, 261	0	0		194. 04 194. 05
	956 THE ARBORS	14, 952	0, 201	Ö	Ö		194. 06
194. 07 079	957 PAIN MANAGEMENT	0	83	0	ō	0	194. 07
194. 08 079		0	0	0	0		194. 08
	959 MHL ROCHESTER HEALTH CENTER		0	0	0		194. 09 194. 10
	961 RHEUMATOLOGY 960 SPORTS HEALTH		315 0		0		194. 10
200.00	Cross Foot Adjustments		Ü		٩	U	200.00
201.00	Negative Cost Centers	o	0	0	О		201. 00
202.00	TOTAL (sum lines 118 through 201)	176, 431	91, 894	75, 828	133, 506	75, 140	202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0072 Peri od: Worksheet B From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 4/1/2019 4:24 pm Cost Center Description MEDI CAL SOCI AL Subtotal Intern & Total RECORDS & SERVI CE Resi dents LI BRARY Cost & Post Stepdown Adjustments 16. 00 17.00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 MOB 1.01 1 01 1.02 00102 OPS 1.02 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 241, 621 16.00 01700 SOCIAL SERVICE 17.00 17.00 48. 186 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 14, 154 23, 110 1, 162, 139 1, 162, 139 30.00 03100 INTENSIVE CARE UNIT 202, 573 0 31.00 2,557 4, 187 202, 573 31.00 o 04100 SUBPROVI DER - I RF 41.00 41.00 0 C 0 04200 SUBPROVI DER 0 42.00 0 \cap Ω 42.00 43.00 04300 NURSERY 2,030 6,612 44, 934 0 44, 934 43.00 04400 SKILLED NURSING FACILITY 44.00 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 45, 964 703, 333 703, 333 50.00 05200 DELIVERY ROOM & LABOR ROOM 4, 739 173, 290 0 173, 290 52.00 52.00 53.00 05300 ANESTHESI OLOGY 0 3,623 0 57, 825 57,825 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54 00 19.541 0 334, 769 334, 769 54 00 05700 CT SCAN 57.00 0 0 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 58.00 58.00 0 0 0 0 05900 CARDI AC CATHETERI ZATI ON 59.00 0 0 \cap 0 59.00 06000 LABORATORY 60.00 0 28.875 215, 354 215, 354 60 00 o 60.01 06001 BLOOD LABORATORY 0 0 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 1.758 2.562 2,562 63.00 65.00 06500 RESPIRATORY THERAPY 9, 505 0 30, 930 0 0 30, 930 65.00 06600 PHYSI CAL THERAPY 5.578 129, 991 129, 991 66.00 C 66.00 69.00 06900 ELECTROCARDI OLOGY 5, 177 55, 207 55, 207 69.00 69 01 06901 CARDI AC REHAB 906 0 175, 287 0 0 175, 287 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 141.254 141. 254 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72 00 0 C 9, 589 9, 589 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 120, 306 0 120, 306 73.00 03020 NUCLEAR MEDICINE-DIAGNOSTIC 15, 492 0 76.00 0 42.071 42.071 76.00 03040 RADIATION ONCOLOGY 114<u>, 97</u>2 114<u>, 97</u>2 76.01 12, 158 76.01 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 21, 143 2, 013 264, 901 0 264, 901 90.00 09001 WOUND CARE 4, 321 90.01 34, 093 0 34, 093 90.01 12, 264 91 00 91.00 09100 EMERGENCY 23, 426 550, 763 0 550, 763 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 95.00 95.00 0 0 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 220, 947 48, 186 4, 566, 143 0 4, 566, 143 118. 00 194. 00 07950 FOUNDATI ON 452 194.00 0 452 194. 01 07951 MOB 0 C 73, 259 0 73, 259 194. 01 0 194.02 194. 02 07952 NONREI MBURSABLE OTHER 0 0 C 0 194. 03 07953 PIH 0 0 194.03 0 0 194. 04 07954 HEALTH COMPANIES 79, 096 79, 096 194. 04 0 C 0 194. 05 07955 PHYSI CLANS OFFI CE 19, 986 329, 971 329, 971 194. 05 194.06 07956 THE ARBORS 14, 952 14, 952 194. 06 0 0 0 0 2, 193 194. 07 194. 07 07957 PAIN MANAGEMENT 592 0 2 193 78, 736 194. 08 194. 08 07958 OPS 0 C 78, 736 194. 09 07959 MHL ROCHESTER HEALTH CENTER 0 0 905 0 905 194.09 0 194. 10 07961 RHEUMATOLOGY 96 0 44, 993 44, 993 194. 10 0 1, 145 194. 11 194. 11 07960 SPORTS HEALTH 1, 145 C 0 200.00 Cross Foot Adjustments 0 0 0 200.00 201.00 Negative Cost Centers 0 201.00 5, 191, 845 202. 00 202.00 TOTAL (sum lines 118 through 201) 241, 621 48, 186 5, 191, 845

| Period: | Worksheet B-1 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0072

					o 12/31/2018	Date/Time Pre 4/1/2019 4:24	
		CAPI	TAL RELATED CO	STS		47 17 20 1 7 4 . 24	рііі
	Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	OPS (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	
	PENEDAL CEDIMOS COCT CENTEDO	1. 00	1. 01	1. 02	4. 00	5A	
	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FLXT	188, 294					1.00
1.01	00101 MOB	0	43, 769				1. 01
1	00102 OPS 00400 EMPLOYEE BENEFITS DEPARTMENT	0 1, 667	0	27, 643			1. 02 4. 00
5.00 0	00500 ADMINISTRATIVE & GENERAL	14, 340	4, 107			-8, 578, 239	5.00
	00700 OPERATION OF PLANT	35, 311	266	2, 196		0	7.00
	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	624 1, 397	0 142	(81	_	0	8. 00 9. 00
10.00	01000 DI ETARY	5, 731	0			o o	10.00
1	01100 CAFETERI A	2, 858	0	(,	0	11.00
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	2, 217 4, 127	0		609, 609 230, 992	0	13. 00 14. 00
15. 00 C	01500 PHARMACY	2, 103	0	(509, 667	0	15. 00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	7, 445 1, 424	0			0	16. 00 17. 00
	NPATIENT ROUTINE SERVICE COST CENTERS	1, 424	<u>_</u>		313, 632		17.00
	03000 ADULTS & PEDIATRICS	29, 542	0	(,	l	30.00
1	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	5, 283 0	0		572, 004	0	31. 00 41. 00
1	04200 SUBPROVI DER	0	0		0	Ö	42.00
1	04300 NURSERY	902	0	(202,27	0	43.00
	04400 SKILLED NURSING FACILITY NCILLARY SERVICE COST CENTERS	0	0) 0	0	44.00
_	05000 OPERATING ROOM	19, 487	0	525	1, 741, 621	0	50.00
	D5200 DELIVERY ROOM & LABOR ROOM	4, 949	0	(659, 131	0	52.00
1	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	1, 763 9, 028	0	1, 559	1, 053, 869	0	53. 00 54. 00
57.00	05700 CT SCAN	0	0	(0	0	57.00
	D5800 MAGNETIC RESONANCE IMAGING (MRI) D5900 CARDIAC CATHETERIZATION	0	0	(0	0	58. 00 59. 00
	06000 LABORATORY	4, 837	1, 345	727	0	0	60.00
60. 01	06001 BLOOD LABORATORY	O	0	C	0	0	60. 01
	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY	0 344	0		0 588, 114	0	63. 00 65. 00
1	06600 PHYSI CAL THERAPY	3, 820	0			ő	66.00
	06900 ELECTROCARDI OLOGY	479	2, 830	(354, 637	0	69.00
	06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 563 0	0		325, 326	0	69. 01 71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	o	0		0	o o	72.00
	07300 DRUGS CHARGED TO PATIENTS 03020 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0	0	73. 00 76. 00
	03040 RADIATION ONCOLOGY	733 0	0	1			•
0	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC 09001 WOUND CARE	210	16, 954 2, 738		6, 749, 202 122, 795		90. 00 90. 01
91.00 0	99100 EMERGENCY	15, 321	2, 730			l	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS OP500 AMBULANCE SERVICES	0	0	(0	0	95. 00
S	PECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) IONREI MBURSABLE COST CENTERS	181, 505	28, 382	14, 135	25, 080, 935	-8, 578, 239	118. 00
	07950 FOUNDATION	0	0	(0	0	194. 00
	07951 MOB	o	7, 431	C	0		194. 01
	07952 NONREIMBURSABLE OTHER 07953 PIH	0	0		0		194. 02 194. 03
	07954 HEALTH COMPANIES	2, 285	0		526, 202		194. 04
	07955 PHYSI CI ANS OFFI CE	4, 504	3, 574	5, 772	6, 421, 959	•	194. 05
	07956 THE ARBORS 07957 PAIN MANAGEMENT	0	0	(1, 306	l	194. 06 194. 07
194.080	07958 OPS		0	7, 736		0	194. 08
	07959 MHL ROCHESTER HEALTH CENTER	0	4 300		48, 522	l	194.09
	07961 RHEUMATOLOGY 07960 SPORTS HEALTH		4, 382 0		135, 206 83, 191		194. 10 194. 11
200.00	Cross Foot Adjustments		Ĭ		33, . , 1		200. 00
201. 00	Negative Cost Centers	4 010 017	225 502	147 00/	11 707 047		201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	4, 819, 016	225, 503	147, 326	11, 707, 047		202.00
		<u> </u>			1	1	

Heal th Finar	ncial Systems	MEMORIAL HOSPITA	L LOGANSPORT		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CC		Period: From 01/01/2018	Worksheet B-1	
					To 12/31/2018		
		CAPI 1	TAL RELATED CO	STS			
	Cost Center Description	NEW BLDG & FLXT (SQUARE FEET)	MOB (SQUARE FEET)	OPS (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	
		1. 00	1. 01	1. 02	4. 00	5A	
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	25. 593041	5. 152117	5. 32959	42, 664		203. 00 204. 00
205. 00	Unit cost multiplier (Wkst. B, Part				0. 001321		205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS MEMORIAL HOSPITAL LOGANSPORT In Lieu of Form CMS-2552-10 Provider CCN: 15-0072

					10) 12/31/2018	Date/lime Pre 4/1/2019 4:24	
		Cost Center Description	ADMI NI STRATI V E & GENERAL (ACCUM.	OPERATION OF PLANT (SQUARE	LAUNDRY & LINEN SERVICE (LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVICE)	DI ETARY (PATI ENT DAYS)	p
			COST) 5. 00	FEET) 7. 00	8. 00	9. 00	10.00	
	GENER	AL SERVICE COST CENTERS						
1.00	1	NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101							1.01
1. 02 4. 00	00102	EMPLOYEE BENEFITS DEPARTMENT						1. 02 4. 00
5. 00		ADMINISTRATIVE & GENERAL	61, 014, 867					5.00
7. 00		OPERATION OF PLANT	3, 946, 878	201, 819				7. 00
8.00		LAUNDRY & LINEN SERVICE	185, 180	624				8. 00
9. 00	1	HOUSEKEEPI NG	973, 808	1, 620		7, 531		9. 00
10.00		DI ETARY CAFETERI A	439, 403	5, 731		0	4, 602	10.00 11.00
11. 00 13. 00	1	NURSING ADMINISTRATION	767, 775 895, 725	2, 858 2, 217		20	0	13.00
14. 00		CENTRAL SERVICES & SUPPLY	592, 698	4, 127		368	0	•
15.00	01500	PHARMACY	1, 160, 208	2, 103	0	40	0	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	1, 640, 155	7, 445		60	0	16.00
17. 00		SOCIAL SERVICE	486, 331	1, 424	0	0	0	17. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	3, 613, 909	29, 542	70, 070	2, 601	3, 777	30.00
31. 00		INTENSIVE CARE UNIT	954, 561	5, 283		400	435	•
41.00	04100	SUBPROVI DER - I RF	o	0	0	0	0	41.00
42.00	1	SUBPROVI DER	0	0		0	0	
43.00		NURSERY SKILLED NURSING FACILITY	452, 621	902		24	0	
44. 00		LARY SERVICE COST CENTERS	0	0	0	0	0	44.00
50. 00		OPERATING ROOM	3, 474, 282	20, 012	92, 599	900	0	50.00
52.00		DELIVERY ROOM & LABOR ROOM	1, 129, 669	4, 949	0	134	0	52.00
53.00	1	ANESTHESI OLOGY	130, 910	1, 763		0	0	53.00
54.00	1	RADI OLOGY-DI AGNOSTI C	2, 532, 250	10, 587		320	0	54.00
57. 00 58. 00		CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	١	0	-	0	0	57. 00 58. 00
59. 00		CARDI AC CATHETERI ZATI ON		0		ol	0	59.00
60.00		LABORATORY	2, 894, 675	6, 909	0	140	0	60.00
60. 01		BLOOD LABORATORY	0	0		0	0	60. 01
63.00		BLOOD STORING, PROCESSING & TRANS.	124, 887	0		0	0	63.00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	975, 352 1, 085, 527	344 3, 820		180 80	0	65. 00 66. 00
69. 00		ELECTROCARDI OLOGY	627, 247	3, 309		180	0	69.00
69. 01		CARDI AC REHAB	605, 462	5, 563		0	0	69. 01
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 203, 340	0	0	0	0	71. 00
72.00	1	IMPL. DEV. CHARGED TO PATIENT	1, 489, 183	0	-	0	0	72.00
73. 00 76. 00		DRUGS CHARGED TO PATIENTS NUCLEAR MEDICINE-DIAGNOSTIC	7, 014, 435 506, 687	0 733	1	0	0	73. 00 76. 00
76. 01		RADI ATI ON ONCOLOGY	1, 015, 232	9, 047		320	0	76.00
		TIENT SERVICE COST CENTERS	,	, , ,				
		CLI NI C	5, 712, 819	17, 164		240	0	
		WOUND CARE	256, 191	2, 738		100	0	
		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	2, 597, 151	15, 321	69, 675	640	Ü	91. 00 92. 00
72.00		REIMBURSABLE COST CENTERS				I		72.00
95.00		AMBULANCE SERVICES	0	0	0	0	0	95.00
440.0-		AL PURPOSE COST CENTERS	40 40 55	4// 40=	202 255			110.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	49, 484, 551	166, 135	280, 838	6, 747	4, 212	118. 00
194 00		FOUNDATION	2, 276	0	0	64	0	194. 00
194. 01			39, 006	7, 431		Ö		194. 01
	1	NONREI MBURSABLE OTHER	o	0		0		194. 02
194. 03			0	0	-	0		194. 03
		HEALTH COMPANIES PHYSICIANS OFFICE	960, 348 9, 750, 842	2, 285 13, 850		80 480		194. 04 194. 05
		THE ARBORS	9, 750, 642	13, 650		460		194. 05
		PAIN MANAGEMENT	235, 489	0	1	Ö		194. 07
194. 08			41, 230	7, 736	0	160		194. 08
		MHL ROCHESTER HEALTH CENTER	130, 614	0	0	0		194. 09
		RHEUMATOLOGY	209, 730	4, 382	0	0		194. 10
200.00		SPORTS HEALTH Cross Foot Adjustments	160, 781	Ü	ا	٩	U	194. 11 200. 00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B,	8, 578, 239	4, 501, 781	225, 134	1, 146, 855	629, 016	
202 62		Part I)	0.440500	22 22/22	0.004/54	150 004557	40/ /00401	202 22
203.00 204.00	1	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0. 140593 392, 885	22. 306032 943, 048		152. 284557 51, 455	136. 683181 176, 431	
204.00	1	Part II)	372,000	743, 040	20,076	31, 400	170, 431	207.00
		· /	ı I			I		<u> </u>

Heal th Financial	I Systems	MEMORIAL HOSPIT	AL LOGANSPORT		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION	I - STATISTICAL BASIS		Provi der C		Period: From 01/01/2018	Worksheet B-1	
		_			Го 12/31/2018	Date/Time Pre 4/1/2019 4:24	
Cos	st Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	PLANT	LINEN SERVICE	(HOURS OF	(PATI ENT	
		(ACCUM.	(SQUARE	(LAUNDRY)	SERVICE)	DAYS)	
		COST)	FEET)				
		5. 00	7. 00	8. 00	9. 00	10.00	
205. 00 Uni	t cost multiplier (Wkst. B, Part	0. 006439	4. 672741	0. 071493	6. 832426	38. 337897	205.00
206. 00 NAH	HE adjustment amount to be allocated						206. 00
(pe	er Wkst. B-2)						
207. 00 NAH	HE unit cost multiplier (Wkst. D,						207.00
Par	rts III and IV)						

	HI OCATION STATISTICAL BASIS	MEMORIAL HOSPII		N 15 0070 D		Wardington CMS	
COST A	LLOCATION - STATISTICAL BASIS		Provi der CC	F	eriod: rom 01/01/2018 o 12/31/2018	Worksheet B-1 Date/Time Pre 4/1/2019 4:24	pared:
	Cost Center Description	CAFETERI A (MAN HOURS)	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (100% SUPPLI ES)	PHARMACY (100% DRUGS)	MEDI CAL RECORDS & LI BRARY (REVENUE)	Į į į
		11. 00	13. 00	14. 00	15.00	16.00	
1 00	GENERAL SERVICE COST CENTERS		1				1 00
14. 00 15. 00 16. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 MOB 00102 OPS 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	684, 411 15, 035 14, 632 22, 892 32, 777	240, 122 0 0 0	100 0 0	100 0	160, 713, 368	
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	11, 472	2 0	0	0	0	17.00
41.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	80, 990 20, 093 0 0 9, 235	20, 093 0 0 0 9, 235	0 0 0 0 0	0 0 0 0	9, 416, 894 1, 701, 563 0 0 1, 350, 338	31. 00 41. 00 42. 00 43. 00
50. 00	05000 OPERATING ROOM	52, 724	56, 396	0	0	30, 536, 679	50.00
52. 00 53. 00 54. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	21, 564 0 38, 150	0 0	0 0 0	0	3, 153, 170 2, 410, 450 13, 001, 245	53. 00 54. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1 -1	0	1	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0		0	1	0	
60. 00 60. 01	06000 LABORATORY 06001 BL00D LABORATORY			0	1	19, 211, 563 0	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	o	0	0	1, 169, 421	63.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	20, 311 6, 858	1	0	1	6, 323, 935 3, 711, 210	
	06900 ELECTROCARDI OLOGY	14, 833	1	0		3, 444, 141	
69. 01 71. 00	06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 539	1	0 100	- I	602, 525 0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT		1	0	l l	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS 03020 NUCLEAR MEDICINE-DIAGNOSTIC	6, 319	1 -1	0		10 207 547	
	03040 RADI ATI ON ONCOLOGY	21, 053			1	10, 307, 567 8, 089, 163	1
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	159, 980	ما ما	0	0	14, 067, 114	90.00
90. 00	09001 WOUND CARE	2, 807	1	0	l .	2, 874, 876	1
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	51, 844	51, 844	0	0	15, 585, 867	91. 00 92. 00
	O7520 O5520 O5520) 0	0	0	0	
95.00	SPECIAL PURPOSE COST CENTERS) O	0	Į d	0	95.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	616, 108	240, 122	100	100	146, 957, 721	118. 00
	07950 FOUNDATI ON	0	1	0			194. 00
	07951 MOB 07952 NONREI MBURSABLE OTHER	0	1	0			194. 01 194. 02
	07953 PIH		1	0	l l		194. 02
	07954 HEALTH COMPANIES 07955 PHYSICIANS OFFICE	18, 713	1	0	l l	0 13, 297, 609	194.04
	07956 THE ARBORS	46, 629		0			194. 05
	07957 PAIN MANAGEMENT	618	1	0		394, 208	
	07958 0PS 07959 MHL ROCHESTER HEALTH CENTER	0		0	· · · · · · · · · · · · · · · · · · ·		194. 08 194. 09
	07961 RHEUMATOLOGY	2, 343	o o	0			194. 10
200.00	07960 SPORTS HEALTH Cross Foot Adjustments		ή	0		0	194. 11 200. 00
201.00	Negative Cost Centers	000 470	1 004 701	044 040	4 407 740	2 000 044	201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	939, 470	1, 094, 794	844, 210	1, 407, 749	2, 090, 946	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	1. 372669	4. 559324	8, 442. 100000	14, 077. 490000	0. 013010	203. 00

Heal th	Financial Systems	MEMORIAL HOSPIT	AL LOGANSPORT		In Lie	u of Form CMS-2	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2018 To 12/31/2018		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(MAN	ADMI NI STRATI O	SERVICES &	(100%	RECORDS &	
		HOURS)	N	SUPPLY	DRUGS)	LI BRARY	
			(DI RECT	(100%		(REVENUE)	
			NRSING HRS)	SUPPLI ES)			
		11. 00	13. 00	14.00	15.00	16.00	
204.00	Cost to be allocated (per Wkst. B,	91, 894	75, 828	133, 50	6 75, 140	241, 621	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 134267	0. 315789	1, 335. 06000	0 751. 400000	0. 001503	205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS MEMORIAL HOSPITAL LOGANSPORT In Lieu of Form CMS-2552-10

Provider CCN: 15-0072

			4/1/2019 4: 24	
	Cost Center Description	SOCIAL SERVICE (HOURS)		
	GENERAL SERVICE COST CENTERS	17. 00		
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT			1.00
1. 01	00101 MOB			1. 01
1. 02	00102 OPS			1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500 ADMINISTRATIVE & GENERAL			5.00
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9. 00	00900 HOUSEKEEPI NG			9. 00
	01000 DI ETARY			10.00
	01100 CAFETERI A			11.00
	01300 NURSING ADMINISTRATION			13.00
	01400 CENTRAL SERVICES & SUPPLY			14.00
	01500 PHARMACY			15.00
	01600 MEDICAL RECORDS & LIBRARY			16.00
17. 00	01700 SOCIAL SERVICE	10, 530		17. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	F 0F0		1 20 00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	5, 050		30.00
	1 I	915 0		31.00
	04100 SUBPROVI DER	0		41.00
	04300 NURSERY	1, 445		42.00
	04400 SKILLED NURSING FACILITY	1, 445		44.00
- -+. ∪∪	ANCILLARY SERVICE COST CENTERS	u U		1 -4.00
50.00	05000 OPERATING ROOM	0		50.00
	05200 DELIVERY ROOM & LABOR ROOM	o		52.00
	05300 ANESTHESI OLOGY	o		53.00
	05400 RADI OLOGY-DI AGNOSTI C	o		54.00
	05700 CT SCAN	O		57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	O		58.00
	05900 CARDI AC CATHETERI ZATI ON	O		59.00
	06000 LABORATORY	0		60.00
60. 01	06001 BLOOD LABORATORY	0		60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		63.00
65.00	06500 RESPI RATORY THERAPY	0		65.00
66.00	06600 PHYSI CAL THERAPY	0		66.00
69.00	06900 ELECTROCARDI OLOGY	0		69.00
	06901 CARDI AC REHAB	0		69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0		72.00
	07300 DRUGS CHARGED TO PATIENTS	0		73.00
	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0		76.00
76. 01	03040 RADI ATI ON ONCOLOGY	0		76. 01
00 00	OUTPATIENT SERVICE COST CENTERS	440		1 00 00
	09000 CLI NI C 09001 WOUND CARE	440		90.00
	09100 EMERGENCY	2, 680		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,080		91.00
7Z. UU	OTHER REIMBURSABLE COST CENTERS			72.00
95 00	09500 AMBULANCE SERVICES	0		95.00
. 3. 00	SPECIAL PURPOSE COST CENTERS	<u> </u>		1
118. 00		10, 530		118.00
	NONREI MBURSABLE COST CENTERS			1
194.00	07950 FOUNDATI ON	0		194. 00
194. 01	07951 MOB	0		194. 01
194. 02	07952 NONREI MBURSABLE OTHER	0		194. 02
	07953 PI H	0		194. 03
	07954 HEALTH COMPANIES	0		194. 04
	07955 PHYSICIANS OFFICE	0		194. 05
	07956 THE ARBORS	0		194. 06
	07957 PAIN MANAGEMENT	0		194. 07
	07958 OPS	0		194. 08
	07959 MHL ROCHESTER HEALTH CENTER	0		194. 09
194. 10	07961 RHEUMATOLOGY	0		194. 10
	07960 SPORTS HEALTH	0		194. 11
	Cross Foot Adjustments			200.00
200.00	, ,			201.00
200. 00 201. 00	Negative Cost Centers	, 0.5		000
200.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	602, 217		202.00
200. 00 201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)			
200. 00 201. 00 202. 00 203. 00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)	57. 190598		203. 00
200. 00 201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)			

Heal th Finar	ncial Systems	MEMORIAL HOSPITAL	LOGANSPORT	In Lieu	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CCN: 15-0072	Peri od: From 01/01/2018	Worksheet B-1	
				To 12/31/2018	Date/Time Pre 4/1/2019 4:24	
	Cost Center Description	SOCI AL				
		SERVI CE				
		(HOURS)				
		17. 00				
205. 00	Unit cost multiplier (Wkst. B, Part	4. 576068				205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207. 00

Health Financial Systems	MEMORIAL HOSPITAL	LOGANSPORT	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0072	From 01/01/2018	Worksheet C Part I Date/Time Prepared:

					0 12/31/2018	Date/IIme Pre 4/1/2019 4:24	pared:
			Title	XVIII	Hospi tal	PPS	рш
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	'	(from Wkst.	Áďj.		Di sal I owance		
		B, Part I,	•				
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	6, 641, 239		6, 641, 239		6, 641, 239	30.00
	03100 INTENSIVE CARE UNIT	1, 527, 138		1, 527, 138	0	1, 527, 138	31.00
	04100 SUBPROVI DER - I RF	0		C	0	0	41.00
42.00	04200 SUBPROVI DER	0		C	0	0	42.00
43.00	04300 NURSERY	710, 547		710, 547	0	710, 547	43.00
44.00	04400 SKILLED NURSING FACILITY	0		C	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	5, 347, 268		5, 347, 268		5, 347, 268	
	05200 DELIVERY ROOM & LABOR ROOM	1, 588, 232		1, 588, 232	. 0	1, 588, 232	
	05300 ANESTHESI OLOGY	220, 001		220, 001	l l	220, 001	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 410, 249		3, 410, 249	0	3, 410, 249	
	05700 CT SCAN	0		[C	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		[C	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		C	0	0	59. 00
	06000 LABORATORY	3, 727, 020		3, 727, 020	0	3, 727, 020	
60. 01	06001 BLOOD LABORATORY	0		C	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	157, 659		157, 659		157, 659	
	06500 RESPI RATORY THERAPY	1, 257, 718	0	1,20,,,		1, 257, 718	
66.00	06600 PHYSI CAL THERAPY	1, 394, 497	0	1, 394, 497		1, 394, 497	
	06900 ELECTROCARDI OLOGY	881, 825		881, 825		881, 825	
	06901 CARDI AC REHAB	839, 725		839, 725		839, 725	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 216, 731		2, 216, 731		2, 216, 731	
	07200 IMPL. DEV. CHARGED TO PATIENT	1, 698, 552		1, 698, 552		1, 698, 552	
	07300 DRUGS CHARGED TO PATIENTS	9, 408, 364		9, 408, 364		9, 408, 364	
	03020 NUCLEAR MEDICINE-DIAGNOSTIC	737, 049		737, 049		737, 049	
76. 01	03040 RADIATION ONCOLOGY	1, 542, 640		1, 542, 640	0	1, 542, 640	76. 01
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	7, 363, 187		7, 363, 187		7, 387, 906	
	09001 WOUND CARE	409, 767		409, 767		409, 767	
	09100 EMERGENCY	4, 120, 942		4, 120, 942		4, 120, 942	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 454, 314		1, 454, 314		1, 454, 314	92.00
05 00	OTHER REIMBURSABLE COST CENTERS				ا	0	05 00
	09500 AMBULANCE SERVICES	0	^	C		0	
200.00		56, 654, 664	0	,,			
201.00	1	1, 454, 314	^	1, 454, 314		1, 454, 314	
202.00	Total (see instructions)	55, 200, 350	0	55, 200, 350	24, 719	55, 225, 069	J2U2. UU

Health Financial Systems	MEMORIAL HOSPITAL LOGANSPORT	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0072		Worksheet C
		From 01/01/2018	
		To 12/21/2010	Data/Tima Droparadi

				To 12/31/2018	Date/Time Pre 4/1/2019 4:24	pared:
		Title	xVIII	Hospi tal	PPS	
		Charges	<u>. </u>	·		
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Rati o	I npati ent	
					Ratio	
	6. 00	7.00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	6, 637, 258		6, 637, 25	3		30.00
31.00 03100 INTENSIVE CARE UNIT	881, 540		881, 54)		31.00
41. 00 04100 SUBPROVI DER - I RF	0		()		41.00
42. 00 04200 SUBPROVI DER	0)		42.00
43. 00 04300 NURSERY	1, 350, 338		1, 350, 33	3		43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	4, 100, 469	26, 426, 887			0.000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 158, 543	532, 626			0.000000	
53. 00 05300 ANESTHESI OLOGY	248, 500	2, 161, 950			0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	811, 532	12, 136, 990	12, 948, 52		0.000000	
57.00 05700 CT SCAN	0	0	1	0.000000	0.000000	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	1	0. 000000	0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	1	0. 000000	0.000000	
60. 00 06000 LABORATORY	2, 599, 200	16, 612, 363	19, 211, 56		0.000000	
60. 01 06001 BL00D LABORATORY	0	0	1	0. 000000	0.000000	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	589, 928	838, 993			0.000000	
65. 00 06500 RESPIRATORY THERAPY	3, 001, 781	2, 201, 694			0.000000	
66. 00 06600 PHYSI CAL THERAPY	388, 473	3, 322, 737			0.000000	
69. 00 06900 ELECTROCARDI OLOGY	712, 088	3, 852, 513		1	0.000000	
69. 01 06901 CARDI AC REHAB	978	601, 547			0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 295, 875	5, 151, 218			0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 644, 730	6, 277, 725			0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 993, 373	39, 510, 327			0.000000	73.00
76.00 03020 NUCLEAR MEDICINE-DIAGNOSTIC	704, 992	7, 695, 698			0.000000	
76. 01 03040 RADI ATI ON ONCOLOGY	34, 690	8, 054, 473	8, 089, 16	0. 190705	0. 000000	76. 01
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLI NI C	38, 900	1, 872, 272			0. 000000	
90. 01 09001 WOUND CARE	18, 135	2, 138, 892			0. 000000	
91. 00 09100 EMERGENCY	1, 557, 268	13, 970, 729			0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	175, 792	2, 831, 023	3, 006, 81	0. 483673	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS			1			
95. 00 09500 AMBULANCE SERVICES	0	0	l .	0. 000000	0. 000000	
200.00 Subtotal (see instructions)	32, 944, 383	156, 190, 657	189, 135, 04)		200.00
201.00 Less Observation Beds	20 044 222	45/ 400 /57	400 405 34			201.00
202.00 Total (see instructions)	32, 944, 383	156, 190, 657	189, 135, 04	ا ا		202. 00

Health Financial Systems	MEMORIAL HOSPITAL LOGAN	ISPORT	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Prov	ider CCN: 15-0072	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 4/1/2019 4:24 pm

				4/1/2019 4: 24 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
41. 00 04100 SUBPROVI DER - I RF				41.00
42. 00 04200 SUBPROVI DER				42.00
43. 00 04300 NURSERY				43.00
44.00 04400 SKILLED NURSING FACILITY				44. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 175163			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 590164			52.00
53. 00 05300 ANESTHESI OLOGY	0. 091270			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 263370			54.00
57. 00 05700 CT SCAN	0. 000000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 193999			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 110334			63.00
65. 00 06500 RESPIRATORY THERAPY	0. 241707			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 375753			66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 193188			69.00
69. 01 06901 CARDI AC REHAB	1. 393677			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 343834			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 214397			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 216266			73.00
76. 00 03020 NUCLEAR MEDICINE-DIAGNOSTIC	0. 087737			76. 00
76. 01 03040 RADIATION ONCOLOGY	0. 190705			76. 01
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	3. 865642			90.00
90. 01 09001 WOUND CARE	0. 189968			90. 01
91. 00 09100 EMERGENCY	0. 265388			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 483673			92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
				•

Health Financial Systems	MEMORIAL HOSPITAL	LOGANSPORT	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0072	Peri od: From 01/01/2018	Worksheet C
				Nate/Time Prenared

			Т	o 12/31/2018	Date/Time Pre 4/1/2019 4:24	pared:
		Ti tl	e XIX	Hospi tal	Cost	
		<u>'</u>		Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	6, 641, 239		6, 641, 239		6, 641, 239	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 527, 138		1, 527, 138	0	1, 527, 138	
41. 00 04100 SUBPROVI DER - I RF	0		0	0	0	41.00
42. 00 04200 SUBPROVI DER	0		0	0	0	42.00
43. 00 04300 NURSERY	710, 547		710, 547		710, 547	43.00
44. 00 04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	5, 347, 268		5, 347, 268		5, 347, 268	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 588, 232		1, 588, 232		1, 588, 232	52.00
53. 00 05300 ANESTHESI OLOGY	220, 001		220, 001		220, 001	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 410, 249		3, 410, 249	0	3, 410, 249	54.00
57. 00 05700 CT SCAN	0		0	0	0	57.00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0		0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0 707 000		0 707 000	0	0	59.00
60. 00 06000 LABORATORY	3, 727, 020		3, 727, 020	0	3, 727, 020	60.00
60. 01 06001 BLOOD LABORATORY	457 (50		457 (50	0	0	60.01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	157, 659		157, 659		157, 659	63.00
65. 00 06500 RESPIRATORY THERAPY	1, 257, 718	l e			1, 257, 718	
66. 00 06600 PHYSI CAL THERAPY	1, 394, 497		1, 394, 497		1, 394, 497	
69. 00 06900 ELECTROCARDI OLOGY	881, 825		881, 825		881, 825	
69. 01 06901 CARDI AC REHAB	839, 725		839, 725		839, 725	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 216, 731		2, 216, 731		2, 216, 731	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	1, 698, 552		1, 698, 552		1, 698, 552	72. 00 73. 00
	9, 408, 364	l .	9, 408, 364		9, 408, 364	•
76. 00 03020 NUCLEAR MEDICINE-DIAGNOSTIC	737, 049		737, 049		737, 049	76.00
76. 01 03040 RADIATION ONCOLOGY OUTPATIENT SERVICE COST CENTERS	1, 542, 640		1, 542, 640	l U	1, 542, 640	76. 01
90. 00 09000 CLINIC	7, 363, 187		7, 363, 187	24, 719	7, 387, 906	90.00
90. 00 09000 CET NT C 90. 01 09001 WOUND CARE	409, 767		409, 767		409, 767	90.00
91. 00 09100 EMERGENCY	4, 120, 942	l e	4, 120, 942		4, 120, 942	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 454, 314		1, 454, 314		1, 454, 314	92.00
OTHER REIMBURSABLE COST CENTERS	1, 454, 514		1, 454, 514		1, 454, 514	72.00
95. 00 09500 AMBULANCE SERVICES	0		0	ام	0	95.00
200.00 Subtotal (see instructions)	56, 654, 664	0	56, 654, 664	24, 719	56, 679, 383	
201.00 Less Observation Beds	1, 454, 314		1, 454, 314		1, 454, 314	
202.00 Total (see instructions)	55, 200, 350					
202.00, 1000 (300 1130 400 013)	1 00, 200, 000	, ,	1 00, 200, 000		00, 220, 007	1-52.00

Health Financial Systems	MEMORIAL HOSPITAL LOGANSPORT		In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCI	N: 15-0072	Peri od:	Worksheet C
			From 01/01/2018	
				D-+- /T! D

				T	o 12/31/2018	Date/Time Pre 4/1/2019 4:24	epared:
			Ti +I	e XIX	Hospi tal	4/1/2019 4.24 Cost	ғ <u>р</u> ш
			Charges	C XIX	nospi tai	0031	
	Cost Center Description	Inpatient	Outpati ent	Total (col 6	Cost or Other	TEFRA	
	cost center bescription	Tripatrent	outpatrent	+ col . 7)	Ratio	Inpatient	
				1 001. 7)	Ratio	Ratio	
		6. 00	7. 00	8. 00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
30.00	03000 ADULTS & PEDI ATRI CS	6, 637, 258		6, 637, 258			30.00
	03100 NTENSI VE CARE UNI T	881, 540		881, 540			31.00
	04100 SUBPROVI DER - I RF	001,010		001,010			41.00
	04200 SUBPROVI DER						42.00
	04300 NURSERY	1, 350, 338		1, 350, 338			43.00
	04400 SKILLED NURSING FACILITY	1, 550, 550		1, 330, 330			44.00
44.00	ANCI LLARY SERVI CE COST CENTERS	٩			1		1 44.00
50.00	05000 OPERATING ROOM	4, 100, 469	26, 426, 887	30, 527, 356	0. 175163	0. 000000	50.00
	05200 DELIVERY ROOM & LABOR ROOM	2, 158, 543	532, 626			0. 000000	1
	05300 ANESTHESI OLOGY	248, 500	2, 161, 950			0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	811, 532	12, 136, 990			0. 000000	1
	05700 CT SCAN	011, 332	12, 130, 770			0.000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	1		0. 000000	
	05900 CARDI AC CATHETERI ZATI ON		0		0.000000	0. 000000	
	06000 LABORATORY	2, 599, 200	16, 612, 363	19, 211, 563		0.000000	
	06001 BLOOD LABORATORY	2,377,200	10, 012, 303	17, 211, 303		0. 000000	
	06300 BLOOD STORING, PROCESSING & TRANS.	589, 928	838, 993			0. 000000	
	06500 RESPIRATORY THERAPY	3, 001, 781	2, 201, 694			0. 000000	
	06600 PHYSI CAL THERAPY	388, 473	3, 322, 737			0. 000000	1
	06900 ELECTROCARDI OLOGY	712, 088	3, 852, 513			0.000000	
	06901 CARDI AC REHAB	978	601, 547			0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 295, 875	5, 151, 218		1	0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENT	1, 644, 730	6, 277, 725			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	3, 993, 373	39, 510, 327		1	0. 000000	
	03020 NUCLEAR MEDICINE-DIAGNOSTIC	704, 992	7, 695, 698		1	0.000000	
	03040 RADI ATI ON ONCOLOGY	34, 690	8, 054, 473			0. 000000	
70.01	OUTPATIENT SERVICE COST CENTERS	34, 070	0,034,473	0,007,100	0. 170703	0.000000	70.01
90.00	09000 CLINIC	38, 900	1, 872, 272	1, 911, 172	3. 852708	0. 000000	90.00
	09001 WOUND CARE	18, 135	2, 138, 892			0.000000	
	09100 EMERGENCY	1, 557, 268	13, 970, 729			0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	175, 792	2, 831, 023			0. 000000	
72.00	OTHER REIMBURSABLE COST CENTERS	175, 772	2,031,023	3,000,010	0. 403073	0.00000	72.00
95. 00	09500 AMBULANCE SERVICES		0		0. 000000	0. 000000	95.00
200.00		32, 944, 383	156, 190, 657	_		0.000000	200.00
201.00		32, 744, 303	130, 170, 037	107, 133, 040			201.00
201.00		32, 944, 383	156, 190, 657	189, 135, 040			202.00
202.00	Total (see That delibra)	1 32, 744, 303	130, 170, 037	107, 133, 040	η I		1202.00

Health Financial Systems	MEMORIAL HOSPITAL LOGANSPORT	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0072	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 4/1/2019 4:24 pm

					4/1/2019 4: 24	pm
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDI ATRI CS					30.00
	03100 NTENSIVE CARE UNIT					31.00
	04100 SUBPROVI DER - I RF					41.00
	04200 SUBPROVI DER					42.00
	04300 NURSERY					43.00
	04400 SKILLED NURSING FACILITY					44.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	0. 000000				50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
	05300 ANESTHESI OLOGY	0. 000000				53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
	05700 CT SCAN	0. 000000				57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58. 00
	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
	06000 LABORATORY	0. 000000				60.00
	06001 BLOOD LABORATORY	0. 000000				60. 01
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
	06500 RESPI RATORY THERAPY	0. 000000				65.00
	06600 PHYSI CAL THERAPY	0. 000000				66. 00
	06900 ELECTROCARDI OLOGY	0. 000000				69. 00
	06901 CARDI AC REHAB	0. 000000				69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000				76. 00
	03040 RADIATION ONCOLOGY	0. 000000				76. 01
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C	0. 000000				90.00
	09001 WOUND CARE	0. 000000				90. 01
	09100 EMERGENCY	0. 000000				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
	OTHER REIMBURSABLE COST CENTERS	1				
	09500 AMBULANCE SERVICES	0. 000000				95.00
200. 00						200.00
201.00						201.00
202. 00	Total (see instructions)					202. 00

Health Financial Systems	MEMORIAL HOSPIT	AL LOGANSPORT		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2018 To 12/31/2018		pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II,	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 -	Total Patient Days	Per Diem (col. 3 / col. 4)	
	col . 26)	2.00	col . 2) 3.00	4. 00	5. 00	
INDATIENT DOUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199) Cost Center Description	1, 162, 139 202, 573 0 0 44, 934 0 1, 409, 646 Inpatient Program days	0	1, 162, 13 202, 57 44, 93 1, 409, 64	3 435 0 0 0 0 4 1,044 0 0	465. 69 0. 00 0. 00 43. 04 0. 00	41. 00 42. 00 43. 00
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)	1, 668 220 0 0 0 0 0	102, 452 0 0 0 0				30. 00 31. 00 41. 00 42. 00 43. 00 44. 00 200. 00

Health Financial S	ystems	MEMORIAL HOSPITAL	LOGANSPORT	In Lieu	u of Form CMS-2552-10
ADDODTI ONMENT OF I	NDATIENT ANOLILIADY CEDVICE	OADLEAL COCTO	D	D	Wasaliala a de D

Health Financial Systems MEMORIAL HOSPITAL LOGANSPORT In Lieu of Form CMS-255						2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provi der C		Period: From 01/01/2018 To 12/31/2018		
-		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	703, 333				25, 326	
52.00 05200 DELIVERY ROOM & LABOR ROOM	173, 290					52.00
53. 00 05300 ANESTHESI OLOGY	57, 825		•			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	334, 769	12, 948, 522			12, 848	
57. 00 05700 CT SCAN	0	0	0. 00000		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0. 00000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000		0	59.00
60. 00 06000 LABORATORY	215, 354	19, 211, 563				
60. 01 06001 BL00D LABORATORY	0	0	0.00000		0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	2, 562				407	63.00
65. 00 06500 RESPI RATORY THERAPY	30, 930					
66. 00 06600 PHYSI CAL THERAPY	129, 991	3, 711, 210			•	1
69. 00 06900 ELECTROCARDI OLOGY	55, 207	4, 564, 601			5, 115	1
69. 01 06901 CARDI AC REHAB	175, 287	•			180	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	141, 254				11, 543	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	9, 589				1, 111	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	120, 306				•	
76. 00 03020 NUCLEAR MEDICINE-DIAGNOSTIC	42, 071	8, 400, 690				
76. 01 03040 RADI ATI ON ONCOLOGY	114, 972	8, 089, 163	0. 01421	32, 247	458	76. 01
OUTPATIENT SERVICE COST CENTERS	_			_		
90. 00 09000 CLI NI C	264, 901	1, 911, 172			•	
90. 01 09001 WOUND CARE	34, 093		•		128	
91. 00 09100 EMERGENCY	550, 763					1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	254, 487	3, 006, 815	0. 08463	7 47, 220	3, 997	92.00
OTHER REIMBURSABLE COST CENTERS			1	T		
95. 00 09500 AMBULANCE SERVICES	0 440	100 0/5		10.040 :=:		95.00
200.00 Total (lines 50 through 199)	3, 410, 984	180, 265, 904	l	10, 342, 656	141, 172	J200.00

Health Financial Systems	MEMORIAL HOSPIT	AL LOGANSPORT		In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P.			CN: 15-0072	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part III	pared:
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		h Allied Health	All Other	
'	School	School	Post-Stepdow		Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments		1		Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>		•	_		
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	l .	1	0 0	l o	
41. 00 04100 SUBPROVI DER - RF	0	0		0 0	0	
42. 00 04200 SUBPROVI DER	0	0		0 0	o o	1
43. 00 04300 NURSERY		١			o o	
44.00 04400 SKILLED NURSING FACILITY		١		0 0	Ĭ	44.00
200.00 Total (lines 30 through 199)				0 0	_	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	0	Inpati ent	200.00
cost center bescription	Adjustment	(sum of cols.	Days	(col . 5 ÷	Program Days	
	Amount (see	1 through 3,	Days	col. 6)	11 Ograiii Days	
		minus col. 4)		COI. 0)		
	4. 00	5.00	6. 00	7. 00	8. 00	
INPATIENT POLITINE SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						30,00
30. 00 03000 ADULTS & PEDIATRICS	4.00	0	4, 83	0.00	1, 668	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	0	0	4, 83	36 0. 00 35 0. 00	1, 668 220	31.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF	0	0	4, 83	36 0.00 35 0.00 0 0.00	1, 668 220 0	31. 00 41. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER	0	0	4, 83	36 0.00 35 0.00 0 0.00 0 0.00	1, 668 220 0 0	31. 00 41. 00 42. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER 43. 00 04300 NURSERY	0	000000000000000000000000000000000000000	4, 83 43 1, 04	36 0.00 35 0.00 0 0.00 0 0.00 14 0.00	1, 668 220 0 0	31.00 41.00 42.00 43.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER 43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSING FACILITY	0	000000000000000000000000000000000000000	4, 83 43 1, 04	36 0.00 35 0.00 0 0.00 0 0.00 14 0.00 0 0.00	1, 668 220 0 0 0	31.00 41.00 42.00 43.00 44.00
30. 00	0 0	000000000000000000000000000000000000000	4, 83 43 1, 04	36 0.00 35 0.00 0 0.00 0 0.00 14 0.00 0 0.00	1, 668 220 0 0 0	31.00 41.00 42.00 43.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER 43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSING FACILITY	0 0 0	000000000000000000000000000000000000000	4, 83 43 1, 04	36 0.00 35 0.00 0 0.00 0 0.00 14 0.00 0 0.00	1, 668 220 0 0 0	31.00 41.00 42.00 43.00 44.00
30. 00	0 0 0 Inpatient Program	000000000000000000000000000000000000000	4, 83 43 1, 04	36 0.00 35 0.00 0 0.00 0 0.00 14 0.00 0 0.00	1, 668 220 0 0 0	31.00 41.00 42.00 43.00 44.00
30. 00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	4, 83 43 1, 04	36 0.00 35 0.00 0 0.00 0 0.00 14 0.00 0 0.00	1, 668 220 0 0 0	31.00 41.00 42.00 43.00 44.00
30. 00	Inpatient Program Pass-Through Cost (col. 7	000000000000000000000000000000000000000	4, 83 43 1, 04	36 0.00 35 0.00 0 0.00 0 0.00 14 0.00 0 0.00	1, 668 220 0 0 0	31.00 41.00 42.00 43.00 44.00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 41.00 04100 SUBPROVI DER - IRF 42.00 04200 SUBPROVI DER 43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY Total (lines 30 through 199)	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	000000000000000000000000000000000000000	4, 83 43 1, 04	36 0.00 35 0.00 0 0.00 0 0.00 14 0.00 0 0.00	1, 668 220 0 0 0	31.00 41.00 42.00 43.00 44.00
30. 00	Inpatient Program Pass-Through Cost (col. 7	000000000000000000000000000000000000000	4, 83 43 1, 04	36 0.00 35 0.00 0 0.00 0 0.00 14 0.00 0 0.00	1, 668 220 0 0 0	31.00 41.00 42.00 43.00 44.00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 41.00 04100 SUBPROVIDER - IRF 42.00 04200 SUBPROVIDER 43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199) Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	0 0 0 0 0 0	4, 83 43 1, 04	36 0.00 35 0.00 0 0.00 0 0.00 14 0.00 0 0.00	1, 668 220 0 0 0	31. 00 41. 00 42. 00 43. 00 44. 00 200. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER 43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSING FACILITY 200. 00 Total (lines 30 through 199) Cost Center Description INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 30. 00 03000 ADULTS & PEDIATRICS 31. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 ADULTS 03100	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	000000000000000000000000000000000000000	4, 83 43 1, 04	36 0.00 35 0.00 0 0.00 0 0.00 14 0.00 0 0.00	1, 668 220 0 0 0	31. 00 41. 00 42. 00 43. 00 44. 00 200. 00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 41.00 04100 SUBPROVIDER - IRF 42.00 04200 SUBPROVIDER 43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199) Cost Center Description INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	000000000000000000000000000000000000000	4, 83 43 1, 04	36 0.00 35 0.00 0 0.00 0 0.00 14 0.00 0 0.00	1, 668 220 0 0 0	31. 00 41. 00 42. 00 43. 00 44. 00 200. 00
30. 00	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	000000000000000000000000000000000000000	4, 83 43 1, 04	36 0.00 35 0.00 0 0.00 0 0.00 14 0.00 0 0.00	1, 668 220 0 0 0	31. 00 41. 00 42. 00 43. 00 44. 00 200. 00 30. 00 31. 00 41. 00
30. 00	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	000000000000000000000000000000000000000	4, 83 43 1, 04	36 0.00 35 0.00 0 0.00 0 0.00 14 0.00 0 0.00	1, 668 220 0 0 0	31. 00 41. 00 42. 00 43. 00 44. 00 200. 00 30. 00 31. 00 41. 00 42. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER 43. 00 04400 SUBPROVIDER 44. 00 04400 SKILLED NURSING FACILITY Total (lines 30 through 199) Cost Center Description Cost Center Description INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER 43. 00 04300 NURSERY 44. 00 04300 NURSERY 44. 00 04300 NURSERY 44. 00 04300 NURSERY 44. 00 04300 NURSERY 45. 00 0430	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	000000000000000000000000000000000000000	4, 83 43 1, 04	36 0.00 35 0.00 0 0.00 0 0.00 14 0.00 0 0.00	1, 668 220 0 0 0	30. 00 31. 00 42. 00 43. 00 44. 00 200. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER 43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSING FACILITY Total (lines 30 through 199) Cost Center Description Cost Center Description INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 031. 00 04100 SUBPROVIDER IRF 42. 00 04200 SUBPROVIDER 43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSING FACILITY 41. 00 04400 SKILLED NURSING FACILITY 43. 00 04400 SKILLED NURSING FACILITY 44. 00 04400 0	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	000000000000000000000000000000000000000	4, 83 43 1, 04	36 0.00 35 0.00 0 0.00 0 0.00 14 0.00 0 0.00	1, 668 220 0 0 0	31. 00 41. 00 42. 00 43. 00 44. 00 200. 00 31. 00 41. 00 42. 00 43. 00 44. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER 43. 00 04400 SUBPROVIDER 44. 00 04400 SKILLED NURSING FACILITY Total (lines 30 through 199) Cost Center Description Cost Center Description INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER 43. 00 04300 NURSERY 44. 00 04300 NURSERY 44. 00 04300 NURSERY 44. 00 04300 NURSERY 44. 00 04300 NURSERY 45. 00 0430	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	000000000000000000000000000000000000000	4, 83 43 1, 04	36 0.00 35 0.00 0 0.00 0 0.00 14 0.00 0 0.00	1, 668 220 0 0 0	30. 00 31. 00 42. 00 43. 00 44. 00 200. 00

Peri od: Worksheet D From 01/01/2018 Part IV To 12/31/2018 Date/Time Prepared: THROUGH COSTS

						4/1/2019 4: 24	pm
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
69. 01	06901 CARDI AC REHAB	0	O		0 0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	O		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	O		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	O		0 0	0	73.00
76.00	03020 NUCLEAR MEDICINE-DIAGNOSTIC	0	O		0 0	0	76.00
76. 01	03040 RADI ATI ON ONCOLOGY	0	0		0 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90.00
90. 01	09001 WOUND CARE	0	0		0 0	0	90. 01
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95.00
200.00		0	o		0 0	0	200.00
	1.222. (1.1100 00 01.1100g). 177)	1	·	1	-1		

| Peri od: | Worksheet D | From 01/01/2018 | Part IV | To | 12/31/2018 | Date/Time Prepared: THROUGH COSTS

ANCILLARY SERVICE COST CENTERS				'	12/01/2010	4/1/2019 4: 24	
Medical Education Cost County Cost Cost (sum of cols. Cost (Title	XVIII	Hospi tal	PPS	
Education Cost (sum of col s. 2, 3, and 4)	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
ANCI LLARY SERVICE COST CENTERS		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
ANCI LLARY SERVICE COST CENTERS		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
ANCILLARY SERVICE COST CENTERS		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
ANCILLARY SERVICE COST CENTERS 50.00 C5000 OFFRATING ROOM O O O O O O O O O				and 4)			
50. 00		4. 00	5. 00	6. 00	7. 00	8. 00	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 2, 691, 169 0.000000 52. 00 53. 00 05300 ARSTHESI LOGY 0 0 0 0 2, 410, 450 0.000000 53. 00 0.000000 54. 00 0.000000 54. 00 0.000000 54. 00 0.000000 54. 00 0.000000 54. 00 0.000000 54. 00 0.000000 54. 00 0.000000 57. 00 0.000000 57. 00 0.000000 58. 00 0.000000 59. 00 0.000000 59. 00 0.000000 59. 00 0.000000 59. 00 0.000000 59. 00 0.000000 59. 00 0.000000 59. 00 0.000000 59. 00 0.000000 59. 00 0.000000 69. 00 0.000000 69. 00 0.000000 69. 00 0.000000 69. 00 0.000000 69. 00 0.000000 69. 00 0.000000 69. 00 0.000000 69. 00 0.000000 69. 00 0.000000 60. 00 0.0000000 60. 00 0.000000 60. 00 0.0000000 60. 00 0.0000000000							
53. 00 05300 ANESTHESI OLOGY 0 0 0 2, 410, 450 0.000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 12, 948, 522 0.000000 54. 00 57. 00 05700 CT SCAN 0 0 0 0 0 0.000000 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 0.000000 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0.000000 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0.000000 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0.000000 63. 00 06500 RESPI RATORY THERAPY 0 0 0 0 1, 428, 921 0.000000 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 5, 203, 475 0.000000 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 3, 711, 210 0.000000 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 4, 564, 601 0.000000 69. 01 06901 CARDI AC REHAB 0 0 0 0 602, 525 0.000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 43, 503, 700 0.000000 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 43, 503, 700 0.000000 73. 00 07300 RUSC SCHARGED TO PATI ENTS 0 0 0 0 8, 400, 690 0.000000 74. 01 07400 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 1, 911, 172 0.000000 75. 00 07000 CLINI C 0 0 0 0 1, 911, 172 0.000000 76. 01 07400 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0.00000 76. 01 07400 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 76. 01 07400 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 76. 01 07400 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 76. 01 07400 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 76. 01 07400 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 76. 01 07400 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0		0	0	(30, 527, 356		
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 12, 948, 522 0.000000 54. 00 57. 00 57. 00 5700 CT SCAN 0 0 0 0 0.000000 57. 00 58. 00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0 0 0 0 0.000000 58. 00 59. 00 0.000000 59. 00 0.000000 59. 00 0.000000 59. 00 0.000000 59. 00 0.000000 60. 00 0 0 0.000000 60. 00 0.0000000 60. 00 0.000000000 60. 00 0.0000000000	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(2, 691, 169	0.000000	52.00
57. 00 05700 CT SCAN 0 0 0 0 0 0 0 0 0	53. 00 05300 ANESTHESI OLOGY	0	0	(2, 410, 450	0. 000000	53.00
58. 00	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(12, 948, 522	0. 000000	54.00
59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 0 0 0 0	57. 00 05700 CT SCAN	0	0	(0	0. 000000	57.00
60. 00 06000 LABORATORY 0 0 0 0 19, 211, 563 0. 000000 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0. 000000 60. 01 63. 00 06001 BLOOD STORING, PROCESSING & TRANS. 0 0 0 1, 428, 921 0. 000000 65. 00 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 5, 203, 475 0. 000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 3, 711, 210 0. 000000 66. 00 69. 00 06900 ELECTROCARDIOLOGY 0 0 0 4, 564, 601 0. 000000 69. 00 69. 01 06901 CARDIAC REHAB 0 0 0 0 602, 525 0. 000000 69. 01 071. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 6, 447, 093 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 7, 922, 455 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 8, 43, 503, 700 0. 000000 73. 00 76. 00 03020 NUCLEAR MEDICINE-DIAGNOSTIC 0 0 0 8, 400, 690 0. 000000 76. 00 0 0 8, 089, 163 0. 000000 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(0	0.000000	58. 00
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0.000000 60. 01 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 1, 428, 921 0.000000 63. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 5, 203, 475 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 3, 711, 210 0.000000 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 4, 564, 601 0.000000 69. 00 69. 01 06901 CARDI AC REHAB 0 0 0 0 0 602, 525 0.000000 69. 01 071. 00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 6, 447, 093 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 6, 447, 093 0.000000 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 43, 503, 700 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 43, 503, 700 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 8, 400, 690 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 8, 400, 690 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 8, 899, 163 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 1, 911, 172 0.000000 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0.000000	59.00
63. 00	60. 00 06000 LABORATORY	0	0	(19, 211, 563	0.000000	60.00
65. 00	60. 01 06001 BL00D LABORATORY	0	0	(0	0.000000	60. 01
66. 00	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(1, 428, 921	0.000000	63.00
69. 00	65. 00 06500 RESPIRATORY THERAPY	0	0	(5, 203, 475	0.000000	65.00
69. 01	66. 00 06600 PHYSI CAL THERAPY	0	0	(3, 711, 210	0.000000	66.00
71. 00	69. 00 06900 ELECTROCARDI OLOGY	0	0	(4, 564, 601	0.000000	69.00
72. 00	69. 01 06901 CARDI AC REHAB	0	0		602, 525	0. 000000	69. 01
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 43, 503, 700 0.000000 73. 00 76. 00 03020 NUCLEAR MEDICINE-DIAGNOSTIC 0 0 0 8, 400, 690 0.000000 76. 00 76. 00 0 0 0 0 0 0 0 0 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		6, 447, 093	0. 000000	71.00
76. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		7, 922, 455	0. 000000	72.00
76. 01 03040 RADIATION ONCOLOGY 0 0 0 8,089,163 0.000000 76. 01 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 1,911,172 0.000000 90. 00 90. 01 09001 WOUND CARE 0 0 0 2,157,027 0.000000 90. 01 91. 00 09100 EMERGENCY 0 0 0 15,527,997 0.000000 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 3,006,815 0.000000 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		43, 503, 700	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS OUTP	76.00 03020 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		8, 400, 690	0. 000000	76.00
90. 00	76. 01 03040 RADIATION ONCOLOGY	0	0		8, 089, 163	0. 000000	76. 01
90. 01 09001 WOUND CARE	OUTPATIENT SERVICE COST CENTERS	,					1
91. 00	90. 00 09000 CLI NI C	0	0	(1, 911, 172	0.000000	90.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 3,006,815 0.000000 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	90. 01 09001 WOUND CARE	o	0	(2, 157, 027	0.000000	90. 01
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	91. 00 09100 EMERGENCY	o	0	(15, 527, 997	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	0	(3, 006, 815	0.000000	92.00
							1
200.00 Total (Lines 50 through 199) 0 0 180,265,904 200.00	95. 00 09500 AMBULANCE SERVICES						95.00
	200.00 Total (lines 50 through 199)	0	0	(180, 265, 904		200.00

Health Financial Systems	MEMORIAL HOSPITAL	LOGANSPORT	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0072	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared:

Cost Center Description	TIROUGH GGG13			To	12/31/2018	Date/Time Pre 4/1/2019 4:24	
Cost Center Description			Title	XVIII	Hospi tal		РШ
To Charges Col. 6 + Col. 7) To Charges Charges Charges Charges Costs (col. 8 x col. 12) To Costs (col. 9 x col. 12) To Costs (col. 12) To Costs (col. 9 x col. 12) To Costs (col. 12) T	Cost Center Description	Outpati ent	Inpatient	Inpatient		Outpati ent	
Col 6 Col 7 Col 7 Costs (col 8 Costs (col 8 x col 12 x co	·	Ratio of Cost	Program	Program	Program	Program	
Col. 7)		to Charges	Charges	Pass-Through	Charges	Pass-Through	
ANCILLARY SERVICE COST CENTERS		(col. 6 ÷		Costs (col. 8		Costs (col. 9	
ANCILLARY SERVICE COST CENTERS				x col. 10)		x col. 12)	
50. 00 05000 DERATTING ROOM 0.000000 1,099,267 0 6,386,429 0 50. 00		9. 00	10. 00	11. 00	12.00	13.00	
52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 12, 434 0 0 0 55.0 960 0 53.00							
53.00 05300 ANESTHESI OLOGY 0.000000 61,770 0 550,960 0 53.00 54.00 05400 ADIO (DADIO LOGY-DI AGNOSTI C 0.000000 496,962 0 3,113,579 0 54.00 57.00 05700 CT SCAN 0.000000 0 0 0 0 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 0 0 0 0 0 0 58.00 59.00 05900 CARDI AC CATHETTERI ZATI ON 0.000000 0 0 0 0 0 0 59.00 60.00 06000 LABORATORY 0.000000 1,249,969 0 2,379,728 0 60.01 63.00 05300 BLOOD STORING, PROCESSI NG & TRANS. 0.000000 227,056 0 240,129 0 63.00 65.00 06500 RESPI RATORY THERAPY 0.000000 227,056 0 240,129 0 63.00 66.00 PHYSI CAL THERAPY			1, 099, 267	0	6, 386, 429	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 496, 962 0 3, 113, 579 0 54. 00 57. 00 05700 CT SCAN 0.000000 0 0 0 0 57.00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 0 0 0 59. 00 60. 00 06000 LABORATORY 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0. 000000	12, 434	0	0	0	
57. 00 05700 CT SCAN 0.000000 0 0 0 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0.000000 0 0 0 0 58. 00 59. 00 05900 CARDIA C CATHETERI ZATI ON 0.000000 0 0 0 0 0 60. 00 06000 LABORATORY 0.000000 1, 249, 969 0 2, 379, 728 0 60. 00 60. 01 06001 BLOOD LABORATORY 0.000000 0 0 0 0 0 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 227, 056 0 240, 129 0 63. 00 65. 00 06500 RESPI RATORY THERAPY 0.000000 1, 725, 176 0 760, 725 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 249, 940 0 30, 811 0 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 422, 861 0 1, 337, 935 0 69. 00 69. 01 06901 CARDIA C REHAB 0.000000 620 0 251, 181 0 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 526, 830 0 902, 705 0 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.000000 918, 231 0 2, 001, 372 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 431, 979 0 2, 681, 532 0 76. 00 76. 01 03020 NUCLEAR MEDI CINE -DI AGNOSTI C 0.000000 431, 979 0 2, 681, 532 0 76. 00 76. 01 03040 RADIATION ONCOLOGY 0.000000 431, 979 0 2, 546, 502 0 76. 01 79. 00 09000 CLINIC 0.000000 993, 695 0 3, 282, 443 0 91. 00 79. 01 09001 WOUND CARE 0.000000 47, 220 0 725, 650 0 79. 00 09000 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 47, 220 0 725, 650 0 79. 00 09000 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 47, 220 0 725, 650 0 79. 00 07500 ABBULANCE SERVICES 95. 00	53. 00 05300 ANESTHESI OLOGY	0. 000000	61, 770	0	550, 960	0	53.00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 0 0 0 59. 00 60. 00 06000 LABORATORY 0.000000 0	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	496, 962	0	3, 113, 579	0	54.00
59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 59.00 60.00 06000 LABORATORY 0.000000 1,249,969 0 2,379,728 0 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 <td>57.00 05700 CT SCAN</td> <td>0. 000000</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>57.00</td>	57.00 05700 CT SCAN	0. 000000	0	0	0	0	57.00
60. 00			0	0	0	0	
60. 01 06001 BLOOD LABORATORY 0.000000 0 0 0 0 0 0 0 60. 01 63. 00 6300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 1, 725, 176 0 760, 725 0 63. 00 65. 00 06500 RESPI RATORY THERAPY 0.0000000 1, 725, 176 0 760, 725 0 66. 00 06600 PHYSI CAL THERAPY 0.000000 249, 940 0 30, 811 0 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 422, 861 0 1, 337, 935 0 69. 00 69. 01 06901 CARDI AC REHAB 0.000000 620 0 251, 181 0 69. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 526, 830 0 902, 705 0 71. 00 7200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 1, 821, 639 0 14, 341, 258 0 73. 00 73.00 DRUGS CHARGED TO PATI ENTS 0.000000 1, 821, 639 0 14, 341, 258 0 73. 00 73. 00 03020 NUCLEAR MEDI CI NE-DI AGNOSTI C 0.000000 1, 821, 639 0 14, 341, 258 0 73. 00 03020 NUCLEAR MEDI CI NE-DI AGNOSTI C 0.000000 32, 247 0 2, 681, 532 0 76. 00 09000 CLI NI C 0.000000 1, 821, 639 0 14, 341, 258 0 73. 00 074. 01 07	59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	0	0	0	59.00
63. 00	60. 00 06000 LABORATORY	0. 000000	1, 249, 969	0	2, 379, 728	0	60.00
65. 00 06500 RESPIRATORY THERAPY 0.000000 1,725,176 0 760,725 0 65. 00 66. 00 06600 Physical Therapy 0.000000 249,940 0 30,811 0 66. 00 69. 00 06900 Electrocardiology 0.000000 422,861 0 1,337,935 0 69. 00 69. 00 06901 Cardia	60. 01 06001 BLOOD LABORATORY	0. 000000	0	0	0	0	60. 01
66. 00 06600 PHYSI CAL THERAPY 0. 000000 249, 940 0 30, 811 0 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 000000 422, 861 0 1, 337, 935 0 69. 00 69. 01 06901 CARDI AC REHAB 0. 000000 620 0 251, 181 0 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 526, 830 0 902, 705 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 000000 918, 231 0 2, 001, 372 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 1, 821, 639 0 14, 341, 258 0 73. 00 76. 00 03020 NUCLEAR MEDI CI NE-DI AGNOSTI C 0. 000000 431, 979 0 2, 681, 532 0 76. 00 76. 01 03040 RADI ATI ON ONCOLOGY 0. 000000 32, 247 0 2, 546, 502 0 76. 01 09000 CLI NI C 0. 000000 32, 247 0 2, 546, 502 0 76. 01 09000 WOUND CARE 0. 000000 8, 092 0 982, 837 0 90. 01 791. 00 09100 EMERGENCY 0. 000000 47, 220 0 792. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 47, 220 795. 00 OP500 AMBULANCE SERVI CES	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	227, 056	0	240, 129	0	63.00
69. 00 06900 ELECTROCARDI OLOGY 0. 000000 422, 861 0 1, 337, 935 0 69. 00 69. 01 06901 CARDI AC REHAB 0. 0000000 620 0 251, 181 0 69. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 000000 526, 830 0 902, 705 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0. 0000000 918, 231 0 2, 001, 372 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 0000000 1, 821, 639 0 14, 341, 258 0 73. 00 76. 01 03020 NUCLEAR MEDI CI NE-DI AGNOSTI C 0. 0000000 431, 979 0 2, 681, 532 0 76. 01 03040 RADI ATI ON ONCOLOGY 0. 000000 32, 247 0 2, 546, 502 0 76. 01 000000 09000 CLI NI C 0. 0000000 32, 247 0 2, 546, 502 0 76. 01 090000 09000 09000 090000 090000	65. 00 06500 RESPIRATORY THERAPY	0. 000000	1, 725, 176	0	760, 725	0	65.00
69. 01 06901 CARDI AC REHAB 0.000000 620 0 251, 181 0 69. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 526, 830 0 902, 705 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.000000 918, 231 0 2, 001, 372 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 1, 821, 639 0 14, 341, 258 0 73. 00 76. 00 03020 NUCLEAR MEDI CI NE-DI AGNOSTI C 0.000000 431, 979 0 2, 681, 532 0 76. 00 76. 01 03040 RADI ATI ON ONCOLOGY 0.000000 32, 247 0 2, 546, 502 0 76. 01 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0.000000 8, 092 0 982, 837 0 90. 01 91. 00 09100 EMERGENCY 0.000000 47, 220 0 725, 650 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 47, 220 0 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	66. 00 06600 PHYSI CAL THERAPY	0. 000000	249, 940	0	30, 811	0	66.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 526, 830 0 902, 705 0 71. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00 74. 341, 258 0 73. 00 74. 341, 258 0 73. 00 74. 341, 258 0 73. 00 74. 341, 258 24. 341, 258 24. 341, 258 24. 341, 258 24. 341, 258 24. 341, 258 24. 341, 258 24.	69. 00 06900 ELECTROCARDI OLOGY	0. 000000	422, 861	0	1, 337, 935	0	69.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 000000 918, 231 0 2, 001, 372 0 72. 00 73. 00 73. 00 73. 00 73. 00 74. 341, 258 0 73. 00 74. 341, 258 0 73. 00 74. 341, 258 24. 341, 241, 241, 241, 241, 241, 241, 241, 2	69. 01 06901 CARDI AC REHAB	0. 000000	620	0	251, 181	0	69. 01
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 1,821,639 0 14,341,258 0 73.00 76. 00 03020 NUCLEAR MEDICINE-DIAGNOSTIC 0.000000 431,979 0 2,681,532 0 76.00 76. 01 03040 RADIATION ONCOLOGY 0.000000 32,247 0 2,546,502 0 76. 01 OUTPATIENT SERVICE COST CENTERS	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	526, 830	0	902, 705	0	71.00
76. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	918, 231	0	2, 001, 372	0	72.00
76. 01 03040 RADI ATI ON ONCOLOGY 0. 000000 32, 247 0 2, 546, 502 0 76. 01 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0. 000000 16, 668 0 1, 621, 810 0 90. 00 90. 01 09001 WOUND CARE 0. 0. 000000 8, 092 0 982, 837 0 90. 01 91. 00 09100 EMERGENCY 0. 000000 993, 695 0 3, 282, 443 0 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 47, 220 0 0 725, 650 0 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 821, 639	0	14, 341, 258	0	73.00
OUTPATI ENT SERVI CE COST CENTERS 90.00 09000 CLI NI C 0.000000 16,668 0 1,621,810 0 90.00 90.01 090001 WOUND CARE 0.000000 8,092 0 982,837 0 90.01 91.00 09100 EMERGENCY 0.000000 993,695 0 3,282,443 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0.000000 47,220 0 725,650 0 92.00 OTHER REI MBURSABLE COST CENTERS 95.00	76. 00 03020 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	431, 979	0	2, 681, 532	0	76.00
90. 00 09000 CLI NI C 0.000000 16, 668 0 1, 621, 810 0 90. 00 90. 01 09001 WOUND CARE 0.000000 8, 092 0 982, 837 0 90. 01 91. 00 09100 EMERGENCY 0.000000 993, 695 0 3, 282, 443 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0.000000 47, 220 0 725, 650 0 07 09500 AMBULANCE SERVI CES 95. 00	76. 01 03040 RADIATION ONCOLOGY	0. 000000	32, 247	0	2, 546, 502	0	76. 01
90. 01 09001 WOUND CARE 0. 000000 8, 092 0 982, 837 0 90. 01 91. 00 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0. 000000 47, 220 0 725, 650 0 92. 00 09500 AMBULANCE SERVI CES 95. 00 95. 00 95. 00 000000 000000 0000000 000000	OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY 0. 000000 993, 695 0 3, 282, 443 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0. 000000 47, 220 0 725, 650 0 92. 00 071 072 07	90. 00 09000 CLI NI C	0. 000000	16, 668	0	1, 621, 810	0	90.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0. 000000 47, 220 0 725, 650 0 92. 00 0 0 0 0 0 0 0 0 0	90. 01 09001 WOUND CARE	0. 000000	8, 092	0	982, 837	0	90. 01
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	91. 00 09100 EMERGENCY	0. 000000	993, 695	0	3, 282, 443	0	91.00
95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	47, 220	0	725, 650	0	92.00
	OTHER REIMBURSABLE COST CENTERS				•		
200. 00 Total (Lines 50 through 199) 10, 342, 656 0 44, 137, 586 0 200. 00	95. 00 09500 AMBULANCE SERVICES						95.00
	200.00 Total (lines 50 through 199)		10, 342, 656	0	44, 137, 586	0	200.00

Provider CCN: 15-0072 Peri od: Worksheet D From 01/01/2018 Part V Pate/Time Prepared:

					4/1/2019 4: 24	pm
		Title	: XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1. 00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 175163	6, 386, 429	0	0	1, 118, 666	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 590164	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 091270	550, 960	0	0	50, 286	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 263370	3, 113, 579	0	0	820, 023	54.00
57. 00 05700 CT SCAN	0. 000000	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0	0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	0	0	0	59. 00
60. 00 06000 LABORATORY	0. 193999		1, 040	0	461, 665	60.00
60. 01 06001 BL00D LABORATORY	0. 000000	0	0	0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 110334	240, 129	0	0	26, 494	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 241707	760, 725	0	0	183, 873	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 375753	30, 811	0	0	11, 577	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 193188	1, 337, 935	0	0	258, 473	69.00
69. 01 06901 CARDI AC REHAB	1. 393677	251, 181	0	0	350, 065	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 343834	902, 705	0	0	310, 381	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 214397	2, 001, 372	0	0	429, 088	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 216266	14, 341, 258	320	84, 687	3, 101, 527	73.00
76.00 03020 NUCLEAR MEDICINE-DIAGNOSTIC	0. 087737	2, 681, 532	0	0	235, 270	76.00
76. 01 03040 RADIATION ONCOLOGY	0. 190705	2, 546, 502	0	0	485, 631	76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	3. 852708	1, 621, 810	0	31	6, 248, 360	90.00
90. 01 09001 WOUND CARE	0. 189968	982, 837	0	0	186, 708	90. 01
91. 00 09100 EMERGENCY	0. 265388	3, 282, 443	0	15	871, 121	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 483673	725, 650	0	0	350, 977	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 000000		0			95.00
200.00 Subtotal (see instructions)		44, 137, 586	1, 360	84, 733	15, 500, 185	200.00
201.00 Less PBP Clinic Lab. Services-Program			0	0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		44, 137, 586	1, 360	84, 733	15, 500, 185	202.00
-	•		•	*	-	•

				To 12/31/2018	Part V Date/Time Pro 4/1/2019 4:24	
		Title	XVIII	Hospi tal	PPS	
<u> </u>	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	1			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
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	202	0				60.00
60. 01 06001 BL00D LABORATORY	0	0				60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
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 CARDI AC REHAB	0	0				69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	69	18, 315				73.00
76. 00 03020 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	•			76. 00
76. 01 03040 RADI ATI ON ONCOLOGY	0	0				76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	119				90.00
90. 01 09001 WOUND CARE	0	0				90. 01
91. 00 09100 EMERGENCY	0	4				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
OTHER REIMBURSABLE COST CENTERS	_		1			
95. 00 09500 AMBULANCE SERVI CES	0					95.00
200.00 Subtotal (see instructions)	271	18, 438				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	074	10 400				202 00
202.00 Net Charges (line 200 - line 201)	271	18, 438	l			202. 00

MEMORIAL HOSPITAL L	_OGANSPORT	In Lie	u of Form CMS-2	2552-10
	Provider CCN: 15-0072	Peri od:	Worksheet D-1	
		To 12/31/2018		
			4/1/2019 4: 24	pm
	Title XVIII	Hospi tal	PPS	
			1. 00	
			Provi der CCN: 15-0072 Peri od: From 01/01/2018 To 12/31/2018	Provider CCN: 15-0072

		Title XVIII	Hospi tal	PPS	Piii	
	Cost Center Description			1.00		
	PART I - ALL PROVIDER COMPONENTS			1. 00		
	I NPATI ENT DAYS					
1. 00	Inpatient days (including private room days and swing-bed day			4, 836	1.00	
2.00	Inpatient days (including private room days, excluding swing-			4, 836		
3. 00	Private room days (excluding swing-bed and observation bed dado not complete this line.	ys). If you have only pr	Tvate room days,	0	3. 00	
4. 00	Semi-private room days (excluding swing-bed and observation b	ed days)		3, 777	4.00	
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	0	5.00	
	reporting period	d) -6t D	21 -6			
6. 00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	om days) arter becember	31 of the cost	0	6. 00	
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00	
	reporting period					
8. 00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	m days) after December 3	31 of the cost	0	8. 00	
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	1, 668	9. 00	
7. 00	newborn days)	o the rrogram (exertain)	, swilling boarding	1,000	7.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.00	
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		coom days) after	0	11.00	
11.00	December 31 of the cost reporting period (if calendar year, e		doili days) arter	U	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00	
40.00	through December 31 of the cost reporting period				40.00	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.00	
14. 00	Medically necessary private room days applicable to the Progr			0	14.00	
15.00	Total nursery days (title V or XIX only)		,	0		
16. 00	Nursery days (title V or XIX only)			0	16. 00	
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	of the cost	0.00	17. 00	
17.00	reporting period	es till odgir beceilber 31 c	in the cost	0.00	17.00	
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00	
10.00	reporting period					
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 01	the cost	0.00	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0. 00	20.00	
	reporting period					
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing ported (lind	6, 641, 239 0	21. 00 22. 00	
22.00	5 x line 17)	er 31 of the cost report	ing period (inte	U	22.00	
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23.00	
	x line 18)					
24. 00	Swing-bed cost applicable to NF type services through Decembe 7 x line 19)	r 31 of the cost reporti	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	Total swing-bed cost (see instructions)	(11 01 11 04)		0	26.00	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		6, 641, 239	27. 00	
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28. 00	
	Private room charges (excluding swing-bed charges)		,	0		
	Semi-private room charges (excluding swing-bed charges)			0	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000		
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00		
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	tions)	0.00	1	
35. 00	Average per diem private room cost differential (line 34 x li		, (1 0113)	0. 00		
36. 00	Private room cost differential adjustment (line 3 x line 35)	31)		0.00	36.00	
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	6, 641, 239	37.00	
37.00	27 minus line 36)	p		3, 311, 207	07.00	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		·			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ					
38.00	Adjusted general inpatient routine service cost per diem (see			1, 373. 29		
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	•		2, 290, 648 0	39. 00 40. 00	
	Total Program general inpatient routine service cost (line 39			2, 290, 648		
11.00	1.01a ogram gonorar impatront routino service cost (illie or		I	2, 270, 040	1 00	

Cost Center Description		Financial Systems NATION OF INPATIENT OPERATING COST	IEMORIAL HOSPITA	L LOGANSPORT Provi der C	CN: 15-0072	In Lie Period:	u of Form CMS-2 Worksheet D-1		
Cost Center Description	COMITOT	ATTON OF THE ATTENT OF ENATING COST		Trovider of		From 01/01/2018	Date/Time Pre	pared:	
Cost Center Description	-			Title	XVIII	Hospi tal		рш	
1.00 NIRSERY (title V & XIX only) 0 0 0 0 0 0 0 0 0		Cost Center Description	Inpatient	Total I npati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x		
Intensive Care Type Inpatient Mospital Units 1,527,138 435 3,510.66 220 772,345 44.00 INTENSIVE CARE UNIT 1,527,138 435 3,510.66 220 772,345 44.00 INTENSIVE CARE UNIT 47.00 SMICLOLI INTENSIVE CARE UNIT 47.00 SMICLO						4. 00			
	42.00		0	0	0.0	0 0	0	42.00	
44.00	42.00		1 527 120	425	2 E10 4	4 220	772 245	1 42 00	
45.00 SURCIAL INTENSIVE CARE UNIT 46.00 SURCIAL INTENSIVE CARE			1, 527, 138	435	3,510.6	0 220	112, 345	44.00	
47.00 OTHER SPECIAL CASE (SPECIFY)								45. 00	
Cost Centrer Description	46.00	SURGICAL INTENSIVE CARE UNIT						46. 00	
1.00	47. 00							47. 00	
PROGRET INTO PROGRAM IN PROCESS AD 18 19 19 19 19 19 19 19		Cost Center Description					1 00		
49.00 Prostant inpattent costs (sum of lines 41 through 48) (see instructions) 5.428, e951 40.	48. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3	. line 200)				48. 00	
50.00 Pass through costs applicable to Program inpatient routine services (from West. D., sum of Parts II and III) 51.00 Pass through costs applicable to Program inpatient ancillary services (from West. D., sum of Parts II and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program excludable cost (sum of lines 50 and 51) 54.00 Total Program excludable cost (sum of lines 50 and 51) 55.00 Total Program excludable cost (sum of lines 50 and 51) 56.00 Target amount per discharge 56.00 Target amount per discharge 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket and the size of					ons)				
111) 111, 112 11, 117 12, 13, 117 13									
11.00 Pass through costs applicable to Program inpatient and illary services (from West. D, sum of Parts II 141,172 51.	50. 00		atient routine	servi ces (fro	m Wkst. D, sur	n of Parts I and	503, 289	50.00	
and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 4,784,490 53.00 Program inpatient costs (line 40 minus line 52) 54.00 Program discharges 55.00 Total Program inpatient costs (line 40 minus line 52) 56.00 Program discharges 57.00 Target amount per discharge 58.00 Iarget amount (line 50 km ne 55) 59.00 Lesser amount (line 50 km ne 55) 59.00 Lesser of lines 53/54 or 55 from prior year cost reporting period ending 1996, updated and compounded by the market basket 59.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 59.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 59.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 59.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 59.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 59.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 59.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 59.00 Relief payment (see instructions) 60.00 Lesser of lines 53/54 or 55 from prior year cost report ing period of the from year indicated by which operating costs (line 54) are year lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 60.00 Relief payment (see instructions) 60.00 Lost Payment Market Minus Based State Payment (see instructions) 60.00 Total repayment payment from the costs through December 31 of the cost reporting period (See Instructions) 60.00 Total case wing p-bed StF inpatient routine costs after December 31 of the cost reporting period (See Instructions) 60.00 Total Repayment Payment Repayment Payment Repayment Payment Payme	51 00		atient ancillar	v services (fi	rom Wkst D s	sum of Parts II	141 172	51.00	
Sacrage Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	01.00		attont unortrar	y services (ii	om with b,	Jam Of Tar to 11	111, 172	01.00	
medical education costs (fine 49 minus line 52) FARCET ANDUMT AND LIMIT COMPITATION							644, 461	52.00	
TARCET AMOUNT AND LIMIT COMPUTATION 54.00 65.00 Target amount per discharge 0.56.00 Target amount per discharge	53.00			lated, non-phy	ysician anesth	netist, and	4, 784, 490	53.00	
54.00 Program discharges 0.0 55.00 Target amount per discharges 0.0 55.00 Target amount per discharges 0.0 55.00 Target amount (line 54 x line 55) 0.0 55.00 Target amount (line 54 x line 55) 0.5 56.00 Target amount (line 54 x line 55) 0.5 56.00 Target amount (line 54 x line 55) 0.5 57.00 0.5 57.00 0.5 57.00 0.5 57.00 0.5 57.00 0.5 57.00 0.5 57.00 0.5 57.00 0.5 57.00 0.5 57.00 0.5 57.00 0.5 57.00 0.5 57.00 0.5 57.00 0.0 57.00 0.0 57.00 0.0 57.00 0.0 57.00 0.0 57.00 0.0 0			52)						
55.00 Target amount (pine 54 x line 55) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Brous payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from the cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report to lesser of 50% of the amount by which operating costs (line 54 x 60), or 1% of the target 61.00 Lesser of lines 53/54 or 55 from prior year cost report to lesser of 50% of the target 62.00 Relief payment (see instructions) 62.00 Relief payment (see instructions) 63.00 Aluable Inpatient cost plus Incentive payment (see instructions) 64.00 Market payment (see instructions) 65.00 Medicare swing-bed SMF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) (litle XVIII only) 66.00 Total Medicare swing-bed NF inpatient routine costs (line 67 + line 68) 67.00 Total litle V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 68.00 Total lesser swing-bed SMF inpatient routine service costs (line 77 + line	54.00						0	54.00	
57. 00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57. 58. 00 Bonus payment (see instructions) 0 58. 59. 00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 69. 60. 00 Lesser of lines 53/54 or 55 from the cost report, updated by the market basket 0.00 60. 60. 00 Lesser of lines 53/54 is less than the lower of lines 55,59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0 6. 62. 00 Relief payment (see instructions) 0 6. 63. 00 Allowable inpatient cost plus incentive payment (see instructions) 0 6. 64. 00 Motable inpatient cost plus incentive payment (see instructions) 0 6. 65. 00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (litle XVIII only) 0 6. 66. 00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) (litle XVIII only) 0 6. 67. 00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (line 12 x line 19) 0 6. 68. 00 Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 0 6. 69. 00 Total Hiel V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 0 6. 69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 6. 69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 2) 7. 70. 00 Skilled oursing facility/offruit Drutine service cost (line 37) 7. 71. 00 Medically necessary private room cost applicable to Program (line 14 x line 25) 7. 72. 00 Program routine service cost (line 75 + line 71) 7. 73. 00 Wedically necessary private room cost appli		Target amount per discharge					0. 00	55.00	
58.00 Bonus payment (see Instructions) 0 58.		, ,				>			
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73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 78 × line 76) 78.00 Inpatient routine service cost (line 74 winus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 winus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 373.29 88.	71. 00	Adjusted general inpatient routine service c	ost per diem (I		• • •			71.00	
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75. 00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76. 00 Per diem capital-related costs (line 75 ÷ line 2) 77. 00 Program capital-related costs (line 9 x line 76) 11 Inpatient routine service cost (line 74 minus line 77) 78. 00 Inpatient routine service cost (line 74 minus line 77) 80. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation 81. 00 Inpatient routine service cost per diem limitation 82. 00 Inpatient routine service cost (see instructions) 83. 00 Reasonable inpatient routine services (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)								73.00 74.00	
76. 00 Per diem capital-related costs (line 75 ÷ line 2) 77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 78. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 80. 00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation 82. 00 Inpatient routine service cost limitation (line 9 x line 81) 82. 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 76. 07 76. 07 77. 08 76. 08 76. 09 77. 07 78. 07 78. 07 79. 07 79. 07 70 70 70 70 70 70 70 70 70 70 70 70 7		Capital-related cost allocated to inpatient	•		•	Part II, column		75. 00	
77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 80. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation 82. 00 Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 76. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 77. 78. 79. 79. 79. 79. 79. 79. 79. 79. 79. 79	76 00		ne 2)					76.00	
78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 100 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80. 01 Inpatient routine service cost per diem limitation 81. 02. 00 Inpatient routine service cost limitation (line 9 x line 81) 82. 00 Reasonable inpatient routine service costs (see instructions) 83. 00 Reasonable inpatient ancillary services (see instructions) 84. 00 Utilization review - physician compensation (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) 87. 00 RAT IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87. 00 Adjusted general inpatient routine cost per diem (line 27 ± line 2) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ± line 2) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ± line 2)								77.00	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Total Program inpatient routine cost per diem (line 27 ÷ line 2) 80.00 Total Program routine service costs (see instructions) 80.01 Total observation bed days (see instructions) 81.02 Total observation bed days (see instructions) 82.03 Total observation bed days (see instructions) 83.04 Total observation bed days (see instructions) 84.05 Total observation bed days (see instructions) 85.06 Total observation bed days (see instructions) 86.07 Total observation bed days (see instructions) 87.08 Total observation bed days (see instructions)								78. 00	
81. 00 Inpatient routine service cost per diem limitation 82. 00 Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 373. 29 88.					,	11 70		79.00	
82. 00 Inpatient routine service cost limitation (line 9 x line 81) 82. 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 80 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				80. 00 81. 00					
83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) 87. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				82.00					
85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) 87. 00 Total observation bed days (see instructions) 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		·		* .				83.00	
86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 373. 29 88.				,				84.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 373. 29 88.			•	,				85.00	
87.00 Total observation bed days (see instructions) 1,059 87. 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,373.29 88.	00.00			i ougii oo)				86. 00	
	87. 00						1, 059	87.00	
89. UU TUDSERVALION DEC COST (TINE 87 X TINE 88) (See INSTRUCTIONS)		,	•	line 2)			-	1	
1 1/10/10/10/10/10/10/10/10/10/10/10/10/10	87. UU	Jouservation bed cost (Time 87 x Time 88) (Se	e instructions)				1, 454, 314	89. UU	

Health Financial Systems	MEMORIAL HOSPIT	AL LOGANSPORT		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 162, 139	6, 641, 239	0. 17498	8 1, 454, 314	254, 487	90.00
91.00 Nursing School cost	0	6, 641, 239	0.00000	0 1, 454, 314	0	91.00
92.00 Allied health cost	0	6, 641, 239	0.00000	0 1, 454, 314	0	92.00
93.00 All other Medical Education	0	6, 641, 239	0. 00000	0 1, 454, 314	0	93.00

Health Financial Systems	MEMORIAL HOSPITAL LOGANSPORT	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0072	Peri od: From 01/01/2018	Worksheet D-1	
			Date/Time Pre	
			4/1/2019 4: 24	pm
	Title XIX	Hospi tal	Cost	
Cost Center Description	_			

		Title XIX	Hospi tal	4/1/2019 4: 24 Cost	pm	
	Cost Center Description	THE XIX	поэрг саг	Cost		
	DADT I ALL DROWNER COMPONENTS			1. 00		
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					
1. 00	Inpatient days (including private room days and swing-bed day	s. excludina newborn)		4, 836	1.00	
2.00	Inpatient days (including private room days, excluding swing-			4, 836	2.00	
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	rivate room days,	0	3.00	
4. 00	do not complete this line.	ad daya)		3, 777	4.00	
5. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost		5.00	
0.00	reporting period	om daye, tin edgi. Beecimbe			0.00	
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.00	
7 00	reporting period (if calendar year, enter 0 on this line)		04 . 6 . 11		7 00	
7. 00	Total swing-bed NF type inpatient days (including private roc reporting period	m days) through December	31 or the cost	0	7. 00	
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8. 00	
	reporting period (if calendar year, enter 0 on this line)	3 .				
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	182	9. 00	
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	coom days)	o	10.00	
10.00	through December 31 of the cost reporting period (see instruc	oom days)	ı	10.00		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11.00	
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)					
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including privat	te room days)	0	12.00	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	e room days)	0	13.00		
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)					
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00	
15.00						
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT					
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	of the cost	0.00	17. 00	
	reporting period					
18. 00	Medicare rate for swing-bed SNF services applicable to service	0. 00	18. 00			
19. 00	reporting period	0.00	19. 00			
19.00	Medicaid rate for swing-bed NF services applicable to service reporting period	0.00	19.00			
20.00	Medicaid rate for swing-bed NF services applicable to service	0. 00	20.00			
	reporting period					
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing ported (line	6, 641, 239	21. 00 22. 00	
22.00	5 x line 17)	er 31 of the cost report	ing period (inte	0	22.00	
23. 00		31 of the cost reportin	ng period (line 6	0	23.00	
	x line 18)					
24. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 ine 19)	r 31 of the cost reporti	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)		, , , , , , , , , , , , , , , , , , , ,	1		
26. 00	Total swing-bed cost (see instructions)			0	26.00	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		6, 641, 239	27. 00	
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28. 00	
29. 00			9/	0		
30. 00	Semi-private room charges (excluding swing-bed charges)			0		
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000		
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00		
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	ctions)	0.00		
35. 00	Average per diem private room cost differential (line 34 x li		/	0. 00	35.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00	
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	6, 641, 239	37. 00	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see			1, 373. 29	38. 00	
39. 00	Program general inpatient routine service cost (line 9 x line	•		249, 939		
	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39	,		0 249, 939	40.00	
41.00	Trotal trogram general impatrent routine service cost (ITNE 39	+ 1111C 4U)		247, 739	41.00	

		MEMORIAL HOSPITA		ON. 15 0070		u of Form CMS-2	
COMPUI	ATION OF INPATIENT OPERATING COST		Provi der C		Peri od: From 01/01/2018	Worksheet D-1	
					To 12/31/2018	Date/Time Pre 4/1/2019 4:24	pared: pm
	Cost Contar Description	Total	Ti tl Total	e XIX	Hospi tal	Cost Program Cost	
	Cost Center Description	Inpatient	Inpatient	Average Per Diem (col. 1	Program Days	(col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
42.00	NURSERY (title V & XIX only)	1. 00 710, 547	2. 00 1, 044	3. 00 680. 6	4. 00 0 0	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units		1, 044	000.0	0 0	0	42.00
43.00	INTENSIVE CARE UNIT	1, 527, 138	435	3, 510. 6	6 0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00							46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			252, 806	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		502, 745	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	patient routine	services (fro	m Wkst. D. sui	m of Parts I and	0	50.00
00.00	[111)		•				00.00
51. 00	Pass through costs applicable to Program inpand IV)	oatient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclu	ıding capital re	lated, non-phy	ysician anest	netist, and	0	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	54.00
	Target amount per discharge					0. 00 0	55. 00 56. 00
56. 00 57. 00	.00 Target amount (line 54 x line 55) .00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						
58. 00	Bonus payment (see instructions)	0					
59. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996, i	updated and c	ompounded by the	0.00	59.00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report up	dated by the i	market basket		0. 00	60.00
	If line 53/54 is less than the lower of line	es 55, 59 or 60	enter the less	ser of 50% of		0	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% o	f the target		
62. 00	Relief payment (see instructions)	This tructrons)				0	62.00
63. 00	Allowable Inpatient cost plus incentive paym	nent (see instru	ctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Dece	mber 31 of the	e cost report	ing period (See	0	64.00
	instructions)(title XVIII only)	Ü		•			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after Decemb	er 31 of the (cost reportin	g period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
/7.00	CAH (see instructions)		D	6 11			/7.00
67. 00	Title V or XIX swing-bed NF inpatient routir (line 12 x line 19)	ne costs through	December 31 (or the cost r	eporting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost rep	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	2 68)		0	69.00
07.00	PART III - SKILLED NURSING FACILITY, OTHER N					<u> </u>	07.00
70.00	Skilled nursing facility/other nursing facil	,		•)		70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine /U ÷ iine	2)			71. 00 72. 00
73.00	Medically necessary private room cost applic	,	(line 14 x li	ne 35)			73.00
74.00	Total Program general inpatient routine serv				Dort II golumn		74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from)	worksneet B,	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 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	,	rovi der recor	ds)			79.00
80.00	Total Program routine service costs for comp		ost limitation	n (line 78 mi	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation ()				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (* .				83.00
84.00	Program inpatient ancillary services (see in	nstructions)					84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85. 00 86. 00
00.00	PART IV - COMPUTATION OF OBSERVATION BED PAS		ug 50 <i>)</i>				35.55
87.00	Total observation bed days (see instructions	•	Line 2)			1, 059	1
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•				1, 373. 29 1, 454, 314	
	(30)				Į.	, ,	

Health Financial Systems	MEMORIAL HOSPIT	AL LOGANSPORT		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 162, 139	6, 641, 239	0. 17498	8 1, 454, 314	254, 487	90.00
91.00 Nursing School cost	0	6, 641, 239	0.00000	0 1, 454, 314	0	91.00
92.00 Allied health cost	0	6, 641, 239	0.00000	0 1, 454, 314	0	92.00
93.00 All other Medical Education	0	6, 641, 239	0. 00000	0 1, 454, 314	0	93. 00

	Financial Systems MEMORIAL HOSPITAL ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 1F 0070	Period:	u of Form CMS-2 Worksheet D-3	
INPAII	ENT ANGILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0072	From 01/01/2018)
				To 12/31/2018		
		Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col. 2)	
	LUBATI SUT DOUTLUS OSDIVI OF COOT OSUTEDO		1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			0.047.400	I	
30.00	03000 ADULTS & PEDI ATRI CS			2, 846, 133		30.00
31.00	03100 I NTENSI VE CARE UNI T			421, 937		31.00
	04100 SUBPROVI DER - I RF			0		41.00
42.00	04200 SUBPROVI DER			0		42.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00	05000 OPERATING ROOM		0. 1751	1, 099, 267	192, 551	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 17310			1
53. 00	05300 ANESTHESI OLOGY		0. 0912			1
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 2633		130, 885	
	05700 CT SCAN		0. 00000		130,003	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 00000		0	1
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 00000		0	
60.00	06000 LABORATORY		0. 1939		-	
60. 01	06001 BLOOD LABORATORY		0. 00000		0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0. 1103			1
65.00	06500 RESPI RATORY THERAPY		0. 24170			
66.00	06600 PHYSI CAL THERAPY		0. 3757!			
69.00	06900 ELECTROCARDI OLOGY		0. 1931	38 422, 861	81, 692	69.00
69. 01	06901 CARDI AC REHAB		1. 3936	77 620	864	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3438	34 526, 830	181, 142	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		0. 21439	97 918, 231	196, 866	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 2162	56 1, 821, 639	393, 959	73.00
	03020 NUCLEAR MEDICINE-DIAGNOSTIC		0. 0877			
76. 01	03040 RADI ATI ON ONCOLOGY		0. 1907	05 32, 247	6, 150	76. 01
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C		3. 8656			
90. 01	09001 WOUND CARE		0. 1899			
	09100 EMERGENCY		0. 2653			
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4836	73 47, 220	22, 839	92.00
	OTHER REIMBURSABLE COST CENTERS		1			
95. 00 200. 00	09500 AMBULANCE SERVICES Total (sum of lines 50 through 94 and 96 through 98)			10 342 656	2 365 958	95.00
2010 (10)	I INTELLECTION OF LINGS BUTTHPOLINE UN AND US THPOLINE US)		1	111 3/17 656		

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

Net charges (line 200 minus line 201)

202.00

2, 365, 958 200. 00 201. 00

10, 342, 656

10, 342, 656

200.00

201.00 202.00

Health Financial Systems MEMORIAL HOSPITA	I LOGANSPORT		In lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-3	pared:
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER			228, 675 14, 946 0 0		30. 00 31. 00 41. 00 42. 00
43. 00 04300 NURSERY			66, 318		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 0PERATI NG ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY		0. 17516 0. 59016 0. 09127	181, 558	107, 149	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN		0. 26337 0. 00000		4, 267 0	54. 00 57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION		0. 00000 0. 00000		0	58. 00 59. 00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY		0. 19399 0. 00000		15, 074 0	60. 00 60. 01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 65. 00 06500 RESPIRATORY THERAPY		0. 11033 0. 24170	26, 539	2, 928 16, 563	
66. 00 06600 PHYSI CAL THERAPY		0. 37575	805	302	66. 00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB		0. 19318 1. 39367		1, 794 0	69. 00 69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 34383 0. 21439		22, 997 0	71. 00 72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 21626	6 119, 212	25, 782	73.00
76. 00 03020 NUCLEAR MEDICINE-DIAGNOSTIC 76. 01 03040 RADIATION ONCOLOGY		0. 08773 0. 19070		1, 813 0	
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		3. 85270	0 8	0	90.00
90. 01 09001 WOUND CARE		0. 18996			

0. 265388

0. 483673

37, 878

5, 337

875, 020

875, 020

90.01 0 10, 052 2, 581

91.00

92.00

95.00

252, 806 200. 00 201. 00 202. 00

91.00

92.00

95.00

200.00

201.00 202.00

09100 EMERGENCY

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

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

OTHER REIMBURSABLE COST CENTERS
09500 AMBULANCE SERVICES

Health Financial Systems	MEMORIAL HOSPITAL	LOGANSPORT		In Lie	eu of Form CMS-:	2552_10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	WEWORTAL HOSTITAL	Provi der C	CN: 15-0072	Peri od:	Worksheet D-3	
THE PROPERTY OF THE STATE OF TH				From 01/01/2018		
		Component	CCN: 15-U072	To 12/31/2018	Date/Time Pre 4/1/2019 4:24	epared:
		Ti tl	e XIX	Swing Beds - SNI	PPS	
Cost Center Description			Ratio of Cos	t Inpatient	Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS				C)	30.00
31. 00 03100 I NTENSI VE CARE UNI T				C)	31.00
41. 00 04100 SUBPROVI DER - I RF				C)	41.00
42. 00 04200 SUBPROVI DER				C)	42.00
43. 00 04300 NURSERY				C		43.00
ANCILLARY SERVICE COST CENTERS				1	_	
50. 00 05000 OPERATI NG ROOM			0.00000		_	
52. 00 05200 DELIVERY ROOM & LABOR ROOM			0.00000		_	02.00
53. 00 05300 ANESTHESI OLOGY			0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0.00000		0	54.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)			0.00000			57. 00 58. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION			0.00000			59.00
60. 00 06000 LABORATORY			0.00000			60.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY			0.00000		0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.			0.00000			63.00
65. 00 06500 RESPIRATORY THERAPY			0.00000			
66. 00 06600 PHYSI CAL THERAPY			0.00000			1
69. 00 06900 ELECTROCARDI OLOGY			0.00000		l ~	
69. 01 06901 CARDI AC REHAB			0.00000		l ~	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 00000		l ~	I
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT			0. 00000			
73. 00 07300 DRUGS CHARGED TO PATIENTS			0. 00000			1
76. 00 03020 NUCLEAR MEDICINE-DIAGNOSTIC			0. 00000		1	1
76. 01 03040 PADLATION ONCOLOGY			0.00000			

0

0 0 0

0 76.01

0 90.00

0 90.01

0

0

91.00

92.00

0. 000000 0. 000000

0. 000000 0. 000000

0.000000

0.000000

03040 RADIATION ONCOLOGY

09000 CLI NI C

09001 WOUND CARE

09100 EMERGENCY

90.00

90.01 91.00

92.00

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Health Financial Systems	MEMORIAL HOSPITAL	LOGANSPORT	In Lieu	ı of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0072	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 4/1/2019 4:24 pm
		T' 11 . \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	11	DDC

NACL A - INPATIENT HOSPITAL SERVICES MORE IPPS 1.00			Title XVIII	Hospi tal	4/1/2019 4: 24 PPS	pm
PART A - INPATIBET MOSPITAL SERVICES UNDER IPPS 0 1.00 1.			TI LIE XVIII	110Spi tai	FF3	
DRK Amounts other than outiler payments for discharges occurring prior to October 1 (see 3,000,400 1.01		DADT A LUDGET FUT HOOD TALL OFFILE OF			1. 00	
1.00 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 3,008,040 1.01 Instructions) DRG amounts other than outlier payments for discharges occurring on a rafter October 1 (see 841,097 1.02 1.03 DRG for Foderal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see Instructions) 1.04 DRG for Federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see Instructions) 1.04 DRG for Federal specific operating payment for Model 4 BPCI for discharges occurring on a rafter 0 1.04 DRG for Federal specific operating payment for discharges (see instructions) 1.04 DRG for Federal specific operating payments for discharges occurring on a rafter 0 1.04 DRG for Federal specific operating payments for discharges occurring on a rafter 0 1.04 DRG for Federal specific operating payments for discharges occurring on a rafter 0 1.04 DRG for Federal specific operating payments for discharges occurring on a rafter 0 1.04 DRG for Federal specific operating payments for discharges occurring on a rafter 0 1.04 DRG for Federal specific operations 0 2.01 DRG for Federal specific operations 0 2.00 DRG for Federal specific opera	1 00				0	1 00
1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 841,097 1.02 Instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 0.0 1.04		DRG amounts other than outlier payments for discharges occurri	ing prior to October 1 ((see	-	
1 (see instructions) 1.04 OR for Federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 1.04 October 1 (see Instructions) 2.00 Outlier record discharges (see instructions) 3.00 Outlier record discharges (see instructions) 4.00 Outlier record discharges (see instructions) 6.00 Outlier record discharges (see	1. 02	DRG amounts other than outlier payments for discharges occurri	ing on or after October	1 (see	841, 097	1. 02
October 1 (see instructions)	1. 03		or di scharges occurri ng	prior to October	0	1. 03
2.01 Outlier reconcilitation amount 0 2.01	1. 04	DRG for federal specific operating payment for Model 4 BPCI fo	or di scharges occurri ng	on or after	0	1. 04
Managed Carr's Simulated Payments						
Red days available divided by number of days in the cost reporting period (see instructions) 42.60 4.00		Outlier payment for discharges for Model 4 BPCI (see instructi	i ons)		-	
FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending of or before 12/31/19/96, (see instructions) 0.00 6.00		, ,	rting period (see instru	ucti ons)	-	
6.00 FIE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 0.00 6.00 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the cost report straddies July 1, 2011 then see instructions. 0.00 0.0	5. 00		t recent cost reporting	period ending or	0.00	5. 00
7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the cost report straddles July 1, 2011 then see instructions. 0.00 40 street of the cost report straddles July 1, 2011 then see instructions. 0.00 40 street of the cost report straddles July 1, 2011 then see instructions. 0.00 40 street of the cost report straddles July 1, 2011 then see instructions. 0.00 8.00 8.00 All systemet (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b). 413.79(c)(2)(iv). 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 0.00 8.00 8.01 The amount of increase if the hospital was awarded FTE cap slots under \$5500 of ACA. (see Instructions). 0.00 8.01 9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see Instructions). 0.00 0.00 10.00 FTE count for all opathic and osteopathic programs in the current year from your records. 0.00 1.00 11.00 FTE count for all owable FTE (see instructions). 0.00 1.00 12.00 Current year allowable FTE (see instructions). 0.00 1.00 13.00 Total all owable FTE count for the period year. 0.00 1.00 14.00	6. 00	· · · · · · · · · · · · · · · · · · ·	he criteria for an add-o	on to the cap for	0.00	6. 00
cost report straddles July 1, 2011 then see instructions. 8. 00 All ustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(1v), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8. 01 The amount of increase if the hospital was awarded FTE cap slots under \$ 5500 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions). 9. 00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 9.00 instructions). 9. 00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 10.00 current year allowable FTE (see instructions). 9. 00 Current year allowable FTE (see instructions). 9. 00 Current year allowable FTE (see instructions). 9. 00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero. 9. 00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero. 9. 00 Adjustment for residents in initial years of the program 0.00 15.00 Adjustment for residents in initial years of the program 0.00 17.00 Adjustment for residents in initial years of the program 0.00 17.00 Adjustment for residents in initial years of the program 0.00 17.00 Current year resident to bed ratio (see instructions) 0.000000 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 Prior year resident to bed ratio (see instructions) 0.00	7. 00		under 42 CFR §412.105(f)	(1) (i v) (B) (1)	0. 00	7. 00
Agl Justment (Increase or decrease) to the FIE count for al Iopathic and osteopathic programs for affiliated programs in accordance with 42 CER 413.75(b). 413.79(c)(2)(1)(v), 64 FR 26340 (Way 12.1998), and 67 FR 50069 (August 1, 2002).	7. 01		42 CFR §412. 105(f)(1)(i	v)(B)(2) If the	0. 00	7. 01
8. 01 The amount of Increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report stradies July 1, 2011, see instructions. 2. 01 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see Instructions) 9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see instructions) 9.00 FTE count for residents in dental and podiatric programs in the current year from your records 0.00 1	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
B. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost				8. 01
Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00	8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital				8. 02
10.00 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 10.00	9. 00					9. 00
13.00 Total allowable FTE count for the prior year. 0.00 13.00 14.00	11. 00	FTE count for allopathic and osteopathic programs in the curreFTE count for residents in dental and podiatric programs.	ent year from your recor	rds	0. 00	11.00
Otherwise enter zero. Sum of lines 12 through 14 divided by 3. 0.00 15.00 16		, , , , , , , , , , , , , , , , , , , ,				
16. 00 Adjustment for residents in initial years of the program 0.00 16. 00 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 (see instructions) 0.000000 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0.000000 21. 00 21. 00 Inter the lesser of lines 19 or 20 (see instructions) 0.000000 21. 00 22. 01 IME payment adjustment (see instructions) 0.000000 22. 00 22. 01 IME payment adjustment - Managed Care (see instructions) 0.000000 22. 01 1 Imidirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.000000 23. 00 23. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.00 25. 00 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.000000 25. 00 26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26. 00 27. 00 IME payments adjustment factor. (see instruction	14. 00		ar ended on or after Sep	otember 30, 1997,	0. 00	14. 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 1 IME payment adjustment - Managed Care (see instructions) 0.22.01 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.00 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(c). 0.00 23.00 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.01 IME add-on adjustment amount (see instructions) 0.28.01 29.01 Total IME payment - Managed Care (sum of lines 22.01 and		, ,				
19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.0000000 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 1 ME payment adjustment - Managed Care (see instructions) 0.22.01 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.00 23.00 (f)(1)(iv)(C) 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 instructions) 0.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27.00 27.00 IME payments adjustment factor. (see instructions) 0.00000 27.00 28.00 IME add-on adjustment amount (see instructions) 0.00000 27.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.00 29.01 Total IME payment (sum of lines 22 and 28) 0.29.00 70 tal IME payment - Managed Care (sum of lines 22.01 and 28.01)			sui e			
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 1 IME payment adjustment - Managed Care (see instructions) 0.22.01 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.00 23.00 (f)(1)(iv)(c). 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) 0.000000 27.00 IME payments adjustment factor. (see instructions) 0.000000 28.00 IME add-on adjustment amount (see instructions) 0.000000 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.00 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) 0.29.00 Disproportionate Share Adjustment 0.000000 27.00 30.00 Percentage of Medicaid patient days		, , , , , , , , , , , , , , , , , , , ,)			
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00			, .			
22.00 IME payment adjustment (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 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) 28.01 IME add-on adjustment amount (see instructions) 29.00 IME add-on adjustment amount (see instructions) 20.00 Total IME payment (sum of lines 22 and 28) 29.01 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 Sum of lines 30 and 31 31.05 Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions) 21.00 22.01 Individe Ime 25 of the MMA 22.01 Individe Ime 25 of the MMA 23.00 Allowable disproportionate share percentage (see instructions) 24.00 Individe Imenation Adjustment amount (see instructions) 25.00 Individe Imenation Adjustment amount (see instructions) 26.00 Individe Imenation Adjustment amount (see instructions) 27.00 Individe Imenation Adjustment amount (see instructions) 28.01 Individe Imenation Adjustment amount (see instructions) 29.01 Individual Allowable Individual Imenation Adjustment Adjustment Adjustment Adjustment Adjustment Adjustment Adjustment Adjustment Adjustment					0.000000	
IME payment adjustment - Managed Care (see instructions) 0 1ndi rect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f)(1)(iv)(c) .	22.00	IME payment adjustment (see instructions)			0	22. 00
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f) (1) (iv) (C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 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) 26.00 Resident to bed ratio (divide line 25 by line 4) 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) 0.28.00 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) 0.29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4.39 30.00 31.00 Sum of lines 30 and 31 31.85 32.00 33.00 Allowable disproportionate share percentage (see instructions) 12.00 33.00	22. 01				0	22. 01
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 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 IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment 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 31.85 32.00 33.00 Allowable disproportionate share percentage (see instructions) 32.00 IME add-on adjustment amount - Managed Care (see instructions) 32.00 Sum of lines 30 and 31 33.00	23. 00	Number of additional allopathic and osteopathic IME FTE reside		CFR 412. 105	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 instructions) Resident to bed ratio (divide line 25 by line 4) O.000000 26.00 IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions) Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) Sum of lines 30 and 31 31.85 32.00 33.00 Allowable disproportionate share percentage (see instructions) 10.000 25.00 0.000000 26.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 0.000000 27.00 0.000000 0.000000 0.000000 0.000000	24 00				0.00	24 00
26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0.28.00 28.01 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 29.10 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.00 Disproportionate Share Adjustment 29.01 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4.39 30.00 31.00 Percentage of Medicaid patient days (see instructions) 27.46 31.00 32.00 Sum of lines 30 and 31 31.85 32.00 33.00 Allowable disproportionate share percentage (see instructions) 12.00 33.00		If the amount on line 24 is greater than -0-, then enter the I	lower of line 23 or line	e 24 (see		
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 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4. 39 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 27. 46 31. 00 32. 00 Sum of lines 30 and 31 31. 85 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 12. 00 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 Percentage of Medicaid patient days (see instructions) 30.00 Sum of lines 30 and 31 31.85 32.00 33.00 Allowable disproportionate share percentage (see instructions) 28.00 28.00 29.01 29.00 29.01 29						
28.01 IME add-on adjustment amount - Managed Care (see instructions) 7 Total IME payment (sum of lines 22 and 28) 7 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 8 Disproportionate Share Adjustment 9 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 10 Percentage of Medicaid patient days (see instructions) 21 Add 31.00 22 Add 31.00 31.00 Sum of lines 30 and 31 31.85 32.00 33.00 Allowable disproportionate share percentage (see instructions) 28 .01 29 .01 29 .00 29 .01 29 .01 29 .01 29 .01 29 .01 20 .01 21 .02 31 .00 32 .00 33 .00						
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 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4.39 30.00 31.00 Percentage of Medicaid patient days (see instructions) 27.46 31.00 32.00 Sum of lines 30 and 31 31.85 32.00 33.00 Allowable disproportionate share percentage (see instructions) 12.00 33.00	28. 01)		0	
Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4.39 30.00 Percentage of Medicaid patient days (see instructions) 27.46 31.00 Sum of lines 30 and 31 31.85 32.00 Allowable disproportionate share percentage (see instructions) 12.00 33.00	29.00				0	29. 00
31.00 Percentage of Medicaid patient days (see instructions) 27.46 31.00 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 27.46 31.00 31.00 31.00 32.00 32.00	29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0	29. 01
32.00 Sum of lines 30 and 31 31.85 32.00 33.00 Allowable disproportionate share percentage (see instructions) 12.00 33.00	30.00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	ctions)	4. 39	30.00
33.00 Allowable disproportionate share percentage (see instructions) 12.00 33.00	31.00	Percentage of Medicaid patient days (see instructions)			27. 46	31.00
34.00 Disproportionate share adjustment (see instructions) 115, 474 34.00		, ,)			
	34. 00	Disproportionate share adjustment (see instructions)		l	115, 474	34.00

	Financial Systems MEMORIAL HOSPITAL			u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Peri od: From 01/01/2018 To 12/31/2018		
		Title XVIII	Hospi tal	PPS	_p
	· · · · · · · · · · · · · · · · · · ·		Prior to 10/1	On/After 10/1	
	To the second se		1.00	2. 00	
25 00	Uncompensated Care Adjustment		/ 7// /05 1/4	0 070 070 447	25 00
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0. 000070470	8, 272, 872, 447 0. 000078327	35. 00 35. 01
35. 01		ter zero on this line) (s			35. 01
33. 02	instructions)	ter zero on tili s i i le) (s	470,047	030, 477	33.02
35.03	Pro rata share of the hospital uncompensated care payment am	nount (see instructions)	356, 657	158, 915	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.		515, 572		36.00
	Additional payment for high percentage of ESRD beneficiary d				
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding	g discharges for MS-DRGs	0		40.00
41 00	652, 682, 683, 684 and 685 (see instructions)	492 494 an 49E (coo	0		41. 00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	683, 684 all 685. (See	0		41.00
41. 01	1	S-DRGs 652, 682, 683 68	4 0		41. 01
	an 685. (see instructions)		`		
42.00	Divide line 41 by line 40 (if less than 10%, you do not qual	ify for adjustment)	0. 00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6	582, 683, 684 an 685. (se	е 0		43.00
	instructions)				
44. 00	Ratio of average length of stay to one week (line 43 divided	d by line 41 divided by /	0. 000000		44. 00
45. 00	days) Average weekly cost for dialysis treatments (see instruction	ne)	0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line 4		0.00		46. 00
47. 00	Subtotal (see instructions)	,	4, 499, 219		47. 00
48.00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	5, 966, 225		48.00
	only. (see instructions)				
				Amount	
40.00	T-t-1	>		1. 00	10.00
49. 00 50. 00	Total payment for inpatient operating costs (see instruction Payment for inpatient program capital (from Wkst. L, Pt. I a)	5, 966, 225 310, 787	49. 00 50. 00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. 1 a		•	310, 787	51.00
52. 00	Direct graduate medical education payment (from Wkst. E-4, I			Ö	52.00
53.00	Nursing and Allied Health Managed Care payment	ŕ		0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54. 01	Islet isolation add-on payment			0	54. 01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see int	•	+brough 2E)	0	56.00
57. 00 58. 00	Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt.		tili ougii 35).	0	57. 00 58. 00
59.00	Total (sum of amounts on lines 49 through 58)	1 V, Cor. 11 1111e 200)		6, 277, 012	
60.00				7, 839	60.00
61.00	Total amount payable for program beneficiaries (line 59 minu	us line 60)		6, 269, 173	61.00
62.00	1 9			683, 232	
63.00	Coinsurance billed to program beneficiaries			670	63.00
64.00	Allowable bad debts (see instructions)			33, 561	
	Adjusted reimbursable bad debts (see instructions)	structions)		21, 815	65.00
67.00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63)	Structi UIIS)		33, 561 5, 607, 086	66. 00 67. 00
	Credits received from manufacturers for replaced devices for	annlicable to MS-DRGs (see instructions)	0,007,000	68. 00
68. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96)			0	69.00
68. 00 69. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		,	0	70.00
	1	stration) adjustment (see	instructions)	0	70. 50
69. 00 70. 00 70. 50	Rural Community Hospital Demonstration Project (§410A Demons			0	70. 87
69. 00 70. 00 70. 50 70. 87	Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration	1			70 00
69. 00 70. 00 70. 50 70. 87 70. 88	Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)			0	
69. 00 70. 00 70. 50 70. 87 70. 88 70. 89	Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins				70. 89
69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90	Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 88 70. 89 70. 90
69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91	Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	70. 89 70. 90 70. 91
69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92	Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0 0	70. 89 70. 90 70. 91 70. 92
69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92 70. 93	Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0 0 0 4, 537	70. 89 70. 90 70. 91

Health Financial Systems	MEMORIAL HOSPITAL	LOGANSPORT		In Lieu	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CC	CN: 15-0072	Peri od: From 01/01/2018 To 12/31/2018		pared:
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70.96 Low volume adjustment for federal fisca the corresponding federal year for the		n column 0		2018	720, 106	70. 96
70.97 Low volume adjustment for federal fisca the corresponding federal year for the				2019	206, 541	70. 97
70 00 Low Volume Dayment 2					0	70 00

70. 96		0	1. 00	
, U. 7U	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	2018	720, 106	70. 9
	the corresponding federal year for the period prior to 10/1)			
	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	2019	206, 541	70.9
	the corresponding federal year for the period ending on or after 10/1)			
- 1	Low Volume Payment-3		0	70.9
	HAC adjustment amount (see instructions)		0	70.9
	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6, 538, 270	
1. 01	Sequestration adjustment (see instructions)		130, 765	71. C
1. 02 I	Demonstration payment adjustment amount after sequestration		0	71. C
2. 00	Interim payments		6, 391, 734	72. C
3.00	Tentative settlement (for contractor use only)		0	73.0
4. 00 I	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and		15, 771	74.0
1.	73)			
5.00	Protested amounts (nonallowable cost report items) in accordance with		536, 352	75. C
(CMS Pub. 15-2, chapter 1, §115.2			
7	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
0.00 (Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90. C
ı	plus 2.04 (see instructions)			
1.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.0
	Operating outlier reconciliation adjustment amount (see instructions)		o	92. (
	Capital outlier reconciliation adjustment amount (see instructions)		o	93. (
	The rate used to calculate the time value of money (see instructions)		0.00	
	Time value of money for operating expenses (see instructions)		0	95.
4	Time value of money for capital related expenses (see instructions)		0	96.
J. 00	Trine varieties indirection to the capital related expenses (see tristiaetrons)	Prior to 1	0/1 0n/After 10/1	70. (
		1.00	2.00	
ŀ	HSP Bonus Payment Amount	1.00	2.00	
	HSP bonus amount (see instructions)		0 0	1 100. c
	HVBP Adjustment for HSP Bonus Payment		٥,	1.00.0
	HVBP adjustment factor (see instructions)	0. 0000000	0.0000000000000000000000000000000000000	101 0
	HVBP adjustment amount for HSP bonus payment (see instructions)	0.000000		102.0
	HRR Adjustment for HSP Bonus Payment		0 0	1.02.
	HRR adjustment factor (see instructions)	0.0	0.000	103 (
	HRR adjustment amount for HSP bonus payment (see instructions)	0. 0	l l	104. 0
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjust	mont	0 0	1104.
	Is this the first year of the current 5-year demonstration period under the			200. (
	Century Cures Act? Enter "Y" for yes or "N" for no.	2151		200. 1
	Cost Reimbursement		_	-
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			I
1 00E				201
02.00	Medicare discharges (see instructions)			202. (
02. 00 l 03. 00 l	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)			202. (
02.00 I 03.00 (Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of	the current 5-year de		202. (
02. 00 I 03. 00 (Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period)	the current 5-year de	monstration	202. (203. (
02.00 03.00 04.00	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of Deriod) Medicare target amount	the current 5-year de	monstration	202. (203. (204. (
02. 00 1 03. 00 0 04. 00 1 05. 00	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	the current 5-year de	monstration	202. (203. (204. (205. (
02.00 03.00 04.00 05.00	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	the current 5-year de	monstration	202. (203. (204. (205. (
02. 00 1 03. 00 0 04. 00 1 05. 00 0 06. 00 1	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	the current 5-year de	monstration	202. (203. (204. (205. (206. (
02. 00 1 03. 00 0 04. 00 1 05. 00 0 06. 00 1	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	the current 5-year de	monstration	202. (203. (204. (205. (206. (
02. 00 1 03. 00 0 04. 00 1 05. 00 0 06. 00 1	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	the current 5-year de	monstration	202. (203. (204. (205. (206. (
02. 00 03. 00 05.	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)	the current 5-year de	monstrati on	202. (203. (204. (205. (206. (207. (208. (
02. 00 03. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09.	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of beriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)	the current 5-year de	monstrati on	202. (203. (204. (205. (206. (207. (208. (209. (
02. 00 03. 00 05. 00 05. 00 06. 00 07.	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	the current 5-year de	monstration	202. (203. (204. (205. (206. (207. (208. (209. (210. (
02. 00 00 00 00 00 00 00 0	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	the current 5-year de	monstration	202. 203. 204. 205. 206. 207. 208. 209. 210.
02. 00 0 0 0 0 0 0 0 0 0	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	the current 5-year de	monstration	202. (203. (204. (205. (206. (207. (208. (210. (211. (
02. 00 03. 00 05 04. 00 05. 00 07. 00	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211)	the current 5-year de	monstration	202. (203. (204. (205. (206. (207. (208. (210. (211. (211. (
02. 00 03. 00 05. 00 05. 00 07.	Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement		monstration	201. (202. (203. (204. (205. (206. (207. (209. (211. (211. (212. (213. (218. (218. (

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2018 Part A Exhi bit 4 To 12/31/2018 Date/Time Prepared: Provider CCN: 15-0072

					Ic	12/31/2010	Date/lime Pre 4/1/2019 4:24	
		W (0 E D) A			XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2. 00	3. 00	4.00	5. 00	
1. 00	DRG amounts other than outlier payments	1. 00	0	0	0	0	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	3, 008, 040	0	3, 008, 040		3, 008, 040	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	841, 097	0		841, 097	841, 097	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1. 03
1. 04	October 1 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	2. 00	19, 036	0	19, 036	0	19, 036	2. 00
2. 01	discharges (see instructions) Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3.00	Operating outlier	2. 01	0	0	0	0	0	3. 00
4. 00	reconciliation Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
	Indirect Medical Education Adj							
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	0	0	0	0	6. 01
	Indirect Medical Education Adj	ustment for th	e Add-on for Se	ection 422 of 1	the MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see	28. 01	0	0	0	0	0	8. 01
9. 00	instructions) 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	0	0	0	0	9. 01
	Disproportionate Share Adjustm	ent						
10.00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1200	0. 1200	0. 1200	0. 1200		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	115, 474	0	90, 241	25, 233	115, 474	
11. 01	Uncompensated care payments Additional payment for high pe	36.00	515, 572	0 di scharges	356, 657	158, 915	515, 572	11. 01
12. 00	Total ESRD additional payment (see instructions)	46. 00	0 Denericiary	0 o	0	0	0	12.00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	4, 499, 219 5, 966, 225	0	3, 473, 974 4, 668, 391	1, 025, 245 1, 297, 834	4, 499, 219 5, 966, 225	
15. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	5, 966, 225	0	4, 668, 391	1, 297, 834	5, 966, 225	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	310, 787	0	243, 423	67, 364	310, 787	16.00
17. 00	Special add-on payments for new technologies	54. 00	0	0	0	0	0	
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	О	0	0	0	0	17. 01 17. 02

Heal th	Financial Systems	N	MEMORIAL HOSPIT	AL LOGANSPORT		In Lie	u of Form CMS-2	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provi der C		Period: From 01/01/2018 To 12/31/2018		pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	0n/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2. 00	3.00	4.00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0		0	0	
19. 00	SUBTOTAL			0	4, 911, 81	4 1, 365, 198	6, 277, 012	19. 00
		W/S L, line	(Amounts from L)					
		0	1. 00	2. 00	3.00	4. 00	5. 00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier		307, 975 0	0	2.0,0.	1 67, 364 0 0	307, 975 0	
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	2, 812 0	0	2, 81	0 0	2, 812 0	21. 00 21. 01
22. 00		5. 00	0. 0000	0. 0000	0. 000	0.0000		22.00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0.0000	0. 0000	0. 000	0. 0000		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0		0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	310, 787	0	243, 42	3 67, 364	310, 787	26. 00
		W/S E, Part A	(Amounts to					
		l i ne	E, Part A)					

Provider CCN: 15-0072

Peri od:

From 01/01/2018

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Part A Exhibit 5

Date/Time Prepared: 12/31/2018 4/1/2019 4: 24 pm Title XVIII Hospi tal Period to Total (cols. Wkst. E, Pt. Amt. from Period on A, line Wkst. E, Pt. 10/01 after 10/01 2 and 3) A) 0 1.00 2.00 3.00 4.00 1.00 DRG amounts other than outlier payments 1. 00 1.00 DRG amounts other than outlier payments for 1.01 1.01 3,008,040 3,008,040 3,008,040 1.01 discharges occurring prior to October 1 1 02 DRG amounts other than outlier payments for 841, 097 841, 097 841, 097 1 02 1.02 discharges occurring on or after October 1 DRG for Federal specific operating payment 1.03 1.03 0 1.03 for Model 4 BPCI occurring prior to October 1 04 DRG for Federal specific operating payment 1 04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 19,036 19,036 0 19,036 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 0 2.01 **BPCI** 3.00 2.01 O 3.00 Operating outlier reconciliation 0 Managed care simulated payments 4.00 4.00 3.00 0 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21. 00 0.000000 0.000000 0.000000 5.00 (see instructions) 6.00 IME payment adjustment (see instructions) 22. 00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 0. 000000 7.00 IME payment adjustment factor (see 27.00 0.000000 0.000000 7.00 instructions) IME adjustment (see instructions) 8 00 28 00 8 00 0 0 8.01 IME payment adjustment add on for managed 28. 01 C 0 0 0 8.01 care (see instructions) 9 00 Total IME payment (sum of lines 6 and 8) 29. 00 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 0 0 9.01 0 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.1200 0.1200 0.1200 10.00 (see instructions) Di sproporti onate share adjustment (see 11.00 34.00 115, 474 90. 241 115, 474 25, 233 11.00 instructions) 11.01 Uncompensated care payments 36.00 515, 572 356, 657 158, 915 515, 572 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment (see 12.00 12.00 46.00 instructions) 4, 499, 219 13.00 Subtotal (see instructions) 47.00 3, 473, 974 1, 025, 245 4, 499, 219 13.00 Hospital specific payments (completed by SCH 48.00 5, 966, 225 14.00 14.00 and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs 49.00 5, 966, 225 5, 966, 225 15.00 5, 966, 225 0 (see instructions) 16,00 Payment for inpatient program capital (from 50.00 310, 787 243, 423 67, 364 310, 787 16.00 Wkst. L, Pt. I, if applicable)
Special add-on payments for new technologies 17.00 17.00 54 00 0 0 0 17.01 Net organ acquisition cost 17.01 17.02 Credits received from manufacturers for 68.00 0 0 17.02 replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment 18.00 93.00 0 \cap amount (see instructions) 19.00 SUBTOTAL 6, 209, 648 67.364 6, 277, 012 19.00

th Financial Systems	MEMORIAL HOSPITAL LOGANSPORT	In Lieu of Form CMS-2552-10
	•	1

		MEMORIAL HOSPIT			In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5		-	Period: From 01/01/2018 To 12/31/2018		pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4. 00	
20. 00	Capital DRG other than outlier	1. 00	307, 975	240, 61	67, 364	307, 975	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		o	0	
21.00	Capital DRG outlier payments	2. 00	2, 812	2, 812	2 0	2, 812	21.00
	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0	0	21. 01
	Indirect medical education percentage (see instructions)	5. 00	0.0000	0. 0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	(0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0.0000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	(0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	310, 787	243, 423	67, 364	310, 787	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. A)				
		0	1.00	2. 00	3. 00	4. 00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70. 96	720, 106	720, 100	5	720, 106	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	206, 541		206, 541	206, 541	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	4, 537	1, 145	3, 392	4, 537	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	(0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	0	(0	0	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	(0	0	31.01
						(Amt. to Wkst. E, Pt.	
						A)	
		0	1.00	2.00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99		(32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	MEMORIAL HOSPITAL	LOGANSPORT	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0072	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 4/1/2019 4:24 pm
		T: +1 - W// L I	11: +-1	47 17 20 19 4. 24 pill

ABAT R - MEDICAL AND CHIEF HEAT THIS FEWLOPS 1.00				0 12/01/2010	4/1/2019 4: 24	
Mart B - MEDICAL AND OTHER REALTH SERVICES 10.00			Title XVIII	Hospi tal		
Mart B - MEDICAL AND OTHER REALTH SERVICES 1.00 Moderal and other services (see instructions) 1.5,709 1.00 1.00 Moderal and other services (see instructions) 1.5,709 1.00				·		
					1. 00	
Medical and other services relimbursed under OPPS (see Instructions) 15, 500, 185 2.00		PART B - MEDICAL AND OTHER HEALTH SERVICES				
0.0076 payments	1.00	Medical and other services (see instructions)			18, 709	1.00
0.00 1.00	2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		15, 500, 185	2.00
0.00 0.000 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.000 0.00	3.00	OPPS payments			10, 235, 425	3.00
Enter the hospital specific payment to cost ratio (see instructions)	4.00	Outlier payment (see instructions)		71, 917	4.00	
Line 2 Times in 6 0.00 7	4.01	Outlier reconciliation amount (see instructions)			0	4. 01
	5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0. 000	5.00
Transitional corridor payment (see Instructions) 0	6.00	Line 2 times line 5			0	6.00
Ancillary service other pass through costs from Wist. D. Pt. IV, col. 13, line 200 0, 9, 00	7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	7.00
0. 00 0 0 0 0 0 0 0 0	8.00	Transitional corridor payment (see instructions)			0	8.00
Total cost (sum of lines 1 and 10) (see instructions) 18,709 11,00	9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9. 00
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 86,093 12.00 Ancil larry service charges 86,093 12.00 13.00 Organ acquisist not charges (from West . 0-4, Pt. 111, col. 4, line 69) 0.13.00 0.15.00 0.15	10.00	Organ acquisitions			0	10.00
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 86,003 12.00	11.00	Total cost (sum of lines 1 and 10) (see instructions)			18, 709	11.00
12.00 Ancil Hary service charges (sm wkst. 0-4, Pt. 111, col. 4, line 69) 86,093 12,00 Cost forms acquisist ton charges (sm of lines 12 and 13) 86,093 14,00 Cost forms ry charges 50 16,0						
12.00 Ancil Hary service charges (sm wkst. 0-4, Pt. 111, col. 4, line 69) 86,093 12,00 Cost forms acquisist ton charges (sm of lines 12 and 13) 86,093 14,00 Cost forms ry charges 50 16,0		Reasonable charges				
1-0 Total reasonable charges (sum of lines 12 and 13) 1-0	12.00	Ancillary service charges			86, 093	12.00
Country charges Country ch	13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	13.00
Country charges Country ch	14.00	Total reasonable charges (sum of lines 12 and 13)			86, 093	14.00
16.00 Amounts that would have been realized from patients Iable for payment for services on a chargebasis 0 16.00 Nacuch payment been made in accordance with 42 CFR \$413.13(e) 0.000000 17.00 Natio of line 15 to line 16 (not to exceed 1.000000 17.00 Natio of line 15 to line 16 (not to exceed 1.000000 17.00 National Court of the C		Customary charges				
had such payment been made in accordance with 42 CFR §413. 13(e)	15.00	Aggregate amount actually collected from patients liable for	payment for services on a	charge basis	0	15. 00
had such payment been made in accordance with 42 CFR \$413.13(e)	16.00				0	16.00
18. 00 Total customary charges (see instructions) 19. 00 20. 00 10. 00 2				Ŭ		
9, 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 67, 384 9, 00 Instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20, 00 20, 20, 20 20, 20, 20, 20, 20, 20	17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
Instructions 20.00	18.00	Total customary charges (see instructions)			86, 093	18.00
20. 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20. 00 18. 709 11. 00 18. 709 21. 00 22. 00 22. 00 22. 00 22. 00 23. 00 20.	19.00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds line	e 11) (see	67, 384	19.00
Instructions 18,709 21,00		instructions)				
1. 00 Lesser of cost or charges (see instructions) 0. 20. 00	20.00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds line	e 18) (see	0	20.00
22.00 Interns and residents \(\tilde{\t		instructions)				
23. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 23. 00 10,307,342 24. 00 20 20 20 20 20 20 20	21.00	Lesser of cost or charges (see instructions)			18, 709	21.00
Total prospective payment (sum of lines 3, 4, 4, 01, 8 and 9)	22.00	Interns and residents (see instructions)			0	22. 00
COMPUTATION OF REINBURSEMENT SETTLEMENT 20	23.00	Cost of physicians' services in a teaching hospital (see inst	ructi ons)		0	23. 00
25 00 Deductible and coinsurance amounts (for CAH, see instructions) 208 25 0.00	24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			10, 307, 342	24.00
24 (For CAH, see instructions) 2,145,832 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 8,180,011 27.00 1 instructions) 0 0 0 0 0 28.00 0 1 0 0 0 0 28.00 0 1 0 0 0 0 28.00 0 1 0 0 0 28.00 0 1 0 0 0 28.00 0 1 0 0 0 30.00 2 0 0 0 0 30.00 2 0 0 0 30.00 2 0 0 0 0 30.00 2 0 0 0 30.00 2 0 0 0 30.00 2 0 0 0 30.00 2 0 0 0 30.00 2 0 0 0 30.00 2 0 0 30.00 2 0 0 30.00 2 0 0 30.00 2 0 0 30.00 2 0 0 30.00 2 0 0 30.00 2 0 0 30.00 2 0 0 30.00 3 0 0 30.00 2 0 30.00 3 0 0 30.00 3 0 0 30.00 3 0 0 30.00 3 0 0 30.00 3 0 0 30.00 3 0 30.00 3 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.00 0 0 0 30.0		COMPUTATION OF REIMBURSEMENT SETTLEMENT				
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 27.00	25.00	Deductibles and coinsurance amounts (for CAH, see instruction	s)		208	25. 00
Instructions Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28	26.00	Deductibles and Coinsurance amounts relating to amount on lin	e 24 (for CAH, see instru	ctions)	2, 145, 832	26.00
28. 00	27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22 a	and 23] (see	8, 180, 011	27.00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 30.00 Subtotal (sum of lines 27 through 29) 8,180,011 31.00 Primary payer payments 2,701 32.00 Subtotal (line 30 minus line 31) 8,177,310 32.00 All Lowable Ead DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 34.00 All lowable bad debts (see instructions) 70,688 35.00 All lowable bad debts (see instructions) 70,688 36.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 112,302 36.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 8,247,998 37.00 Subtotal (see instructions) 8,247,998 38.00 MSP-LCC reconciliation amount from PS&R 10 39.00 OTHER ADJUSTIMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 39.91 Pomonstration payment adjustment amount before sequestration 0 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 40.01 Sequestration adj						
Subtotal (sum of lines 27 through 29) Subtotal (sum of lines 27 through 29) Subtotal (sum of lines 27 through 29) Subtotal (line 30 minus line 31) Subtotal (ser arts ESRD (From Wkst. I -5, line 11) Subtotal (ser arts ESRD (from Wkst. I -5, line 11) Subtotal (see instructions) Sub			ine 50)			
31.00 Primary payer payments 2, 701 31.00 Subtotal (line 30 minus line 31) 8,177, 310 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I - 5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 108,750 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 70,688 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 112,302 36.00 37.00 Subtotal (see instructions) 8,247,998 37.00 38.00 MSP-LCC reconciliation amount from PS&R 10 38.00 MSP-LCC reconciliation amount from PS&R 10 38.00 MSP-LCC reconciliation payment adjustment (see instructions) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.97 Pioneer ACO demonstration payment adjustment (see instructions) 39.97 Pioneer ACO demonstration payment adjustment (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 40.00 Subtotal (see instructions) 40.00 Entrative settlement (for contractors use only) 40.00 Linterim payment adjustment amount after sequestration 40.00		, , , , , , , , , , , , , , , , , , ,				
Subtotal (line 30 minus line 31)						1
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00						
33.00 Composite rate ESRD (from Wkst. I-5, line 11)	32. 00		050)		8, 177, 310	32.00
34.00 Allowable bad debts (see instructions) 108,750 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 70,688 35.00 36.00 Allowable bad debts (see instructions) 112,302 36.00 37.00 Subtotal (see instructions) 8,247,998 37.00 38.00 MSP-LCC reconciliation amount from PS&R 10 38.00 39.00 MSP-LCC reconciliation amount from PS&R 10 38.00 39.50 Ploneer ACO demonstration payment adjustment (see instructions) 39.50 Ploneer ACO demonstration payment adjustment (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 39.97 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.98 39.99 Recovery and adjustment (see instructions) 39.99 Recovery and adjustment (see instructions) 39.99 Recovery of Acceleration adjustment (see instructions) 39.99 Recovery of Acceleration 39.99 Recovery of Acceleration 39.99	22 22	· · · · · · · · · · · · · · · · · · ·	CES)			00.00
35.00 Adjusted reimbursable bad debts (see instructions) 70,688 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 112,302 36.00 37.00 Subtotal (see instructions) 8,247,998 37.00 38.00 MSP-LCC reconciliation amount from PS&R 10 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 164,960 40.01 40.02 Demonstration payment adjustment amount after sequestration 164,960 40.01 40.02 41.00 Interim payments 8,022,226 41.00 42.00 Tentative settlement (for contractors use only) 8al ance due provider/program (see instructions) 60,802 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,						
36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 112, 302 36.00 37.00 Subtotal (see instructions) 8, 247, 988 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 39.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.01 Sequestration adjustment (see instructions) 8, 247, 988 40.00 40.01 Sequestration adjustment (see instructions) 164, 960 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 41.00 Interim payments 8, 022, 226 41.00 42.00 Tentative settlement (for contractors use only) 60, 802 43.00 44.00 Balance due provider/program (see instructions) 60, 802 43.00 41.00 Protest		,				
37.00 Subtotal (see instructions) 8, 247, 998 37.00 38.00 MSP-LCC reconciliation amount from PS&R 10 38.00 39.00 39.00 39.50 91 oneer ACO demonstration payment adjustment (see instructions) 39.97 39.98 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.97 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 8, 247, 988 40.00 40.01 Sequestration adjustment (see instructions) 164, 960 40.01 40.02 Demonstration payment adjustment amount after sequestration 40.02 Demonstration payment adjustment amount after sequestration 40.02 The trait ve settlement (for contractors use only) 42.00 43.00 Balance due provider/program (see instructions) 42.00 43.00 Balance due provider/program (see instructions) 44.00 45.15						•
38.00 MSP-LCC reconciliation amount from PS&R 10 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.97 40.01 Sequestration adjustment (see instructions) 0 39.99 40.01 Sequestration adjustment (see instructions) 8, 247, 988 40.00 40.01 Demonstration payment adjustment amount after sequestration 164, 960 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 41.00 Interim payments 8, 022, 226 41.00 42.00 Interim payments 8, 022, 226 41.00 43.00 Protested amounts (for contractors use only) 0 42.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 915.52 TO BE COMPLETED BY CONTRACTOR 0 90.00		,	ructions)			
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 39.77 Pi oneer ACO demonstration payment adjustment (see instructions) 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 Subtotal (see instructions) 39.99 Subtotal (see instructions) 39.99 Subtotal (see instructions) 39.99 (40.00 Sequestration adjustment (see instructions) 39.99 Subtotal (see instructions) 39.90 Sequestration adjustment (see instructions) 39.90 Sequestration adjustment (see instructions) 39.90 Subtotal (see instructions) 39.90 Subtotal (see instructions) 39.90 Subtotal (see instructions) 39.90 Sequestration adjustment amount after sequestration 39.90 Subtotal (see instructions) 39.						
39. 50 39. 97 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 40. 00 40. 01 40. 02 41. 00 41. 00 42. 00 43. 00 44. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 49. 00 40. 00						•
39. 97 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 50 Sequestration adjustment amount after sequestration 40. 01 Demonstration payment adjustment (see instructions) 40. 02 Interim payments 41. 00 Interim payments 42. 00 Fortative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 1, 0 1, 0 1, 0 1, 0 1, 0 1, 0 1,			->		U	
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 8,247,988 40.00 40.01 40.02 Demonstration payment adjustment amount after sequestration 164,960 40.01 41.00 Interim payments 8,022,226 41.00 42.00 42.00 43.00 Balance due provider/program (see instructions) 60,802 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 44.00 45.00		1 3 3 1	S)			
39. 99 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115. 2 70 BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 99 94. 00 Use instructions 94. 00 One of Money (see instructions) 95. 00 One of Money (see instructions) 96. 00 One of Money (see instructions) 97. 00 One of Money (see instructions) 98. 207 One of Money (see instructions) 99. 00 One of Money (see instructions)						
40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 Interim payments 42.00 Interim payments 42.00 Balance due provider/program (see instructions) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{1}{2}\$ TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Og 93.00		·	ced devices (see instructi	ons)		
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Bal ance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{\text{515.2}}{\text{10 BE COMPLETED BY CONTRACTOR}} 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Og 40.01 94.00 40.02 41.00 42.00 42.00 42.00 43.00 44.00 44.00 45.00 45.00 46.00 47.00 47.00 47.00 47.00 48.00 49.00 49.00 49.00 40.00 4						
40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Qa.00 Qa		· · · · · · · · · · · · · · · · · · ·				
41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)						
Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{115.2}{10.00}\$ Poiginal outlier amount (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, , , , , , , , , , , , , , , , , , , ,				
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 60,802 43.00 44.00 44.00 90.00 Outlier reconciliation adjustment amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 Time Value of Money (see instructions) 93.00						
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\ \ \text{91} \] \[\begin{align*} \text{15.2} \\ \text{TO BE COMPLETED BY CONTRACTOR} \\ \text{90.00} \\ \text{0riginal outlier amount (see instructions)} \\ \text{90.00} \\ \text{00tlier reconciliation adjustment amount (see instructions)} \\ \text{90.00} \\ \text{15.2} \\ \text{10.00} \\ \text{91.00} \\ \text{91.00} \\ \text{92.00} \\ \text{The rate used to calculate the Time Value of Money} \\ \text{90.00} \\ \text{93.00} \\ \text{10.00} \\ \text		,				
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Utlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 Time Value of Money (see instructions) 0 93.00			nce with CMS Dub 1E 2 a	nanter 1		
70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)	44.00		rice with twis Pub. 15-2, ti	iaptei i,	U)	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 92.00 93.00						
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92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00						
93.00 Time Value of Money (see instructions) 0 93.00		The state of the s				
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Health Financial Systems MEMORI ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1 From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared: Provider CCN: 15-0072

					4/1/2019 4: 24	'pm
		Title	XVIII	Hospi tal	PPS	
		I npati en	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		6, 391, 734		8, 022, 226	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	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	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02 3. 03 3. 04	ABSOSTMENTS TO FROM DEN		0 0 0		0 0	3. 02 3. 03 3. 04
3. 05			0		0	3. 05
	Provider to Program					
3. 50 3. 51 3. 52 3. 53 3. 54 3. 99	ADJUSTMENTS TO PROGRAM Subtotal (sum of lines 3.01-3.49 minus sum of lines		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	3.50 3.51 3.52 3.53 3.54 3.99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		6, 391, 734		8, 022, 226	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
г оо	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		T			
5. 00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
F 04	Program to Provider		1 0			F 04
5. 01 5. 02 5. 03	TENTATI VE TO PROVI DER		0 0 0		0 0	5. 01 5. 02 5. 03
	Provider to Program					
5. 50 5. 51 5. 52	TENTATI VE TO PROGRAM		0 0 0		0 0 0	5. 50 5. 51 5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00 6. 01	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER		15, 771		60, 802	6. 00 6. 01
6. 02 7. 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		6, 407, 505		0 8, 083, 028	6. 02
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8.00

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

		'			4/1/2019 4: 24	pm pm
		Title	XVIII S	wing Beds - SNF	PPS	
		I npati en	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1. 00	Total interim payments paid to provider		C)	0	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		C)	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					1
3. 01	ADJUSTMENTS TO PROVIDER		C)	0	3. 01
3.02			l c)	0	3.02
3.03			l c)	0	3.03
3.04			1 0)	0	3.04
3.05			1 0)	0	3.05
	Provider to Program		•	•		1
3.50	ADJUSTMENTS TO PROGRAM)	0	3.50
3. 51			1 0)	0	3.51
3. 52			1 0)	0	3.52
3. 53			1 0)	0	3.53
3. 54			1)	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines)	0	•
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)			.	0	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as			,		4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					1
5. 00	List separately each tentative settlement payment after					5.00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER				0	5. 01
5. 02			1		0	
5. 03			1		0	
	Provi der to Program					1
5. 50	TENTATI VE TO PROGRAM)	0	5.50
5. 51			Ì		0	
5. 52			Ì		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		1		0	
	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		(0	6. 01
6. 02	SETTLEMENT TO PROVIDER					
7. 00	Total Medicare program liability (see instructions)				0	
7.00	Trotal medicale program francistry (see instructions)			Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8.00
	· ·					

Heal th	Financial Systems MEMORIAL HOSPITAL	_ LOGANSPORT	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0072	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E-Part II Date/Time Pro 4/1/2019 4:24	epared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst		ie 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4. 00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	-	,		1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ns)		32.00

Health Financial Systems	MEMORIAL HOSPITAL	LOGANSPORT	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-0072		Worksheet E-2
		Component CCN: 15-U072	From 01/01/2018 To 12/31/2018	Date/Time Prepared:
				4/1/2019 4: 24 pm
		Title XVIII	Swing Reds - SNE	PDS

		Title XVIII S	Swing Beds - SNF	4/1/2019 4: 24 PPS	pm
		TI LIE AVIII	Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, ar	nd sum of Wkst. D,			3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructi	ons)			
4.00	Per diem cost for interns and residents not in approved teaching pro	ogram (see		0. 00	4. 00
	instructions)				
5. 00	Program days		0	0	5.00
6.00	Interns and residents not in approved teaching program (see instruct	•		0	6.00
7. 00 8. 00	Utilization review - physician compensation - SNF optional method or Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	ni y	0	0	7. 00 8. 00
9. 00	Primary payer payments (see instructions)		0	0	
10.00	Subtotal (line 8 minus line 9)		0	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable	to physician	Ö	0	11.00
	professi onal servi ces)	to physician		Ü	
12.00	Subtotal (line 10 minus line 11)		0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (excl	ude coi nsurance	0	0	13.00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	0	15.00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
	Pioneer ACO demonstration payment adjustment (see instructions)				16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstration)) payment	0		16. 55
14 00	adjustment (see instructions)			0	14 00
16. 99	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)		0	0	16. 99 17. 00
	Adjusted reimbursable bad debts (see instructions)		0	0	17. 00
	Allowable bad debts for dual eligible beneficiaries (see instruction	ns)	0	0	18.00
	Total (see instructions)	13)	0	0	19.00
	Sequestration adjustment (see instructions)		Ö	0	19. 01
	Demonstration payment adjustment amount after sequestration)		o	0	19. 02
	Interim payments		O	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21))	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with	th CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstration)				
200.00	Is this the first year of the current 5-year demonstration period un	nder the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
201 00	Cost Reimbursement Medicare swing-bed SNF inpatient routine service costs (from Wkst. [) 1 D+ II lino			201. 00
201.00	66 (title XVIII hospital))	D-1, Ft. II, IIIIC			201.00
202 00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst.	D-3 col 3 line	2		202. 00
202.00	200 (title XVIII swing-bed SNF))	2 07 0011 07 1111			202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A in first	year of the currer	nt 5-year demons	tration	
	peri od)				
205.00	Medicare swing-bed SNF target amount				205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times li	ne 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
	Program reimbursement under the §410A Demonstration (see instruction				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col.	I, sum of lines	!		208. 00
200 00	and 3) Adjustment to Medicare swing-bed SNF PPS payments (see instructions)	1			209. 00
	Reserved for future use)			210. 00
Z 10. 00	Comparision of PPS versus Cost Reimbursement				<u> </u>
215 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plu	us line 210) (see			215. 00
0 . 00	instructions)				
	· · · · · · · · · · · · · · · · · · ·		1		'

Health Financial Systems	MEMORIAL HOSPITAL	LOGANSPORT	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-0072		Worksheet E-2
		Component CCN: 15-U072	From 01/01/2018 To 12/31/2018	
		'		4/1/2019 4: 24 pm
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				4/1/2019 4: 24	pm
		Title XIX S	wing Beds - SNF		
			Part A	Part B	
			1. 00	2. 00	
1 00	COMPUTATION OF NET COST OF COVERED SERVICES				4 00
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0		1.00
2. 00 3. 00	Inpatient routine services - swing bed-NF (see instructions) Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A,	and sum of Wkst D	0		2. 00 3. 00
3.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instru		U		3.00
4. 00	Per diem cost for interns and residents not in approved teaching		0.00		4. 00
1. 00	instructions)	program (See	0.00		1.00
5. 00	Program days		0		5. 00
6.00	Interns and residents not in approved teaching program (see instr	ructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method		0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	-	0		8.00
9.00	Primary payer payments (see instructions)		0		9.00
10.00	Subtotal (line 8 minus line 9)		0		10.00
11. 00	Deductibles billed to program patients (exclude amounts applicabl	e to physician	0		11.00
	professional services)				
12.00	Subtotal (line 10 minus line 11)		0		12.00
13. 00	Coinsurance billed to program patients (from provider records) (e	exclude coinsurance	0		13.00
14.00	for physician professional services)				14.00
14.00	80% of Part B costs (line 12 x 80%)		0		14.00
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0		15. 00 16. 00
16. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)		0		16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstrati	on) navment			16. 55
10. 55	adjustment (see instructions)	on) payment			10. 55
16. 99	Demonstration payment adjustment amount before sequestration		0		16. 99
	Allowable bad debts (see instructions)		0		17. 00
	Adjusted reimbursable bad debts (see instructions)		0		17. 01
	Allowable bad debts for dual eligible beneficiaries (see instruct	ions)	0		18. 00
	Total (see instructions)	,	0		19. 00
	Sequestration adjustment (see instructions)		0		19. 01
	Demonstration payment adjustment amount after sequestration)		0		19. 02
	Interim payments		0		20.00
	Tentative settlement (for contractor use only)		0		21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, and	21)	0		22.00
23. 00	Protested amounts (nonallowable cost report items) in accordance	•	0		23.00
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstrati	on) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period	under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				
201. 00	Medicare swing-bed SNF inpatient routine service costs (from Wkst	D-1, Pt. II, line			201. 00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wk	kst. D-3, col. 3, line	9		202. 00
000 00	200 (title XVIII swing-bed SNF))				000 00
	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)		+ F		204. 00
	Computation of Demonstration Target Amount Limitation (N/A in fir	st year of the curren	it 5-year demons	tration	
205.00	period) Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times	Line 204)			206.00
200.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburseme				200.00
207.00	Program reimbursement under the §410A Demonstration (see instruct				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, c	•			207.00
200.00	and 3)	or. I, sum of filles i			200.00
209 00	Adjustment to Medicare swing-bed SNF PPS payments (see instruction	nns)			209. 00
	Reserved for future use	,,,,,			210. 00
210.00	Comparision of PPS versus Cost Reimbursement				210.00
215 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209	plus line 210) (see			215. 00
	instructions)	p. 10 210) (300			
	1				1

Health Financial Systems	MEMORIAL HOSPITAL LOG	ANSPORT	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pro	ovider CCN: 15-0072	From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 4/1/2019 4:24 pm

			12/31/2010	4/1/2019 4: 24	
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR XI			
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		502, 745		1.00
2. 00	Medical and other services		,	0	1
3. 00	Organ acquisition (certified transplant centers only)		0		3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		502, 745	0	
5. 00	Inpatient primary payer payments		002,710	ŭ	5.00
6. 00	Outpatient primary payer payments			0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		502, 745	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		302, 743		7.00
	Reasonable Charges				1
8. 00			309, 939		0 00
9. 00	Routine service charges			0	8. 00 9. 00
	Ancillary service charges		875, 020	U	
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		1 101 050	0	11.00
12. 00	The state of the s		1, 184, 959	0	12.00
40.00	CUSTOMARY CHARGES	 	1 0		
13. 00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	13.00
	basis			_	
14.00	Amounts that would have been realized from patients liable fo		0	0	14.00
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	
16. 00	Total customary charges (see instructions)		1, 184, 959	0	
17.00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	682, 214	0	17.00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds line	0	0	18.00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	
20.00	Cost of physicians' services in a teaching hospital (see inst		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line		502, 745	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid	ers.		
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		502, 745	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	502, 745	0	
32.00	Deducti bl es	,	0	0	32.00
33. 00	Coinsurance		0	0	
34.00	Allowable bad debts (see instructions)		0	0	
	Utilization review		0	Ü	35.00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	4 33)	502, 745	0	
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	a 55,	002, 743	0	
	Subtotal (line 36 ± line 37)		502, 745	0	
	Direct graduate medical education payments (from Wkst. E-4)		502, 745	U	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		502, 745	0	
	,				
41.00	Interim payments		592, 480	0	
42.00	Balance due provider/program (line 40 minus line 41)	with ONC D t 45 C	-89, 735	0	
43. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2		1		I

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

Provider CCN: 15-0072

Peri od: Worksheet G From 01/01/2018 To 12/31/2018 Date/Time Prepared:

4/1/2019 4: 24 pm General Fund Speci fi c Endowment Plant Fund Purpose Fund Fund 1.00 2.00 4.00 3.00 CURRENT ASSETS 1.00 Cash on hand in banks 24, 128, 912 0 0 0 1.00 0 0 2.00 Temporary investments 0 2.00 0 3 00 Notes receivable 0 0 3 00 0 4.00 Accounts receivable 39, 283, 586 0 4.00 5.00 1, 895, 622 0 0 0 5.00 Other receivable ol 6.00 Allowances for uncollectible notes and accounts receivable -27, 842, 679 0 0 6.00 o Inventory 2, 028, 943 0 7 00 7 00 0 0 8.00 Prepaid expenses 953, 581 0 0 8.00 177, 500 0 9.00 Other current assets 0 9.00 10.00 Due from other funds 24, 128 0 ol 0 10.00 Total current assets (sum of lines 1-10) 40, 649, 593 0 11.00 0 0 11.00 FIXED ASSETS 12.00 Land 205, 783 0 0 0 12.00 Land improvements 0 0 13.00 869.699 0 13.00 οĺ -410, 084 14.00 Accumulated depreciation 0 14.00 Bui I di ngs o 15.00 66, 695, 199 0 0 15.00 16.00 Accumulated depreciation -38, 538, 339 0 0 0 0 0 16.00 0 17.00 Leasehold improvements 0 17.00 0 18 00 Accumulated depreciation 0 18 00 Fixed equipment 7, 616, 441 19.00 19.00 0 0 20.00 Accumulated depreciation -3, 415, 909 0 0 0 20.00 Automobiles and trucks 0 21.00 118, 602 0 21.00 22.00 Accumulated depreciation -102, 906 0 22.00 23.00 Major movable equipment 40, 375, 498 0 0 0 0 23.00 Accumulated depreciation 0 24.00 -30, 127, 147 0 24.00 0 25.00 Minor equipment depreciable 0 25.00 Accumulated depreciation 0 0 0 0 26.00 26.00 27.00 HIT designated Assets 0 0 0 27.00 Accumulated depreciation 0 28.00 0 0 28.00 0 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 30.00 Total fixed assets (sum of lines 12-29) 43, 286, 837 0 0 0 30.00 OTHER ASSETS 31 00 31.00 Investments 0 0 0 0 32.00 Deposits on Leases C 0 0 32.00 0 0 33.00 Due from owners/officers 0 33.00 o 34.00 Other assets 12, 928, 995 0 34.00 0 Total other assets (sum of lines 31-34) 12, 928, 995 0 0 35.00 0 35.00 36.00 Total assets (sum of lines 11, 30, and 35) 96, 865, 425 0 0 0 36.00 CURRENT LIABILITIES 37 00 9 612 304 0 0 n 37 00 Accounts payable 0 0 38.00 Salaries, wages, and fees payable 2, 269, 573 0 38.00 Payroll taxes payable 0 0 0 39.00 39.00 40.00 Notes and Loans payable (short term) 2,018,134 0 0 0 40.00 o 0 Deferred income 41 00 41 00 0 42.00 Accelerated payments 42.00 43.00 Due to other funds -4, 994, 667 0 0 0 43.00 Other current liabilities 1, 331, 899 ol 44.00 0 0 44.00 0 Total current liabilities (sum of lines 37 thru 44) 45.00 10, 237, 243 0 0 45.00 ONG TERM LIABILITIES 46.00 Mortgage payable 0 0 0 46.00 0 0 47.00 Notes payable 0 47.00 C 48.00 Unsecured Loans 0 0 0 48.00 Other long term liabilities 15, 926, 002 0 0 49.00 49.00 0 Total long term liabilities (sum of lines 46 thru 49) 15, 926, 002 0 ol 0 50.00 50.00 51.00 Total liabilities (sum of lines 45 and 50) 26, 163, 245 0 0 0 51.00 CAPITAL ACCOUNTS 70, 702, 180 52.00 General fund balance 52.00 0 53.00 Specific purpose fund 53.00 54 00 Donor created - endowment fund balance - restricted 0 54 00 Donor created - endowment fund balance - unrestricted 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 57.00 0 58.00 0 58.00 replacement, and expansion Total fund balances (sum of lines 52 thru 58) 70, 702, 180 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 96, 865, 425 0 0 0 60.00

STATEMENT OF CHANGES IN FUND BALANCES

Fund balance at end of period per balance

sheet (line 11 minus line 18)

Provider CCN: 15-0072

Period: Worksheet G-1 From 01/01/2018

12/31/2018 Date/Time Prepared: 4/1/2019 4:24 pm General Fund Special Purpose Fund Endowment Fund 5.00 1. 00 2.00 3. 00 4.00 1.00 Fund balances at beginning of period 69, 346, 450 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 1, 355, 730 2.00 2.00 3.00 Total (sum of line 1 and line 2) 70, 702, 180 ol 3.00 4.00 Additions (credit adjustments) (specify) 4.00 0 5.00 0000 0 5.00 0 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 70, 702, 180 Subtotal (line 3 plus line 10) 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 00000 13.00 13.00 14.00 0 0 14.00 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 70, 702, 180 19.00 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 1.00 Fund balances at beginning of period 0 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 0 3.00 3.00 Total (sum of line 1 and line 2) 0 4.00 Additions (credit adjustments) (specify) 4.00 5.00 5.00 6.00 0 6.00 0 7.00 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 0 10.00 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 Deductions (debit adjustments) (specify) 12.00 12.00 13.00 0 13.00 14.00 0 14.00 15.00 15.00 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 0 18.00

0

0

19.00

Health Financial Systems
STATEMENT OF PATIENT REVE

FEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider Co		Peri od: From 01/01/2018 To 12/31/2018	Worksheet G-2 Parts I & II Date/Time Pre 4/1/2019 4:24	pared:
Cost Center Description		I npati ent	Outpati ent	Total	
<u> </u>		1.00	2. 00	3. 00	

				4/1/2019 4: 24	pm
	Cost Center Description	I npati ent	Outpati ent	Total	
		1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1. 00	Hospi tal	7, 987, 653		7, 987, 653	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF	0		0	3.00
4.00	SUBPROVI DER	0		0	4.00
5. 00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7, 987, 653		7, 987, 653	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	881, 540		881, 540	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSI VE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	881, 540		881, 540	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8, 869, 193		8, 869, 193	17. 00
18.00	Ancillary services	22, 284, 535	135, 077, 609	157, 362, 144	18. 00
19.00	Outpati ent servi ces	1, 760, 655	21, 143, 048	22, 903, 703	19. 00
20.00	RURAL HEALTH CLINIC	0	0	0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	o	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES	0	0	0	23. 00
24. 00	CMHC		-	_	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	PHYSI CI AN CLI NI CS	0	14, 906, 590	14, 906, 590	
27. 01	PROFESSI ONAL FEES	855, 288	12, 573, 219	13, 428, 507	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	33, 769, 671	183, 700, 466	217, 470, 137	28. 00
20.00	G-3, line 1)	33, 707, 071	103, 700, 400	217, 470, 137	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		82, 721, 241		29. 00
30.00	ADD (SPECIFY)	0	02/ /2 // 2 / /		30. 00
31. 00	(6.25.1.)	Ö			31. 00
32.00		0			32.00
33. 00		0			33. 00
34. 00		0			34. 00
35. 00		0			35.00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)	0	U		37. 00
38. 00	DEDUCT (SPECITI)	0			38.00
39.00		0			39. 00
40.00		0			40.00
		0			40.00
41.00	Total deductions (sum of lines 37-41)	ا			41.00
42. 00 43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		02 721 241		42. 00 43. 00
43.00	to Wkst. G-3, line 4)		82, 721, 241		43.00
	10 WKSt. 0-3, 11110 4)		l		

		MEMORIAL HOSPITAL		_	u of Form CMS-2	
STATE	IENT OF REVENUES AND EXPENSES		Provi der CCN: 15-0072	Peri od: From 01/01/2018	Worksheet G-3	
					Date/Time Pre	pared:
				12, 01, 2010	4/1/2019 4: 24	
	I=	 	>		1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part				217, 470, 137	1.00
2.00	Less contractual allowances and discounts on	i pati ents' accoun	its		135, 475, 383	
3.00	Net patient revenues (line 1 minus line 2)	0 0 1 11 11	10)		81, 994, 754	3.00
4.00	Less total operating expenses (from Wkst. G-		43)		82, 721, 241	
5. 00	Net income from service to patients (line 3	minus line 4)			-726, 487	5.00
	OTHER I NCOME					, ,,
6.00	Contributions, donations, bequests, etc				0	
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscellane	ous communication	services		0	8.00
9.00	Revenue from television and radio service				0	,
10.00	Purchase di scounts				0	
	Rebates and refunds of expenses				0	
	Parking lot receipts				0	
13.00	,				0	13.00
	Revenue from meals sold to employees and gue	ests			0	14.00
	Revenue from rental of living quarters				0	15.00
	Revenue from sale of medical and surgical su		han patients		0	16.00
	Revenue from sale of drugs to other than pat				0	
	Revenue from sale of medical records and abs				0	
	Tuition (fees, sale of textbooks, uniforms,				0	
20.00	Revenue from gifts, flowers, coffee shops, a	ind canteen			0	20.00
	Rental of vending machines				0	21.00
22. 00	Rental of hospital space				0	22.00
23. 00	Governmental appropriations				0	23. 00
24. 00	OTHER REVENUE				1, 957, 400	
24. 01	I NVESTMENT I NCOME				8, 206	
	GAIN ON SALE OF EQUIPMENT				1, 475	
	OTHER NON OPERATING REVENUE				115, 136	
	Total other income (sum of lines 6-24)				2, 082, 217	
	Total (line 5 plus line 25)				1, 355, 730	
	OTHER EXPENSES (SPECIFY)				0	
28. 00	Total other expenses (sum of line 27 and sub	scripts)			0	28.00

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

> 0 28.00

1, 355, 730 29.00

	Financial Systems MEMORIAL HOSPITAL			u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0072	Peri od: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Pre 4/1/2019 4:24	
-		Title XVIII	Hospi tal	PPS	_рііі
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			307, 975	
1. 01	Model 4 BPCI Capital DRG other than outlier			0	
2.00	Capital DRG outlier payments			2, 812 0	
2. 01 3. 00	Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the cost r	connecting pariod (see inc	tructions)	- 1	
4. 00	Number of interns & residents (see instructions)	eporting period (see ins	tructions)	12. 26 0. 00	
5. 00	Indirect medical education percentage (see instructions)			0.00	1
6. 00	Indirect medical education adjustment (multiply line 5 by the	ne sum of lines 1 and 1.0	1 columns 1 and	0.00	6.00
0.00	1.01) (see instructions)	ie suii or rriies r and r.o	i, corumns rand	0	0.00
7. 00					7. 00
8. 00	Percentage of Medicaid patient days to total days (see instr	suctions)		0. 00	8.00
9. 00	Sum of lines 7 and 8	detions)		0.00	
10.00	Allowable disproportionate share percentage (see instruction	ns)		0.00	
11. 00	Disproportionate share adjustment (see instructions)			0.00	11.00
	Total prospective capital payments (see instructions)			310, 787	
12.00	Trotal prospective suprem payments (ess instructions)			0.07.07	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.00
3. 00	Total inpatient program capital cost (line 1 plus line 2)			0	
4. 00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	
2.00	Program inpatient capital costs for extraordinary circumstar	nces (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)			0 0. 00	
4 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			0.00	
4. 00 E. 00				U	
5.00		netructions)		0.00	1 6 00
5. 00 6. 00	Percentage adjustment for extraordinary circumstances (see i		v line 6)	0.00	
5. 00 6. 00 7. 00	Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar		x line 6)	0	7. 00
5. 00 6. 00 7. 00 8. 00	Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7)	ry circumstances (line 2	x line 6)	0 0	7. 00 8. 00
5. 00 6. 00 7. 00 8. 00 9. 00	Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl	ry circumstances (line 2 icable)	ŕ	0 0 0	7. 00 8. 00 9. 00
5. 00 6. 00 7. 00 8. 00	Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over	ry circumstances (line 2 icable) capital payments (line 8	less line 9)	0 0	7. 00 8. 00 9. 00 10. 00
5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	ry circumstances (line 2 icable) capital payments (line 8 capital payment (from pr	less line 9) ior year	0 0 0 0	7. 00 8. 00 9. 00 10. 00 11. 00
5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payment level	ry circumstances (line 2 icable) capital payments (line 8 capital payment (from propayments (line 10 plus li	less line 9) ior year ne 11)	0 0 0 0 0	7. 00 8. 00 9. 00 10. 00 11. 00
5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payment year exception payment (if line 12 is positive, enter	ry circumstances (line 2 icable) capital payments (line 8 capital payment (from propayments (line 10 plus lier the amount on this line	less line 9) ior year ne 11) e)	0 0 0 0	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payment level	ry circumstances (line 2 icable) capital payments (line 8 capital payment (from propayments (line 10 plus lier the amount on this line	less line 9) ior year ne 11) e)	0 0 0 0 0	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over	icable) capital payments (line 8 capital payment (from pr payments (line 10 plus li er the amount on this lin capital payment for the	less line 9) ior year ne 11) e)	0 0 0 0 0	7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	icable) capital payments (line 8 capital payment (from pr payments (line 10 plus li er the amount on this lin capital payment for the	less line 9) ior year ne 11) e)	0 0 0 0 0	7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00