This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0072 Worksheet S Peri od: From 01/01/2020 Parts I-III AND SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: 8/2/2021 10:57 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 8/2/2021 Time: 10:57 am Manually prepared cost report use only]If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 6. Date Received: 7. Contractor No. 10. NPR Date: Contractor]Cost Report Status (1) As Submitted

7. Contractor No.

(2) Settled without Audit 8. [N] Initial Report for this Provider CCN 12. [0] If line 5, column 1 is 4: Enter (3) Settled with Audit

9. [N] Final Report for this Provider CCN | number of times reopened = 0-9. 11. Contractor's Vendor Code: use only (3) Settled with Audit number of times 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 01/01/2020 and ending 12/31/2020 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.

[X]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) SHERRI GEHLHAUSEN
Officer or Administrator of Provider(s)

CF0 Title

(Dated when report is electronically signed.)

| | | | Ti tle XVIII | | | | |
|-------------------------|-------------------------------|---------|--------------|--------|-------|-----------|--------|
| Cost Center Description | | Title V | Part A | Part B | HI T | Title XIX | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | PART III - SETTLEMENT SUMMARY | | | | | | |
| 1.00 | Hospi tal | 0 | -65, 521 | 9, 962 | 0 | 283, 352 | 1.00 |
| 2.00 | Subprovi der - IPF | 0 | 0 | 0 | | 0 | 2.00 |
| 3.00 | Subprovi der - IRF | 0 | 0 | 0 | | 0 | 3.00 |
| 5.00 | Swing Bed - SNF | 0 | 0 | 0 | | 0 | 5. 00 |
| 6.00 | Swing Bed - NF | 0 | | | | 0 | 6.00 |
| 200.00 | Total | 0 | -65, 521 | 9, 962 | 0 | 283, 352 | 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 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 8/2/2021 10:57 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1101 MICHIGAN AVENUE 1.00 PO Box: 1.00 State: IN 2.00 City: LOGANSPORT Zip Code: 46947-County: CASS 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 MEMORIAL HOSPITAL 150072 99915 07/01/1966 Ν 0 3.00 LOGANSPORT Subprovi der - IPF 4.00 4.00 Subprovi der - IRF 5.00 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF SWING BED - SNF 15U072 99915 Р Р 05/14/2008 7 00 N 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital -Based Health Clinic - RHC 15.00 15 00 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2020 12/31/2020 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 currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days el i gi bl e unpai d paid days days unpai d 1.00 2.00 3.00 4.00 5.00 6.00 24.00 | If this provider is an IPPS hospital, enter the 0 24.00 322 824 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

| Health Financial Systems MEMORIAL | HOSPITAL L | _OGANSPORT | | | In Lie | u of Foi | rm CMS-2 | 2552-10 |
|--|-----------------------|--------------------------|------------------------|----------------------|---------|------------|-------------------------|---------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D | | Provi der CO | CN: 15-0072 | Peri od: | | Worksh | eet S-2 | |
| | | | | From 01/0 To 12/3 | 31/2020 | | ime Pre | |
| | In-State | In-State | Out-of | Out-of | Medi ca | | <u>21 10:5</u>)ther | / am |
| | Medicaid paid days | Medicaid eligible | State Medi cai d | State Medi cai d | HMO da | J . | di cai d days | |
| | para days | unpai d | pai d days | el i gi bl e | | | uays | |
| | 1.00 | 2. 00 | 3.00 | unpai d 4. 00 | 5. 00 | | 6. 00 | |
| 25.00 If this provider is an IRF, enter the in-state | 1.00 | | | 4.00 | 5.00 | 0 | 0.00 | 25. 00 |
| Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, | | | | | | | | |
| out-of-state Medicaid days in column 3, out-of-state | | | | | | | | |
| Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. | | | | | | | | |
| | ' | <u>'</u> | | | | Date of | | |
| 26.00 Enter your standard geographic classification (not w | age) statu: | s at the be | eginning of | the 1. | 2 | ۷. | 00 | 26. 00 |
| cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not w | | s at the en | nd of the co | ct | 2 | | | 27. 00 |
| reporting period. Enter in column 1, "1" for urban o | or"2" for | rural. If a | | 31 | ۷ | | | 27.00 |
| enter the effective date of the geographic reclassif 35.00 If this is a sole community hospital (SCH), enter the | | | SCH status i | n | 1 | | | 35. 00 |
| effect in the cost reporting period. | | | | | | F. 11 | | |
| | | | | Begi n | | Endi 2. | ng: 00 | |
| 36.00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat | | script line | 36 for num | ber 01/01 | /2020 | 12/31 | /2020 | 36. 00 |
| 37.00 If this is a Medicare dependent hospital (MDH), ente | | er of perio | ds MDH stat | us | 0 | | | 37.00 |
| is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for t | he MDH tra | nsitional n | navment in | | | | | 37. 01 |
| accordance with FY 2016 OPPS final rule? Enter "Y" f | | | | | | | | 37.01 |
| instructions) 38.00 If line 37 is 1, enter the beginning and ending date | es of MDH s | tatus. If I | ine 37 is | | | | | 38. 00 |
| greater than 1, subscript this line for the number of periods in excess of one and | | | | | | | | |
| enter subsequent dates. Y/N Y/N | | | | | | | | |
| 39.00 Does this facility qualify for the inpatient hospita | l navment: | adiustment | for Low vol | 1. ume \ | | | 00 Y | 39. 00 |
| hospitals in accordance with 42 CFR §412.101(b)(2)(i |), (ii), o | r (iii)? En | nter in colu | | | | • | 07.00 |
| 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i | the mileage | e requireme in column | ents in 2 "Y" for y | es | | | | |
| or "N" for no. (see instructions) | | | | | , | | | 40.00 |
| 40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo | | | | | | ľ | N | 40.00 |
| no in column 2, for discharges on or after October 1 | . (see ins | tructions) | | | V | XVIII | XIX | |
| 0.000 | | | | | 1.00 | | | |
| Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment | nt for dis | proporti ona | ite share in | accordance | e N | N | N | 45. 00 |
| with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exc | ontion for | ovtraordin | ary direume | tancos | l N | N | N | 46. 00 |
| pursuant to 42 CFR §412.348(f)? If yes, complete Wks | • | | , | | I IN | IN IN | IN IN | 46.00 |
| Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS | capital? | Enter "Y fo | or ves or "N | " for no | N | N | N | 47. 00 |
| 48.00 Is the facility electing full federal capital paymer | | | | | N | N N | N | 48. 00 |
| Teaching Hospitals 56.00 Is this a hospital involved in training residents in | approved | GME program | ns? Enter "Y | " for yes o | or N | | | 56.00 |
| "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for | | | (or subsequ | ent CR), MA | 4 | | | |
| 57.00 If line 56 is yes, is this the first cost reporting | period dur | ing which r | esidents in | approved | | | | 57.00 |
| GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mor | | | | | | | | |
| for yes or "N" for no in column 2. If column 2 is " | Y", comple | te Workshee | | | | | | |
| "N", complete Wkst. D, Parts III & IV and D-2, Pt. I 58.00 If line 56 is yes, did this facility elect cost reim | | | ans' servic | es as | N | | | 58. 00 |
| defined in CMS Pub. 15-1, chapter 21, §2148? If yes, | complete \ | Wkst. D-5. | | | N | | | E0 00 |
| 59.00 Are costs claimed on line 100 of Worksheet A? If ye | .s, compret | C WASE, D-Z | NAHE 413. | | neet A | Pass-T | | 59. 00 |
| | | | Y/N | Lin | e # | | cation erion | |
| | | | | | | Со | de | |
| 60.00 Are you claiming nursing and allied health education | (NAHE) co | sts for | 1. 00 N | 2. | 00 | 3. | 00 | 60.00 |
| any programs that meet the criteria under 42 CFR 413 | 8.85? (see | | | | | | | |
| instructions) Enter "Y" for yes or "N" for no in co is "Y", are you impacted by CR 11642 (or subsequent | | | | | | | | |
| adjustement? Enter "Y" for yes or "N" for no in col | | - | | | | | | |

| Health Financial Systems MEMORIAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D | | AL LOGANSPORT Provi der (| CCN: 15-0072 | Period: From 01/01/2020 | worksheet S-2 Part I | |
|--|-------|------------------------------|--------------|-----------------------------|---------------------------------------|--------|
| | | | | Го 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | |
| | 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 |
| 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) | | | | | | 61.01 |
| 61.02 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 instructions) | | | | | | 61.03 |
| 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). | | | | | | 61. 04 |
| 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) | | | | | | 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 | ogram Name | Program Code | Unweighted IME FTE Count | Unweighted Direct GME FTE Count | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | |
| 61.10 Of the FTEs in line 61.05, 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 | | | | 0.00 | 0.00 | 61. 20 |

| | instructions) Enter in column i, the program name. | | | | | | | | |
|---|---|--------|----------------|--------------|--------------|-------|--|--|--|
| | Enter in column 2, the program code. Enter in column | | | | | | | | |
| | 3, the IME FTE unweighted count. Enter in column 4, | | | | | | | | |
| | the direct GME FTE unweighted count. | | | | | | | | |
| | , | | | | | | | | |
| | | | | | 1. 00 | | | | |
| | ACA Provisions Affecting the Health Resources and Services Administ | ration | n (HRSA) | | | | | | |
| 62.00 | 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 | | | | | | | | |
| | your hospital received HRSA PCRE funding (see instructions) | | | | | | | | |
| 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital (| | | | | | | | | |
| during in this cost reporting period of HRSA THC program. (see instructions) | | | | | | | | | |
| | Teaching Hospitals that Claim Residents in Nonprovider Settings | | | | | | | | |
| 63.00 | 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter | | | | | | | | |
| "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) | | | | | | | | | |
| | | | Unwei ghted | 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 Sett | ings | This base year | is your cost | reporting | | | | |
| | period that begins on or after July 1, 2009 and before June 30, 201 | 0. | | | | | | | |
| 64.00 | Enter in column 1, if line 63 is yes, or your facility trained resi | dents | 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 nonprovide | r | | | | | | | |
| | settings. Enter in column 2 the number of unweighted non-primary o | are | | | | | | | |
| | 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 01/01/2020 Part I Date/Time Prepared: 12/31/2020 8/2/2021 10:57 am 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 HOSFITAL LOGANSFORT | | J OI TOTHI CW3- | |
|--|--|--|--------------------|
| | eriod: rom 01/01/2020 o 12/31/2020 | Worksheet S-2 Part I Date/Time Pre | epared: |
| | | 8/2/2021 10: 5 | / am |
| | | 2.00 3.00 | |
| 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 o no. Column 2: Did this facility train residents in a new teaching program in accordance 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) | r "N" for with 42 | 0 | 76.00 |
| | | 1. 00 | - |
| Long Term Care Hospital PPS | | | |
| 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no. | period? Enter | N N | 80. 00 81. 00 |
| TEFRA Providers | HAIII Comment | N. | 05.00 |
| 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 Sectio §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. | N | 85. 00 86. 00 | |
| 87.00 Is this hospital an extended neoplastic disease care hospital classified under section | | N | 87. 00 |
| 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. | V | XIX | |
| | 1. 00 | 2. 00 | 1 |
| 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 | N | Y | 91.00 |
| full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see | | N | 92.00 |
| instructions) Enter "Y" for yes or "N" for no in the applicable column. 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter | N | N | 93.00 |
| "Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the | N | N | 94.00 |
| applicable column. | | | |
| 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. | 0. 00 N | 0. 00 N | 95. 00 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. 00 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. | Y | 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 1 for title V, and in column 2 for title XIX. | N | N | 98. 03 |
| 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH 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 in column 2 for title XIX. | Y | Υ | 98. 05 |
| 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 column 2 for title XIX. Rural Providers | Y | Υ | 98. 06 |
| 105.00 Does this hospital qualify as a CAH? 106.00 of this facility qualifies as a CAH, has it elected the all-inclusive method of payment | N N | | 105. 00 106. 00 |
| for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an | N | | 107. 00 |
| approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions) 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. | N | | 108. 00 |

| IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provi der (| CCN: 15-0072 | Peri od: From 01/01/2020 To 12/31/2020 | Worksheet S Part I Date/Time P 8/2/2021 10 | repared: |
|---|--|---|--|---|--|
| | Physi cal | Occupati ona | I Speech | Respi rator | |
| 09.00 f this hospital qualifies as a CAH or a cost provider, are | 1. 00 N | 2. 00 N | 3. 00 N | 4. 00 N | 109.00 |
| therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. | IN | IN | IN IN | IV. | 109.00 |
| | | | | 1.00 | |
| 10.00 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 Worlapplicable. | Y" for yes o | or "N" for no. | If yes, | N | 110.00 |
| | | | 1. 00 | 2.00 | |
| 11.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services. | ost reporting Dlumn 1 is Y, Ticipating i | period? Enter enter the n column 2. | - N | | 111.0 |
| | | 1.00 | 2. 00 | 3.00 | |
| 12.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in th demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable. | period? s "Y", enter ne | N | | | 112.00 |
| Miscellaneous Cost Reporting Information 15.00 sthis an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1. | 3, or E only) 93" percent (includes | N | | | 0115.00 |
| 16.00 Is this facility classified as a referral center? Enter "Y" | for yes or | N | | | 116.00 |
| "N" for no. 17.00 s this facility legally-required to carry malpractice insur | cance? Enter | Y | | | 117.00 |
| "Y" for yes or "N" for no. 18.00 s the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurr | icy? Enter 1 | | 1 | | 118.00 |
| it the portey is craim made. Effect 2 if the portey is decar | crice. | Premi ums | Losses | Insurance | |
| | | 1. 00 | 2. 00 | 3.00 | |
| 18.01 List amounts of malpractice premiums and paid losses: | | 641, 2 | 68 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 sched and amounts contained therein. 19.00 DO NOT USE THIS LINE | | | N | | 118. 02 |
| 20.00 s this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu | n column 1, " ualifies for | Y" for yes or the Outpatien | | Y | 120. 00 |
| Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. | | | Y | | 121. 0 |
| Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impla | ntable devic | es charged to | ı ı | | 100.0 |
| Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impla 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. | ined in §190 | 3(w)(3) of the | e N | | 122. 0 |
| Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impla 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 | Fined in §190 is "Y", ent | 93(w)(3) of the | e N | | 125. 0 |
| Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impla 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" fo yes, enter certification date(s) (mm/dd/yyyy) below. | Fined in §190 is "Y", ent or yes and "N | 33(w)(3) of the erin column 2 | N N | | 125. 0 |
| Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impla 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" fo 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 | Fined in §190 is "Y", ent or yes and "Noter the cert | 3(w)(3) of the er in column 2 | N N | | 125. 0 |
| Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impla 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" fo 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 | Fined in §190 is "Y", ent or yes and "Noter the cert | 3(w)(3) of the er in column 2 | N N | | 125. 0 |
| Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impla 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" fo 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 27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, ent | rined in §190 is "Y", ent or yes and "N other the cert? | (%)(3) of the er in column 2 | N N | | 125. 0 126. 0 127. 0 |
| Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impla 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" fo 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 27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 | rined in §190 is "Y", ent or yes and "N other the certicle the certicle the certicle the certicle the certicle the certicle. | 33(w)(3) of the er in column 2 | N N | | 125. 0 126. 0 127. 0 128. 0 |
| Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implated 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. 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 27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified lung transplant center, enter in column 1 and termination date, if applicable, in column 2 | Fined in §190 is "Y", ent or yes and "N enter the certic. Leer the certic. Eer the certificer the certification is supplied to the certification of the certificat | "for no. If ification date fication date fication date fication date | N N | | 125. 0 126. 0 127. 0 128. 0 129. 0 |
| Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implated patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare 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 27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified liver transplant center, enterned the second column and termination date, if applicable, in column 2 29.00 If this is a Medicare certified liver transplant center, enterned center, enterned center in column 2 29.00 If this is a Medicare certified liver transplant center, enterned center, enterned center in column 2 | or yes and "N ter the certic." The cert he certic. The cert he certic. The cert he certifier the certifier the ceumn 2. | "for no. If ification date fication date ication date ication date irrification | N N | | |

| lealth Financial Systems | MEMORIAL HOSPITA | | N 45 0070 | 15 | | u of Form CMS | |
|--|--|---|---------------------------------------|-----------|-----------------------------|--|--------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLE | EX IDENTIFICATION DATA | Provi der CC | N: 15-0072 | | : 1/01/2020 2/31/2020 | Worksheet S- Part I Date/Time Pr 8/2/2021 10: | epared: |
| | | | | | 1. 00 | 2. 00 | - |
| 32.00 If this is a Medicare certified is in column 1 and termination date, | | | cation dat | | 1.00 | 2.00 | 132.00 |
| 33.00 Removed and reserved 34.00 If this is an organ procurement of and termination date, if applicable the providers of the control of the c | | he OPO number i | n column 1 | | | | 133. 00 134. 00 |
| All Providers 40.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the | "N" for no in column 1. If | yes, and home | office cos | | N | | 140.00 |
| 1.00 If this facility is part of a cha | 2.0 | | uah 142 +h | | 3.00 | of the home | |
| office and enter the home office | | | ugn 143 th | e name ar | ia addi ess | or the nome | |
| 41. 00 Name: | Contractor's Name: | | Contrac | ctor's Nu | ımber: | | 141.00 |
| 42.00 Street: | PO Box: | | | | | | 142.0 |
| 43. 00 Ci ty: | State: | | Zi p Coo | de: | | | 143. 0 |
| | | | | | | 1. 00 | + |
| 44.00 Are provider based physicians' cos | sts included in Worksheet | A? | | | | Υ | 144.00 |
| | | | | | | | |
| 45 001 6 far areal | | | - 6 | | 1. 00 | 2. 00 | 145. 00 |
| 45.00 olf costs for renal services are clinpatient services only? Enter "Y' no, does the dialysis facility in period? Enter "Y" for yes or "N" for he cost allocation methodologenter "Y" for yes or "N" for no in yes, enter the approval date (mm/ | " for yes or "N" for no in clude Medicare utilization for no in column 2. gy changed from the previo n column 1. (See CMS Pub. | column 1. If of for this cost usly filed cost | column 1 is reporting t report? | | N | | 146. 0 |
| yee, enter the approval date (iiii) | aa, jjjj) + 11 oo; a 21 | | | | | | |
| 47.00 | inal haring Fatau IIVII for | !!!!!! | | | | 1.00 | 147.00 |
| 47.00Was there a change in the statist 48.00Was there a change in the order o | | | | | | N N | 147. 0 |
| 49.00 Was there a change to the simplifi | | | | or no. | | N | 149.00 |
| | | Part A | Part B | Т | itle V | Title XIX | |
| Dana this facility contains a many | : dans that mind! 6! as 6an an | 1.00 | 2.00 | | 3. 00 | 4.00 | |
| Does this facility contain a prov or charges? Enter "Y" for yes or | | | | | | | |
| 55. 00 Hospi tal | TO THE PER GUELT GENERAL | N | N | 3. (555 | N N | N | 155. 0 |
| 56.00 Subprovi der - IPF | | N | N | | N | N | 156. 0 |
| 57.00 Subprovi der – IRF | | N | N | | N | N | 157. 0 |
| 58. OO SUBPROVI DER 59. OO SNF | | N | N | | N | N | 158. 00 159. 00 |
| 60.00 HOME HEALTH AGENCY | | N N | N | | N | N | 160. 0 |
| 61. OOCMHC | | 1 | N | | N | N | 161. 0 |
| | | | | | | | |
| Mul ti campus | | | | | | 1. 00 | |
| 65.00 Is this hospital part of a Multical Enter "Y" for yes or "N" for no. | ampus hospital that has on | e or more campu | uses in dif | ferent C | BSAs? | N | 165. 00 |
| | Name | County | | Zip Code | CBSA | FTE/Campus | |
| 66 001f line 165 is yes for each | 0 | 1. 00 | 2.00 | 3. 00 | 4.00 | 5. 00 | 0164 0 |
| 66.00 ffline 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) | | | | | | 0.0 | 0 166. 0 |
| | | | | | | 1. 00 | |
| Health Information Technology (HI | | | | | | | |
| 67.00 s this provider a meaningful use 68.00 If this provider is a CAH (line 10 | 05 is "Y") and is a meanin | gful user (line | | | r the | Y | 167. 00 168. 00 |
| reasonable cost incurred for the l 68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) | not a meaningful user, doe | s this provide | | | dshi p | | 168. 0° |
| | . Litter i ioi yes di N | | . 1.5 LT UC LT UI | | | | 1 |

| Health Financial Systems | MEMORIAL HOSPITAL | LOGANSPORT | In Lie | u of Form CMS-2 | 2552-10 |
|--|----------------------------|---------------------|-----------------|-----------------|--------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX | IDENTIFICATION DATA | | Peri od: | Worksheet S-2 | |
| | | | From 01/01/2020 | | |
| | | | To 12/31/2020 | | |
| | | | | 8/2/2021 10: 5 | <u>7 am </u> |
| | Begi nni ng | Endi ng | | | |
| | | | 1. 00 | 2. 00 | |
| 170.00 Enter in columns 1 and 2 the EHR beg period respectively (mm/dd/yyyy) | | | 170. 00 | | |
| | | | | | |
| | | | 1. 00 | 2. 00 | |
| 171.00 If line 167 is "Y", does this provid | ler have any days for indi | viduals enrolled in | N | 0 | 171.00 |
| section 1876 Medicare cost plans rep | | | | | |
| "Y" for yes and "N" for no in column | on | | | | |
| 1876 Medicare days in column 2. (see | e instructions) | | | | |

| SPI T | Financial Systems MEMORIAL HOSPITA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provi der C | CN: 15-0072 | | eriod: rom 01/01/2020 | | 2 epare |
|----------|---|-----------------|--------------|-----|--------------------------|----------------------|------------|
| | | | | | Y/N | Date | |
| | General Instruction: Enter Y for all YES responses. Enter N | for all NO re | oenoneoe En | tor | 1.00 | 2. 00 | |
| | mm/dd/yyyy format. | TOT ALL NO TO | esponses. En | tei | all dates ill | trie | |
| | COMPLETED BY ALL HOSPITALS | | | | | | |
| 00 | <u>Provider Organization and Operation</u> Has the provider changed ownership immediately prior to the | heainnina of | the cost | | N | | 1. |
| | reporting period? If yes, enter the date of the change in co | | instruction | s) | | | <u> </u> |
| | | | 1. 00 | | <u>Date</u> 2.00 | V/I 3. 00 | |
| 00 | Has the provider terminated participation in the Medicare Pr | rogram? If | 1.00 N | | 2.00 | 3.00 | 2. |
| | yes, enter in column 2 the date of termination and in column | | | | | | |
| 00 | voluntary or "I" for involuntary. Is the provider involved in business transactions, including | n management | N N | | | | 3. |
| | contracts, with individuals or entities (e.g., chain home of | | '' | | | | 0. |
| | or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of | | | | | | |
| | of directors through ownership, control, or family and other | | | | | | |
| | relationships? (see instructions) | | | | _ | | \perp |
| | | | 1. 00 | | Type 2. 00 | 3. 00 | |
| | Financial Data and Reports | | 1.00 | | 2.00 | 3.00 | |
| 00 | Column 1: Were the financial statements prepared by a Certi | | Y | | Α | | 4. |
| | Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avai | | | | | | |
| | column 3. (see instructions) If no, see instructions. | | | | | | |
| 00 | Are the cost report total expenses and total revenues differed those on the filed financial statements? If yes, submit reco | rent from | N | | | | 5. |
| | those of the fired financial statements: If yes, submit rect | onci i rati on. | | | Y/N | Legal Oper. | |
| | | | | | 1. 00 | 2.00 | |
| 00 | Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: | If ves ist | he provider | i s | N | | 6. |
| | the legal operator of the program? | 11 yes, 15 th | ne provider | | ., | | 0. |
| 00 | Are costs claimed for Allied Health Programs? If "Y" see ins | | | | N | | 7. |
| 00 | Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions. | and/or renewe | a during the | | N | | 8 |
| 00 | Are costs claimed for Interns and Residents in an approved of | | cal educatio | n | N | | 9. |
| 00 | program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated on | | the current | | N | | 10. |
| 00 | cost reporting period? If yes, see instructions. | i renewed in | the current | | IN | | 10. |
| 00 | Are GME cost directly assigned to cost centers other than I | & R in an Ap | proved | | N | | 11. |
| | Teaching Program on Worksheet A? If yes, see instructions. | | | | | Y/N | |
| | | | | | | 1. 00 | |
| 00 | Bad Debts | ana I natrija | +i one | | | Υ | 12 |
| | Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection po | | | COS | st reportina | N N | 12. 13. |
| | period? If yes, submit copy. | 3 | Ü | | | | |
| 00 | If line 12 is yes, were patient deductibles and/or co-paymer Bed Complement | nts waived? I | f yes, see i | nst | ructions. | N | 14. |
| 00 | Did total beds available change from the prior cost reporting | ng period? If | yes, see in | str | ructions. | N | 15. |
| | _ | | t A | | | t B | |
| | - | 1. 00 | 2. 00 | | Y/N 3. 00 | <u>Date</u> 4. 00 | |
| | PS&R Data | | | | | | |
| 00 | Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through | Υ | 02/24/2021 | | Υ | 02/24/2021 | 16. |
| | date of the PS&R Report used in columns 2 and 4 (see | | | | | | |
| | instructions) | | | | | | |
| 00 | Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If | N | | | N | | 17. |
| | either column 1 or 3 is yes, enter the paid-through date | | | | | | |
| 00 | in columns 2 and 4. (see instructions) | | | | | | |
| 00 | If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed | N | | | N | | 18 |
| | but are not included on the PS&R Report used to file this | | | | | | |
| | cost report? If yes, see instructions. | | | | | | |
| Ω | If line 16 or 17 is yes, were adjustments made to PS&R | N | | | N | | 19. |
| 00 | Report data for corrections of other PS&R Report | | | | l | | |

| Heal th | Financial Systems MEMORIAL HOSPI | TAL LOGANSPORT | | In lie | u of Form CMS- | 2552-10 | | | |
|---------|---|------------------|----------------|---|---|------------------|--|--|--|
| | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provi der C | F | Period: From 01/01/2020 To 12/31/2020 | Worksheet S-2 Part II Date/Time Pre | epared: | | | |
| | | Descri | iption | Y/N | 8/2/2021 10: 5 Y/N | 7 am | | | |
| | | | 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 1.00 | 2. 00 | Y/N 3. 00 | Date 4.00 | | | | |
| 21. 00 | Was the cost report prepared only using the provider's records? If yes, see instructions. | N N | 2.00 | N N | 4.00 | 21.00 | | | |
| | | | | | 1. 00 | | | | |
| | COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC | CEPT CHILDRENS I | HOSPI TALS) | | | | | | |
| | Capital Related Cost Have assets been relifed for Medicare purposes? If yes, se | no instructions | | | N | 22.00 | | | |
| 23. 00 | have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions. | | | ng the cost | N N | 23. 00 | | | |
| 24. 00 | Were new leases and/or amendments to existing leases enter If yes, see instructions | red into during | this cost rep | orting period? | N | 24. 00 | | | |
| 25. 00 | Have there been new capitalized leases entered into during instructions. | If yes, see | N | 25. 00 | | | | | |
| 26. 00 | Were assets subject to Sec. 2314 of DEFRA acquired during tinstructions. | yes, see | N | 26. 00 | | | | | |
| 27. 00 | Has the provider's capitalization policy changed during the copy. | he cost reporti | ng period? If | yes, submit | N | 27. 00 | | | |
| 20.00 | Interest Expense | ontored into du | ring the cost | ranarti na | N | 20.00 | | | |
| | Were new loans, mortgage agreements or letters of credit ϵ period? If yes, see instructions. | | | 28. 00 | | | | | |
| 29. 00 | Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst | serve Fund) | N | 29. 00 | | | | | |
| 30. 00 | Has existing debt been replaced prior to its scheduled matinstructions. | see | N | 30.00 | | | | | |
| 31. 00 | Has debt been recalled before scheduled maturity without instructions. | see | N | 31.00 | | | | | |
| | Purchased Services | | | | | | | | |
| | Have changes or new agreements occurred in patient care searrangements with suppliers of services? If yes, see instr | ructi ons. | Ü | | N | 32.00 | | | |
| | If line 32 is yes, were the requirements of Sec. 2135.2 apno, see instructions. | oplied pertaini | ng to competit | ive bidding? If | N N | 33.00 | | | |
| | Provi der-Based Physi ci ans | | | | | 04.00 | | | |
| | Are services furnished at the provider facility under an allf yes, see instructions. | Ü | | . 3 | N | 34.00 | | | |
| 35. 00 | If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see i | | nts with the p | , | N | 35. 00 | | | |
| | | | | Y/N 1. 00 | 2. 00 | | | | |
| | Home Office Costs | | | | | | | | |
| | Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been $\mbox{\upbeta}$ | prepared by the | home office? | N N | | 36. 00 37. 00 | | | |
| 38. 00 | If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of | | | N | | 38.00 | | | |
| 39. 00 | the provider? If yes, enter in column 2 the fiscal year er If line 36 is yes, did the provider render services to other. | | | N | | 39. 00 | | | |
| 40. 00 | see instructions. If line 36 is yes, did the provider render services to the $\ensuremath{\text{The provider}}$ | e home office? | If yes, see | N | | 40.00 | | | |
| | instructions. | | | | | | | | |
| | | 1. | 00 | 2. | 00 | | | | |
| 41. 00 | Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, | MI CHAEL | | ALESSANDRI NI | | 41. 00 | | | |
| 42. 00 | respectively. Enter the employer/company name of the cost report | BLUE & CO., LL | .C | | | 42.00 | | | |
| 43. 00 | preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively. | 317-713-7959 | | MALESSANDRI NI @ | BLUEANDCO. COM | 43.00 | | | |
| | open of the solution of and 2, 1 oppositivory. | 1 | | ı | | 11 | | | |

| Health Financial Systems | MEMORIAL HOSPIT | AL LOGANSPORT | | In Lie | u of Form CMS-2 | 2552-10 |
|--|-----------------|---------------|----|----------------------------------|--------------------------------|----------------|
| HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT Q | UESTI ONNAI RE | Provi der CC | | Peri od: | Worksheet S-2 | |
| | | | | From 01/01/2020 Fo 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | pared: 7 am |
| | | | | | | |
| | | 3. (| 00 | | | |
| Cost Report Preparer Contact Information | | | | | | |
| 41.00 Enter the first name, last name and the ti | | DI RECTOR | | | | 41.00 |
| held by the cost report preparer in columns | s 1, 2, and 3, | | | | | |
| respecti vel y. | | | | | | |
| 42.00 Enter the employer/company name of the cos | t report | | | | | 42.00 |
| preparer. | | | | | | |
| 43.00 Enter the telephone number and email address | | | | | | 43.00 |
| report preparer in columns 1 and 2, respec | ti vel y. | | | | | |

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2020 | Part | | To 12/31/2020 | Date/Time Prepared:
 Heal th Fi nancial
 Systems
 MEMORIAL I

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provi der CCN: 15-0072

| | | | | | | То | 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | |
|------------------|--|---------------------|-----|---------|-------------------|----|------------|--------------------------------|------------------|
| | | | | | | | | I/P Days / | 7 (3111 |
| | | | | | | | | 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 | | | 32 | | 2 | 0.00 | 5.00 | 1. 00 |
| 1.00 | 8 exclude Swing Bed, Observation Bed and | 30.00 | | 32 | ''', '' | - | 0.00 | O | 1.00 |
| | Hospice days) (see instructions for col. 2 | | | | | | | | |
| | for the portion of LDP room available beds) | | | | | | | | |
| 2. 00 | HMO and other (see instructions) | | | | | | | | 2.00 |
| 3. 00 | HMO IPF Subprovider | | | | | | | | 3.00 |
| 4.00 | HMO IRF Subprovider | | | | | | | | 4.00 |
| 5.00 | Hospital Adults & Peds. Swing Bed SNF | | | | | | | 0 | 5.00 |
| 6.00 | Hospital Adults & Peds. Swing Bed NF | | | | | | | 0 | 6.00 |
| 7.00 | Total Adults and Peds. (exclude observation | | | 32 | 11, 71 | 2 | 0. 00 | 0 | 7.00 |
| | beds) (see instructions) | | | | | | | | |
| 8.00 | INTENSIVE CARE UNIT | 31. 00 | | 5 | 1, 83 | 30 | 0. 00 | 0 | 8.00 |
| 9. 00 | CORONARY CARE UNIT | | | | | | | | 9.00 |
| 10.00 | BURN INTENSIVE CARE UNIT | | | | | | | | 10.00 |
| 11. 00 | SURGI CAL INTENSI VE CARE UNI T | | | | | | | | 11.00 |
| 12. 00 | OTHER SPECIAL CARE (SPECIFY) | | | | | | | _ | 12.00 |
| 13.00 | NURSERY | 43. 00 | | 0.7 | 10.5 | | | 0 | 13.00 |
| 14.00 | Total (see instructions) | | | 37 | 13, 54 | 12 | 0. 00 | 0 | 14.00 |
| 15.00 | CAH visits | | | | | | | 0 | 15.00 |
| 16.00 | SUBPROVIDER - I PF | | | | | | | | 16. 00 17. 00 |
| 17. 00 18. 00 | SUBPROVI DER - I RF SUBPROVI DER | | | | | | | | 17.00 |
| 19. 00 | SKILLED NURSING FACILITY | | | | | | | | 19. 00 |
| 20. 00 | NURSING FACILITY | | | | | | | | 20.00 |
| 21. 00 | OTHER LONG TERM CARE | | | | | | | | 21.00 |
| 22. 00 | HOME HEALTH AGENCY | | | | | | | | 22.00 |
| 23. 00 | AMBULATORY SURGICAL CENTER (D. P.) | | | | | | | | 23. 00 |
| 24. 00 | HOSPI CE | | | | | | | | 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) | | | 37 | | | | | 27.00 |
| 28.00 | Observation Bed Days | | | | | | | 0 | 28.00 |
| 29. 00 | Ambul ance Trips | | | | | | | | 29. 00 |
| 30. 00 | Employee discount days (see instruction) | | | | | | | | 30.00 |
| 31. 00 | Employee discount days - IRF | | | | | | | | 31.00 |
| 32.00 | Labor & delivery days (see instructions) | | | 5 | 1, 83 | 30 | | | 32.00 |
| 32. 01 | Total ancillary labor & delivery room outpatient days (see instructions) | | | | | | | | 32. 01 |
| 33. 00 | LTCH non-covered days | | | | | | | | 33. 00 |
| | LTCH site neutral days and discharges | | | | | | | | 33. 01 |

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0072

Peri od: Worksheet S-3 From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

8/2/2021 10:57 am I/P Days / O/P Visits / Trips Full Time Equivalents Title XVIII Title XIX Total All Component Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 Hospital Adults & Peds. (columns 5, 6, 7 and 1. 00 1, 343 322 4, 262 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) 718 824 2.00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4 00 0 0 4 00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 C 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 7.00 Total Adults and Peds. (exclude observation 322 7.00 1.343 4.262 beds) (see instructions) INTENSIVE CARE UNIT 8 00 166 Ω 455 8 00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 SURGICAL INTENSIVE CARE UNIT 11.00 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12 00 13.00 NURSERY 985 13.00 322 533. 15 14.00 Total (see instructions) 1,509 5, 702 0.00 14.00 CAH visits 15.00 15.00 16.00 SUBPROVIDER - IPF 16.00 17.00 SUBPROVIDER - IRF 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 24.00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 0 24.10 CMHC - CMHC 25.00 25.00 26.00 RURAL HEALTH CLINIC 26.00 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 0 0 0 0.00 0.00 26.25 Total (sum of lines 14-26) 533.15 27 00 0 00 27 00 Observation Bed Days 28.00 20 954 28.00 29.00 Ambul ance Trips 29.00 Employee discount days (see instruction) 30.00 0 30.00 31 00 Employee discount days - IRF O 31.00 Labor & delivery days (see instructions) 32.00 0 0 316 32.00 Total ancillary labor & delivery room 32.01 outpatient days (see instructions) LTCH non-covered days 33.00 33.01 LTCH site neutral days and discharges 33.01

| | | | | | | 8/2/2021 10:5 | 7 am |
|--------|--|---------------|---------|-------------|-----------|---------------|--------|
| | | Full Time | | 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 | 459 | 131 | 1, 501 | 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) | | | 182 | 406 | | 2.00 |
| 3.00 | HMO IPF Subprovider | | | | 0 | | 3.00 |
| 4.00 | HMO IRF Subprovider | | | | 0 | | 4.00 |
| 5.00 | Hospital Adults & Peds. Swing Bed SNF | | | | | | 5.00 |
| 6.00 | Hospital Adults & Peds. Swing Bed NF | | | | | | 6. 00 |
| 7.00 | Total Adults and Peds. (exclude observation | | | | | | 7.00 |
| | beds) (see instructions) | | | | | | |
| 8.00 | INTENSIVE CARE UNIT | | | | | | 8. 00 |
| 9.00 | CORONARY CARE UNIT | | | | | | 9.00 |
| 10.00 | BURN INTENSIVE CARE UNIT | | | | | | 10.00 |
| 11.00 | SURGICAL INTENSIVE CARE UNIT | | | | | | 11.00 |
| 12.00 | OTHER SPECIAL CARE (SPECIFY) | | | | | | 12.00 |
| 13.00 | NURSERY | | | | | | 13.00 |
| 14.00 | Total (see instructions) | 0.00 | 0 | 459 | 131 | 1, 501 | 14.00 |
| 15.00 | CAH vi si ts | | | | | | 15.00 |
| 16.00 | SUBPROVIDER - IPF | | | | | | 16.00 |
| 17.00 | SUBPROVI DER - I RF | | | | | | 17.00 |
| 18.00 | SUBPROVI DER | | | | | | 18.00 |
| 19.00 | SKILLED NURSING FACILITY | | | | | | 19.00 |
| 20.00 | NURSING FACILITY | | | | | | 20.00 |
| 21.00 | OTHER LONG TERM CARE | | | | | | 21.00 |
| 22.00 | HOME HEALTH AGENCY | | | | | | 22.00 |
| 23.00 | AMBULATORY SURGICAL CENTER (D. P.) | | | | | | 23.00 |
| 24.00 | HOSPI CE | | | | | | 24.00 |
| 24. 10 | HOSPICE (non-distinct part) | | | | | | 24. 10 |
| 25.00 | CMHC - CMHC | | | | | | 25.00 |
| 26.00 | RURAL HEALTH CLINIC | | | | | | 26. 00 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 0.00 | | | | | 26. 25 |
| 27.00 | Total (sum of lines 14-26) | 0.00 | | | | | 27. 00 |
| 28.00 | Observation Bed Days | | | | | | 28. 00 |
| 29.00 | Ambul ance 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 |
| | outpatient days (see instructions) | | | | | | |
| 33.00 | LTCH non-covered days | | | 0 | | | 33.00 |
| 33. 01 | LTCH site neutral days and discharges | | | 0 | | | 33. 01 |

| Peri od: | Worksheet S-3 | From 01/01/2020 | Part | I | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0072

| | | | | | Т | o 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | pared: 7 am |
|------------------|---|--------------|---------------|-----------------------|------------------------------|---------------------------|--------------------------------|------------------|
| | | Wkst. A Line | Amount | Reclassi fi cat | Adj usted | Paid Hours | Average | , <u>u</u> |
| | | Number | Reported | i on of Sal ari es | Sal ari es (col. 2 ± col. | Related to Salaries in | Hourly Wage (col. 4 ÷ | |
| | | | | (from Wkst. | 3) | col. 4 | col . 5) | |
| | | 1. 00 | 2. 00 | A-6) 3. 00 | 4.00 | 5. 00 | 6. 00 | |
| | PART II - WAGE DATA SALARIES | | | | | | | |
| 1. 00 | Total salaries (see | 200.00 | 39, 216, 701 | -247, 481 | 38, 969, 220 | 1, 123, 746. 00 | 34. 68 | 1.00 |
| 0.00 | instructions) | | | | | | | |
| 2. 00 | Non-physician anesthetist Part A | | 0 | 0 | 0 | 0. 00 | 0. 00 | 2.00 |
| 3. 00 | Non-physician anesthetist Part | | 0 | 0 | 0 | 0. 00 | 0. 00 | 3. 00 |
| 4. 00 | B Physician-Part A - Administrative | | 289, 092 | 0 | 289, 092 | 1, 385. 00 | 208. 73 | 4. 00 |
| 4. 01 | Physicians - Part A - Teaching | | 0 | 0 | | 0. 00 | 0. 00 | 4. 01 |
| 5. 00 | Physician and Non Physician-Part B | | 7, 828, 305 | 0 | 7, 828, 305 | 53, 158. 00 | 147. 26 | 5. 00 |
| 6. 00 | 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 |
| | approved program) | 21100 | _ | , | | | | |
| 7. 01 | Contracted interns and residents (in an approved programs) | | 0 | 0 | 0 | 0.00 | 0. 00 | 7. 01 |
| 8.00 | Home office and/or related | | 0 | 0 | О | 0. 00 | 0. 00 | 8. 00 |
| 9. 00 | organization personnel SNF | 44. 00 | 0 | 0 | 0 | 0. 00 | 0. 00 | 9. 00 |
| 10. 00 | Excluded area salaries (see instructions) | | 7, 115, 158 | -33, 164 | 7, 081, 994 | 157, 963. 00 | 44. 83 | 10. 00 |
| 11. 00 | OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient | | 4, 139, 863 | 0 | 4, 139, 863 | 55, 160. 00 | 75. 05 | 11. 00 |
| 12.00 | Care | | 0 | 0 | 0 | 0.00 | 0.00 | 12 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 | | 97, 097 | 0 | 97, 097 | 1, 111. 00 | 87. 40 | 13. 00 |
| 14. 00 | A - Administrative Home office and/or related organization salaries and | | 0 | 0 | 0 | 0. 00 | 0. 00 | 14. 00 |
| | wage-related costs | | | | | | | |
| 14. 01 14. 02 | Home office salaries | | 0 | 0 | 0 | 0. 00 0. 00 | 0. 00 0. 00 | 14. 01 14. 02 |
| 15. 00 | Related organization salaries Home office: Physician Part A | | 0 | 0 | | 0.00 | 0.00 | |
| 1/ 00 | - Administrative | | 0 | | | 0.00 | 0.00 | 1/ 00 |
| 16. 00 | Home office and Contract Physicians Part A - Teaching | | 0 | 0 | 0 | 0. 00 | 0. 00 | 16. 00 |
| 16. 01 | Home office Physicians Part A | | 0 | 0 | 0 | 0. 00 | 0. 00 | 16. 01 |
| 16. 02 | - Teaching Home office contract | | 0 | 0 | 0 | 0. 00 | 0. 00 | 16. 02 |
| | Physicians Part A - Teaching WAGE-RELATED COSTS | | | | | | | |
| 17. 00 | Wage-related costs (core) (see | | 8, 383, 767 | 0 | 8, 383, 767 | | | 17. 00 |
| 18. 00 | instructions) Wage-related costs (other) (see instructions) | | | | | | | 18. 00 |
| 19. 00 | Excluded areas | | 1, 527, 638 | 0 | 1, 527, 638 | | | 19. 00 |
| 20. 00 | Non-physician anesthetist Part A | | 0 | 0 | 0 | | | 20.00 |
| 21. 00 | Non-physician anesthetist Part B | | U | U | 0 | | | 21.00 |
| 22. 00 | Physician Part A - Administrative | | 23, 121 | 0 | 23, 121 | | | 22. 00 |
| 22. 01 | Physician Part A - Teaching | | 0 | 0 | 0 | | | 22. 01 |
| 23. 00 24. 00 | Physician Part B Wage-related costs (RHC/FQHC) | | 811, 208 0 | 0 | 811, 208 0 | | | 23. 00 24. 00 |
| 25. 00 | Interns & residents (in an | | 0 | O | o | | | 25. 00 |
| 25. 50 | approved program) Home office wage-related | | 0 | 0 | 0 | | | 25. 50 |
| | (core) | | _ | _ | _ | | | |
| 25. 51 | Related organization wage-related (core) | | 0 | 0 | 0 | | | 25. 51 |
| 25. 52 | Home office: Physician Part A - Administrative - | | 0 | 0 | 0 | | | 25. 52 |
| | wage-related (core) | l | | <u> </u> | l | l | | l |

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

| | | | | | T | o 12/31/2020 | Date/Time Pre | |
|--------|--------------------------------|--------------|-------------|------------------|----------------|---------------------------------------|---------------------------|--------|
| | | Wkst. A Line | Amount | Recl assi fi cat | Adjusted | Paid Hours | 8/2/2021 10: 5 Average | / am |
| | | Number | Reported | i on of | Sal ari es | Related to | Hourly Wage | |
| | | IVallibet | керог сеа | Sal ari es | (col. 2 ± col. | Salaries in | (col . 4 ÷ | |
| | | | | (from Wkst. | 3) | col . 4 | col. 5) | |
| | | | | A-6) | | 001. 1 | 001. 0) | |
| | | 1. 00 | 2. 00 | 3. 00 | 4.00 | 5. 00 | 6. 00 | |
| 25. 53 | Home office: Physicians Part A | | 0 | 0 | 0 | | | 25. 53 |
| | - Teaching - wage-related | | | | | | | |
| | (core) | | | | | | | |
| | OVERHEAD COSTS - DIRECT SALARI | ES | | | | | | |
| 26.00 | Employee Benefits Department | 4.00 | 348, 157 | 0 | 348, 157 | 10, 879. 00 | 32. 00 | 26.00 |
| 27.00 | Administrative & General | 5. 00 | 3, 513, 679 | -10, 849 | 3, 502, 830 | 186, 693. 00 | 18. 76 | 27.00 |
| 28. 00 | Administrative & General under | | 289, 016 | 0 | 289, 016 | 1, 221. 00 | 236. 70 | 28. 00 |
| | contract (see inst.) | | | | | | | |
| 29. 00 | Maintenance & Repairs | 6. 00 | 0 | 0 | 0 | 0. 00 | | 29.00 |
| 30.00 | Operation of Plant | 7. 00 | 790, 318 | -6, 620 | 783, 698 | | 30. 54 | |
| 31.00 | Laundry & Linen Service | 8. 00 | 0 | 0 | 0 | 0. 00 | 0. 00 | |
| 32.00 | Housekeepi ng | 9. 00 | 656, 326 | -3, 537 | 652, 789 | 40, 831. 00 | 15. 99 | |
| 33.00 | Housekeeping under contract | | 0 | 0 | 0 | 0.00 | 0. 00 | 33.00 |
| | (see instructions) | | | | | | | |
| 34.00 | Di etary | 10. 00 | 448, 745 | -367, 836 | 80, 909 | | | 34.00 |
| 35. 00 | Dietary under contract (see | | 0 | 0 | 0 | 0. 00 | 0. 00 | 35.00 |
| | instructions) | | | | | | | |
| 36. 00 | Cafeteri a | 11. 00 | 0 | 367, 836 | 367, 836 | | | 36.00 |
| 37. 00 | Maintenance of Personnel | 12. 00 | 0 | 0 | 0 | 0. 00 | 0. 00 | |
| 38. 00 | Nursing Administration | 13. 00 | 1, 028, 944 | | 1, 028, 944 | | 46. 13 | |
| 39. 00 | Central Services and Supply | 14. 00 | 292, 147 | -1, 334 | | · · · · · · · · · · · · · · · · · · · | 17. 16 | |
| 40.00 | Pharmacy | 15. 00 | 573, 124 | | | · · · · · · · · · · · · · · · · · · · | 33. 70 | |
| 41. 00 | Medical Records & Medical | 16. 00 | 1, 745, 597 | -21, 134 | 1, 724, 463 | 38, 181. 00 | 45. 17 | 41.00 |
| | Records Li brary | | | | | | | |
| 42. 00 | Soci al Servi ce | 17. 00 | 179, 176 | | 179, 176 | | | 42.00 |
| 43.00 | Other General Service | 18. 00 | 0 | 0 | 0 | 0.00 | 0. 00 | 43.00 |

| Health Financial Systems | MEMORIAL HOSPITAL LOGANSPORT | In Lieu of Form CMS-2552-10 |
|---------------------------------|------------------------------|-----------------------------|
| HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0072 | Period: Worksheet S-3 |

| | | | | | | rom 01/01/2020 o 12/31/2020 | | |
|------|--------------------------------|-------------|--------------|------------------|---------------|--------------------------------|-------------|------|
| | | 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 | | 31, 677, 412 | -247, 481 | 31, 429, 931 | 1, 071, 809. 00 | 29. 32 | 1.00 |
| | instructions) | | | | | | | i |
| 2.00 | Excluded area salaries (see | | 7, 115, 158 | -33, 164 | 7, 081, 994 | 157, 963. 00 | 44. 83 | 2.00 |
| | instructions) | | | | | | | i |
| 3.00 | Subtotal salaries (line 1 | | 24, 562, 254 | -214, 317 | 24, 347, 937 | 913, 846. 00 | 26. 64 | 3.00 |
| | minus line 2) | | | | | | | 1 |
| 4.00 | Subtotal other wages & related | | 4, 236, 960 | 0 | 4, 236, 960 | 56, 271. 00 | 75. 30 | 4.00 |
| | costs (see inst.) | | | | | | | i |
| 5.00 | Subtotal wage-related costs | | 8, 406, 888 | 0 | 8, 406, 888 | 0.00 | 34. 53 | 5.00 |
| | (see inst.) | | | | | | | i |
| 6.00 | Total (sum of lines 3 thru 5) | | 37, 206, 102 | -214, 317 | 36, 991, 785 | 970, 117. 00 | 38. 13 | 6.00 |
| 7.00 | Total overhead cost (see | | 9, 865, 229 | -54, 693 | 9, 810, 536 | 393, 057. 00 | 24. 96 | 7.00 |
| | instructions) | | | | | | | 1 |
| | | • | | - | - | • | | |

| | 10 12/31/2020 | 8/2/2021 10:5 | pareu: 7 am |
|--------|---|---------------|----------------|
| | | Amount | |
| | | Reported | |
| | | 1.00 | |
| | PART IV - WAGE RELATED COSTS | | |
| | Part A - Core List | | l |
| | RETI REMENT COST | | l |
| 1.00 | 401K Employer Contributions | 426, 007 | 1.00 |
| 2.00 | Tax Sheltered Annuity (TSA) Employer Contribution | 0 | 2.00 |
| 3.00 | Nonqualified Defined Benefit Plan Cost (see instructions) | 0 | 3.00 |
| 4.00 | Qualified Defined Benefit Plan Cost (see instructions) | 0 | 4.00 |
| | PLAN ADMINISTRATIVE COSTS (Paid to External Organization) | | |
| 5.00 | 401K/TSA Plan Administration fees | 0 | 5.00 |
| 6.00 | Legal /Accounting/Management Fees-Pension Plan | 0 | |
| 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 | 1 0.0. |
| 8. 02 | Health Insurance (Self Funded with a Third Party Administrator) | 6, 847, 263 | |
| 8.03 | Health Insurance (Purchased) | 0 | 8. 03 |
| 9.00 | Prescription Drug Plan | 0 | 9. 00 |
| 10.00 | Dental, Hearing and Vision Plan | 146, 225 | 10.00 |
| 11. 00 | | 50, 982 | |
| 12.00 | | 0 | 1 |
| 13.00 | | 431, 874 | |
| 14.00 | | 0 | |
| 15.00 | | 194, 462 | 15.00 |
| 16. 00 | | 0 | 16.00 |
| | Non cumulative portion) | | 1 |
| | TAXES | | |
| | FICA-Employers Portion Only | 2, 544, 541 | |
| 18. 00 | | 0 | |
| 19. 00 | | 53, 231 | |
| 20. 00 | State or Federal Unemployment Taxes | 0 | 20.00 |
| | OTHER | | |
| 21. 00 | Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see | 0 | 21.00 |
| | instructions)) | | |
| | Day Care Cost and Allowances | 24, 149 | |
| | Tuition Reimbursement | 0 | |
| 24. 00 | Total Wage Related cost (Sum of lines 1 -23) | 10, 718, 734 | 24.00 |
| 05 65 | Part B - Other than Core Related Cost | | 05.05 |
| 25.00 | OTHER WAGE RELATED COSTS (SPECIFY) | į | 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 | Peri od: Worksheet S-3 |

| | | To 12/31/2020 | | |
|--------|---|---------------|--------------|--------|
| | 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 | 4, 139, 863 | | |
| 2. 00 | Hospi tal | 4, 139, 863 | 10, 745, 426 | 1 |
| 3.00 | Subprovi der - IPF | | | 3. 00 |
| 4. 00 | Subprovi der - IRF | | | 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 | | | 8. 00 |
| 9. 00 | Hospi tal -Based NF | | | 9. 00 |
| 10. 00 | Hospi tal -Based OLTC | | | 10.00 |
| | 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 |
| | Hospi tal -Based-CMHC | | | 16. 00 |
| | Renal Dialysis | | ا | 17.00 |
| 18. 00 | Other | 0 | 0 | 18. 00 |

| Heal th | Financial Systems | MEMORIAL HOSPITAL LOC | SANSPORT | | In Lie | u of Form CMS-2 | 2552-10 | |
|------------------|--|---------------------------|-------------------|----------|-----------------------------|--------------------------|----------------|--|
| | TAL UNCOMPENSATED AND INDIGENT CARE DATA | | ovider CCN: 15-00 | | ri od: | Worksheet S-1 | | |
| | | | | Fr | om 01/01/2020 12/31/2020 | Date/Time Pre | narod: | |
| | | | | | 12/31/2020 | 8/2/2021 10: 5 | | |
| | | | | | | 1. 00 | | |
| | Uncompensated and indigent care cost compu | ıtati on | | | | 1.00 | | |
| 1.00 | Cost to charge ratio (Worksheet C, Part I | | ded by line 202 | col umn | 8) | 0. 337697 | 1.00 | |
| 0.00 | Medicaid (see instructions for each line) | | | | | | | |
| 2. 00 3. 00 | Net revenue from Medicaid Did you receive DSH or supplemental paymer | ats from Medicaid? | | | | 7, 095, 372 Y | 2. 00 3. 00 | |
| 4. 00 | If line 3 is yes, does line 2 include all | | l payments from | Medi cai | d? | Ÿ | 4. 00 | |
| 5. 00 | If line 4 is no, then enter DSH and/or sup | | | | | 0 | 5. 00 | |
| 6.00 | Medi cai d charges | | | | | 34, 655, 257 | 6. 00 | |
| 7. 00 | Medicaid cost (line 1 times line 6) | | | | | 11, 702, 976 | 7.00 | |
| 8. 00 | Difference between net revenue and costs f | for Medicaid program (I | ine 7 minus sum | of line | s 2 and 5; if | 4, 607, 604 | 8. 00 | |
| | <pre>< zero then enter zero) Children's Health Insurance Program (CHIP)</pre> | (see instructions for | each line) | | | | | |
| 9. 00 | Net revenue from stand-alone CHIP | (300 111311 4011 6113 101 | cacii i i i i i | | | 0 | 9. 00 | |
| 10.00 | Stand-alone CHIP charges | | | | | 0 | 10.00 | |
| 11. 00 | Stand-alone CHIP cost (line 1 times line 1 | | | | | 0 | 11. 00 | |
| 12. 00 | Difference between net revenue and costs f | for stand-alone CHIP (I | ine 11 minus lin | ne 9; if | < zero then | 0 | 12.00 | |
| | enter zero) Other state or local government indigent of | care program (see instr | uctions for each | line) | | | | |
| 13. 00 | Net revenue from state or local indigent of | | | | I | 0 | 13. 00 | |
| 14.00 | Charges for patients covered under state of | . 9 | · · | , | n lines 6 or | 0 | 14.00 | |
| | 10) | | - | | | | | |
| 15.00 | State or local indigent care program cost | | | | 45 | 0 | 15.00 | |
| 16. 00 | Difference between net revenue and costs f 13; if < zero then enter zero) | for state or local indi | gent care progra | ım (IIne | 15 MINUS IINE | . 0 | 16. 00 | |
| | Grants, donations and total unreimbursed of | cost for Medicaid. CHIP | and state/local | i ndi ae | nt care progra | ms (see | | |
| | instructions for each line) | | | | | | | |
| 17.00 | Private grants, donations, or endowment in | | | | | 0 | 17.00 | |
| 18.00 | Government grants, appropriations or trans | | | | (our of lines | 0 | 18.00 | |
| 19. 00 | Total unreimbursed cost for Medicaid, CHI 8, 12 and 16) | P and State and rocal | rnargent care pr | ograins | (Sull of Titles | 4, 607, 604 | 19.00 | |
| | | | Uni ns | | Insured | Total (col. 1 | | |
| | | | pati e | | patients 2.00 | + col . 2) 3.00 | | |
| | Uncompensated Care (see instructions for e | each line) | 1. (| 50 | 2.00 | 3.00 | | |
| 20. 00 | Charity care charges and uninsured discour (see instructions) | | lity | 744, 765 | 572, 552 | 1, 317, 317 | 20. 00 | |
| 21. 00 | Cost of patients approved for charity care | e and uninsured discoun | ts (see | 251, 505 | 572, 552 | 824, 057 | 21. 00 | |
| | instructions) Payments received from patients for amount | | . | | | | | |
| 22. 00 | charity care | | II as | 0 | 0 | | 22. 00 | |
| 23. 00 | Cost of charity care (line 21 minus line 2 | 22) | | 251, 505 | 572, 552 | 824, 057 | 23. 00 | |
| | | | | | | 1. 00 | | |
| 24.00 | Does the amount on line 20 column 2, inclu | | | ength o | f stay limit | N | 24. 00 | |
| 25. 00 | imposed on patients covered by Medicaid or If line 24 is yes, enter the charges for p | | | rogram' | s length of | 0 | 25. 00 | |
| 24 00 | stay limit | nital compley (see :+ | ructions) | | | 10 047 400 | 24 00 | |
| 26. 00 27. 00 | Total bad debt expense for the entire hosp Medicare reimbursable bad debts for the er | . , | | ıs) | | 10, 847, 420 119, 947 | | |
| 27. 00 | Medicare allowable bad debts for the entir | · | • | , | | 184, 535 | | |
| 28. 00 | Non-Medicare bad debt expense (see instruc | | | | | 10, 662, 885 | 28. 00 | |
| 29. 00 | Cost of non-Medicare and non-reimbursable | • | nse (see instruc | tions) | | 3, 665, 412 | | |
| | Cost of uncompensated care (line 23 column | | 20) | | | 4, 489, 469 | | |
| 31.00 | Total unreimbursed and uncompensated care | cost (line 19 plus lin | e 30) | | l | 9, 097, 073 | 31.00 | |

| Health Financial Systems | MEMORIAL HOSPITA | L LOGANSPORT | | In Lie | u of Form CMS-2 | 2552-10 |
|--|-------------------------|-------------------------|---------------|----------------------------|-------------------------------|--------------------|
| RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O | F EXPENSES | Provi der C | CN: 15-0072 P | eriod: rom 01/01/2020 | Worksheet A | |
| | | | | o 12/31/2020 | Date/Time Pre | pared: |
| | | | | 5 1 16 | 8/2/2021 10: 5 | 7 am |
| Cost Center Description | Sal ari es | Other | + col. 2) | Reclassificat ions (See | Reclassified Trial Balance | |
| | | | + COI. 2) | A-6) | (col. 3 +- | |
| | | | | , | col . 4) | |
| | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| GENERAL SERVICE COST CENTERS | | F / 20 7/1 | F (20 741 | 00/ 05/ | 4 (22 005 | 1 00 |
| 1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT 1.01 O0101 MOB | | 5, 620, 741 0 | | | 4, 623, 885 223, 692 | 1. 00 1. 01 |
| 1. 02 00102 0PS | | 0 | _ | | 147, 326 | 1.01 |
| 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT | 348, 157 | 10, 935, 680 | 1 | | 11, 282, 462 | 4.00 |
| 5. 00 00500 ADMINISTRATIVE & GENERAL | 3, 513, 679 | 7, 015, 792 | 10, 529, 471 | 1, 515 | 10, 530, 986 | 5.00 |
| 7.00 OO700 OPERATION OF PLANT | 790, 318 | 1, 854, 575 | | | 2, 882, 257 | 7.00 |
| 8. 00 00800 LAUNDRY & LI NEN SERVI CE | 0 | 185, 556 | 1 | | 185, 556 | |
| 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY | 656, 326 448, 745 | 191, 787 333, 857 | 1 | | 848, 113 141, 103 | |
| 11. 00 01100 CAFETERI A | 440, 745 | 033, 037 | 1 | | 641, 499 | |
| 13. 00 01300 NURSI NG ADMI NI STRATI ON | 1, 028, 944 | 297, 715 | 1, 326, 659 | | 1, 754, 753 | |
| 14.00 01400 CENTRAL SERVICES & SUPPLY | 292, 147 | 219, 872 | | | 474, 182 | |
| 15. 00 01500 PHARMACY | 573, 124 | 670, 733 | | | 1, 243, 857 | |
| 16. 00 01600 MEDI CAL RECORDS & LI BRARY | 1, 745, 597 | 4, 740, 914 | | | 6, 486, 511 | |
| 17. 00 O1700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS | 179, 176 | 14, 537 | 193, 713 | U | 193, 713 | 17.00 |
| 30. 00 03000 ADULTS & PEDIATRICS | 4, 230, 489 | 563, 121 | 4, 793, 610 | -763, 140 | 4, 030, 470 | 30.00 |
| 31. 00 03100 I NTENSI VE CARE UNI T | 768, 111 | 111, 287 | | | 879, 398 | |
| 43. 00 04300 NURSERY | 0 | 341 | 341 | 316, 529 | 316, 870 | 43.00 |
| ANCILLARY SERVICE COST CENTERS | | | | _ | | |
| 50. 00 05000 OPERATING ROOM | 5, 089, 310 | 1, 613, 916 | | | 6, 703, 226 446, 763 | |
| 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY | 0 | 152 1, 724, 712 | l . | · · | 1, 724, 712 | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 1, 211, 847 | 648, 609 | | | 1, 860, 456 | |
| 57. 00 05700 CT SCAN | 0 | 0 | 0 | 0 | 0 | |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | o | 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 | 3, 815, 109 | | | 3, 815, 109 | |
| 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 65. 00 06500 RESPI RATORY THERAPY | 0 892, 036 | 118, 703 107, 069 | | | 118, 703 999, 105 | |
| 66. 00 06600 PHYSI CAL THERAPY | 866, 453 | 55, 224 | | | 921, 677 | 66.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 354, 445 | 103, 256 | | | 457, 701 | |
| 69. 01 06901 CARDI AC REHAB | 283, 938 | 16, 691 | 300, 629 | 0 | 300, 629 | 69. 01 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 3, 501, 301 | 1 | | 2, 188, 477 | |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | 1 | ., | 1, 312, 824 | |
| 73. 00 O7300 DRUGS CHARGED TO PATLENTS 76. 00 O3450 NUCLEAR MEDICINE - DIAGNOSTIC | 232, 938 | 9, 244, 106 392, 875 | | | 9, 244, 108 625, 813 | |
| 76. 00 03430 NOCLEAR MEDICINE - DIAGNOSTIC | 676, 825 | 2, 048, 020 | | | 2, 724, 845 | |
| OUTPATIENT SERVICE COST CENTERS | 0,0,020 | 2, 0.0, 020 | 2,721,010 | | 2/ /2 1/ 0 10 | 70.0. |
| 90. 00 09000 CLI NI C | 6, 017, 109 | 887, 694 | | -1, 923 | 6, 902, 880 | |
| 90. 01 09001 WOUND CARE | 165, 914 | 610, 543 | | | 776, 457 | |
| 91. 00 09100 EMERGENCY | 1, 735, 913 | 915, 156 | 2, 651, 069 | 0 | 2, 651, 069 | |
| 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS | | | | | | 92.00 |
| 95. 00 09500 AMBULANCE SERVICES | 0 | 0 | 0 | 0 | 0 | 95.00 |
| SPECIAL PURPOSE COST CENTERS | -1 | | - | | | |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 32, 101, 543 | 58, 559, 644 | 90, 661, 187 | 0 | 90, 661, 187 | 118.00 |
| NONREI MBURSABLE COST CENTERS | | | | _ | | |
| 194. 00 07950 FOUNDATI ON | 0 | 1, 947 | | | | 194.00 |
| 194. 01 07951 MOB 194. 02 07952 NONREI MBURSABLE OTHER | 0 | 87 0 | l . | | | 194. 01 194. 02 |
| 194. 03 07953 PI H | | 0 | | 0 | | 194. 02 |
| 194. 04 07954 HEALTH COMPANIES | 502, 460 | 160, 528 | 662, 988 | 0 | 662, 988 | |
| 194. 05 07955 PHYSI CI ANS OFFI CE | 4, 506, 592 | 847, 564 | 5, 354, 156 | 0 | 5, 354, 156 | 194. 05 |
| 194. 06 07956 THE ARBORS | 0 | 0 | 0 | 0 | | 194. 06 |
| 194. 07 07957 PAIN MANAGEMENT | 0 | 0 | 0 | 0 | | 194.07 |
| 194. 08 07958 OPS 194. 09 07959 MHL ROCHESTER HEALTH CENTER | 100 440 | 150 420 | 240 200 | 0 | 0 340, 299 | 194.08 |
| 194. 10 07959 MHL ROCHESTER HEALTH CENTER | 189, 669 1, 446, 951 | 150, 630 15, 435 | 1 | | 1, 462, 386 | |
| 194. 11 07960 SPORTS HEALTH | 323, 403 | 39, 149 | | | 362, 552 | |
| 194. 12 07962 BEHAVI ORAL HEALTH CLINIC | 146, 083 | 16, 684 | 1 | | 162, 767 | 194. 12 |
| 200.00 TOTAL (SUM OF LINES 118 through 199) | 39, 216, 701 | 59, 791, 668 | 99, 008, 369 | 0 | 99, 008, 369 | 200.00 |
| | | | | | | |

Provi der CCN: 15-0072

Peri od: Worksheet A From 01/01/2020 Date/Time Prepared: 9/2/2021 10:57 am

| | | | | 8/2/2021 10 | |
|------------------|--|---------------------------|--------------------------|--|--------------------|
| | Cost Center Description | Adjustments | Net Expenses | | |
| | | (See A-8) | For | | |
| | | | Allocation | | |
| | I | 6. 00 | 7. 00 | | |
| 4 00 | GENERAL SERVICE COST CENTERS | 05.004 | 4 500 004 | T | |
| 1.00 | 00100 NEW CAP REL COSTS-BLDG & FLXT | -95, 884 | 4, 528, 001 | | 1.00 |
| 1. 01 | 00101 MOB 00102 OPS | 0 | 223, 692 | | 1. 01 1. 02 |
| 1. 02 4. 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | -3, 455 | 147, 326 11, 279, 007 | | 4.00 |
| 5.00 | 00500 ADMINISTRATIVE & GENERAL | -3, 931, 608 | 6, 599, 378 | · | 5. 00 |
| 7. 00 | 00700 OPERATION OF PLANT | -15, 185 | 2, 867, 072 | | 7. 00 |
| 8. 00 | 00800 LAUNDRY & LINEN SERVICE | 0 | 185, 556 | | 8. 00 |
| 9. 00 | 00900 HOUSEKEEPI NG | o o | 848, 113 | l control of the cont | 9.00 |
| 10.00 | 01000 DI ETARY | -14, 744 | 126, 359 | l control of the cont | 10.00 |
| 11.00 | 01100 CAFETERI A | -1, 739 | 639, 760 | l control of the cont | 11.00 |
| 13.00 | 01300 NURSING ADMINISTRATION | -1, 708 | 1, 753, 045 | | 13.00 |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | -41, 563 | 432, 619 | | 14.00 |
| 15.00 | 01500 PHARMACY | 0 | 1, 243, 857 | | 15.00 |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY | -24, 899 | 6, 461, 612 | | 16.00 |
| 17.00 | 01700 SOCI AL SERVI CE | -751 | 192, 962 | | 17. 00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | |
| 30. 00 | 03000 ADULTS & PEDI ATRI CS | -940, 885 | 3, 089, 585 | | 30.00 |
| 31.00 | 03100 INTENSIVE CARE UNIT | 0 | 879, 398 | | 31.00 |
| 43.00 | 04300 NURSERY | 0 | 316, 870 | | 43. 00 |
| FO 00 | ANCI LLARY SERVI CE COST CENTERS | 2 502 750 | 2 110 47/ | | |
| 50. 00 52. 00 | 05000 OPERATING ROOM | -3, 583, 750 0 | 3, 119, 476 | · | 50.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY | -1, 696, 178 | 446, 763 28, 534 | • | 52. 00 53. 00 |
| 54. 00 | 05400 RADI OLOGY-DI AGNOSTI C | -1,090,170 | 1, 860, 456 | • | 54.00 |
| 57.00 | 05700 CT SCAN | 0 | 1, 000, 430 | | 57.00 |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | 0 | • | 58. 00 |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | o o | 0 | | 59.00 |
| 60.00 | 06000 LABORATORY | Ö | 3, 815, 109 | | 60.00 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 118, 703 | · | 63.00 |
| 65.00 | 06500 RESPIRATORY THERAPY | 0 | 999, 105 | | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0 | 921, 677 | ' | 66. 00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 457, 701 | | 69. 00 |
| 69. 01 | 06901 CARDI AC REHAB | 0 | 300, 629 | | 69. 01 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 2, 188, 477 | l control of the cont | 71.00 |
| 72. 00 | 07200 I MPL. DEV. CHARGED TO PATIENT | 0 | 1, 312, 824 | l control of the cont | 72. 00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | -132, 825 | 9, 111, 283 | | 73.00 |
| 76.00 | 03450 NUCLEAR MEDICINE - DIAGNOSTIC | 0 | 625, 813 | | 76.00 |
| 76. 01 | 03480 ONCOLOGY | -1, 464, 926 | 1, 259, 919 | | 76. 01 |
| 90. 00 | OUTPATIENT SERVICE COST CENTERS O9000 CLINIC | -4, 889, 026 | 2, 013, 854 | T T | 90.00 |
| 90.00 | 09001 WOUND CARE | -4, 889, 028 -604, 600 | 2, 013, 854 171, 857 | | 90.00 |
| 91. 00 | 09100 EMERGENCY | -755, 986 | 1, 895, 083 | | 91. 00 |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 755, 766 | 1,075,005 | | 92.00 |
| 72.00 | OTHER REIMBURSABLE COST CENTERS | | | | 72.00 |
| 95.00 | 09500 AMBULANCE SERVICES | 0 | 0 | | 95. 00 |
| | SPECIAL PURPOSE COST CENTERS | | | | |
| 118.00 | | -18, 199, 712 | 72, 461, 475 | | 118. 00 |
| | NONREI MBURSABLE COST CENTERS | | | | |
| | 07950 FOUNDATI ON | 0 | 1, 947 | | 194. 00 |
| | 07951 MOB | 0 | 87 | | 194. 01 |
| | 2 07952 NONREI MBURSABLE OTHER | 0 | 0 | | 194. 02 |
| | 3 07953 PI H | 0 | 0 | | 194. 03 |
| | 107954 HEALTH COMPANIES | 0 | 662, 988 | · | 194.04 |
| | 507955 PHYSI CI ANS OFFI CE | 0 | 5, 354, 156 | | 194. 05 |
| | 507956 THE ARBORS | | 0 | | 194.06 |
| | 7 07957 PAIN MANAGEMENT 3 07958 OPS | | 0 | | 194. 07 194. 08 |
| | 007959 MHL ROCHESTER HEALTH CENTER | 0 | 340, 299 | | 194. 08 |
| | 07959 WHE ROCHESTER HEALTH CENTER | 0 | 1, 462, 386 | l control of the cont | 194. 09 |
| | 107960 SPORTS HEALTH | 0 | 362, 552 | | 194. 10 |
| | 207962 BEHAVI ORAL HEALTH CLINIC | o o | 162, 767 | | 194. 12 |
| 200.00 | | -18, 199, 712 | 80, 808, 657 | | 200.00 |
| | | | | • | |

| Peri od: | Worksheet A-6 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared:

| | | | | | To 12 | 2/31/2020 Date/Time P 8/2/2021 10 | |
|--------|-------------------------------|-----------|-------------|-------------------------------|-------|--|-----------|
| | | Increases | | | | 0/2/2021 10 | . 37 dili |
| | Cost Center | Li ne # | Sal ary | Other | | | |
| | 2.00 | 3.00 | 4. 00 | 5. 00 | | | |
| | A - CAFETERIA RECLASS | <u> </u> | | | | | |
| 1.00 | CAFETERI A | 11. 00 | 367, 836 | 273, 663 | | | 1.00 |
| | | $ \top$ | 367, 836 | 273, 663 | | | |
| | B - OB RECLASS | | | | | | |
| 1.00 | NURSERY | 43.00 | 286, 690 | 29, 839 | | | 1.00 |
| 2.00 | DELIVERY ROOM & LABOR ROOM _ | 52. 00 | 404, 211 | 42, 400 | | | 2.00 |
| | 0 | | 690, 901 | 72, 239 | | | |
| | C - MALPRACTICE INS. RECLASS | | | | | | |
| 1.00 | ADMINISTRATIVE & GENERAL | 500 | 0 | <u>625, 8</u> 38 | | | 1.00 |
| | 0 | | 0 | 625, 838 | | | |
| | D - IMPLANT EXPENSE RECLASS | | | | | | |
| 1. 00 | IMPL. DEV. CHARGED TO | 72. 00 | 0 | 1, 312, 824 | | | 1.00 |
| | PATI ENT | | | | | | |
| | 0 | | 0 | 1, 312, 824 | | | |
| | E - UTILITIES RECLASS | | | | | | |
| 1.00 | OPERATION OF PLANT | 7. 00 | 0 | 237, 364 | | | 1.00 |
| 2.00 | | 0.00 | 0 | 0 | | | 2.00 |
| 3.00 | | 0.00 | 0 | 0 | | | 3.00 |
| 4. 00 | | 0.00 | | 0 | | | 4. 00 |
| | 0 | | 0 | 237, 364 | | | _ |
| 1 00 | G - DEPRECIATION RECLASS | 4 04 | | 202 (22 | | | 4 00 |
| 1.00 | MOB | 1. 01 | 0 | 223, 692 | | | 1.00 |
| 2. 00 | OPS | | | 147, 326 | | | 2. 00 |
| | H - COVID-19 SUPPLY RECLASS | | UU | 371, 018 | | | |
| 1. 00 | NURSI NG ADMI NI STRATI ON | 12 00 | ٥ | 429 004 | | | 1.00 |
| 1.00 | TOTALS | 1300 | 0 | 42 <u>8, 0</u> 94 428, 094 | | | 1.00 |
| | I - SHORT TERM DISABILITY REC | 21 ASS | UU | 420, 074 | | | |
| 1. 00 | ADMINISTRATIVE & GENERAL | 5. 00 | O | 10, 849 | | | 1.00 |
| 2. 00 | OPERATION OF PLANT | 7. 00 | Ö | 6, 620 | | | 2.00 |
| 3. 00 | HOUSEKEEPI NG | 9. 00 | Ö | 3, 537 | | | 3.00 |
| 4. 00 | CENTRAL SERVICES & SUPPLY | 14. 00 | Ö | 1, 334 | | | 4.00 |
| 5. 00 | PHARMACY | 15. 00 | ő | 11, 219 | | | 5.00 |
| 6. 00 | MEDICAL RECORDS & LIBRARY | 16. 00 | o | 21, 134 | | | 6.00 |
| 7. 00 | ADULTS & PEDIATRICS | 30.00 | o | 60, 230 | | | 7.00 |
| 8. 00 | INTENSIVE CARE UNIT | 31.00 | o | 3, 521 | | | 8.00 |
| 9. 00 | OPERATING ROOM | 50.00 | o | 32, 363 | | | 9.00 |
| 10.00 | RADI OLOGY-DI AGNOSTI C | 54.00 | o | 4, 920 | | | 10.00 |
| 11. 00 | RESPI RATORY THERAPY | 65. 00 | o | 11, 534 | | | 11.00 |
| 12. 00 | ONCOLOGY | 76. 01 | o | 16, 725 | | | 12.00 |
| 13. 00 | CLINIC | 90.00 | o | 29, 686 | | | 13.00 |
| 14.00 | EMERGENCY | 91.00 | O | 645 | | | 14.00 |
| 15.00 | PHYSICIANS OFFICE | 194. 05 | 0 | 12, 446 | | | 15. 00 |
| 16.00 | MHL ROCHESTER HEALTH CENTER | 194. 09 | 0 | 12, 602 | | | 16. 00 |
| 17.00 | SPORTS HEALTH | 194. 11 | o | 4, 541 | | | 17. 00 |
| 18.00 | BEHAVIORAL HEALTH CLINIC | 194. 12 | 0 | 3, 575 | | | 18. 00 |
| | TOTALS | | | 247, 481 | | | |
| 500.00 | Grand Total: Increases | | 1, 058, 737 | 3, 568, 521 | | | 500.00 |
| | | | | | | | |

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2020 Date/Time Prepared: 9/2/2021 10:57 am Provi der CCN: 15-0072

| | | | | | 1 | o 12/31/2020 Dat | e/Time Prepared: /2021 10:57 am |
|----------------|--|-----------------|------------------|--------------------|----------------|------------------|------------------------------------|
| | | Decreases | | ' | | , 1 0, 2 | , 2021 1010, diii |
| | Cost Center | Li ne # | Sal ary | 0ther | Wkst. A-7 Ref. | | |
| | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | | |
| | A - CAFETERIA RECLASS | | | | | | |
| 1. 00 | DI ETARY | 1000 | 367, 836 | 27 <u>3, 6</u> 63 | | | 1.00 |
| | 0 | | 367, 836 | 273, 663 | 3 | | |
| | B - OB RECLASS | | | | | | |
| 1. 00 | ADULTS & PEDIATRICS | 30. 00 | 690, 901 | 72, 239 | | | 1.00 |
| 2.00 | | 000 | 0_ | 0 | 00 | | 2.00 |
| | 0 | | 690, 901 | 72, 239 |) | | |
| | C - MALPRACTICE INS. RECLASS | | .1 | | | | |
| 1. 00 | NEW CAP REL COSTS-BLDG & | 1. 00 | 0 | 625, 838 | 12 | | 1.00 |
| | FIXT | | | | <u> </u> | | |
| | 0 | | 0 | 625, 838 | 3 | | |
| 4 00 | D - IMPLANT EXPENSE RECLASS | 74 00 | - I | 1 010 001 | | | 4 00 |
| 1. 00 | MEDICAL SUPPLIES CHARGED TO | 71. 00 | 0 | 1, 312, 824 | 0 | | 1.00 |
| | PATI ENTS | + | | | <u> </u> | | |
| | U LITHER DECLARS | | 0 | 1, 312, 824 | | | |
| 1 00 | E - UTILITIES RECLASS EMPLOYEE BENEFITS DEPARTMENT | 4. 00 | O | 1 275 | 0 | | 1 00 |
| 1. 00 2. 00 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 1, 375 196, 229 | | | 1. 00 2. 00 |
| | CENTRAL SERVICES & SUPPLY | 14. 00 | 0 | | | | • |
| 3. 00 4. 00 | CLINIC | 90.00 | O O | 37, 837 1, 923 | | | 3. 00 4. 00 |
| 4.00 | 0 | | | | | | 4.00 |
| | G - DEPRECIATION RECLASS | | U | 237, 304 | • | | |
| 1. 00 | NEW CAP REL COSTS-BLDG & | 1. 00 | 0 | 371, 018 | 9 | | 1, 00 |
| 1.00 | FIXT | 1.00 | ٩ | 371,010 | , | | 1.00 |
| 2. 00 | 117 | 0.00 | 0 | 0 | 9 | | 2. 00 |
| 2.00 | TOTALS | | — — | 371, 018 | | | 2.00 |
| | H - COVI D-19 SUPPLY RECLASS | | <u> </u> | 37.170.10 | 1 | | |
| 1. 00 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 428, 094 | 0 | | 1, 00 |
| | TOTALS | | | 428, 094 | | | |
| | I - SHORT TERM DISABILITY REC | CLASS | | | | | |
| 1.00 | ADMINISTRATIVE & GENERAL | 5. 00 | 10, 849 | 0 | 0 | | 1.00 |
| 2.00 | OPERATION OF PLANT | 7.00 | 6, 620 | 0 | 0 | | 2.00 |
| 3.00 | HOUSEKEEPI NG | 9. 00 | 3, 537 | 0 | 0 | | 3.00 |
| 4.00 | CENTRAL SERVICES & SUPPLY | 14. 00 | 1, 334 | 0 | 0 | | 4.00 |
| 5.00 | PHARMACY | 15. 00 | 11, 219 | 0 | 0 | | 5. 00 |
| 6.00 | MEDICAL RECORDS & LIBRARY | 16. 00 | 21, 134 | 0 | 0 | | 6.00 |
| 7. 00 | ADULTS & PEDIATRICS | 30. 00 | 60, 230 | 0 | 0 | | 7.00 |
| 8.00 | INTENSIVE CARE UNIT | 31. 00 | 3, 521 | 0 | 0 | | 8. 00 |
| 9.00 | OPERATING ROOM | 50.00 | 32, 363 | 0 | 0 | | 9. 00 |
| 10.00 | RADI OLOGY-DI AGNOSTI C | 54.00 | 4, 920 | 0 | 0 | | 10.00 |
| 11.00 | RESPI RATORY THERAPY | 65. 00 | 11, 534 | 0 | 0 | | 11.00 |
| 12.00 | ONCOLOGY | 76. 01 | 16, 725 | 0 | 0 | | 12.00 |
| 13.00 | CLINIC | 90. 00 | 29, 686 | 0 | 0 | | 13.00 |
| 14.00 | EMERGENCY | 91. 00 | 645 | 0 | 0 | | 14.00 |
| 15. 00 | PHYSICIANS OFFICE | 194. 05 | 12, 446 | 0 | 0 | | 15. 00 |
| 16.00 | MHL ROCHESTER HEALTH CENTER | 194. 09 | 12, 602 | 0 | 0 | | 16.00 |
| 17.00 | SPORTS HEALTH | 194. 11 | 4, 541 | 0 | 0 | | 17. 00 |
| 18.00 | BEHAVIORAL HEALTH CLINIC | 1 <u>94.</u> 12 | <u>3, 5</u> 75 | 0 | <u> </u> | | 18.00 |
| | TOTALS | | 247, 481 | 0 |) | | |
| 500.00 | Grand Total: Decreases | | 1, 306, 218 | 3, 321, 040 |) | | 500.00 |

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0072

| | | | | 10 | 0 12/31/2020 | 8/2/2021 10:5 | |
|--------|--|---------------|--------------|-----------------|--------------|---------------|------------|
| | | | | Acqui si ti ons | | 0,2,2021 1010 | , <u>u</u> |
| | | Begi nni ng | Purchases | Donati on | Total | Disposals and | |
| | | Bal ances | | | | Retirements | |
| | | 1.00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE | | | | | | |
| 1.00 | Land | 205, 783 | 0 | 0 | 0 | 0 | |
| 2.00 | Land Improvements | 838, 517 | 0 | 0 | 0 | 0 | 2.00 |
| 3.00 | Buildings and Fixtures | 64, 633, 987 | 410, 000 | 0 | 410, 000 | | 3.00 |
| 4. 00 | Building Improvements | 0 | 0 | 0 | 0 | 0 | 4. 00 |
| 5.00 | Fixed Equipment | 0 | 7, 611, 191 | 0 | 7, 611, 191 | 0 | 5. 00 |
| 6. 00 | Movable Equipment | 46, 864, 773 | 2, 008, 134 | 0 | 2, 008, 134 | | 6. 00 |
| 7. 00 | HIT designated Assets | 0 | 0 | 0 | 0 | 0 | 7. 00 |
| 8.00 | Subtotal (sum of lines 1-7) | 112, 543, 060 | 10, 029, 325 | 0 | 10, 029, 325 | | 8. 00 |
| 9. 00 | Reconciling Items | 0 | 0 | 0 | 0 | 0 | 9. 00 |
| 10.00 | Total (line 8 minus line 9) | 112, 543, 060 | | 0 | 10, 029, 325 | 0 | 10.00 |
| | | Endi ng | Fully | | | | |
| | | Bal ance | Depreci ated | | | | |
| | | | Assets | | | | |
| | DART I ANALYCIC OF CHANGES IN CARLTAL ACCE | 6.00 | 7. 00 | | | | |
| 1 00 | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE | | 0 | | | | 1 00 |
| 1.00 | Land | 205, 783 | 0 | | | ļ | 1.00 |
| 2.00 | Land Improvements | 838, 517 | 0 | | | l | 2.00 |
| 3.00 | Buildings and Fixtures | 65, 043, 987 | 0 | | | l | 3.00 |
| 4. 00 | Building Improvements | 7 (44 404 | 0 | | | l | 4.00 |
| 5. 00 | Fi xed Equi pment | 7, 611, 191 | 0 | | | l | 5.00 |
| 6.00 | Movabl e Equi pment | 48, 872, 907 | 0 | | | l | 6.00 |
| 7.00 | HIT designated Assets | 100 570 005 | 0 | | | l | 7.00 |
| 8. 00 | Subtotal (sum of lines 1-7) | 122, 572, 385 | 0 | | | ļ | 8.00 |
| 9.00 | Reconciling Items | 100 570 005 | 0 | | | ļ | 9.00 |
| 10. 00 | Total (line 8 minus line 9) | 122, 572, 385 | 0 | | | ļ | 10.00 |
| | | | | | | | |

| Health Financial Systems | MEMORIAL HOSPITA | AL LOGANSPORT | | In Lie | u of Form CMS-: | 2552-10 |
|--|--------------------|-----------------|----------|----------------------------------|-----------------|---------|
| RECONCILIATION OF CAPITAL COSTS CENTERS | | Provi der Co | | Peri od: | Worksheet A-7 | |
| | | | | From 01/01/2020 To 12/31/2020 | | pared: |
| | | | | | 8/2/2021 10: 5 | |
| | SUMMARY OF CAPITAL | | | | | |
| Cost Center Description | Depreciation | Lease | Interest | Insurance | Taxes (see | |
| | | | | (see | instructions) | |
| | | | | instructions) | | |
| | 9. 00 | 10. 00 | 11. 00 | 12.00 | 13.00 | |
| PART II - RECONCILIATION OF AMOUNTS FROM WOR | KSHEET A, COLUM | MN 2, LINES 1 a | and 2 | | | |
| 1.00 NEW CAP REL COSTS-BLDG & FLXT | 4, 100, 744 | 0 | 788, 17! | 5 731, 822 | 0 | 1.00 |
| 1. 01 MOB | 0 | 0 | (| 0 | 0 | 1. 01 |
| 1. 02 OPS | 0 | 0 | (| 0 | 0 | 1. 02 |
| 3.00 Total (sum of lines 1-2) | 4, 100, 744 | 0 | 788, 17 | 731, 822 | 0 | 3.00 |
| | SUMMARY O | F CAPITAL | | | | |
| | | | | | | |
| Cost Center Description | 0ther | Total (1) | | | | |
| | Capi tal -Relat | (sum of cols. | | | | |
| | ed Costs (see | 9 through 14) | | | | |
| | instructions) | , | | | | |
| | 14. 00 | 15. 00 | | | | |
| PART II - RECONCILIATION OF AMOUNTS FROM WOR | KSHEET A, COLUM | MN 2, LINES 1 a | and 2 | | | |
| 1.00 NEW CAP REL COSTS-BLDG & FLXT | 0 | 5, 620, 741 | | | | 1.00 |

| | PART II - RECONCILIATION OF AMOUNTS FR | KUW WUKKSHEET A, CULUW | N Z, LINES I a | ind 2 | |
|-------|--|------------------------|----------------|-------|-------|
| 1.00 | NEW CAP REL COSTS-BLDG & FIXT | 0 | 5, 620, 741 | | 1.00 |
| 1. 01 | MOB | 0 | 0 | | 1. 01 |
| 1. 02 | OPS | 0 | 0 | | 1. 02 |
| 3.00 | Total (sum of lines 1-2) | 0 | 5, 620, 741 | | 3.00 |
| | | | | | |

| Heal th | n Financial Systems | MEMORIAL HOSPIT | AL LOGANSPORT | | In Lie | u of Form CMS-2 | 2552-10 | |
|---------|--|--|------------------|------------------|----------------------------------|---------------------------|----------------|--|
| RECON | CILIATION OF CAPITAL COSTS CENTERS | | Provi der C | CN: 15-0072 | Peri od: | Worksheet A-7 | | |
| | | | | | From 01/01/2020 To 12/31/2020 | Part III Date/Time Pre | narodi | |
| | | | | | 10 12/31/2020 | 8/2/2021 10:5 | pareu: 7 am | |
| | | COMF | PUTATION OF RAT | TI 0S | ALLOCATION OF | OTHER CAPITAL | | |
| | | | | | | | | |
| | Cost Center Description | Gross Assets | Capi tal i zed | Gross Assets | | Insurance | | |
| | | | Leases | for Ratio | instructions) | | | |
| | | | | (col . 1 - | | | | |
| | | 1. 00 | 2.00 | col . 2) 3.00 | 4. 00 | 5. 00 | | |
| | PART III - RECONCILIATION OF CAPITAL COSTS C | | 2.00 | 3.00 | 4.00 | 5.00 | | |
| 1. 00 | NEW CAP REL COSTS-BLDG & FIXT | 122, 463, 783 | 0 | 122, 463, 78 | 1. 000000 | 0 | 1.00 | |
| 1. 01 | MOB | 122, 403, 703 | 0 | 122, 403, 70 | 0. 000000 | | 1. 01 | |
| 1. 02 | OPS | 0 | 0 | | 0. 000000 | | 1. 02 | |
| 3. 00 | Total (sum of lines 1-2) | 122, 463, 783 | 0 | 122, 463, 78 | | | 3. 00 | |
| | | ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL | | | | | | |
| | | | | | | | | |
| | Cost Center Description | Taxes | Other | Total (sum of | Depreciation | Lease | | |
| | | | Capi tal -Rel at | | | | | |
| | | | ed Costs | through 7) | | | | |
| | DART III DECONOLILIATION OF CARLTAL COCTO | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | | |
| 1. 00 | PART III - RECONCILIATION OF CAPITAL COSTS C | ENTERS 0 | | 1 | 3, 702, 670 | 0 | 1. 00 | |
| 1. 00 | MOB | 0 | 0 | 1 | 223, 692 | | 1.00 | |
| 1. 01 | OPS | 0 | 0 |] | 147, 326 | | 1.01 | |
| 3. 00 | Total (sum of lines 1-2) | 0 | 0 | | 4, 073, 688 | | 3.00 | |
| 0.00 | | J | SI | JMMARY OF CAPI | | | 0.00 | |
| | | | | | | | | |
| | Cost Center Description | Interest | Insurance | Taxes (see | 0ther | Total (2) | | |
| | | | (see | instructions) | | | | |
| | | | instructions) | | | 9 through 14) | | |
| | | | | | instructions) | | | |
| | DART III DECONOLILIATION OF CARLTAL COCTO | 11. 00 | 12. 00 | 13. 00 | 14. 00 | 15. 00 | | |
| 1. 00 | PART III - RECONCILIATION OF CAPITAL COSTS C | 719, 347 | 105, 984 | 1 , | 0 | 4, 528, 001 | 1. 00 | |
| 1. 00 | MOB | / 19, 34/ | 100, 984 | 1 | | 223, 692 | 1.00 | |
| 1. 01 | OPS | | |] | | 147, 326 | 1.01 | |
| 3. 00 | Total (sum of lines 1-2) | 719, 347 | 105, 984 | | | | | |
| 5.00 | [| 1 717,017 | 100,701 | 1 | 51 | ., 0,,, 0,,, | 0.00 | |

Health Financial Systems
ADJUSTMENTS TO EXPENSES MEMORIAL HOSPITAL LOGANSPORT In Lieu of Form CMS-2552-10 | Peri od: | Worksheet A-8 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Provi der CCN: 15-0072

| | | | | То | 12/31/2020 | Date/Time Prep 8/2/2021 10:5 | |
|-----------------|--|-------------|---------------|-------------------------------|---------------|---------------------------------|-----------------|
| | | | | Expense Classification on V | | 0, 2, 2021 1010 | , diii |
| | | | | To/From Which the Amount is t | o be Adjusted | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Cost Center Description | Basi s/Code | Amount | Cost Center | Li ne # | Wkst. A-7 | |
| | cost center bescription | (2) | Allourt | cost center | LITTIE # | Ref. | |
| 1 00 | Lucia de la casa de la | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | 1 00 |
| 1. 00 | Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter | | | NEW CAP REL COSTS-BLDG & FLXT | 1. 00 | 0 | 1. 00 |
| | 2) | | _ | | | _ | |
| 1. 01 | Investment income - MOB (chapter 2) | | 0 | MOB | 1. 01 | 0 | 1. 01 |
| 1. 02 | Investment income - OPS | | 0 | OPS | 1. 02 | 0 | 1. 02 |
| 2. 00 | (chapter 2) Investment income - CAP REL | | 0 | *** Cost Center Deleted *** | 2. 00 | 0 | 2. 00 |
| | COSTS-MVBLE EQUIP (chapter 2) | | | Sout Server Bereteu | | | |
| 3. 00 | Investment income - other (chapter 2) | | 0 | | 0. 00 | 0 | 3. 00 |
| 4.00 | Trade, quantity, and time | | 0 | | 0. 00 | 0 | 4.00 |
| 5. 00 | discounts (chapter 8) Refunds and rebates of | | 0 | | 0. 00 | 0 | 5. 00 |
| 3.00 | expenses (chapter 8) | | | | 0.00 | Ĭ | 3.00 |
| 6. 00 | Rental of provider space by suppliers (chapter 8) | | 0 | | 0. 00 | 0 | 6. 00 |
| 7. 00 | Tel ephone services (pay | | 0 | | 0. 00 | 0 | 7. 00 |
| | stations excluded) (chapter | | | | | | |
| 8. 00 | 21) Television and radio service | | 0 | | 0. 00 | 0 | 8. 00 |
| | (chapter 21) | | | | | | |
| 9. 00 10. 00 | Parking Lot (chapter 21) Provider-based physician | A-8-2 | -13, 916, 223 | | 0. 00 | 0 | 9. 00 10. 00 |
| | adjustment | 5 2 | | | | | |
| 11. 00 | Sale of scrap, waste, etc. (chapter 23) | | 0 | | 0. 00 | 0 | 11. 00 |
| 12.00 | Related organization | A-8-1 | 0 | | | О | 12.00 |
| 13. 00 | transactions (chapter 10) Laundry and Linen service | | 0 | | 0. 00 | 0 | 13. 00 |
| 14. 00 | | Α | -3 | CAFETERI A | 11. 00 | ő | 14. 00 |
| 15.00 | Rental of quarters to employee | | 0 | | 0. 00 | 0 | 15.00 |
| 16. 00 | and others Sale of medical and surgical | | O | | 0. 00 | o | 16. 00 |
| | supplies to other than | | | | | | |
| 17. 00 | patients Sale of drugs to other than | | 0 | | 0. 00 | 0 | 17. 00 |
| | patients | | | | | | |
| 18. 00 | Sale of medical records and abstracts | | 0 | | 0. 00 | 0 | 18. 00 |
| 19. 00 | Nursing and allied health | | 0 | | 0. 00 | 0 | 19.00 |
| | education (tuition, fees, books, etc.) | | | | | | |
| 20.00 | Vendi ng machi nes | | 0 | | 0. 00 | О | |
| 21. 00 | Income from imposition of interest, finance or penalty | | 0 | | 0. 00 | 0 | 21. 00 |
| | charges (chapter 21) | | | | | | |
| 22. 00 | Interest expense on Medicare overpayments and borrowings to | | 0 | | 0.00 | 0 | 22. 00 |
| | repay Medicare overpayments | | | | | | |
| 23. 00 | Adjustment for respiratory | A-8-3 | 0 | RESPI RATORY THERAPY | 65. 00 | | 23. 00 |
| | therapy costs in excess of limitation (chapter 14) | | | | | | |
| 24. 00 | Adjustment for physical | A-8-3 | 0 | PHYSI CAL THERAPY | 66. 00 | | 24.00 |
| | therapy costs in excess of limitation (chapter 14) | | | | | | |
| 25.00 | Utilization review - | | 0 | *** Cost Center Deleted *** | 114. 00 | | 25.00 |
| | physicians' compensation (chapter 21) | | | | | | |
| 26. 00 | Depreciation - NEW CAP REL | | 0 | NEW CAP REL COSTS-BLDG & | 1. 00 | O | 26.00 |
| 26. 01 | COSTS-BLDG & FIXT Depreciation - MOB | | 0 | FIXT MOB | 1. 01 | 0 | 26. 01 |
| | Depreciation - OPS | | 0 | 0PS | 1. 02 | 0 | 26. 02 |
| 27. 00 | Depreciation - CAP REL | | 0 | *** Cost Center Deleted *** | 2. 00 | О | 27. 00 |
| 28. 00 | COSTS-MVBLE EQUIP Non-physician Anesthetist | | 0 | *** Cost Center Deleted *** | 19. 00 | | 28. 00 |
| | Physi ci ans' assi stant | | 0 | | 0. 00 | o | 29. 00 |

Provider CCN: 15-0072 Peri od: Worksheet A-8 From 01/01/2020 To 12/31/2020 Date/Time Prepared:

| | | | | To | 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | pared: |
|------------------|--|-------------|---------------|---|----------------|--------------------------------|------------------|
| | | | | Expense Classification on | Worksheet A | 0/2/2021 10.5 | / aiii |
| | | | | To/From Which the Amount is | | | |
| | | | | | • | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Cost Center Description | Basi s/Code | Amount | Cost Center | Li ne # | Wkst. A-7 | |
| | cost center bescription | (2) | Alliourt | Cost Center | Line # | 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 |
| | therapy costs in excess of | | | | | | |
| | limitation (chapter 14) | | | | | | |
| 30. 99 | Hospice (non-distinct) (see | | 0 | ADULTS & PEDIATRICS | 30. 00 | | 30. 99 |
| | instructions) | | | | | | |
| 31. 00 | Adjustment for speech | A-8-3 | 0 | *** Cost Center Deleted *** | 68. 00 | | 31.00 |
| | pathology costs in excess of limitation (chapter 14) | | | | | | |
| 32. 00 | CAH HIT Adjustment for | | 0 | | 0. 00 | 0 | 32.00 |
| 32.00 | Depreciation and Interest | | O | | 0.00 | 0 | 32.00 |
| 33.00 | OTHER REVENUE - BAD DEBT | В | -84 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33.00 |
| 34.00 | OTHER REVENUE - MEDICARE | В | -49, 537 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 34.00 |
| 35.00 | OTHER REVENUE - BLUE CROSS | В | -7, 279 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 35.00 |
| 37.00 | OTHER REVENUE - MEDICAID | В | -1, 182 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 37.00 |
| 38. 00 | OTHER REVENUE - SCRAP SAL | В | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | |
| 39. 00 | OTHER REVENUE - CASH OVER | В | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | |
| 40.00 | MHL A/P DI SCOUNTS | В | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | |
| 41.00 | MEALS ON WHEELS | B B | | CAFETERI A | 11.00 | 0 | |
| 45. 00 | OTHER REVENUE - CAFETERIA SALES | В | -3 | CAFETERI A | 11. 00 | 0 | 45. 00 |
| 45. 01 | OTHER REVENUE - CPR TRAINING | В | -1 708 | NURSING ADMINISTRATION | 13. 00 | 0 | 45. 01 |
| 45. 02 | OTHER REVENUE - REBATES MMT | В | | CENTRAL SERVICES & SUPPLY | 14. 00 | 0 | |
| 45. 03 | HIM MEDICAL RECORDS FEES | В | | MEDICAL RECORDS & LIBRARY | 16. 00 | 0 | |
| 45.04 | 340B OFFSET | Α | | DRUGS CHARGED TO PATIENTS | 73. 00 | 0 | 45. 04 |
| 45.05 | INTEREST INCOME | В | -68, 828 | NEW CAP REL COSTS-BLDG & | 1. 00 | 11 | 45. 05 |
| | | | | FLXT | | | |
| 45. 06 | DI ETARY REVENUE | В | | DIETARY | 10.00 | 0 | |
| 45. 07 | PATIENT TELEVISIONS | A | | OPERATION OF PLANT | 7. 00 | 0 | |
| 45. 08 45. 09 | PATIENT TELEPHONES PATIENT TELEPHONES | A A | | EMPLOYEE BENEFITS DEPARTMENT NEW CAP REL COSTS-BLDG & | 4. 00 1. 00 | 0 | |
| 43. 09 | PATTENT TELEPHONES | A | -2, 130 | FIXT | 1.00 | 9 | 45.09 |
| 45. 10 | PATI ENT TELEPHONES | Α | -1.573 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 45. 10 |
| 45. 12 | I HA & AHA LOBBYING FEES | A | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 1 |
| 45. 13 | GIFT SHOP | А | | NEW CAP REL COSTS-BLDG & | 1.00 | 9 | 45. 13 |
| | | | | FIXT | | | |
| 45. 14 | GI FT SHOP | А | | OPERATION OF PLANT | 7. 00 | 0 | |
| 45. 15 | ADVERTI SI NG | Α | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 1 .00 |
| 45. 16 | TAXES | A | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | |
| 45. 17 | DONATION EXPENSE | A | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | |
| 45. 18 45. 19 | PHYSICIAN RECRUITMENT VENDING | A A | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 45. 18 45. 19 |
| 40. 19 | VENUTING | A | -3, 314 | NEW CAP REL COSTS-BLDG & | 1. 00 | 9 | 45. 19 |
| 45. 20 | VENDI NG | А | -1 817 | OPERATION OF PLANT | 7. 00 | 0 | 45. 20 |
| 45. 21 | HOSPITAL ASSESSMENT FEE OFFSET | A | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 45. 21 |
| 45. 23 | HOSPI TALI ST OFFSET | A | | ADULTS & PEDIATRICS | 30.00 | 0 | |
| 50.00 | TOTAL (sum of lines 1 thru 49) | | -18, 199, 712 | 1 | | | 50.00 |
| | (Transfer to Worksheet A, | | | | | | |
| | column 6, line 200.) | | | | | | |

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1. (2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 15-0072

| | | | | | | - | To 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | |
|--------|----------------|--------------------------|----------------|-------------------|--------------|---------|---------------|--------------------------------|---------|
| | Wkst. A Line # | Cost Center/Physician | Total | Professi or | nal Provid | der | RCE Amount | Physi ci an/Prov | |
| | | I denti fi er | Remuneration | Componen | t Compon | ent | | ider Component | |
| | | | | · · | · · | | | Hours | |
| | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 |) | 6. 00 | 7. 00 | |
| 1. 00 | 5. 00 | ADMINISTRATIVE & GENERAL | 33, 316 | | 0 | 33, 316 | 211, 500 | 389 | 1. 00 |
| 2.00 | 17. 00 | SOCIAL SERVICE | 6, 750 | | 0 | 6, 750 | 211, 501 | 59 | 2.00 |
| 3.00 | 30.00 | ADULTS & PEDIATRICS | 942, 973 | 921, | 006 | 21, 967 | 211, 500 | 255 | 3.00 |
| 4.00 | 50.00 | OPERATING ROOM | 3, 692, 379 | 3, 459, | 796 23 | 32, 583 | 246, 400 | 917 | 4.00 |
| 5.00 | 53. 00 | ANESTHESI OLOGY | 1, 696, 178 | 1, 696, | 178 | 0 | 211, 500 | 0 | 5.00 |
| 6.00 | 54. 00 | RADI OLOGY-DI AGNOSTI C | 35, 064 | | 0 | 35, 064 | 211, 500 | 407 | 6.00 |
| 7.00 | 76. 01 | ONCOLOGY | 1, 464, 926 | 1, 464, | 926 | 0 | 211, 500 | o | 7.00 |
| 8.00 | 90.00 | CLINIC | 4, 936, 614 | 4, 850, | 392 | 36, 222 | 211, 500 | 468 | 8.00 |
| 9.00 | 90. 01 | WOUND CARE | 604, 600 | 604, | 600 | 0 | 211, 500 | O | 9.00 |
| 10.00 | 91. 00 | EMERGENCY | 755, 986 | 755, | 986 | 0 | 211, 500 | 0 | 10.00 |
| 200.00 | | | 14, 168, 786 | 13, 752, | 884 4 | 15, 902 | | 2, 495 | 200.00 |
| | Wkst. A Line # | Cost Center/Physician | Unadjusted RCE | 5 Percent | of Cost | of | Provi der | Physician Cost | |
| | | I denti fi er | Li mi t | Unadj usted | RCE Membersh | ips & | Component | of Mal practi ce | |
| | | | | Limit | Continu | ui ng | Share of col. | Insurance | |
| | | | | | Educat | ion | 12 | | |
| | 1. 00 | 2. 00 | 8. 00 | 9. 00 | 12.0 | | 13. 00 | 14. 00 | |
| 1.00 | | ADMINISTRATIVE & GENERAL | 39, 555 | | 978 | 0 | | 0 | 1.00 |
| 2.00 | | SOCI AL SERVI CE | 5, 999 | | 300 | 0 | | 0 | 2.00 |
| 3.00 | | ADULTS & PEDIATRICS | 25, 929 | | 296 | 0 | | 0 | 3.00 |
| 4. 00 | | OPERATING ROOM | 108, 629 | 5, | 431 | 0 | 1 | 0 | 4.00 |
| 5. 00 | | ANESTHESI OLOGY | 0 | | 0 | 0 | 0 | 0 | 5.00 |
| 6. 00 | | RADI OLOGY-DI AGNOSTI C | 41, 385 | 2, | 069 | 0 | 0 | 0 | 6. 00 |
| 7.00 | | ONCOLOGY | 0 | | 0 | 0 | 0 | 0 | 7.00 |
| 8.00 | | CLINIC | 47, 588 | 2, | 379 | 0 | 0 | 0 | 8.00 |
| 9.00 | | WOUND CARE | 0 | | 0 | 0 | 0 | 0 | 9.00 |
| 10.00 | 91. 00 | EMERGENCY | 0 | | 0 | 0 | 0 | 0 | 10.00 |
| 200.00 | | | 269, 085 | | 453 | 0 | | 0 | 200.00 |
| | Wkst. A Line # | | Provi der | Adjusted F | | | Adjustment | | |
| | | l denti fi er | Component | Limit | Di sal I o | wance | | | |
| | | | Share of col. | | | | | | |
| | 4.00 | 0.00 | 14 | 1/ 00 | 47.0 | | 10.00 | | |
| 1 00 | 1.00 | 2.00 | 15. 00 | 16. 00 | 17. C | | 18. 00 | | 1 00 |
| 1.00 | | ADMINISTRATIVE & GENERAL | 0 | | 555 | 754 | | | 1.00 |
| 2.00 | | SOCIAL SERVICE | 0 | | 999 | 751 | 1 | | 2.00 |
| 3.00 | | ADULTS & PEDIATRICS | 0 | | 929 | 0 | | | 3.00 |
| 4.00 | | OPERATING ROOM | 0 | 108, | | 23, 954 | | | 4.00 |
| 5.00 | | ANESTHESI OLOGY | 0 | | 0 | 0 | , | | 5.00 |
| 6.00 | | RADI OLOGY-DI AGNOSTI C | 0 | 41, | 385 | 0 | 1 | | 6.00 |
| 7.00 | | ONCOLOGY | 0 | | 0 | 0 | .,, | | 7.00 |
| 8. 00 | | CLINIC | 0 | 47, | | 38, 634 | | | 8.00 |
| 9.00 | | WOUND CARE | 0 | | 0 | 0 | | | 9.00 |
| 10.00 | 91.00 | EMERGENCY | 0 | 6.0 | 0 | 0 | | | 10.00 |
| 200.00 | l l | | 0 | ₁ 269, | 085 10 | 53, 339 | 13, 916, 223 | | 200. 00 |

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2020 | Part I | Date/Time Prepared: | Provi der CCN: 15-0072

| | | | To | 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | |
|---|----------------------------|-----------------------|-------------|--------------|--------------------------------|------------------|
| | | CAPITAL RELATED COSTS | | | 0/2/2021 10.5 | 7 alli |
| | <u>-</u> | | | | | |
| Cost Center Description | Net Expenses for Cost | NEW BLDG & FLXT | MOB | 0PS | EMPLOYEE BENEFITS | |
| | Allocation | 1171 | | | DEPARTMENT | |
| | (from Wkst A | | | | DEI / II CI III EI VI | |
| | col. 7) | | | | | |
| | 0 | 1. 00 | 1. 01 | 1. 02 | 4. 00 | |
| GENERAL SERVICE COST CENTERS 1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT | 4 520 001 | 4 520 001 | | | | 1 00 |
| 1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 1.01 00101 MOB | 4, 528, 001 223, 692 | 4, 528, 001 0 | 223, 692 | | | 1. 00 1. 01 |
| 1. 02 00101 MOB | 147, 326 | 0 | 223, 072 | 147, 326 | | 1.01 |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT | 11, 279, 007 | 8, 983 | Ö | 0 | 11, 287, 990 | 4.00 |
| 5. 00 00500 ADMINISTRATIVE & GENERAL | 6, 599, 378 | 367, 418 | 20, 990 | o | 1, 023, 790 | 5. 00 |
| 7.00 00700 OPERATION OF PLANT | 2, 867, 072 | 837, 314 | | 11, 704 | 229, 055 | 7. 00 |
| 8. 00 00800 LAUNDRY & LI NEN SERVI CE | 185, 556 | 14, 673 | | 0 | 100 704 | 8.00 |
| 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY | 848, 113 126, 359 | 32, 850 139, 043 | | 432 | 190, 794 23, 648 | 9. 00 10. 00 |
| 11. 00 01100 CAFETERI A | 639, 760 | 67, 205 | | ő | 107, 509 | 11.00 |
| 13.00 01300 NURSING ADMINISTRATION | 1, 753, 045 | 52, 132 | | o | 300, 735 | 13.00 |
| 14.00 01400 CENTRAL SERVICES & SUPPLY | 432, 619 | 97, 045 | | o | 84, 997 | 14.00 |
| 15. 00 01500 PHARMACY | 1, 243, 857 | 49, 452 | | 0 | 164, 231 | 15. 00 |
| 16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE | 6, 461, 612 | 175, 067 29, 205 | | 0 | 504, 017 52, 369 | 16. 00 17. 00 |
| 17. 00 O1700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS | 192, 962 | 29, 205 | l o | <u> </u> | 52, 309 | 17.00 |
| 30. 00 03000 ADULTS & PEDIATRICS | 3, 089, 585 | 819, 231 | 0 | 0 | 1, 016, 929 | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 879, 398 | 124, 228 | | o | 223, 471 | 31.00 |
| 43. 00 04300 NURSERY | 316, 870 | 6, 114 | 0 | 0 | 83, 792 | 43.00 |
| ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM | 3, 119, 476 | 458, 232 | 0 | 22 540 | 1 479 010 | E0 00 |
| 50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM | 446, 763 | 458, 232 100, 243 | | 33, 560 0 | 1, 478, 019 118, 141 | 50. 00 52. 00 |
| 53. 00 05300 ANESTHESI OLOGY | 28, 534 | 41, 457 | | ő | 0 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 1, 860, 456 | 212, 291 | 0 | 8, 309 | 352, 755 | 54.00 |
| 57.00 05700 CT SCAN | O | 0 | 0 | o | 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 60. 00 06000 LABORATORY | 2 915 100 | 112 741 | 0 6, 874 | 2 075 | 0 | 59. 00 60. 00 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | 3, 815, 109 118, 703 | 113, 741 0 | 0,874 | 3, 875 | 0 | 63.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 999, 105 | 8, 089 | ĺ | Ö | 257, 349 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 921, 677 | 89, 826 | | o | 253, 243 | 1 |
| 69. 00 06900 ELECTROCARDI OLOGY | 457, 701 | 11, 264 | | 0 | 103, 595 | |
| 69. 01 06901 CARDI AC REHAB | 300, 629 | 130, 813 | | 0 | 82, 988 | 1 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENT | 2, 188, 477 | 0 | 0 | 0 | 0 | 71. 00 72. 00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 1, 312, 824 9, 111, 283 | 0 | 0 | 0 | 1 | 73.00 |
| 76. 00 03450 NUCLEAR MEDICINE - DIAGNOSTIC | 625, 813 | 17, 236 | l ő | ő | 68. 082 | 76.00 |
| 76. 01 03480 ONCOLOGY | 1, 259, 919 | 0 | 22, 395 | 48, 216 | 192, 931 | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLI NI C 90. 01 09001 WOUND CARE | 2, 013, 854 171, 857 | 4, 938 0 | | 0 | 1, 749, 991 48, 493 | 90. 00 90. 01 |
| 91. 00 09100 EMERGENCY | 1, 895, 083 | 360, 270 | | 0 | 507, 175 | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1,075,005 | 300, 270 | | Ĭ | 307, 173 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 95. 00 09500 AMBULANCE SERVI CES | 0 | 0 | 0 | 0 | 0 | 95.00 |
| SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 72, 461, 475 | 4, 368, 360 | 161, 790 | 106, 096 | 9, 218, 100 | 110 00 |
| NONREI MBURSABLE COST CENTERS | /2,401,4/5 | 4, 308, 300 | 161, 790 | 100, 096 | 9, 218, 100 |] 18.00 |
| 194. 00 07950 FOUNDATION | 1, 947 | 0 | 0 | 0 | 0 | 194. 00 |
| 194. 01 07951 MOB | 87 | 0 | 7, 569 | o | | 194. 01 |
| 194. 02 07952 NONREI MBURSABLE OTHER | 0 | 0 | 0 | 0 | | 194. 02 |
| 194. 03 07953 PIH | 442 000 | E2 721 | 0 | 0 | | 194.03 |
| 194. 04 07954 HEALTH COMPANIES 194. 05 07955 PHYSICIANS OFFICE | 662, 988 5, 354, 156 | 53, 731 105, 910 | | 0 | 146, 856 1, 313, 527 | 194.04 |
| 194. 06 07956 THE ARBORS | 0, 354, 130 | 0 | 0 | Ö | | 194. 06 |
| 194. 07 07957 PAIN MANAGEMENT | o | 0 | 7, 186 | o | | 194. 07 |
| 194. 08 07958 OPS | 0 | 0 | 0 | 41, 230 | | |
| 194. 09 07959 MHL ROCHESTER HEALTH CENTER | 340, 299 | 0 | 0 | 0 | 51, 752 | |
| 194. 10 07961 RHEUMATOLOGY 194. 11 07960 SPORTS HEALTH | 1, 462, 386 | 0 | 28, 881 | 0 | 422, 908 93, 195 | |
| 194. 11 07960 SPORTS HEALTH 194. 12 07962 BEHAVI ORAL HEALTH CLINI C | 362, 552 162, 767 | O O | | 0 | | 194. 11 |
| 200.00 Cross Foot Adjustments | 102,707 | | | ٩ | 11,002 | 200.00 |
| 201.00 Negative Cost Centers | | 0 | 0 | О | | 201. 00 |
| 202.00 TOTAL (sum lines 118 through 201) | 80, 808, 657 | 4, 528, 001 | 223, 692 | 147, 326 | 11, 287, 990 | 202.00 |
| | | | | | | |

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-0072

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

8/2/2021 10:57 am Cost Center Description Subtotal ADMI NI STRATI V OPERATION OF LAUNDRY & HOUSEKEEPI NG E & GENERAL **PLANT** LINEN SERVICE 4A 7.00 8.00 9.00 5.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.01 00101 MOB 1.01 1 02 00102 OPS 1 02 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 8, 011, 576 8, 011, 576 5.00 7.00 00700 OPERATION OF PLANT 3, 946, 504 434, 329 4, 380, 833 7.00 00800 LAUNDRY & LINEN SERVICE 200 229 22, 036 235, 549 8 00 8 00 13, 284 9.00 00900 HOUSEKEEPI NG 1,072,915 118,079 34, 487 1, 225, 481 9.00 01000 DI ETARY 289, 050 125, 876 10.00 10.00 31, 811 945 11.00 01100 CAFETERI A 814, 474 89, 636 60, 841 0 11.00 0 01300 NURSING ADMINISTRATION 2, 105, 912 231.764 47, 196 3, 325 13 00 0 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 614, 661 67, 646 87, 856 0 7, 979 14.00 15.00 01500 PHARMACY 1, 457, 540 160, 408 44, 769 0 6,649 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 7.140.696 785, 862 158, 490 0 9, 974 16,00 01700 SOCIAL SERVICE 17.00 274, 536 30, 214 26, 440 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 410, 266 03000 ADULTS & PEDIATRICS 4, 925, 745 542,098 741, 655 63 458 30.00 66, 494 03100 INTENSIVE CARE UNIT 8, 285 1, 227, 097 135, 047 31.00 112, 465 31.00 04300 NURSERY 43.00 406, 776 44, 767 5, 535 14,666 2,660 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 5, 089, 287 560, 096 548, 892 70, 679 149, 611 50.00 05200 DELIVERY ROOM & LABOR ROOM 90, 751 52.00 665, 147 73, 202 0 45, 881 52.00 53.00 05300 ANESTHESI OLOGY 69, 991 7,703 37, 531 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 433, 811 267, 851 225, 377 17, 116 53, 195 54.00 05700 CT SCAN 57.00 57.00 0 0 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 59.00 0 0 60.00 06000 LABORATORY 3, 939, 599 433, 569 147, 079 0 23, 273 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 118.703 13.064 C 0 0 63.00 06500 RESPI RATORY THERAPY 65.00 1, 264, 543 139, 168 7, 323 0 29, 922 65.00 66, 00 06600 PHYSI CAL THERAPY 1, 264, 746 139, 190 81, 320 1, 378 13, 299 66.00 06900 ELECTROCARDI OLOGY 587, 023 64, 604 70, 442 29, 922 69.00 0 69.00 06901 CARDI AC REHAB 514.430 69.01 69 01 56, 615 118, 426 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 188, 477 240, 851 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 1, 312, 824 144, 482 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 9, 111, 284 1,002,697 ol 73.00 0 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 76.00 711, 131 78, 263 15, 604 Λ 76.00 03480 ONCOLOGY 76.01 1, 523, 461 167, 663 285, 878 0 53, 195 76.01 OUTPATIENT SERVICE COST CENTERS 90.00 3, 849, 773 423 683 341 823 0 36, 572 90 00 09000 CLI NI C 09001 WOUND CARE 90.01 234, 343 25, 790 58, 287 0 16,623 90.01 09100 EMERGENCY 2, 762, 528 304, 027 326, 155 59, 022 91.00 91.00 106, 390 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 70, 128, 812 6, 836, 215 3, 813, 782 235, 549 1, 065, 230 118. 00 118.00 NONREI MBURSABLE COST CENTERS 194. 00 07950 FOUNDATI ON 1, 947 214 C 10, 639 194. 00 194. 01 07951 MOB 31, 528 ol 0 194. 01 7.656 843 194. 02 07952 NONREI MBURSABLE OTHER 0 0 194 02 0 C 194. 03 07953 PIH 0 0 0 0 194, 03 194. 04 07954 HEALTH COMPANIES 863, 575 95,040 0 13, 299 194. 04 48.643 0 194. 05 07955 PHYSICIANS OFFICE 6, 791, 859 79, 793 194. 05 747.471 171, 965 0 194.06 194.06 07956 THE ARBORS 0 194. 07 07957 PAIN MANAGEMENT 7, 186 791 29, 931 0 0 194. 07 26, 598 194. 08 194. 08 07958 OPS 0 41, 230 4,538 164, 685 194. 09 07959 MHL ROCHESTER HEALTH CENTER 0 0 194.09 392.051 43.147 194. 10 07961 RHEUMATOLOGY 1, 914, 175 210,663 120, 299 0 29, 922 194. 10 194. 11 07960 SPORTS HEALTH 455, 747 50, 157 0 0 194. 11 0 194. 12 07962 BEHAVI ORAL HEALTH CLINIC 204, 419 22, 497 0 0 0 194. 12 200.00 Cross Foot Adjustments 200.00 0 201.00 Negative Cost Centers 0 201.00 80, 808, 657 TOTAL (sum lines 118 through 201) 4, 380, 833 1, 225, 481 202.00 202.00 8, 011, 576 235, 549

Provider CCN: 15-0072

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

| | | | 10 |) 12/31/2020 | Date/IIme Pre 8/2/2021 10:5 | |
|--|---------------------|---------------------|---------------------------------------|------------------------|----------------------------------|--------------------|
| Cost Center Description | DI ETARY | CAFETERI A | NURSI NG ADMI NI STRATI O | CENTRAL SERVI CES & | PHARMACY | , din |
| | | | N | SUPPLY | | |
| GENERAL SERVICE COST CENTERS | 10. 00 | 11. 00 | 13. 00 | 14. 00 | 15. 00 | |
| 1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 1. 01 00101 MOB | | | | | | 1.00 |
| 1. 02 00102 0PS | | | | | | 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 & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG | | | | | | 8. 00 9. 00 |
| 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY | 447, 682 | | | | | 10.00 |
| 11. 00 01100 CAFETERI A | 447,002 | 964, 951 | | | | 11.00 |
| 13. 00 01300 NURSING ADMINISTRATION | o | 48, 571 | 2, 436, 768 | | | 13.00 |
| 14.00 01400 CENTRAL SERVICES & SUPPLY | o | 2, 375 | | 780, 517 | | 14.00 |
| 15. 00 01500 PHARMACY | 0 | 18, 363 | 0 | 0 | 1, 687, 729 | 15. 00 |
| 16.00 01600 MEDICAL RECORDS & LIBRARY | 0 | 271 | 0 | 0 | 0 | 16.00 |
| 17. 00 01700 SOCI AL SERVI CE | 0 | 17, 346 | 0 | 0 | 0 | 17.00 |
| 30. 00 O3000 ADULTS & PEDIATRICS | 404 400 | 100 010 | 946, 875 | ol | 0 | 30.00 |
| 31. 00 03000 ADULTS & PEDIATRICS | 404, 499 43, 183 | 123, 813 27, 080 | 207, 095 | ol Ol | 0 | 31.00 |
| 43. 00 04300 NURSERY | 45, 105 | 9, 019 | | 0 | 0 | 43.00 |
| ANCI LLARY SERVI CE COST CENTERS | <u> </u> | 7,017 | 00, 717 | <u>o</u> l | | 10.00 |
| 50. 00 05000 OPERATING ROOM | 0 | 86, 597 | 662, 256 | 0 | 0 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 12, 718 | 97, 258 | 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 | 44, 445 | 0 | 0 | 0 | 54.00 |
| 57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) | 0 | 0 | 0 | U O | 0 | 57. 00 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | | 0 | | 0 | 0 | 59.00 |
| 60. 00 06000 LABORATORY | | 0 | | Ö | 0 | 60.00 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | 0 | O | 0 | 63.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 0 | 22, 190 | 0 | o | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 30, 174 | 0 | 0 | 0 | 66.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 9, 386 | 0 | 0 | 0 | 69.00 |
| 69. 01 06901 CARDIAC REHAB 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 14, 052 | 0 | 700 517 | 0 | 69.01 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | | 0 | 0 | 780, 517 | 0 | 71. 00 72. 00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | | 0 | 0 | 0 | 1, 687, 729 | 73.00 |
| 76. 00 03450 NUCLEAR MEDICINE - DIAGNOSTIC | o | 6, 879 | · · · · · · · · · · · · · · · · · · · | Ö | 0 | 76.00 |
| 76. 01 03480 ONCOLOGY | 0 | 18, 723 | 0 | 0 | 0 | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLI NI C | 0 | 161, 102 | | 0 | 0 | 90.00 |
| 90. 01 09001 WOUND CARE 91. 00 09100 EMERGENCY | 0 | 25, 709 | | 0 | 0 | 90. 01 91. 00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 59, 405 | 454, 307 | 0 | U | 91.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | 72.00 |
| 95. 00 09500 AMBULANCE SERVICES | 0 | 0 | 0 | 0 | 0 | 95.00 |
| SPECIAL PURPOSE COST CENTERS | | | | | | |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 447, 682 | 738, 218 | 2, 436, 768 | 780, 517 | 1, 687, 729 | 118. 00 |
| NONREI MBURSABLE COST CENTERS | 1 1 | | | | | |
| 194. 00 07950 FOUNDATI ON 194. 01 07951 MOB | 0 | 0 | 0 | ol Ol | | 194. 00 194. 01 |
| 194. 01 07951 MOB 194. 02 07952 NONREI MBURSABLE OTHER | 0 | 0 | 0 | 0 | | 194.01 |
| 194. 03 07953 PI H | | 0 | 0 | 0 | | 194. 02 |
| 194. 04 07954 HEALTH COMPANIES | o | 32, 705 | O | Ö | | 194.04 |
| 194. 05 07955 PHYSI CI ANS OFFI CE | o | 61, 954 | 0 | О | | 194. 05 |
| 194. 06 07956 THE ARBORS | 0 | 0 | 0 | o | | 194. 06 |
| 194. 07 07957 PAIN MANAGEMENT | 0 | 2, 568 | 0 | 0 | | 194. 07 |
| 194.08 07958 OPS 194.09 07959 MHL ROCHESTER HEALTH CENTER | 0 | 20.400 | 0 | O | | 194. 08 194. 09 |
| 194. 09 07959 MHL ROCHESTER HEALTH CENTER 194. 10 07961 RHEUMATOLOGY | | 20, 499 32, 508 | | 0 | | 194. 09 |
| 194. 11 07960 SPORTS HEALTH | 0 | 10, 977 | | 0 | | 194. 10 |
| 194. 12 07962 BEHAVI ORAL HEALTH CLINIC | | 65, 522 | | o | | 194. 12 |
| 200.00 Cross Foot Adjustments | | • | | | | 200. 00 |
| 201.00 Negative Cost Centers | 0 | 0 | 0 | 0 | | 201. 00 |
| 202.00 TOTAL (sum lines 118 through 201) | 447, 682 | 964, 951 | 2, 436, 768 | 780, 517 | 1, 687, 729 | 202. 00 |
| | | | | | | |

| COCT A | Financial Systems 1 | MEMORIAL HOSPITAL | LUGANSPURT | | In Lieu | of Form CMS-2 | <u> 2552-10</u> |
|---|--|-----------------------------------|--------------------------|--|---|---|---|
| CUST A | LLOCATION - GENERAL SERVICE COSTS | | Provi der CC | F | Period: From 01/01/2020 To 12/31/2020 | Worksheet B Part I Date/Time Pre 8/2/2021 10:5 | epared: |
| | Cost Center Description | MEDI CAL RECORDS & LI BRARY | SOCI AL SERVI CE | Subtotal | Intern & Residents Cost & Post Stepdown Adjustments | Total | , diii |
| | | 16. 00 | 17. 00 | 24. 00 | 25. 00 | 26.00 | |
| 1. 00 1. 01 1. 02 4. 00 5. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 | GENERAL SERVICE COST CENTERS 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 | 8, 095, 293 0 | 348, 536 | | | | 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 16.00 17.00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | <u> </u> | 0.107.000 | | | | 1 |
| 30. 00 31. 00 43. 00 | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY ANCILLARY SERVICE COST CENTERS | 561, 128 103, 558 65, 387 | 268, 264 26, 449 0 | 8, 987, 801 1, 956, 753 617, 787 | 0 | 8, 987, 801 1, 956, 753 617, 787 | 31.00 |
| 50. 00 | 05000 OPERATING ROOM | 2, 149, 390 | 1, 295 | 9, 318, 103 | sl ol | 9, 318, 103 | 50.00 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 92, 191 | 0 | 1, 077, 148 | | 1, 077, 148 | |
| 53.00 | 05300 ANESTHESI OLOGY | 97, 219 | 0 | 212, 444 | | 212, 444 | |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 647, 696 | 0 | 3, 689, 491 | 0 | 3, 689, 491 | |
| 57. 00 58. 00 | 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | 0 | (| | 0 | |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | | 0 | | | 0 | |
| 60.00 | 06000 LABORATORY | 962, 129 | Ö | 5, 505, 649 | ol ol | 5, 505, 649 | 1 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 55, 766 | 0 | 187, 533 | | 187, 533 | 1 |
| 65.00 | 06500 RESPI RATORY THERAPY | 313, 824 | 0 | 1, 776, 970 | | 1, 776, 970 | |
| 66.00 | 06600 PHYSI CAL THERAPY | 169, 605 | 0 | 1, 699, 712 | | 1, 699, 712 | 1 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 132, 035 | 0 | 893, 412 | | 893, 412 | |
| 69. 01 71. 00 | 06901 CARDI AC REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS | 19, 798 | 0 | 723, 321 3, 209, 845 | | 723, 321 3, 209, 845 | |
| | 07200 I MPL. DEV. CHARGED TO PATIENT | | o | 1, 457, 306 | | 1, 457, 306 | |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | o | 11, 801, 710 | | 11, 801, 710 | 1 |
| 76.00 | 03450 NUCLEAR MEDICINE - DIAGNOSTIC | 495, 580 | 0 | 1, 307, 457 | 0 | 1, 307, 457 | 76.00 |
| 76. 01 | 03480 ONCOLOGY | 527, 430 | 0 | 2, 576, 350 | 0 | 2, 576, 350 | 76. 01 |
| | OUTPATIENT SERVICE COST CENTERS | 104 070 | 00.000 | 5 000 // | | 5 000 /// | 4 |
| 90.00 | 09000 CLI NI C 09001 WOUND CARE | 496, 378 119, 497 | 30, 333 | 5, 339, 664 480, 249 | | 5, 339, 664 480, 249 | |
| | 09100 EMERGENCY | 707, 090 | 22, 195 | 4, 801, 119 | _ | 4, 801, 119 | |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | , | .,, | O | .,, | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | 4 |
| 95. 00 | 09500 AMBULANCE SERVI CES | 0 | 0 | |) 0 | 0 | 95.00 |
| 118. 00 | NONREI MBURSABLE COST CENTERS | 7, 715, 701 | 348, 536 | 67, 619, 824 | | 67, 619, 824 |] 118. 00 |
| | 07950 FOUNDATI ON | 0 | 0 | 12, 800 | | | 194. 00 |
| | 07951 MOB | 0 | 0 | 40, 027 | | | 194. 01 |
| | 07952 NONREI MBURSABLE OTHER 07953 PI H | 0 | 0 | (| | | 194. 02 194. 03 |
| | 07954 HEALTH COMPANIES | 0 | 0 | 1, 053, 262 | | 1, 053, 262 | |
| | 07955 PHYSI CI ANS OFFI CE | 288, 757 | o | 8, 141, 799 | | 8, 141, 799 | |
| | 07956 THE ARBORS | 0 | 0 | C | 0 | | 194. 06 |
| | 07957 PAIN MANAGEMENT | 0 | 0 | 40, 476 | | | 194. 07 |
| | 07958 OPS | 0 540 | 0 | 237, 051 | | 237, 051 | |
| | 07959 MHL ROCHESTER HEALTH CENTER 07961 RHEUMATOLOGY | 8, 548 68, 307 | ٥ | 464, 245 2, 375, 874 | | 464, 245 2, 375, 874 | |
| | 07960 SPORTS HEALTH | 00, 307 | 0 | 516, 881 | | 516, 881 | |
| 194. 11 | 07962 BEHAVI ORAL HEALTH CLINIC | 13, 980 | o | 306, 418 | | 306, 418 | |
| | | | 1 | | | | |
| 194. 12 200. 00 | Cross Foot Adjustments | | | C | 1 | | 200.00 |
| 194. 12 | Cross Foot Adjustments Negative Cost Centers | 0 8, 095, 293 | 0 348, 536 | 0 0 80, 808, 657 | Ö | | 201. 00 |

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0072

| | | | | T | o 12/31/2020 | Date/Time Pre | |
|--------------------|--|--------------------------|---|--------------------|--------------|----------------------|--------------------|
| | | | CAP | TAL RELATED CO | STS | 8/2/2021 10: 5 | am |
| | | | | | | | |
| | Cost Center Description | Directly Assigned New | NEW BLDG & FLXT | MOB | 0PS | Subtotal | |
| | | Capi tal | FIAI | | | | |
| | | Related Costs | | | | | |
| | T | 0 | 1. 00 | 1. 01 | 1. 02 | 2A | |
| 1. 00 | GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 1. 01 | 00100 NEW CAL REE COSTS-BEDG & TTXT | | | | | | 1.00 |
| 1. 02 | 00102 OPS | | | | | | 1. 02 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 0 | 8, 983 | | 0 | 8, 983 | 4.00 |
| 5.00 | 00500 ADMINISTRATIVE & GENERAL | 0 | 367, 418 | | | 388, 408 | |
| 7. 00 8. 00 | 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE | 0 | 837, 314 14, 673 | | 11, 704 | 850, 377 14, 673 | 7. 00 8. 00 |
| 9. 00 | 00900 HOUSEKEEPING | | 32, 850 | | 432 | 34, 008 | 1 |
| 10.00 | 01000 DI ETARY | O | 139, 043 | | 0 | 139, 043 | 1 |
| 11. 00 | 01100 CAFETERI A | 0 | 67, 205 | | 0 | 67, 205 | 1 |
| 13.00 | 01300 NURSI NG ADMI NI STRATI ON | 0 | 52, 132 | | 0 | 52, 132 | 1 |
| 14. 00 15. 00 | 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY | 0 | 97, 045 49, 452 | | 0 | 97, 045 49, 452 | 1 |
| 16. 00 | 01600 MEDICAL RECORDS & LIBRARY | | 175, 067 | | 0 | 175, 067 | 1 |
| 17. 00 | 01700 SOCIAL SERVICE | O | 29, 205 | | Ō | 29, 205 | 1 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 31. 00 | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT | 0 | 819, 231 124, 228 | | 0 | 819, 231 124, 228 | 1 |
| 43. 00 | 04300 NURSERY | | 6, 114 | | 0 | 6, 114 | 1 |
| .0.00 | ANCILLARY SERVICE COST CENTERS | | 37 | .1 | ٩ | 37 |] |
| 50.00 | 05000 OPERATING ROOM | 0 | 458, 232 | | 33, 560 | 491, 792 | |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 100, 243 | | 0 | 100, 243 | 1 |
| 53. 00 54. 00 | 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C | 0 | 41, 457 212, 291 | | 8, 309 | 41, 457 220, 600 | |
| 57.00 | 05700 CT SCAN | | 212, 271 | | 0, 309 | 220, 000 | 1 |
| 58.00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | C | 0 | 0 | 0 | 1 |
| 59.00 | 05900 CARDI AC CATHETERI ZATI ON | 0 | C | 0 | 0 | 0 | |
| 60.00 | 06000 LABORATORY | 0 | 113, 741 | 6, 874 | 3, 875 | 124, 490 | 1 |
| 63. 00 65. 00 | 06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY | 0 | 8, 089 | | 0 | 0 8, 089 | 1 |
| 66. 00 | 06600 PHYSI CAL THERAPY | l ő | 89, 826 | 1 | ő | 89, 826 | 1 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 11, 264 | | 0 | 25, 727 | 1 |
| 69. 01 | 06901 CARDI AC REHAB | 0 | 130, 813 | 0 | 0 | 130, 813 | 1 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | C | 0 | 0 | 0 | |
| 72. 00 73. 00 | 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS | 0 | (| | 0 | 0 | 72. 00 73. 00 |
| 76.00 | 03450 NUCLEAR MEDICINE - DIAGNOSTIC | Ö | 17, 236 | o o | o | 17, 236 | 1 |
| 76. 01 | 03480 ONCOLOGY | 0 | | 1 | 48, 216 | 70, 611 | 76. 01 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | 05.000 | |
| 90. 00 90. 01 | 09000 CLI NI C 09001 WOUND CARE | 0 | 4, 938 | 80, 990 13, 993 | 0 | 85, 928 13, 993 | 1 |
| | 09100 EMERGENCY | | 360, 270 | | 0 | 360, 270 | |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | 0 | |
| 05.00 | OTHER REIMBURSABLE COST CENTERS | | | | ام | | 05.00 |
| 95.00 | O9500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS | 0 | | 0 | 0 | 0 | 95.00 |
| 118. 00 | | 0 | 4, 368, 360 | 161, 790 | 106, 096 | 4, 636, 246 | 118.00 |
| | NONREI MBURSABLE COST CENTERS | | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | |
| | 07950 FOUNDATI ON | 0 | C | 0 | 0 | | 194.00 |
| | 07951 MOB 07952 NONREIMBURSABLE OTHER | 0 | (| 7, 569 | 0 | | 194. 01 194. 02 |
| | 07952 NONKET WOOKSABLE OTHER 307953 PIH | | (| | 0 | | 194. 02 |
| | 07954 HEALTH COMPANIES | 0 | 53, 731 | il o | 0 | | 194. 04 |
| | 07955 PHYSI CLANS OFFI CE | 0 | 105, 910 | 18, 266 | 0 | 124, 176 | |
| | 07956 THE ARBORS | 0 | C | 0 | 0 | | 194.06 |
| | 7 07957 PALN MANAGEMENT 8 07958 OPS | 0 | (| 7, 186 | 0 41, 230 | | 194. 07 194. 08 |
| | 07959 MHL ROCHESTER HEALTH CENTER | | (| | 41, 230 | | 194.00 |
| | 07961 RHEUMATOLOGY | | C | 28, 881 | o | | 194. 10 |
| 194. 11 | 07960 SPORTS HEALTH | 0 | C | 0 | O | 0 | 194. 11 |
| | 07962 BEHAVI ORAL HEALTH CLINIC | 0 | C | 0 | 0 | | 194. 12 |
| 200. 00 201. 00 | 1 1 | | | | | | 200. 00 201. 00 |
| 201.00 | | 0 | 4, 528, 001 | 223, 692 | 147, 326 | | |
| | | ٠ - ١ | .,, | | , ==0 | ., | |

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0072

Peri od: Worksheet B From 01/01/2020 Part II To 12/31/2020 Date/Time Prepared:

8/2/2021 10:57 am Cost Center Description **EMPLOYEE** ADMI NI STRATI V OPERATION OF LAUNDRY & HOUSEKEEPI NG **BENEFITS** LINEN SERVICE E & GENERAL **PLANT** DEPARTMENT 5.00 7.00 8. 00 9.00 4 00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.01 00101 MOB 1.01 00102 OPS 1 02 1 02 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 8, 983 4.00 00500 ADMINISTRATIVE & GENERAL 389, 224 5.00 816 5.00 7.00 00700 OPERATION OF PLANT 183 21, 102 871, 662 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 Ω 1.071 2.643 18.387 8 00 9.00 00900 HOUSEKEEPI NG 5, 737 6,862 46, 759 9.00 152 10.00 01000 DI ETARY 19 1, 546 25,046 74 0 10.00 01100 CAFETERI A 4.355 12, 106 11.00 86 0 11.00 0 01300 NURSING ADMINISTRATION 9, 391 13.00 240 11, 260 0 127 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 68 3, 287 17, 481 0 304 14.00 15.00 01500 PHARMACY 131 7, 793 8, 908 0 254 15.00 01600 MEDICAL RECORDS & LIBRARY 38, 181 31, 535 0 16.00 402 381 16.00 17.00 01700 SOCIAL SERVICE 42 1, 468 5, 261 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 147, 567 30.00 03000 ADULTS & PEDIATRICS 4.954 15, 653 30.00 811 26, 338 03100 INTENSIVE CARE UNIT 31.00 178 6, 561 22, 377 647 2,537 31 00 04300 NURSERY 43.00 67 2, 175 1, 101 1, 145 101 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 5, 709 50.00 1, 178 27, 212 109, 214 5, 516 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 94 3, 557 18,057 0 1, 751 52.00 53.00 05300 ANESTHESI OLOGY 0 374 7.468 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 281 2,030 13.014 44.844 1.336 54.00 05700 CT SCAN 57 00 0 C Ω 0 Ω 57 00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58.00 C 05900 CARDI AC CATHETERI ZATI ON 59.00 0 0 0 0 59.00 06000 LABORATORY 0 21, 065 ol 888 60.00 29, 265 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 635 \cap 0 Ω 63.00 65.00 06500 RESPIRATORY THERAPY 205 6, 762 1, 457 0 1, 142 65.00 06600 PHYSI CAL THERAPY 66.00 202 6, 763 16, 180 108 507 66.00 69 00 06900 ELECTROCARDI OLOGY 83 3.139 14 016 0 1, 142 69 00 06901 CARDI AC REHAB 0 69.01 66 2, 751 23, 563 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 11, 702 0 0 71.00 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 7,020 0 ol 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73 00 48, 695 Ω 73 00 0 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 76.00 54 3,802 3, 105 0 76.00 03480 ONCOLOGY 2, 030 76.01 154 8, 146 56,882 76.01 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1, 379 20, 585 68,013 0 1, 395 90.00 90.01 09001 WOUND CARE 1, 253 11, 597 90.01 39 634 91.00 09100 EMERGENCY 404 14,771 64, 896 4,607 4,059 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 SPECIAL PURPOSE COST CENTERS 40, 644 118. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 7, 334 332, 120 758, 835 18, 387 NONREI MBURSABLE COST CENTERS 194. 00 07950 FOUNDATI ON 406 194, 00 1C 194. 01 07951 MOB 0 0 194. 01 0 41 6, 273 194. 02 07952 NONREI MBURSABLE OTHER 0 C 0 0 0 194 02 194. 03 07953 PI H 0 0 0 194.03 194. 04 07954 HEALTH COMPANIES 117 4,618 9,679 0 507 194.04 0 194. 05 07955 PHYSICIANS OFFICE 3, 045 194. 05 1,047 36, 316 34, 216 0 194.06 194.06 07956 THE ARBORS Ω 194. 07 07957 PAIN MANAGEMENT 5, 955 0 0 194. 07 0 38 194. 08 07958 OPS 0 0 220 1, 015 194. 08 32, 768 0 194. 09 07959 MHL ROCHESTER HEALTH CENTER 2,096 0 194.09 41 0 194. 10 07961 RHEUMATOLOGY 337 10, 235 23, 936 0 1, 142 194. 10 194. 11 07960 SPORTS HEALTH 74 2, 437 0 0 194. 11 194. 12 07962 BEHAVI ORAL HEALTH CLINIC 33 1,093 0 0 0 194. 12 200.00 Cross Foot Adjustments lann nn 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 8, 983 389, 224 871, 662 18, 387 46, 759 202. 00

Provider CCN: 15-0072

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2020 Part II
To 12/31/2020 Date/Time Prepared:
8/2/2021 10:57 am

| | | | | | 12/31/2020 | 8/2/2021 10: 5 | |
|------------------|---|---------------------|-------------------|-----------------------------------|----------------------------------|----------------|--------------------|
| | Cost Center Description | DI ETARY | CAFETERI A | NURSI NG ADMI NI STRATI O N | CENTRAL SERVI CES & SUPPLY | PHARMACY | |
| | | 10. 00 | 11. 00 | 13.00 | 14.00 | 15. 00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1. 00 | 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 1.01 | 00101 MOB | | | | | | 1.01 |
| 1. 02 | 00102 OPS | | | | | | 1.02 |
| 4. 00 5. 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL | | | | | | 4. 00 5. 00 |
| 7. 00 | 00700 OPERATION OF PLANT | | | | | | 7.00 |
| 8. 00 | 00800 LAUNDRY & LINEN SERVICE | | | | | | 8.00 |
| 9. 00 | 00900 HOUSEKEEPI NG | | | | | | 9. 00 |
| 10.00 | 01000 DI ETARY | 165, 728 | | | | | 10.00 |
| 11.00 | 01100 CAFETERI A | 0 | 83, 752 | | | | 11.00 |
| 13.00 | 01300 NURSING ADMINISTRATION | 0 | 4, 216 | 77, 366 | | | 13.00 |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 0 | 206 | 0 | 118, 391 | | 14.00 |
| | 01500 PHARMACY | 0 | 1, 594 | 0 | 0 | 68, 132 | 1 |
| 16. 00 | 01600 MEDI CAL RECORDS & LI BRARY | 0 | 24 | 0 | 0 | 0 | 16. 00 |
| 17. 00 | 01700 SOCIAL SERVICE | 0 | 1, 506 | 0 | 0 | 0 | 17.00 |
| 20.00 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 140 740 | 10 744 | 30, 063 | ol | 0 | 20.00 |
| | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT | 149, 742 15, 986 | 10, 746 2, 350 | | 0 | 0 | |
| | 04300 NURSERY | 15, 960 | 2, 350 783 | | 0 | 0 | 43.00 |
| 43.00 | ANCI LLARY SERVI CE COST CENTERS | O _I | 703 | 2, 170 | <u> </u> | | 43.00 |
| 50.00 | 05000 OPERATING ROOM | 0 | 7, 516 | 21, 026 | 0 | 0 | 50.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 1, 104 | | 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 | 3, 858 | 0 | 0 | 0 | 54.00 |
| 57.00 | 05700 CT SCAN | 0 | 0 | 0 | 0 | 0 | 57.00 |
| 58. 00 | 05800 MAGNETIC RESONANCE I MAGING (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 |
| 63. 00 65. 00 | 06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY | 0 | 0 1, 926 | 0 | U O | 0 | 63. 00 65. 00 |
| 66. 00 | 06600 PHYSI CAL THERAPY | 0 | 2, 619 | | 0 | 0 | 66.00 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 0 | 815 | | | 0 | 69.00 |
| 69. 01 | 06901 CARDI AC REHAB | ő | 1, 220 | | o | 0 | 69. 01 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 0 | 118, 391 | 0 | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | 0 | 0 | 0 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 68, 132 | 73. 00 |
| 76. 00 | 03450 NUCLEAR MEDICINE - DIAGNOSTIC | 0 | 597 | 0 | 0 | 0 | 76. 00 |
| 76. 01 | 03480 ONCOLOGY | 0 | 1, 625 | 0 | 0 | 0 | 76. 01 |
| 00.00 | OUTPATIENT SERVICE COST CENTERS | 0 | 12 000 | O | O | 0 | 90.00 |
| 90. 00 90. 01 | 09000 CLI NI C 09001 WOUND CARE | 0 | 13, 980 2, 231 | 0 | 0 | 0 | |
| 91. 00 | 09100 EMERGENCY | 0 | 5, 156 | - | 0 | 0 | 91.00 |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | o o | 0, 100 | 11, 121 | Ĭ | Ü | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 95.00 | 09500 AMBULANCE SERVICES | 0 | 0 | 0 | 0 | 0 | 95.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| 118. 00 | 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | 165, 728 | 64, 072 | 77, 366 | 118, 391 | 68, 132 | 118. 00 |
| 104.00 | NONREI MBURSABLE COST CENTERS 07950 FOUNDATION | ما | 0 | O | ما | 0 | 194. 00 |
| | 07950 FOUNDATT ON 07951 MOB | 0 | 0 | - | O O | | 194.00 |
| | 07952 NONREI MBURSABLE OTHER | 0 | 0 | | 0 | | 194.01 |
| | 07953 PI H | 0 | 0 | 0 | 0 | | 194. 02 |
| | 07954 HEALTH COMPANIES | Ö | 2, 839 | - | 0 | | 194. 04 |
| | 07955 PHYSI CI ANS OFFI CE | 0 | 5, 377 | | 0 | | 194. 05 |
| 194.06 | 07956 THE ARBORS | 0 | 0 | 0 | 0 | 0 | 194. 06 |
| 194. 07 | 07957 PAIN MANAGEMENT | 0 | 223 | 0 | 0 | | 194. 07 |
| | 07958 OPS | 0 | 0 | - | 0 | | 194. 08 |
| | 07959 MHL ROCHESTER HEALTH CENTER | 0 | 1, 779 | | 0 | | 194. 09 |
| | 07961 RHEUMATOLOGY | 0 | 2, 822 | | 0 | | 194. 10 |
| | 07960 SPORTS HEALTH | 0 | 953 5 697 | | 0 | | 194. 11 |
| 200.00 | 07962 BEHAVIORAL HEALTH CLINIC Cross Foot Adjustments | | 5, 687 | | ٩ | U | 194. 12 200. 00 |
| 200.00 | | n | 0 | 0 | n | n | 200.00 |
| 202. 00 | | 165, 728 | 83, 752 | ١ | 118, 391 | | 202.00 |
| 50 | | | , | | = / = / . | , .02 | |

| | | <i>y</i> | <u>IEMORIAL HOSPITAL</u> | | | | i of Form CMS-2 | 2552-10 |
|--------------------|---------|--|--------------------------|--------------|---------------------|--------------------------|--------------------------------|--------------------|
| ALLOCA | ATION (| OF CAPITAL RELATED COSTS | | Provi der CC | | eriod: rom 01/01/2020 | Worksheet B Part II | |
| | | | | | T | | Date/Time Pre 8/2/2021 10:5 | pared: |
| | | Cost Center Description | MEDI CAL | SOCI AL | Subtotal | Intern & | Total | 7 alli |
| | | · | RECORDS & | SERVI CE | | Resi dents | | |
| | | | LI BRARY | | | Cost & Post Stepdown | | |
| | | | | | | Adjustments | | |
| | | | 16. 00 | 17. 00 | 24. 00 | 25. 00 | 26. 00 | |
| 1. 00 | | AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FLXT | | | | | | 1.00 |
| 1. 01 | 00101 | | | | | | | 1.00 |
| 1. 02 | 00102 | | | | | | | 1. 02 |
| 4. 00 5. 00 | 1 | EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5. 00 7. 00 | | ADMINISTRATIVE & GENERAL OPERATION OF PLANT | | | | | | 5. 00 7. 00 |
| 8.00 | 00800 | LAUNDRY & LINEN SERVICE | | | | | | 8. 00 |
| 9.00 | 1 | HOUSEKEEPI NG | | | | | | 9.00 |
| 10. 00 11. 00 | | DI ETARY CAFETERI A | | | | | | 10.00 11.00 |
| 13. 00 | | NURSI NG ADMI NI STRATI ON | | | | | | 13.00 |
| 14. 00 | | CENTRAL SERVICES & SUPPLY | | | | | | 14.00 |
| 15. 00 16. 00 | | PHARMACY MEDICAL RECORDS & LIBRARY | 245, 590 | | | | | 15. 00 16. 00 |
| 17. 00 | 1 | SOCIAL SERVICE | 243, 370 | 37, 482 | | | | 17. 00 |
| | | ENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | | ADULTS & PEDIATRICS | 17, 018 | 28, 850 | 1, 250, 973 | 0 | 1, 250, 973 | 1 |
| 31. 00 43. 00 | | INTENSIVE CARE UNIT NURSERY | 3, 141 1, 983 | 2, 844 0 | 187, 424 15, 659 | 0 | 187, 424 15, 659 | 1 |
| .0.00 | | LARY SERVICE COST CENTERS | .,,,,,, | ٥١ | | 9 | 10,007 | 10.00 |
| 50.00 | 1 | OPERATI NG ROOM | 65, 259 | 139 | 734, 561 | 0 | 734, 561 | 50.00 |
| 52. 00 53. 00 | | DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY | 2, 796 2, 949 | 0 | 130, 690 52, 248 | 0 | 130, 690 52, 248 | 1 |
| 54. 00 | 1 | RADI OLOGY-DI AGNOSTI C | 19, 644 | ő | 305, 607 | 0 | 305, 607 | 1 |
| 57.00 | | CT SCAN | 0 | o | 0 | o | 0 | |
| 58. 00 59. 00 | | MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION | 0 | 0 | 0 | 0 | 0 | 58. 00 59. 00 |
| 60.00 | | LABORATORY | 29, 180 | ol | 204, 888 | 0 | 204, 888 | • |
| 63.00 | 06300 | BLOOD STORING, PROCESSING & TRANS. | 1, 691 | o | 2, 326 | 0 | 2, 326 | • |
| 65.00 | | RESPI RATORY THERAPY | 9, 518 | 0 | 29, 099 | 0 | 29, 099 | • |
| 66. 00 69. 00 | | PHYSI CAL THERAPY ELECTROCARDI OLOGY | 5, 144 4, 004 | 0 | 121, 349 48, 926 | 0 | 121, 349 48, 926 | 1 |
| 69. 01 | | CARDI AC REHAB | 600 | Ö | 159, 013 | o | 159, 013 | 1 |
| 71.00 | | MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 130, 093 | 0 | 130, 093 | • |
| 72. 00 73. 00 | | IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS | 0 | 0 | 7, 020 116, 827 | 0 | 7, 020 116, 827 | 1 |
| 76. 00 | | NUCLEAR MEDICINE - DIAGNOSTIC | 15, 030 | o | 39, 824 | 0 | 39, 824 | • |
| 76. 01 | 03480 | ONCOLOGY | 15, 996 | 0 | 155, 444 | 0 | 155, 444 | 76. 01 |
| 90. 00 | | TIENT SERVICE COST CENTERS CLINIC | 15, 055 | 3, 262 | 209, 597 | O | 209, 597 | 90.00 |
| | 1 | WOUND CARE | 3, 624 | 3, 202 | | | 33, 371 | 1 |
| 91.00 | 09100 | EMERGENCY | 21, 445 | 2, 387 | 492, 419 | 0 | 492, 419 | |
| 92. 00 | | OBSERVATION BEDS (NON-DISTINCT PART) | | | | 0 | | 92.00 |
| 95. 00 | 09500 | REIMBURSABLE COST CENTERS AMBULANCE SERVICES | O | o | 0 | O | 0 | 95. 00 |
| 70.00 | | AL PURPOSE COST CENTERS | | ٥١ | | | | 70.00 |
| 118.00 | | SUBTOTALS (SUM OF LINES 1 through 117) | 234, 077 | 37, 482 | 4, 427, 358 | 0 | 4, 427, 358 | 118. 00 |
| 194 00 | | I MBURSABLE COST CENTERS FOUNDATION | 0 | ol | 416 | O | 416 | 194. 00 |
| 194. 01 | | | Ö | Ö | 13, 883 | Ö | 13, 883 | 1 |
| | | NONREI MBURSABLE OTHER | 0 | 0 | 0 | 0 | | 194. 02 |
| 194. 03 | | PIH HEALTH COMPANIES | 0 | 0 | 0 71, 491 | 0 | 0 71, 491 | 194. 03 |
| | | PHYSICIANS OFFICE | 8, 758 | ő | 212, 935 | | 212, 935 | |
| | | THE ARBORS | 0 | o | 0 | o | | 194. 06 |
| 194. 07 194. 08 | 1 | PAIN MANAGEMENT | 0 | 0 | 13, 402 | 0 | | 194.07 |
| | | MHL ROCHESTER HEALTH CENTER | 259 | ol | 75, 233 4, 175 | 0 | | 194. 08 194. 09 |
| 194. 10 | 07961 | RHEUMATOLOGY | 2, 072 | ő | 69, 425 | Ö | 69, 425 | 194. 10 |
| | | SPORTS HEALTH | 0 | 0 | 3, 464 | 0 | | 194. 11 |
| 194. 12 200. 00 | | BEHAVIORAL HEALTH CLINIC Cross Foot Adjustments | 424 | ٥ | 7, 237 0 | 0 | | 194. 12 200. 00 |
| 201.00 | 1 | Negative Cost Centers | o | О | 0 | 0 | 0 | 201.00 |
| 202.00 |) | TOTAL (sum lines 118 through 201) | 245, 590 | 37, 482 | 4, 899, 019 | o | 4, 899, 019 | |
| | | | | | | | | |

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS MEMORIAL HOSPITAL LOGANSPORT In Lieu of Form CMS-2552-10 Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 8/2/2021 10:57 am Provider CCN: 15-0072

| CAPITAL RELATED COSTS | 1. 1. 1. 4. 76 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 16. 0 17. 0 30. 0 31. 0 43. 0 50. 0 52. |
|--|--|
| FIXT | 1. 1. 1. 4. 76 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 16. 0 17. 0 30. 0 31. 0 43. 0 50. 0 52. |
| FIXT | 1. 1. 1. 4. 76 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 16. 0 17. 0 30. 0 31. 0 43. 0 50. 0 52. |
| COUNTRY FEET COUNTRY FEET COUNTRY COUNTRY | 1. 1. 4. 76 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 16. 0 17. 0 30. 0 31. 0 43. 0 50. 0 52. |
| FEET) GROSS SALARI ES | 1. 1. 4. 76 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 16. 0 17. 0 30. 0 31. 0 43. 0 50. 0 52. |
| CENERAL SERVICE COST CENTERS | 1. 1. 4. 76 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 16. 0 17. 0 30. 0 31. 0 43. 0 50. 0 52. |
| 1.00 | 1. 1. 4. 76 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 16. 0 17. 0 30. 0 31. 0 43. 0 50. 0 52. |
| CEMERAL SERVICE COST CENTERS | 1. 1. 4. 76 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 16. 0 17. 0 30. 0 31. 0 43. 0 50. 0 52. |
| 1. 00 | 1. 1. 4. 76 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 16. 0 17. 0 30. 0 31. 0 43. 0 50. 0 52. |
| 1. 01 00101 MOB | 1. 1. 4. 76 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 16. 0 17. 0 30. 0 31. 0 43. 0 50. 0 52. |
| 1. 02 | 1. 4. 76 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 16. 0 17. 0 30. 0 31. 0 43. 0 50. 0 52. |
| 4. 00 | 76 5. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 16. 0 17. 0 30. 0 31. 0 43. 0 50. 0 52. |
| 5. 00 00500 ADMIN IN STRATI VE & GENERAL 15, 625 4, 107 0 3, 502, 830 -8, 011, 7. 00 00700 OPERATION OF PLANT 35, 608 266 2, 196 783, 698 0 00800 LAUINBRY & LINEN SERVICE 624 0 0 0 0 0 0 0 0 0 | 76 |
| 7. 00 00700 OPERATI ON OF PLANT 35,608 266 2,196 783,698 8.00 00800 LAUNDRY & LI NEN SERVI CE 624 0 0 0 0 0 0 0 0 0 | 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 16. 0 17. 0 30. 0 31. 0 43. |
| 8. 00 00800 LAUNDRY & LI NEN SERVI CE 6.24 0 0 0 0 0 0 0 0 0 | 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 16. 0 30. 0 31. 0 34. 0 50. |
| 9. 00 00900 HOUSEKEEPING | 0 9. 0 10. 0 11. 0 13. 0 14. 0 15. 0 16. 0 17. 0 30. 0 31. 0 43. |
| 10. 00 01000 DI ETARY 5, 913 0 0 80, 909 11. 00 01100 CAFETERI A 2, 858 0 0 367, 836 13. 00 01300 NURSI NG ADMINISTRATION 2, 217 0 0 1, 028, 944 14. 00 01400 CENTRAL SERVI CES & SUPPLY 4, 127 0 0 290, 813 15. 00 01500 PHARMACY 2, 103 0 0 561, 905 16. 00 01600 MEDI CAL RECORDS & LI BRARY 7, 445 0 0 1, 724, 463 17. 00 1700 SOCI AL SERVI CE 1, 242 0 0 179, 176 1700 1700 SOCI AL SERVI CE 1, 242 0 0 179, 176 1700 1700 SOCI AL SERVI CE 1, 242 0 0 0 179, 176 1700 1700 SOCI AL SERVI CE 1, 242 0 0 0 179, 176 1700 1700 1700 SOCI AL SERVI CE 1, 242 0 0 0 3, 479, 358 13. 00 03100 INTENSI VE CARE UNI T 5, 283 0 0 764, 590 1700 | 0 10. 0 11. 0 13. 0 14. 0 15. 0 16. 0 17. 0 30. 0 31. 0 43. |
| 11.00 01100 CAFETERIA 2,858 0 0 367,836 13.00 01300 NURSI NG ADMINISTRATION 2,217 0 0 1,028,944 14.00 01400 CENTRAL SERVICES & SUPPLY 4,127 0 0 290,813 15.00 01500 PHARMACY 2,103 0 0 561,905 16.00 01500 PHARMACY 7,445 0 0 1,724,463 17.00 1700 SOCI AL SERVICE 1,242 0 0 179,176 1700 SOCI AL SERVICE COST CENTERS 1,242 0 0 3,479,358 1.00 03100 NURSERY 260 0 0 286,690 1.00 1700 1 | 0 11. 0 13. 0 14. 0 15. 0 16. 0 17. 0 30. 0 31. 0 43. 0 50. 0 52. |
| 13. 00 01300 NURSING ADMINISTRATION 2, 217 0 0 290, 813 14. 00 01400 CENTRAL SERVICES & SUPPLY 4, 127 0 0 290, 813 15. 00 01500 PHARMACY 2, 103 0 0 561, 905 16. 00 01500 PHARMACY 7, 445 0 0 1, 724, 463 17. 00 01700 SOCI AL SERVICE 1, 242 0 0 0 179, 176 NPATI ENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRICS 34, 839 0 0 764, 590 43. 00 03100 INTENSIVE CARE UNIT 5, 283 0 0 764, 590 43. 00 04300 NURSERY 260 0 0 286, 690 43. 00 05000 DERATING ROOM 19, 487 0 6, 297 5, 056, 947 52. 00 05000 DERATING ROOM 4, 263 0 0 404, 211 53. 00 05300 ANESTHESI OLOGY 1, 763 0 0 0 404, 211 53. 00 05400 RADI OLOGY-DI AGNOSTI C 9, 028 0 1, 559 1, 206, 927 57. 00 05700 CT SCAN 0 0 0 0 0 0 58. 00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 60. 00 06000 LABORATORY 4, 837 1, 345 727 0 65. 00 06500 RESPI RATORY THERAPY 3, 820 0 0 880, 502 66. 00 06600 PHYSI CAL THERAPY 3, 820 0 0 886, 453 69. 01 06901 CARDI AC REHAB 5, 563 0 0 283, 938 71. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 07300 O7300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 07300 O7300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 | 0 13. 0 14. 0 15. 0 16. 0 17. 0 30. 0 31. 0 43. 0 50. 0 52. |
| 14. 00 01400 (ENTRAL SERVICES & SUPPLY 4, 127 0 0 0 290, 813 15. 00 01500 PHARMACY 2, 103 0 0 551, 905 16. 00 01600 MEDI CAL RECORDS & LI BRARY 7, 445 0 0 1, 724, 463 17. 00 01600 MEDI CAL SERVICE 1, 242 0 0 1770, 1724, 463 17. 00 01700 SOCI AL SERVICE 1, 242 0 0 1779, 176 178 | 0 14. 0 15. 0 16. 0 17. 0 30. 0 31. 0 43. 0 50. 0 52. |
| 15. 00 0 1500 PHARMACY | 0 15. 0 16. 0 17. 0 30. 0 31. 0 43. 0 50. 0 52. |
| 16. 00 | 0 16. 0 17. 0 30. 0 31. 0 43. 0 50. 0 52. |
| 17. 00 | 0 17. 0 30. 0 31. 0 43. 0 50. 0 52. |
| INPATI ENT ROUTI NE SERVI CE COST CENTERS 34, 839 0 0 3, 479, 358 31. 00 03100 INTENSI VE CARE UNIT 5, 283 0 0 764, 590 04300 NURSERY 260 0 0 286, 690 | 0 30. 0 31. 0 43. 0 50. 0 52. |
| 30. 00 | 0 31. 0 43. 0 50. 0 52. |
| 31. 00 | 0 31. 0 43. 0 50. 0 52. |
| A3. 00 | 0 43. 0 50. 0 52. |
| ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 59. 00 05900 CARDI AC CATHETERI ZATI ON 59. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 50 06500 RESPI RATORY THERAPY 50 06500 RESPI RATORY THERAPY 51 00 06900 ELECTROCARDI OLOGY 52 00 06900 ELECTROCARDI OLOGY 53 00 06900 CARDI AC REHAB 50 06900 CARDI AC REHAB 51 00 06900 CARDI AC REHAB 52 00 06900 CARDI AC CATHETERI ZATI ON 53 00 06900 CARDI AC CATHETERI ZATI ON 54 00 06500 RESPI RATORY THERAPY 56 00 06500 RESPI RATORY THERAPY 57 00 06500 RESPI RATORY THERAPY 58 00 06500 RESPI RATORY THERAPY 59 00 06900 ELECTROCARDI OLOGY 59 00 06900 CARDI AC REHAB 50 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 50 00 07300 DRUGS CHARGED TO PATI ENTS | 0 50. 0 52. |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM 4, 263 0 0 404, 211 53. 00 05300 ANESTHESI OLOGY 1, 763 0 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 9, 028 0 1, 559 1, 206, 927 57. 00 05700 CT SCAN 0 0 0 0 58. 00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 60. 00 06000 LABORATORY 4, 837 1, 345 727 0 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 344 0 0 880, 502 66. 00 06600 PHYSI CAL THERAPY 3, 820 0 0 866, 453 69. 01 06900 CARDI AC REHAB 5, 563 0 0 283, 938 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 <td>0 52.</td> | 0 52. |
| 53. 00 05300 ANESTHESI OLOGY 1, 763 0 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 9, 028 0 1, 559 1, 206, 927 57. 00 05700 CT SCAN 0 0 0 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 60. 00 06000 LABORATORY 4, 837 1, 345 727 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 344 0 0 880, 502 66. 00 06600 PHYSI CAL THERAPY 3, 820 0 0 866, 453 69. 00 06900 ELECTROCARDI OLOGY 479 2, 830 0 354, 445 69. 01 06901 CARDI AC REHAB 5, 563 0 0 283, 938 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C 9, 028 0 1, 559 1, 206, 927 57. 00 05700 CT SCAN 0 0 0 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 60. 00 06000 LABORATORY 4, 837 1, 345 727 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 344 0 0 880, 502 66. 00 06600 PHYSI CAL THERAPY 3, 820 0 0 866, 453 69. 00 06900 ELECTROCARDI OLOGY 479 2, 830 0 354, 445 69. 01 06901 CARDI AC REHAB 5, 563 0 0 283, 938 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 | al |
| 57. 00 05700 CT SCAN 0 0 0 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 60. 00 06000 LABORATORY 4,837 1,345 727 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 3,44 0 0 880, 502 66. 00 06600 PHYSI CAL THERAPY 3,820 0 0 866, 453 69. 01 06900 ELECTROCARDI OLOGY 479 2,830 0 354, 445 69. 01 06901 CARDI AC REHAB 5,563 0 0 283, 938 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 <t< td=""><td>0 53.</td></t<> | 0 53. |
| 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 60. 00 06000 LABORATORY 4,837 1,345 727 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 344 0 0 880,502 66. 00 06600 PHYSI CAL THERAPY 3,820 0 0 866,453 69. 01 06900 ELECTROCARDI OLOGY 479 2,830 0 354,445 69. 01 06901 CARDI AC REHAB 5,563 0 0 283,938 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 | 0 54. |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 60. 00 06000 LABORATORY 4,837 1,345 727 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 344 0 0 880, 502 66. 00 06600 PHYSI CAL THERAPY 3,820 0 0 866, 453 69. 00 06900 ELECTROCARDI OLOGY 479 2,830 0 354, 445 69. 01 06901 CARDI AC REHAB 5,563 0 0 283, 938 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 | 0 57. |
| 60. 00 | 0 58. |
| 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0 | 0 59. |
| 65. 00 06500 RESPI RATORY THERAPY 344 0 0 880, 502 66. 00 06600 PHYSI CAL THERAPY 3,820 0 0 866, 453 69. 00 06900 ELECTROCARDI OLOGY 479 2,830 0 354, 445 69. 01 06901 CARDI AC REHAB 5,563 0 0 283, 938 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 74. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 75. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 76. 00 07300 | 0 60. |
| 66. 00 06600 PHYSI CAL THERAPY 3,820 0 0 866,453 69.00 06900 ELECTROCARDI OLOGY 479 2,830 0 354,445 69.01 06901 CARDI AC REHAB 5,563 0 0 283,938 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 | 0 63. |
| 69. 00 06900 ELECTROCARDI OLOGY 479 2, 830 0 354, 445 69. 01 06901 CARDI AC REHAB 5, 563 0 0 0 0 0 0 0 0 0 | 0 65. |
| 69. 01 06901 CARDI AC REHAB 5,563 0 0 283,938 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 | 0 66. |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 | 0 69. |
| 72. 00 07200 MPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 2 | 0 69. |
| 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 2 | 0 71. |
| | 0 72. 0 73. |
| 70.00 03430 NOCLEAR WEDICTIVE - DIAGNOSTIC 7331 OI OI 232. 4361 | 0 76. |
| 76. 01 03480 0NCOLOGY | 0 76. |
| OUTPATIENT SERVICE COST CENTERS | -0, 70. |
| 90. 00 09000 CLI NI C 210 15, 847 0 5, 987, 423 | 0 90. |
| 90. 01 09001 WOUND CARE 0 2, 738 0 165, 914 | 0 90. |
| 91. 00 09100 EMERGENCY 15, 321 0 0 1, 735, 268 | 0 91. |
| 92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) | 92. |
| OTHER REIMBURSABLE COST CENTERS | |
| 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 | 0 95. |
| SPECIAL PURPOSE COST CENTERS | |
| 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 185, 771 31, 657 19, 907 31, 539, 069 -8, 011, | <u>76</u> 118. |
| NONREI MBURSABLE COST CENTERS | 0 194. |
| | |
| 194. 01 07951 M0B | 0 194. |
| 194. 03 07953 PI H 0 0 0 0 | 0 194. |
| 194. 04 07954 HEALTH COMPANI ES 2, 285 0 0 502, 460 | 0 194. |
| 194. 05 07955 PHYSI CI ANS OFFI CE 4, 504 3, 574 0 4, 494, 146 | 0 194. |
| 194. 06 07956 THE ARBORS 0 0 0 0 | 0 194. |
| 194. 07 07957 PAI N MANAGEMENT 0 1, 406 0 | 0 194. |
| 194. 08 07958 OPS 0 7, 736 0 | 0 194. |
| 194. 09 07959 MHL ROCHESTER HEALTH CENTER 0 0 0 177, 067 | 0 194. |
| 194. 10 07961 RHEUMATOLOGY 0 5, 651 0 1, 446, 951 | 0 194. |
| 194. 11 07960 SPORTS HEALTH 0 0 0 318, 862 | 0 194. |
| 194. 12 07962 BEHAVI ORAL HEALTH CLINIC 0 0 142, 508 | 0 194. |
| 200.00 Cross Foot Adjustments | 200. |
| 201.00 Negative Cost Centers | 201. |
| 202.00 Cost to be allocated (per Wkst. B, 4,528,001 223,692 147,326 11,287,990 | 202. |
| Part I) | 1 |
| 203.00 Unit cost multiplier (Wkst. B, Part I) 23.514754 5.110740 5.329595 0.292275 | |
| 204.00 Cost to be allocated (per Wkst. B, 8,983 | 203. |
| Part II) | |

| Heal th Finar | ncial Systems | MEMORIAL HOSPITA | AL LOGANSPORT | | In Lie | u of Form CMS-2 | 2552-10 |
|---------------|--|------------------|----------------|-------------|-----------------------------|-----------------|---------|
| COST ALLOCA | TION - STATISTICAL BASIS | | Provi der C | CN: 15-0072 | Peri od: From 01/01/2020 | Worksheet B-1 | |
| | | | | | To 12/31/2020 | | |
| | | CAPI | TAL RELATED CO | OSTS | | | |
| | Cost Center Description | NEW BLDG & | MOB | 0PS | EMPLOYEE | Reconciliatio | |
| | | FLXT | (SQUARE | (SQUARE | BENEFITS | n | |
| | | (SQUARE | FEET) | FEET) | DEPARTMENT | | |
| | | FEET) | | | (GROSS | | |
| | | | | | SALARI ES) | | |
| | | 1.00 | 1. 01 | 1. 02 | 4. 00 | 5A | |
| 205. 00 | Unit cost multiplier (Wkst. B, Part | | | | 0. 000233 | | 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

Peri od: Worksheet B-1 From 01/01/2020 Date/Time Prepared: 9/2/2021 10:57 am

| | | | | Т | o 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | |
|----------------------------------|--|--|----------------------------------|---|---|--------------------------------|----------------------------------|
| | Cost Center Description | ADMI NI STRATI V E & GENERAL (ACCUM. | OPERATION OF PLANT (SQUARE | LAUNDRY & LINEN SERVICE (LAUNDRY) | HOUSEKEEPI NG (HOURS OF SERVI CE) | DI ETARY (PATI ENT DAYS) | diii |
| | | COST) 5. 00 | 7. 00 | 8.00 | 9. 00 | 10.00 | |
| 1.00 | GENERAL SERVICE COST CENTERS | 1 | | 1 | | | 1 |
| 1. 00 1. 01 1. 02 4. 00 | 00100 NEW CAP REL COSTS-BLDG & FIXT 00101 MOB 00102 OPS 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 1. 00 1. 01 1. 02 4. 00 |
| 5. 00 7. 00 8. 00 | 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE | 72, 797, 081 3, 946, 504 200, 229 | 205, 788 624 | | | | 5. 00 7. 00 8. 00 |
| 9. 00 10. 00 11. 00 | 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A | 1, 072, 915 289, 050 814, 474 | 1, 620 5, 913 2, 858 | 0 1, 048 | 1, 843 | 4, 717 0 | 9. 00 10. 00 |
| 13. 00 14. 00 15. 00 | 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY | 2, 105, 912 614, 661 1, 457, 540 | 2, 217 4, 127 2, 103 | 0 | 5 12 10 | 0 0 0 | 14.00 |
| | 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS | 7, 140, 696 274, 536 | 7, 445 1, 242 | 0 | 15 0 | 0 | |
| 30. 00 31. 00 43. 00 | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY | 4, 925, 745 1, 227, 097 406, 776 | 34, 839 5, 283 260 | 9, 186 | l . | 4, 262 455 0 | 31.00 |
| 10.00 | ANCILLARY SERVICE COST CENTERS | 100,770 | 200 | 107202 | •1 | | 10.00 |
| | O5000 OPERATING ROOM O5200 DELIVERY ROOM & LABOR ROOM | 5, 089, 287 665, 147 | 25, 784 4, 263 | 0 | | 0 | 52.00 |
| 53. 00 54. 00 57. 00 | 05300 ANESTHESI OLOGY | 69, 991 2, 433, 811 0 | 1, 763 10, 587 0 | l . | 0 80 0 | 0 0 0 | 53. 00 54. 00 57. 00 |
| 58. 00 59. 00 60. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY | 0 0 3, 939, 599 | 0 0 6, 909 | 0 | 0 0 35 | 0 | 58. 00 59. 00 60. 00 |
| 63. 00 65. 00 | 06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY | 118, 703 1, 264, 543 | 0, 707 0 344 | 0 | 0 45 | 0 | 63. 00 65. 00 |
| 66. 00 69. 00 | 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY | 1, 264, 746 587, 023 | 3, 820 3, 309 | 0 | 45 | 0 | 66. 00 69. 00 |
| 69. 01 71. 00 72. 00 | 06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT | 514, 430 2, 188, 477 1, 312, 824 | 5, 563 0 0 | 0 | 0 | 0 0 0 | 69. 01 71. 00 72. 00 |
| 73. 00 76. 00 | 07300 DRUGS CHARGED TO PATIENTS 03450 NUCLEAR MEDICINE - DIAGNOSTIC | 9, 111, 284 711, 131 | 733 | Ō | 0 | 0 | 73. 00 76. 00 |
| 76. 01 | 03480 ONCOLOGY OUTPATIENT SERVICE COST CENTERS | 1, 523, 461 | 13, 429 | | 1 | 0 | |
| 90. 00 90. 01 91. 00 | 09000 | 3, 849, 773 234, 343 2, 762, 528 | 16, 057 2, 738 15, 321 | 0 | 55 25 160 | 0 0 0 | 90. 01 |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS | | -, - | | | | 92.00 |
| 95. 00 | O9500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 95.00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS | | 179, 151 | | | | 118.00 |
| 194. 01 | 07950 FOUNDATION 07951 MOB 07952 NONREI MBURSABLE OTHER | 1, 947 7, 656 0 | 0 1, 481 0 | 0 0 | О | 0 | 194. 00 194. 01 194. 02 |
| 194. 03 194. 04 | 07953 PIH 07954 HEALTH COMPANIES | 0 863, 575 | 0 2, 285 | 1 | 20 | 0 | 194. 03 194. 04 |
| 194.06 | 07955 PHYSICIANS OFFICE 07956 THE ARBORS 07957 PAIN MANAGEMENT | 6, 791, 859 0 7, 186 | 8, 078 0 1, 406 | 0 | o | 0 | 194. 05 194. 06 194. 07 |
| 194. 08 | 07959 OPS 07958 OPS 07959 MHL ROCHESTER HEALTH CENTER | 41, 230 392, 051 | 7, 736 0 | 1 | · · | 0 | 194. 07 194. 08 194. 09 |
| 194. 11 | 07961 RHEUMATOLOGY 07960 SPORTS HEALTH | 1, 914, 175 455, 747 | 5, 651 0 | 0 | 45 0 | 0 | 194. 10 194. 11 |
| 194. 12 200. 00 201. 00 | | 204, 419 | 0 | 0 | O | 0 | 194. 12 200. 00 201. 00 |
| 202.00 | Cost to be allocated (per Wkst. B, Part I) | 8, 011, 576 | 4, 380, 833 | | | 447, 682 | 202. 00 |
| 203. 00 204. 00 | Cost to be allocated (per Wkst. B, Part II) | 0. 110054 389, 224 | 21. 288088 871, 662 | 1 | 664. 938144 46, 759 | 94. 908204 165, 728 | 1 |
| 205.00 | Unit cost multiplier (Wkst. B, Part | 0. 005347 | 4. 235728 | 0. 070400 | 25. 371134 | 35. 134195 | 205. 00 |

| Health Finar | ncial Systems | MEMORIAL HOSPIT | AL LOGANSPORT | | In Lie | u of Form CMS-2 | 2552-10 |
|--------------|--|------------------|---------------|---------------|----------------------------------|--------------------------------|---------|
| COST ALLOCA | TION - STATISTICAL BASIS | | Provi der C | | Peri od: | Worksheet B-1 | |
| | | , | | | From 01/01/2020 To 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | |
| | Cost Center Description | ADMI NI STRATI V | | 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 | |
| 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) | | | | | | |
| | | | | | | | |

| | | MEMORIAL HUSPII | | N 45 0070 D | | J OT FORM CMS- | |
|-------------------|---|--------------------|------------------------|----------------------|---------------------------------------|--------------------------------|--------------------|
| COST ALL | OCATION - STATISTICAL BASIS | | Provi der CO | | eriod: rom 01/01/2020 | Worksheet B-1 | |
| | | | | Т | o 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | |
| | Cost Center Description | CAFETERI A | NURSI NG | CENTRAL | PHARMACY | MEDI CAL | / alli |
| | | (MAN | ADMI NI STRATI O | SERVICES & | (100% | RECORDS & | |
| | | HOURS) | N | SUPPLY | DRUGS) | LI BRARY | |
| | | | (DI RECT | (100% | | (REVENUE) | |
| | | 11.00 | NRSI NG HRS) 13. 00 | SUPPLI ES) 14. 00 | 15. 00 | 16. 00 | |
| GF | ENERAL SERVICE COST CENTERS | 11.00 | 13.00 | 14.00 | 15.00 | 10.00 | |
| | 0100 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 1 | 0101 MOB | | | | | | 1. 01 |
| 1 | 0102 OPS | | | | | | 1.02 |
| | D400 EMPLOYEE BENEFITS DEPARTMENT D500 ADMINISTRATIVE & GENERAL | | | | | | 4. 00 5. 00 |
| | 0700 OPERATION OF PLANT | | | | | | 7.00 |
| | 0800 LAUNDRY & LINEN SERVICE | | | | | | 8.00 |
| | 0900 HOUSEKEEPI NG | | | | | | 9.00 |
| | 1000 DI ETARY | | | | | | 10.00 |
| | 1100 CAFETERI A | 854, 817 | 1 | | | | 11.00 |
| | 1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY | 43, 027 2, 104 | | 100 | | | 13. 00 14. 00 |
| | 1500 PHARMACY | 16, 267 | 1 | 0 | I I | | 15.00 |
| | 1600 MEDICAL RECORDS & LIBRARY | 240 | 1 | 0 | l . | 165, 225, 057 | |
| 17. 00 <u>0</u> 1 | 1700 SOCIAL SERVICE | 15, 366 | 0 | 0 | 0 | 0 | 17.00 |
| | NPATIENT ROUTINE SERVICE COST CENTERS | | | _ | | | |
| | 3000 ADULTS & PEDIATRICS | 109, 682 | | 0 | | 11, 452, 518 | |
| | 3100 INTENSIVE CARE UNIT 4300 NURSERY | 23, 989 7, 990 | | 0 | | 2, 113, 591 1, 334, 534 | |
| _ | NCILLARY SERVICE COST CENTERS | 1,770 | 1,770 | | <u> </u> | 1, 334, 334 | 1 43.00 |
| | 5000 OPERATING ROOM | 76, 713 | 76, 713 | 0 | 0 | 43, 870, 243 | 50.00 |
| | 5200 DELIVERY ROOM & LABOR ROOM | 11, 266 | 11, 266 | 0 | | 1, 881, 593 | |
| | 5300 ANESTHESI OLOGY | 0 | 1 | 0 | I I | 1, 984, 215 | |
| | 5400 RADI OLOGY-DI AGNOSTI C | 39, 372 | 1 1 | 0 | · · · · · · · · · · · · · · · · · · · | 13, 219, 370 | |
| | 5700 CT SCAN 5800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | - | 0 | | 0 | 57. 00 58. 00 |
| | 5900 CARDI AC CATHETERI ZATI ON | | | 0 | · · | 0 | |
| | 6000 LABORATORY | 0 | o | 0 | · · · · · · · · · · · · · · · · · · · | 19, 636, 889 | |
| | 6300 BLOOD STORING, PROCESSING & TRANS. | 0 | 1 | 0 | · · | 1, 138, 175 | |
| | 6500 RESPI RATORY THERAPY | 19, 657 | 1 | 0 | · · · · · · · · · · · · · · · · · · · | 6, 405, 088 | |
| | 6600 PHYSI CAL THERAPY | 26, 730 | 1 | 0 | · · · · · · · · · · · · · · · · · · · | 3, 461, 599 | |
| | 6900 ELECTROCARDI OLOGY 6901 CARDI AC REHAB | 8, 315 12, 448 | 1 | 0 | I I | 2, 694, 814 404, 068 | 1 |
| | 7100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 12, 440 | Ö | 100 | · · | 0 0 | 1 |
| | 7200 IMPL. DEV. CHARGED TO PATIENT | 0 | o | 0 | I I | 0 | 72.00 |
| | 7300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | | 0 | |
| | 3450 NUCLEAR MEDICINE - DIAGNOSTIC | 6, 094 | | 0 | | 10, 114, 698 | |
| | 3480 ONCOLOGY JTPATIENT SERVICE COST CENTERS | 16, 586 | 0 | 0 | 0 | 10, 764, 757 | 76. 01 |
| | 9000 CLINIC | 142, 716 | 0 | 0 | o | 10, 130, 986 | 90 00 |
| | 9001 WOUND CARE | 22, 775 | 1 | | I I | | |
| 91.00 09 | 9100 EMERGENCY | 52, 625 | 1 | | | 14, 431, 592 | |
| 92.00 09 | 9200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| | THER REIMBURSABLE COST CENTERS | | .l | | ٥ | | 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) | 653, 962 | 282, 265 | 100 | 100 | 157, 477, 646 | 118. 00 |
| | ONREI MBURSABLE COST CENTERS | | | | | | |
| | 7950 FOUNDATI ON | 0 | 1 | 0 | I I | | 194. 00 |
| 194. 01 07 | | 0 | 1 | 0 | l I | | 194. 01 |
| 194. 02 07 | 7952 NONREI MBURSABLE OTHER | 0 | - | 0 | · · · · · · · · · · · · · · · · · · · | | 194. 02 194. 03 |
| | 7954 HEALTH COMPANIES | 28, 972 | - | 0 | · · · · · · · · · · · · · · · · · · · | | 194. 03 |
| | 7955 PHYSI CI ANS OFFI CE | 54, 883 | | 0 | · · · · · · · · · · · · · · · · · · · | 5, 893, 472 | |
| | 7956 THE ARBORS | 0 | o | 0 | 0 | | 194. 06 |
| | 7957 PAIN MANAGEMENT | 2, 275 | 1 | 0 | · · · · · · · · · · · · · · · · · · · | | 194. 07 |
| 194. 08 07 | | 0 | 0 | 0 | · · | | 194. 08 |
| | 7959 MHL ROCHESTER HEALTH CENTER 7961 RHEUMATOLOGY | 18, 159 28, 798 | | 0 | - | 174, 463 1, 394, 141 | |
| | 7960 SPORTS HEALTH | 9, 724 | 1 | 0 | · · | | 194. 10 |
| | 7962 BEHAVI ORAL HEALTH CLINIC | 58, 044 | 1 | 0 | | 285, 335 | |
| 200.00 | Cross Foot Adjustments | | | | | | 200. 00 |
| 201.00 | Negative Cost Centers | | | | | | 201. 00 |
| 202. 00 | Cost to be allocated (per Wkst. B, | 964, 951 | 2, 436, 768 | 780, 517 | 1, 687, 729 | 8, 095, 293 | 202. 00 |
| 203. 00 | Part I) Unit cost multiplier (Wkst. B, Part I) | 1. 128839 | 8. 632909 | 7.805 170000 | 16, 877. 290000 | 0. 048996 | 203 00 |
| 204.00 | Cost to be allocated (per Wkst. B, | 83, 752 | 1 | 118, 391 | | 245, 590 | |
| | Part II) | | | | | | |
| 205. 00 | Unit cost multiplier (Wkst. B, Part | 0. 097977 | 0. 274090 | 1, 183. 910000 | 681. 320000 | 0. 001486 | 205.00 |
| | 11) | 1 | | | | | I |
| | | | | | | | |

| Health Finar | ncial Systems | MEMORIAL HOSPIT | AL LOGANSPORT | | In Lie | u of Form CMS- | 2552-10 |
|--------------|--|-----------------|------------------|-------------|----------------------------------|----------------|---------|
| COST ALLOCA | TION - STATISTICAL BASIS | | Provi der CO | CN: 15-0072 | Peri od: | Worksheet B-1 | |
| | | | | | From 01/01/2020 To 12/31/2020 | | |
| | 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 | |
| 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) | | | | | | |
| | | | | | | | |

| | | To 12/31/2020 Date/Time Pre | |
|--|------------|-----------------------------|--------------------|
| Cost Center Description | SOCI AL | 07272021 10. 3 | , all |
| | SERVI CE | | |
| | (HOURS) | | |
| GENERAL SERVICE COST CENTERS | 17. 00 | | _ |
| 1. 00 O0100 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 ADMI NI STRATI VE & GENERAL | | | 5.00 |
| 7. 00 00700 OPERATION OF PLANT | | | 7.00 |
| 8. 00 00800 LAUNDRY & LI NEN SERVI CE | | | 8.00 |
| 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY | | | 9.00 |
| 11. 00 01100 CAFETERI A | | | 11.00 |
| 13. 00 01300 NURSING ADMINISTRATION | | | 13. 00 |
| 14.00 01400 CENTRAL SERVICES & SUPPLY | | | 14.00 |
| 15. 00 01500 PHARMACY | | | 15. 00 |
| 16.00 01600 MEDICAL RECORDS & LIBRARY | | | 16. 00 |
| 17. 00 01700 SOCIAL SERVICE | 9, 422 | | 17. 00 |
| INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS | 7, 252 | | 30.00 |
| 31. 00 03100 NTENSI VE CARE UNIT | 7, 252 | | 31.00 |
| 43. 00 04300 NURSERY | 0 | | 43.00 |
| ANCILLARY SERVICE COST CENTERS | <u> </u> | | 1 .0.00 |
| 50. 00 05000 OPERATING ROOM | 35 | | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | | 54.00 |
| 57. 00 05700 CT SCAN | 0 | | 57.00 |
| 58.00 O5800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 O5900 CARDIAC CATHETERIZATION | O O | | 58. 00 59. 00 |
| 60. 00 06000 LABORATORY | o | | 60.00 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | Ö | | 63. 00 |
| 65. 00 06500 RESPIRATORY THERAPY | 0 | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | | 66. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | | 69. 00 |
| 69. 01 06901 CARDI AC REHAB | 0 | | 69. 01 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | | 71.00 |
| 72.00 O7200 IMPL. DEV. CHARGED TO PATIENT 73.00 O7300 DRUGS CHARGED TO PATIENTS | 0 | | 72. 00 73. 00 |
| 76. 00 03450 NUCLEAR MEDICINE - DIAGNOSTIC | o | | 76.00 |
| 76. 01 03480 ONCOLOGY | Ö | | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | <u>'</u> | | |
| 90. 00 09000 CLINIC | 820 | | 90.00 |
| 90. 01 09001 WOUND CARE | 0 | | 90. 01 |
| 91. 00 09100 EMERGENCY | 600 | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS | | | 92.00 |
| 95. 00 09500 AMBULANCE SERVICES | 0 | | 95. 00 |
| SPECIAL PURPOSE COST CENTERS | -1 | | 1 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 9, 422 | | 118. 00 |
| NONREI MBURSABLE COST CENTERS | | | 4 |
| 194. 00 07950 FOUNDATI ON | 0 | | 194.00 |
| 194. 01 07951 MOB 194. 02 07952 NONREI MBURSABLE OTHER | 0 | | 194. 01 194. 02 |
| 194. 03 07952 NONKET MBORSABLE OTHER | O O | | 194. 02 |
| 194. 04 07954 HEALTH COMPANIES | o | | 194. 04 |
| 194. 05 07955 PHYSI CI ANS OFFI CE | Ö | | 194. 05 |
| 194. 06 07956 THE ARBORS | 0 | | 194.06 |
| 194.07 07957 PAIN MANAGEMENT | 0 | | 194. 07 |
| 194. 08 07958 0PS | 0 | | 194.08 |
| 194. 09 07959 MHL ROCHESTER HEALTH CENTER | 0 | | 194. 09 |
| 194. 10 07961 RHEUMATOLOGY 194. 11 07960 SPORTS HEALTH | 0 | | 194. 10 194. 11 |
| 194. 11 07960 SPORTS HEALTH 194. 12 07962 BEHAVI ORAL HEALTH CLINIC | 0 | | 194. 11 |
| 200.00 Cross Foot Adjustments | ٩ | | 200.00 |
| 201.00 Negative Cost Centers | | | 201.00 |
| 202.00 Cost to be allocated (per Wkst. B, | 348, 536 | | 202.00 |
| Part I) | | | |
| 203.00 Unit cost multiplier (Wkst. B, Part I) | 36. 991722 | | 203. 00 |
| 204.00 Cost to be allocated (per Wkst. B, | 37, 482 | | 204. 00 |
| Part II) 205.00 Unit cost multiplier (Wkst. B, Part | 3. 978136 | | 205. 00 |
| 205.00 Unit cost multiplier (wkst. B, Part | 3. 7/0130 | | 200.00 |
| 206.00 NAHE adjustment amount to be allocated | | | 206. 00 |
| (per Wkst. B-2) | | | |
| | | | |

| Health Fina | ancial Systems | MEMORIAL HOSPITA | L LOGANSPORT | | In Lieu | u of Form CMS-: | 2552-10 |
|-------------|-------------------------------------|------------------|--------------|--------------|-----------------|-----------------|---------|
| COST ALLOCA | ATION - STATISTICAL BASIS | | Provi der C | CCN: 15-0072 | Peri od: | Worksheet B-1 | |
| | | | | | From 01/01/2020 | | |
| | | | | | To 12/31/2020 | Date/Time Pre | epared: |
| | | | | | | 8/2/2021 10: 5 | 7 am |
| | Cost Center Description | SOCI AL | | | | | |
| | | SERVI CE | | | | | |
| | | (HOURS) | | | | | |
| | | 17. 00 | | | | | |
| 207. 00 | NAHE unit cost multiplier (Wkst. D, | | | | | | 207.00 |
| | Parts III and IV) | | | | | | |

| Health Financial Systems | MEMORIAL HOSPITAL LOGANSPORT | In Lieu of Form CMS-2552-10 |
|--|------------------------------|--|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-0072 | Period: Worksheet C From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared: |

| | | | T | o 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | |
|---|--------------|---------------|--------------|-----------------|--------------------------------|---------|
| | | Title | XVIII | Hospi tal | PPS | |
| | | <u>'</u> | | Costs | | |
| Cost Center Description | Total Cost | Therapy Limit | Total Costs | RCE | Total Costs | |
| | (from Wkst. | Ādj . | | Di sal I owance | | |
| | B, Part I, | | | | | |
| | col. 26) | | | | | |
| | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 8, 987, 801 | | 8, 987, 801 | 0 | 8, 987, 801 | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 1, 956, 753 | | 1, 956, 753 | 0 | 1, 956, 753 | 31.00 |
| 43. 00 04300 NURSERY | 617, 787 | | 617, 787 | 0 | 617, 787 | 43.00 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 9, 318, 103 | | 9, 318, 103 | 123, 954 | 9, 442, 057 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 1, 077, 148 | | 1, 077, 148 | 0 | 1, 077, 148 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 212, 444 | | 212, 444 | 0 | 212, 444 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 3, 689, 491 | | 3, 689, 491 | 0 | 3, 689, 491 | 54.00 |
| 57. 00 05700 CT SCAN | 0 | | 0 | 0 | 0 | 57.00 |
| 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) | 0 | | C | 0 | 0 | 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0 | | C | 0 | 0 | 59.00 |
| 60. 00 06000 LABORATORY | 5, 505, 649 | | 5, 505, 649 | 0 | 5, 505, 649 | 60.00 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | 187, 533 | | 187, 533 | 0 | 187, 533 | 63.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 1, 776, 970 | 0 | 1, 776, 970 | 0 | 1, 776, 970 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 1, 699, 712 | 0 | 1, 699, 712 | 0 | 1, 699, 712 | 66.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 893, 412 | | 893, 412 | 0 | 893, 412 | 69.00 |
| 69. 01 06901 CARDI AC REHAB | 723, 321 | | 723, 321 | 0 | 723, 321 | 69. 01 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 3, 209, 845 | | 3, 209, 845 | 0 | 3, 209, 845 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 1, 457, 306 | | 1, 457, 306 | 0 | 1, 457, 306 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 11, 801, 710 | | 11, 801, 710 | 0 | 11, 801, 710 | 73.00 |
| 76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC | 1, 307, 457 | | 1, 307, 457 | 0 | 1, 307, 457 | 76. 00 |
| 76. 01 03480 ONCOLOGY | 2, 576, 350 | | 2, 576, 350 | 0 | 2, 576, 350 | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLI NI C | 5, 339, 664 | | 5, 339, 664 | 38, 634 | 5, 378, 298 | 90.00 |
| 90. 01 09001 WOUND CARE | 480, 249 | | 480, 249 | 0 | 480, 249 | 90. 01 |
| 91. 00 09100 EMERGENCY | 4, 801, 119 | | 4, 801, 119 | 0 | 4, 801, 119 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1, 643, 856 | | 1, 643, 856 | | 1, 643, 856 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 95. 00 09500 AMBULANCE SERVICES | 0 | | O | 0 | 0 | 95.00 |
| 200.00 Subtotal (see instructions) | 69, 263, 680 | 0 | 69, 263, 680 | 162, 588 | 69, 426, 268 | 200.00 |
| 201.00 Less Observation Beds | 1, 643, 856 | | 1, 643, 856 | | 1, 643, 856 | 201.00 |
| 202.00 Total (see instructions) | 67, 619, 824 | 0 | 67, 619, 824 | 162, 588 | 67, 782, 412 | 202. 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 | Peri od: From 01/01/2020 | Worksheet C Part I |
| | | | To 12/31/2020 | Date/Time Prepared: |

| | | | Т | o 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | |
|--|--------------|---------------|---------------|---------------|--------------------------------|---------|
| | | Title | XVIII | Hospi tal | PPS | |
| | | Charges | | | | |
| Cost Center Description | I npati ent | Outpati ent | | Cost or Other | TEFRA | |
| | | | + col. 7) | Ratio | I npati ent | |
| | | | | | Rati o | |
| | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | , | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 7, 433, 921 | | 7, 433, 921 | | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 965, 620 | | 965, 620 | | | 31.00 |
| 43. 00 04300 NURSERY | 1, 329, 944 | | 1, 329, 944 | | | 43.00 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 5, 304, 616 | 26, 517, 406 | | | 0. 000000 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 2, 134, 832 | 243, 112 | | | 0. 000000 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 294, 861 | 1, 689, 354 | | | 0. 000000 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 801, 056 | 12, 327, 626 | 13, 128, 682 | | 0.000000 | 54.00 |
| 57.00 05700 CT SCAN | 0 | 0 | 0 | 0. 000000 | 0. 000000 | 57.00 |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | 0 | 0 | 0. 000000 | 0. 000000 | 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0 | 0 | 0 | 0. 000000 | 0. 000000 | 1 |
| 60. 00 06000 LABORATORY | 3, 060, 170 | 16, 576, 698 | 19, 636, 868 | 0. 280373 | 0.000000 | |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | 631, 230 | 749, 525 | 1, 380, 755 | | 0.000000 | |
| 65. 00 06500 RESPI RATORY THERAPY | 3, 585, 112 | 1, 630, 611 | 5, 215, 723 | 0. 340695 | 0.000000 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 317, 446 | 3, 138, 403 | | | 0.000000 | 66.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 583, 781 | 3, 393, 923 | 3, 977, 704 | | 0.000000 | 69.00 |
| 69. 01 06901 CARDI AC REHAB | 47 | 404, 021 | 404, 068 | 1. 790097 | 0.000000 | 69. 01 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 1, 885, 699 | 6, 503, 394 | 8, 389, 093 | 0. 382621 | 0.000000 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 1, 341, 809 | 5, 642, 413 | 6, 984, 222 | 0. 208657 | 0.000000 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 7, 458, 932 | 44, 742, 518 | | | 0.000000 | 73.00 |
| 76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC | 774, 939 | 8, 040, 111 | 8, 815, 050 | 0. 148321 | 0.000000 | 76. 00 |
| 76. 01 03480 ONCOLOGY | 32, 556 | 9, 783, 599 | 9, 816, 155 | 0. 262460 | 0.000000 | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLI NI C | 545, 243 | 596, 873 | 1, 142, 116 | | 0.000000 | 90.00 |
| 90. 01 09001 WOUND CARE | 411 | 2, 076, 865 | 2, 077, 276 | | 0.000000 | 90. 01 |
| 91. 00 09100 EMERGENCY | 1, 451, 910 | 12, 606, 274 | 14, 058, 184 | 0. 341518 | 0.000000 | 91.00 |
| 92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) | 413, 217 | 3, 228, 282 | 3, 641, 499 | 0. 451423 | 0.000000 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 95. 00 09500 AMBULANCE SERVICES | 0 | 0 | C | 0.000000 | 0.000000 | 95.00 |
| 200.00 Subtotal (see instructions) | 40, 347, 352 | 159, 891, 008 | 200, 238, 360 | | | 200. 00 |
| 201.00 Less Observation Beds | | | | | | 201.00 |
| 202.00 Total (see instructions) | 40, 347, 352 | 159, 891, 008 | 200, 238, 360 | | | 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 | From 01/01/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 10:57 am |
| | T1 11 \ \0.01 11 | | 550 |

| | | | | | 8/2/2021 10: 5 | 7 am |
|---------|--|---------------|-------------|-----------|----------------|---------|
| | | | Title XVIII | Hospi tal | PPS | |
| | Cost Center Description | PPS Inpatient | | | | |
| | | Ratio | | | | |
| | | 11. 00 | | | | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| | 03000 ADULTS & PEDIATRICS | | | | | 30.00 |
| | 03100 INTENSIVE CARE UNIT | | | | | 31.00 |
| | 04300 NURSERY | | | | | 43.00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | |
| | 05000 OPERATING ROOM | 0. 296715 | | | | 50.00 |
| 1 | 05200 DELIVERY ROOM & LABOR ROOM | 0. 452975 | | | | 52.00 |
| | 05300 ANESTHESI OLOGY | 0. 107067 | | | | 53.00 |
| | 05400 RADI OLOGY-DI AGNOSTI C | 0. 281025 | | | | 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. 280373 | | | | 60.00 |
| | 06300 BLOOD STORING, PROCESSING & TRANS. | 0. 135819 | | | | 63.00 |
| | 06500 RESPI RATORY THERAPY | 0. 340695 | | | | 65.00 |
| | 06600 PHYSI CAL THERAPY | 0. 491836 | | | | 66. 00 |
| | 06900 ELECTROCARDI OLOGY | 0. 224605 | | | | 69. 00 |
| | 06901 CARDI AC REHAB | 1. 790097 | | | | 69. 01 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 382621 | | | | 71.00 |
| | 07200 IMPL. DEV. CHARGED TO PATIENT | 0. 208657 | | | | 72.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0. 226080 | | | | 73.00 |
| | 03450 NUCLEAR MEDICINE - DIAGNOSTIC | 0. 148321 | | | | 76. 00 |
| | 03480 ONCOLOGY | 0. 262460 | | | | 76. 01 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | |
| | 09000 CLI NI C | 4. 709065 | | | | 90.00 |
| | 09001 WOUND CARE | 0. 231192 | | | | 90. 01 |
| | 09100 EMERGENCY | 0. 341518 | | | | 91.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 451423 | | | | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | |
| 1 | 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 of Form CMS-2552-10 |
|--|------------------------------|--|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-0072 | Period: Worksheet C From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared: |

| | | | | | Date/Time Pre 8/2/2021 10:5 | | |
|--------|--|--------------|---------------|--------------|--------------------------------|--------------|---------|
| | | | Ti tl | e XIX | Hospi tal | Cost | 7 dili |
| | | | | , x | Costs | 0001 | |
| | 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 | | | | | | |
| | 03000 ADULTS & PEDIATRICS | 8, 987, 801 | | 8, 987, 801 | 0 | 8, 987, 801 | 30.00 |
| | 03100 INTENSIVE CARE UNIT | 1, 956, 753 | | 1, 956, 753 | 0 | 1, 956, 753 | 31.00 |
| | 04300 NURSERY | 617, 787 | | 617, 787 | 0 | 617, 787 | 43.00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| | 05000 OPERATING ROOM | 9, 318, 103 | | 9, 318, 103 | · · | 9, 442, 057 | 50.00 |
| | 05200 DELIVERY ROOM & LABOR ROOM | 1, 077, 148 | | 1, 077, 148 | 0 | 1, 077, 148 | |
| | 05300 ANESTHESI OLOGY | 212, 444 | | 212, 444 | 0 | 212, 444 | 53.00 |
| | 05400 RADI OLOGY-DI AGNOSTI C | 3, 689, 491 | | 3, 689, 491 | 0 | 3, 689, 491 | 54.00 |
| | 05700 CT SCAN | 0 | | 0 | 0 | 0 | 57.00 |
| | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | | 0 | 0 | 0 | |
| | 05900 CARDI AC CATHETERI ZATI ON | 0 | | 0 | 0 | 0 | 59.00 |
| | 06000 LABORATORY | 5, 505, 649 | | 5, 505, 649 | 0 | 5, 505, 649 | 60.00 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 187, 533 | | 187, 533 | 0 | 187, 533 | 63.00 |
| | 06500 RESPI RATORY THERAPY | 1, 776, 970 | 0 | 1, 776, 970 | 0 | 1, 776, 970 | 65.00 |
| | 06600 PHYSI CAL THERAPY | 1, 699, 712 | 0 | ., | | 1, 699, 712 | |
| 69.00 | 06900 ELECTROCARDI OLOGY | 893, 412 | | 893, 412 | 0 | 893, 412 | 69. 00 |
| | 06901 CARDI AC REHAB | 723, 321 | | 723, 321 | 0 | 723, 321 | 69. 01 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 3, 209, 845 | | 3, 209, 845 | 0 | 3, 209, 845 | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 1, 457, 306 | | 1, 457, 306 | 0 | 1, 457, 306 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 11, 801, 710 | | 11, 801, 710 | 0 | 11, 801, 710 | 73.00 |
| | 03450 NUCLEAR MEDICINE - DIAGNOSTIC | 1, 307, 457 | | 1, 307, 457 | 0 | 1, 307, 457 | 76. 00 |
| | 03480 ONCOLOGY | 2, 576, 350 | | 2, 576, 350 | 0 | 2, 576, 350 | 76. 01 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90.00 | 09000 CLI NI C | 5, 339, 664 | | 5, 339, 664 | 38, 634 | 5, 378, 298 | 90.00 |
| 90. 01 | 09001 WOUND CARE | 480, 249 | | 480, 249 | 0 | 480, 249 | 90. 01 |
| 91.00 | 09100 EMERGENCY | 4, 801, 119 | | 4, 801, 119 | 0 | 4, 801, 119 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1, 643, 856 | | 1, 643, 856 | | 1, 643, 856 | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 95.00 | 09500 AMBULANCE SERVICES | 0 | | 0 | 0 | 0 | 95.00 |
| 200.00 | Subtotal (see instructions) | 69, 263, 680 | 0 | 69, 263, 680 | 162, 588 | 69, 426, 268 | 200.00 |
| 201.00 | Less Observation Beds | 1, 643, 856 | | 1, 643, 856 | | 1, 643, 856 | 201.00 |
| 202.00 | Total (see instructions) | 67, 619, 824 | 0 | 67, 619, 824 | 162, 588 | 67, 782, 412 | 202. 00 |

| Health Financial Systems | MEMORIAL HOSPITAL L | LOGANSPORT | In Lieu | of Form CMS-2552-10 |
|--|---------------------|-----------------------|-----------------------------|---------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider CCN: 15-0072 | Peri od: From 01/01/2020 | Worksheet C |
| | | | | Date/Time Prepared |

| | | | | 0 12/31/2020 | Date/lime Pre 8/2/2021 10:5 | |
|--|--------------|---------------|---------------|---------------|----------------------------------|---------|
| | | Ti tl | e XIX | Hospi tal | Cost | 7 (3111 |
| | | Charges | | | | |
| Cost Center Description | Inpatient | Outpati ent | Total (col. 6 | Cost or Other | TEFRA | |
| | | | + col. 7) | Ratio | I npati ent | |
| | | | ŕ | | Rati o | |
| | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 7, 433, 921 | | 7, 433, 921 | | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 965, 620 | | 965, 620 | l l | | 31.00 |
| 43. 00 04300 NURSERY | 1, 329, 944 | | 1, 329, 944 | | | 43.00 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 5, 304, 616 | 26, 517, 406 | 31, 822, 022 | 0. 292819 | 0.000000 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 2, 134, 832 | 243, 112 | 2, 377, 944 | 0. 452975 | 0.000000 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 294, 861 | 1, 689, 354 | 1, 984, 215 | 0. 107067 | 0.000000 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 801, 056 | 12, 327, 626 | 13, 128, 682 | 0. 281025 | 0.000000 | 54.00 |
| 57. 00 05700 CT SCAN | 0 | 0 | C | 0. 000000 | 0.000000 | 57.00 |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | 0 | C | 0. 000000 | 0.000000 | 58.00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0 | 0 | C | 0. 000000 | 0.000000 | 59.00 |
| 60. 00 06000 LABORATORY | 3, 060, 170 | 16, 576, 698 | 19, 636, 868 | 0. 280373 | 0.000000 | 60.00 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | 631, 230 | 749, 525 | 1, 380, 755 | 0. 135819 | 0.000000 | 63.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 3, 585, 112 | 1, 630, 611 | 5, 215, 723 | 0. 340695 | 0.000000 | 65.00 |
| 66.00 06600 PHYSI CAL THERAPY | 317, 446 | 3, 138, 403 | 3, 455, 849 | 0. 491836 | 0.000000 | 66.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 583, 781 | 3, 393, 923 | 3, 977, 704 | 0. 224605 | 0.000000 | 69.00 |
| 69. 01 06901 CARDI AC REHAB | 47 | 404, 021 | 404, 068 | 1. 790097 | 0.000000 | 69. 01 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 1, 885, 699 | 6, 503, 394 | 8, 389, 093 | 0. 382621 | 0.000000 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 1, 341, 809 | 5, 642, 413 | 6, 984, 222 | 0. 208657 | 0.000000 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 7, 458, 932 | 44, 742, 518 | 52, 201, 450 | 0. 226080 | 0.000000 | 73.00 |
| 76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC | 774, 939 | 8, 040, 111 | 8, 815, 050 | 0. 148321 | 0.000000 | 76.00 |
| 76. 01 03480 ONCOLOGY | 32, 556 | 9, 783, 599 | 9, 816, 155 | 0. 262460 | 0.000000 | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLI NI C | 545, 243 | 596, 873 | 1, 142, 116 | 4. 675238 | 0.000000 | 90.00 |
| 90. 01 09001 WOUND CARE | 411 | 2, 076, 865 | 2, 077, 276 | 0. 231192 | 0.000000 | 90. 01 |
| 91. 00 09100 EMERGENCY | 1, 451, 910 | 12, 606, 274 | 14, 058, 184 | 0. 341518 | 0.000000 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 413, 217 | 3, 228, 282 | 3, 641, 499 | 0. 451423 | 0.000000 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 95. 00 09500 AMBULANCE SERVI CES | 0 | 0 | C | 0.000000 | 0.000000 | 95.00 |
| 200.00 Subtotal (see instructions) | 40, 347, 352 | 159, 891, 008 | 200, 238, 360 | | | 200. 00 |
| 201.00 Less Observation Beds | | | | | | 201. 00 |
| 202.00 Total (see instructions) | 40, 347, 352 | 159, 891, 008 | 200, 238, 360 | | | 202. 00 |
| | | | | | | |

| Health Financial Systems | MEMORIAL HOSPITAL | LOGANSPORT | In Lieu | ı of Form CMS- | 2552-10 |
|--|-------------------|------------------------|--|----------------|---------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provi der CCN: 15-0072 | Peri od: From 01/01/2020 To 12/31/2020 | | |
| | | Title XIX | Hospi tal | Cost | _ |
| Cost Center Description | PPS Inpatient | | | | |
| | Rati o | | | | |
| | 11. 00 | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | · · | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | | | | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | | | | | 31.00 |

| | | 11 11 0 711 71 | 0001 |
|--|---------------|----------------|--------|
| Cost Center Description | PPS Inpatient | | |
| | Ratio | | |
| | 11. 00 | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | | | 31.00 |
| 43. 00 04300 NURSERY | | | 43.00 |
| ANCILLARY SERVICE COST CENTERS | | | |
| 50.00 05000 OPERATING ROOM | 0. 000000 | | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0. 000000 | | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0. 000000 | | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 000000 | | 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. 000000 | | 60.00 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | 0. 000000 | | 63.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 0. 000000 | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 000000 | | 66.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 000000 | | 69.00 |
| 69. 01 06901 CARDI AC REHAB | 0. 000000 | | 69. 01 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000 | | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0. 000000 | | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 000000 | | 73.00 |
| 76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC | 0. 000000 | | 76.00 |
| 76. 01 03480 ONCOLOGY | 0. 000000 | | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | | | |
| 90. 00 09000 CLI NI C | 0. 000000 | | 90.00 |
| 90. 01 09001 WOUND CARE | 0. 000000 | | 90. 01 |
| 91. 00 09100 EMERGENCY | 0. 000000 | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000 | | 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 HOSPIT | AL LOGANSPORT | | In Lieu of Form CMS-2552-1 | | |
|--|-----------------|---------------|--------------|----------------------------|--------------------------------|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL | COSTS | Provi der C | | Peri od: | Worksheet D | |
| | | | | From 01/01/2020 | | |
| | | | | To 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | |
| - | | Title | XVIII | Hospi tal | PPS | 7 (1111 |
| Cost Center Description | Capi tal | Swi ng Bed | Reduced | Total Patient | Per Diem | |
| | Related Cost | Adjustment | Capi tal | Days | (col. 3 / | |
| | (from Wkst. | | Related Cost | | col. 4) | |
| | B, Part II, | | (col. 1 - | | | |
| | col. 26) | | col . 2) | | | |
| | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 ADULTS & PEDIATRICS | 1, 250, 973 | 0 | 1, 250, 97 | 5, 216 | 239. 83 | 30.00 |
| 31.00 INTENSIVE CARE UNIT | 187, 424 | | 187, 42 | 4 455 | 411. 92 | 31.00 |
| 43. 00 NURSERY | 15, 659 | | 15, 65 | 9 985 | 15. 90 | 43.00 |
| 200.00 Total (lines 30 through 199) | 1, 454, 056 | | 1, 454, 05 | 6, 656 | | 200.00 |
| Cost Center Description | I npati ent | Inpatient | | | | |
| | Program days | Program | | | | |
| | | Capital Cost | | | | |
| | | (col. 5 x | | | | |
| | | col. 6) | | | | |
| | 6. 00 | 7. 00 | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 ADULTS & PEDIATRICS | 1, 343 | 322, 092 | | | | 30.00 |
| 31.00 INTENSIVE CARE UNIT | 166 | 68, 379 | | | | 31.00 |
| 43. 00 NURSERY | 0 | 0 | l . | | | 43.00 |
| 200.00 Total (lines 30 through 199) | 1, 509 | 390, 471 | | | | 200. 00 |

| Health Financial | Systems | MEMORIAL HOSPITAL | LOGANSPORT | In Lieu | of Form CMS-2552-10 |
|--------------------|-------------|----------------------------------|--------------------|---------|---------------------|
| ADDODEL ON MENT OF | LAIDATLENIT | ANGLEL ABY OF BY OF CARLEY COOPS | D 1 1 0001 45 0070 | D 1 1 | |

| Health Financial Systems | MEMORIAL HOSPIT | AL LOGANSPORT | | In Lie | u of Form CMS-2 | 2552-10 |
|--|-------------------------|---------------|------------|---|-----------------------------|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT | TAL COSTS | Provi der C | | Period: From 01/01/2020 To 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | |
| | | | XVIII | Hospi tal | PPS | |
| Cost Center Description | Capi tal | Total Charges | | | 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. 26) | col. 8) | col . 2) | | | |
| | 1. 00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 734, 561 | 31, 822, 022 | 0. 02308 | 1, 432, 669 | 33, 070 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 130, 690 | 2, 377, 944 | 0. 0549 | 59 0 | 0 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 52, 248 | 1, 984, 215 | 0. 02633 | 32 70, 205 | 1, 849 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 305, 607 | 13, 128, 682 | 0. 0232 | 78 391, 585 | 9, 115 | 54.00 |
| 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 | 204, 888 | 19, 636, 868 | 0. 01043 | 1, 224, 120 | 12, 772 | 60.00 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | 2, 326 | 1, 380, 755 | 0. 00168 | 35 162, 785 | | 63.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 29, 099 | 5, 215, 723 | 0.0055 | 79 1, 620, 305 | 9, 040 | |
| 66. 00 06600 PHYSI CAL THERAPY | 121, 349 | 3, 455, 849 | 0. 0351 | 14 167, 916 | | |
| 69. 00 06900 ELECTROCARDI OLOGY | 48, 926 | 3, 977, 704 | 0. 01230 | 272, 140 | 3, 347 | 69.00 |
| 69. 01 06901 CARDI AC REHAB | 159, 013 | 404, 068 | 0. 39353 | 30 0 | 0 | 69. 01 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 130, 093 | | | 07 670, 119 | 10, 392 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 7, 020 | 6, 984, 222 | 0.00100 | 05 609, 102 | 612 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 116, 827 | 52, 201, 450 | 0.00223 | 38 2, 780, 740 | 6, 223 | 73.00 |
| 76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC | 39, 824 | 8, 815, 050 | 0. 00451 | 18 388, 974 | 1, 757 | 76.00 |
| 76. 01 03480 ONCOLOGY | 155, 444 | 9, 816, 155 | 0. 01583 | 36 21, 548 | 341 | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLINIC | 209, 597 | | 1 | | 1, 018 | |
| 90. 01 09001 WOUND CARE | 33, 371 | | | | 0 | 90. 01 |
| 91. 00 09100 EMERGENCY | 492, 419 | | | | | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 228, 802 | 3, 641, 499 | 0. 06283 | 32 27, 940 | 1, 756 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | T | 1 | | | 05.06 |
| 95. 00 09500 AMBULANCE SERVICES | 0.000.101 | 100 500 075 | | 40 504 077 | 404 450 | 95.00 |
| 200.00 Total (lines 50 through 199) | 3, 202, 104 | 190, 508, 875 | 1 | 10, 521, 966 | 121, 150 | 1200.00 |

| Nursing School Post-Stepdown Adjustments Provider CCN: 15-0072 Period: From 01/01/2020 Provider CCN: 15-0072 Pro | Health Financial Systems | MEMORIAL HOSPIT | AL LOGANSPORT | | In Lie | u of Form CMS- | 2552-10 |
|--|--|-----------------------|---------------|---------------|----------------------------------|--|---------|
| Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments School Post-Stepdown Adjustments All Other Medical Education Cost | APPORTIONMENT OF INPATIENT ROUTINE SERVICE C | THER PASS THROUGH COS | TS Provider C | | From 01/01/2020 To 12/31/2020 | Part III Date/Time Pre 8/2/2021 10:5 | epared: |
| Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments School Post-Stepdown Adjustments All Other Medical Education Cost | | | Title | e XVIII | Hospi tal | PPS | |
| NPATIENT ROUTINE SERVICE COST CENTERS Adjustments Adjustment Ad | Cost Center Description | Nursi ng | Nursi ng | Allied Health | Allied Health | All Other | |
| NPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2A 2.00 3.0 | | School | School | Post-Stepdowr | Cost | Medi cal | |
| INPATI ENT ROUTI NE SERVICE COST CENTERS 1 | | Post-Stepdown | | Adjustments | | Educati on | |
| INPATIENT ROUTINE SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 | | Adjustments | | | | | |
| 30. 00 3000 ADULTS & PEDIATRICS 0 0 0 0 0 0 30. 00 | | 1A | 1. 00 | 2A | 2. 00 | 3. 00 | |
| NATIENT ROUTINE SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 | INPATIENT ROUTINE SERVICE COST CENTERS | S | | | | | |
| A3.00 04300 NURSERY 0 0 0 0 0 0 0 0 0 | 30. 00 03000 ADULTS & PEDIATRICS | 0 | 0 |) | 0 | 0 | 30.00 |
| Total (lines 30 through 199) | 31.00 03100 INTENSIVE CARE UNIT | 0 | 0 |) | o | 0 | 31.00 |
| Cost Center Description | 43. 00 04300 NURSERY | 0 | 0 |) | o | 0 | 43.00 |
| Adjustment Amount (see 1 through 3, instructions) minus col. 4) NPATIENT ROUTINE SERVICE COST CENTERS | 200.00 Total (lines 30 through 199) | 0 | 0 |) | o | 0 | 200.00 |
| Amount (see instructions) 1 through 3, minus col. 4) | Cost Center Description | Swi ng-Bed | Total Costs | Total Patient | Per Diem | I npati ent | |
| Instructions minus col 4 | | Adj ustment | (sum of cols. | Days | (col. 5 ÷ | Program Days | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | Amount (see | 1 through 3, | | col . 6) | | |
| INPATI ENT ROUTI NE SERVI CE COST CENTERS 0 0 5, 216 0.00 1, 343 30.00 31.00 03100 INTENSI VE CARE UNI T 0 455 0.00 166 31.00 43.00 04300 NURSERY 0 985 0.00 0 43.00 200.00 Total (lines 30 through 199) 0 6,656 1,509 200.00 | | instructions) | minus col. 4) | | | | |
| 30. 00 | | 4. 00 | 5. 00 | 6.00 | 7. 00 | 8. 00 | |
| 31. 00 | | S | | | | | |
| 43.00 | | 0 | 0 | 5, 21 | 6 0.00 | 1, 343 | 30.00 |
| Total (lines 30 through 199) 0 6,656 1,509 200.00 | 31.00 03100 INTENSIVE CARE UNIT | | 0 | 45 | 5 0.00 | 166 | 31.00 |
| Inpati ent | 43. 00 04300 NURSERY | | 0 | 98 | 5 0.00 | 0 | 43.00 |
| Program Pass-Through Cost (col. 7 x col. 8) 9.00 | 200.00 Total (lines 30 through 199) | | 0 | 6, 65 | 6 | 1, 509 | 200.00 |
| Pass-Through Cost (col. 7 x col. 8) 9.00 | Cost Center Description | Inpatient | | | | | |
| Cost (col . 7 x col . 8) 9.00 | | Program | | | | | |
| X COİ . 8) 9.00 | | Pass-Through | | | | | |
| 9.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 3000 ADULTS & PEDIATRICS 0 31.00 31.00 INTENSIVE CARE UNIT 0 31.00 43.00 NURSERY 0 43.00 | | Cost (col. 7 | | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS 30.00 3000 ADULTS & PEDIATRICS 0 31.00 31.00 INTENSIVE CARE UNIT 0 31.00 43.00 NURSERY 0 43.00 | | x col. 8) | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS 0 30. 00 31. 00 03100 I NTENSI VE CARE UNI T 0 31. 00 43. 00 04300 NURSERY 0 43. 00 | | | | | | | |
| 31. 00 03100 INTENSIVE CARE UNIT 0 31. 00 43. 00 04300 NURSERY 0 43. 00 | | | | | | | |
| 43. 00 04300 NURSERY 0 43. 00 | | 0 | | | | | |
| | | 0 | | | | | |
| 200.00 Total (lines 30 through 199) 0 200.00 | | 0 | | | | | |
| | 200.00 Total (lines 30 through 199) | 0 | | | | | 200.00 |

THROUGH COSTS

| | | | | | 10 12/31/2020 | 8/2/2021 10: 5 | |
|--------|--|---------------|---------------|----------|---------------|----------------|---------|
| | | | 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 | | | | |
| | T | 1. 00 | 2A | 2. 00 | 3A | 3. 00 | |
| | ANCILLARY SERVICE COST CENTERS | . 1 | | | | | |
| | 05000 OPERATING ROOM | 0 | 0 | | 0 | 0 | 50.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | | 0 | 0 | 52.00 |
| | 05300 ANESTHESI OLOGY | 0 | 0 | | 0 | 0 | 53.00 |
| | 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | 0 | 0 | 54.00 |
| 57. 00 | 05700 CT SCAN | 0 | 0 | | 0 | 0 | 57. 00 |
| | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | 0 | | 0 | 0 | 58. 00 |
| | 05900 CARDI AC CATHETERI ZATI ON | 0 | 0 | | 0 | 0 | 59. 00 |
| | 06000 LABORATORY | 0 | 0 | | 0 | 0 | 60.00 |
| | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | | 0 | 0 | 63.00 |
| 65. 00 | | 0 | 0 | | 0 | 0 | 65.00 |
| 66. 00 | 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 | 0 | 66. 00 |
| 69. 00 | | 0 | 0 | | 0 | 0 | 69. 00 |
| 69. 01 | 06901 CARDI AC REHAB | 0 | 0 | | 0 | 0 | 69. 01 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 | 0 | 71. 00 |
| | 07200 I MPL. DEV. CHARGED TO PATIENT | 0 | 0 | | 0 | 0 | 72.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 | 0 | 73.00 |
| | 03450 NUCLEAR MEDICINE - DIAGNOSTIC | 0 | 0 | | 0 | 0 | 76. 00 |
| 76. 01 | 03480 ONCOLOGY | 0 | 0 | | 0 0 | 0 | 76. 01 |
| | OUTPATIENT SERVICE COST CENTERS | 1 .1 | | | | | |
| | 09000 CLI NI C | 0 | 0 | | 0 | 0 | 90.00 |
| 90. 01 | 09001 WOUND CARE | 0 | 0 | | 0 | 0 | 90. 01 |
| 91.00 | 09100 EMERGENCY | 0 | 0 | | 0 | 0 | 91.00 |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | | | 0 | 0 | 92.00 |
| 05.55 | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| | 09500 AMBULANCE SERVICES | | _ | | | _ | 95. 00 |
| 200.00 | Total (lines 50 through 199) | 0 | 0 | | 0 | 0 | 200. 00 |

| Peri od: | Worksheet D | From 01/01/2020 | Part IV | To | 12/31/2020 | Date/Time Prepared: THROUGH COSTS

| | | | ' | 0 12/01/2020 | 8/2/2021 10: 5 | |
|--|------------|---------------|--------------|---|----------------|--------|
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | All Other | Total Cost | Total | Total Charges | Ratio of Cost | |
| | Medi cal | (sum of cols. | Outpati ent | (from Wkst. | to Charges | |
| | Educati on | 1, 2, 3, and | Cost (sum of | C, Part I, | (col. 5 ÷ | |
| | Cost | 4) | col s. 2, 3, | col. 8) | col. 7) | |
| | | | and 4) | | (see | |
| | | | | | instructions) | |
| | 4. 00 | 5. 00 | 6. 00 | 7. 00 | 8. 00 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50. 00 05000 OPERATING ROOM | 0 | 0 | (| 31, 822, 022 | | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | (| 2, 377, 944 | 0.000000 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | (| 1, 984, 215 | 0.000000 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | (| 13, 128, 682 | 0.000000 | 54.00 |
| 57.00 05700 CT SCAN | 0 | 0 | (| 0 | 0.000000 | 57.00 |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | 0 | (| 0 | 0.000000 | 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0 | 0 | | 0 | 0.000000 | 59.00 |
| 60. 00 06000 LABORATORY | 0 | 0 | | 19, 636, 868 | 0.000000 | 60.00 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | | 1, 380, 755 | 0.000000 | 63.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 0 | 0 | | 5, 215, 723 | 0. 000000 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | 3, 455, 849 | 0. 000000 | 66.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 3, 977, 704 | 0. 000000 | 69.00 |
| 69. 01 06901 CARDI AC REHAB | 0 | 0 | | 404, 068 | | 69. 01 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | (| 8, 389, 093 | 0. 000000 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | (| 6, 984, 222 | 0. 000000 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 52, 201, 450 | 0. 000000 | 73.00 |
| 76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC | 0 | 0 | | 8, 815, 050 | | |
| 76. 01 03480 ONCOLOGY | 0 | 0 | | 9, 816, 155 | | |
| OUTPATIENT SERVICE COST CENTERS | | | | , | | |
| 90. 00 09000 CLI NI C | 0 | 0 | | 1, 142, 116 | 0.000000 | 90.00 |
| 90. 01 09001 WOUND CARE | 0 | 0 | | 2, 077, 276 | 0. 000000 | 90. 01 |
| 91, 00 09100 EMERGENCY | 0 | 0 | | 14, 058, 184 | | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | 3, 641, 499 | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | 1 |
| 95. 00 09500 AMBULANCE SERVICES | | | | | | 95.00 |
| 200.00 Total (lines 50 through 199) | 0 | 0 | | 190, 508, 875 | | 200.00 |
| | 1 | | • | | 1 | |

| Health Financial Systems | MEMORIAL HOSPITAL | LOGANSPORT | In Lieu | ı of Form CMS-2552-10 |
|---------------------------------------|------------------------------|-----------------------|-----------------|-----------------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT | ANCILLARY SERVICE OTHER PASS | Provider CCN: 15-0072 | Peri od: | Worksheet D |
| THROUGH COSTS | | | From 01/01/2020 | Part IV |

| Title XVIII Hospital PPS Cost Center Description Cost Center Description Ratio of Cost to Charges (col. 6 ÷ col. 7) Program (Charges (col. 7) Program (Charges (col. 7) Program (Charges (col. 8) x col. 10) To 0 T | THROUGH COSTS | | | | From 01/01/2020 Fo 12/31/2020 | | nared. |
|--|--|---------------|--------------|---------------|----------------------------------|---------------|---------|
| Cost Center Description | | | | | 12/01/2020 | | |
| Ratio of Cost to Charges (col . 6 ÷ col . 7) Program Charges (col . 8 x col . 10) Program Pass-Through Costs (col . 9 x col . 12) | | | Title | XVIII | Hospi tal | PPS | |
| to Charges (col . 6 ÷ col . 7) ANCI LLARY SERVICE COST CENTERS Pass-Through Costs (col . 8 x col . 10) Pass-Through Costs (col . 9 x col . 12) | Cost Center Description | Outpati ent | I npati ent | I npati ent | Outpati ent | Outpati ent | |
| Costs (col. 8 Costs (col. 8 x col. 10) x col. 12) | | Ratio of Cost | Program | Program | Program | Program | |
| COI | | to Charges | Charges | Pass-Through | Charges | Pass-Through | |
| 9. 00 10. 00 11. 00 12. 00 13. 00 ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 0. 000000 1, 432, 669 0 4, 633, 322 0 50. 0 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 000000 0 0 0 284, 515 0 52. 0 53. 00 05300 ANESTHESI OLOGY 0. 000000 70, 205 0 284, 515 0 53. 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 000000 391, 585 0 2, 704, 578 0 54. 0 57. 00 05700 CT SCAN 0. 000000 0 0 0 0 0 57. 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 000000 0 0 0 0 0 58. 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000 0 0 0 1, 856, 046 0 60. 0 | | (col. 6 ÷ | | Costs (col. 8 | | Costs (col. 9 | |
| ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 0.000000 1, 432, 669 0 4, 633, 322 0 50. 0 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 0 0 284, 515 0 53. 0 53. 00 05300 ANESTHESI OLOGY 0.000000 70, 205 0 284, 515 0 53. 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 391, 585 0 2, 704, 578 0 54. 0 57. 00 05700 CT SCAN 0.000000 0 0 0 0 0 57. 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 0 0 0 0 59. 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 1, 856, 046 0 60. 0 60. 00 06000 LABORATORY 0.000000 1, 224, 120 0 1, 856, 046 0 60. 0 | | | | | | | |
| 50. 00 05000 OFERATI NG ROOM 0.000000 1,432,669 0 4,633,322 0 50.00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 0 0 0 52.00 53. 00 05300 ANESTHESI OLOGY 0.000000 70,205 0 284,515 0 53.0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 391,585 0 2,704,578 0 54.0 57. 00 05700 CT SCAN 0.000000 0 0 0 0 0 57.0 58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0.000000 0 0 0 0 0 59.0 0 0 0 0 0 0 59.0 | | 9. 00 | 10. 00 | 11. 00 | 12.00 | 13.00 | |
| 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 0 0 0 52. 00 52. 00 53. 00 05300 ANESTHESI OLOGY 0.000000 70, 205 0 284, 515 0 53. 00 53. 00 53. 00 54. 00 54. 00 54. 00 57. 00 05700 57. 00 57. 00 0 0 0 0 0 57. 00 57. 00 0 0 0 0 0 0 57. 00 0 57. 00 < | | | | | | | |
| 53. 00 05300 05300 ANESTHESI OLOGY 0.000000 70,205 0 284,515 0 53.00 53.00 54.00 54.00 54.00 55.00 57.00 57.00 57.00 57.00 58.00 58.00 58.00 60.00 | | | 1, 432, 669 | | 4, 633, 322 | 0 | 50.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 391, 585 0 2, 704, 578 0 54. 00 57. 00 05700 CT SCAN 0.000000 0 0 0 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 0 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 1,224,120 0 1,856,046 0 60. 0 | | 1 | 0 | | 0 | | 52.00 |
| 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 0 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 0 0 59.00 60. 00 06000 LABORATORY 0.000000 1,224,120 0 1,856,046 0 60.00 | | | | | · · | | 53.00 |
| 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 0 59.00 60. 00 06000 LABORATORY 0.000000 1,224,120 0 1,856,046 0 60.00 | | | 391, 585 | | 2, 704, 578 | 0 | 54.00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | | 1 | 0 | | 0 | 0 | 57.00 |
| 60. 00 06000 LABORATORY 0. 000000 1, 224, 120 0 1, 856, 046 0 60. 0 | | | 0 | | 0 | 0 | 58.00 |
| | | 0. 000000 | 0 | | 0 | 0 | 59.00 |
| 63. 00 06300 BLOOD STORING PROCESSING & TRANS. 0.000000 162. 785 0 83. 552 0 63. 0 | | | | | | | 60.00 |
| | 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | 0. 000000 | 162, 785 | | 83, 552 | 0 | 63.00 |
| | | | 1, 620, 305 | | 395, 373 | 0 | 65.00 |
| | | 0. 000000 | 167, 916 | | 10, 098 | 0 | 66.00 |
| | | | 272, 140 | | 968, 685 | 0 | 69. 00 |
| | | 0. 000000 | 0 | | 165, 647 | 0 | 69. 01 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 670,119 0 725,930 0 71.0 | 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000 | 670, 119 | | 725, 930 | 0 | 71.00 |
| | | 0. 000000 | 609, 102 | | 1, 270, 564 | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 2,780,740 0 11,825,369 0 73.0 | 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 000000 | 2, 780, 740 | | 11, 825, 369 | 0 | 73.00 |
| 76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0.000000 388,974 0 2,432,229 0 76.0 | 76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC | 0. 000000 | 388, 974 | | 2, 432, 229 | 0 | 76. 00 |
| 76. 01 03480 0NC0L0GY 0. 000000 21, 548 0 3, 282, 948 0 76. 0 | 76. 01 03480 ONCOLOGY | 0. 000000 | 21, 548 | (| 3, 282, 948 | 0 | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| | | 0. 000000 | 5, 549 | | 447, 157 | 0 | 90.00 |
| 90. 01 09001 WOUND CARE 0. 000000 0 678, 465 0 90. 0 | 90. 01 09001 WOUND CARE | 0. 000000 | 0 | | 678, 465 | 0 | 90. 01 |
| 91. 00 09100 EMERGENCY 0. 000000 676, 269 0 2, 387, 546 0 91. 0 | 91. 00 09100 EMERGENCY | 0. 000000 | 676, 269 | | 2, 387, 546 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 27,940 0 657,573 0 92.0 | 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000 | 27, 940 | (| 657, 573 | 0 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 95. 00 09500 AMBULANCE SERVI CES 95. 0 | 95. 00 09500 AMBULANCE SERVI CES | | | | | | 95.00 |
| 200.00 Total (lines 50 through 199) 10,521,966 0 34,809,597 0 200.0 | 200.00 Total (lines 50 through 199) | | 10, 521, 966 | | 34, 809, 597 | 0 | 200. 00 |

| Health Financial Systems | MEMORIAL HOSPITAL | LOGANSPORT | In Lieu | ı of Form CMS-2552-10 |
|---------------------------|--|-----------------------|----------|-----------------------|
| APPORTIONMENT OF MEDICAL, | OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0072 | Peri od: | Worksheet D |

From 01/01/2020 Part V To 12/31/2020 Date/Time Prepared: 8/2/2021 10:57 am Title XVIII Hospi tal Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 292819 4, 633, 322 1, 356, 725 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 0.452975 52.00 53.00 05300 ANESTHESI OLOGY 0. 107067 284, 515 30, 462 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 281025 2, 704, 578 0 0 760, 054 54.00 0 57.00 05700 CT SCAN 0.000000 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58 00 0.000000 58.00 Ω Ω 0 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 59.00 60.00 06000 LABORATORY 0. 280373 1, 856, 046 0 0 0 520, 385 60.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 0. 135819 83, 552 11, 348 63.00 63.00 06500 RESPIRATORY THERAPY 0 134, 702 65.00 0.340695 395, 373 65.00 66.00 06600 PHYSI CAL THERAPY 0.491836 10,098 4, 967 66.00 06900 ELECTROCARDI OLOGY 0 o 217, 571 69.00 0. 224605 968, 685 69.00 0 o 06901 CARDI AC REHAB 1.790097 69 01 165 647 296, 524 69 01 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 382621 725, 930 0 277, 756 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 208657 1, 270, 564 0 0 265, 112 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0. 226080 11, 825, 369 56, 287 2, 673, 479 73.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC 2, 432, 229 0 76 00 0 148321 360, 751 76 00 0 03480 ONCOLOGY 0 76.01 0. 262460 3, 282, 948 861, 643 76.01 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 4. 675238 447, 157 0 0 2, 090, 565 90.00 0 09001 WOUND CARE 90.01 0.231192 678, 465 0 156, 856 90.01 91.00 09100 EMERGENCY 0.341518 2, 387, 546 35 815, 390 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 451423 0 92.00 657, 573 296, 844 OTHER REIMBURSABLE COST CENTERS 95 00 95 00 09500 AMBULANCE SERVICES 0.000000 0 56, 322 200.00 Subtotal (see instructions) 34, 809, 597 11, 131, 134 200.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges 0 11, 131, 134 202. 00 202.00 Net Charges (line 200 - line 201) 34, 809, 597 56, 322

| | | | | From 01/01/2020 To 12/31/2020 | | pared: |
|---|---------------|---------------|-------|----------------------------------|---------------|--------|
| | | | | | 8/2/2021 10:5 | 7 am |
| | | | XVIII | Hospi tal | PPS | |
| | | sts | | | | |
| Cost Center Description | Cost | Cost | | | | |
| | Rei mbursed | Rei mbursed | | | | |
| | Servi ces | Services Not | | | | |
| | Subject To | Subject To | | | | |
| | Ded. & Coins. | Ded. & Coins. | | | | |
| | (see inst.) | (see inst.) | - | | | |
| ANCILLARY SERVICE COST CENTERS | 6. 00 | 7. 00 | | | | |
| 50. 00 05000 OPERATING ROOM | | 0 | | | | 50.00 |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM | | _ | 1 | | | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | | | | 52.00 |
| 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 CARDIAC CATHETERIZATION | 0 | 0 | | | | 59.00 |
| 60. 00 06000 LABORATORY | 0 | 0 | | | | 60.00 |
| 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | | | | 63.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 0 | 0 | | | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | | | 66.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | | | 69.00 |
| 69. 01 06901 CARDI AC REHAB | | 0 | | | | 69. 01 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0 | | | | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | | 0 | | | | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | | 12, 725 | | | | 73.00 |
| 76. 00 03450 NUCLEAR MEDICINE - DIAGNOSTIC | | 12, 723 | i | | | 76.00 |
| 76. 00 03450 NOCLEAR MEDICINE - DI AGNOSTIC | | 0 | 1 | | | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | 0 | 0 | 1 | | | 70.01 |
| 90. 00 09000 CLINI C | 0 | 0 | 1 | | | 90.00 |
| 90. 01 09001 WOUND CARE | 0 | - | | | | 90.01 |
| 91. 00 09100 EMERGENCY | 0 | | | | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | 1 | | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | 72.00 |
| 95. 00 09500 AMBULANCE SERVI CES | 0 | | | | | 95.00 |
| 200.00 Subtotal (see instructions) | 0 | 12, 737 | | | | 200.00 |
| 201.00 Less PBP Clinic Lab. Services-Program | 0 | | | | | 201.00 |
| Only Charges | | | | | | |
| 202.00 Net Charges (line 200 - line 201) | 0 | 12, 737 | | | | 202.00 |
| | • | • | • | | | • |

| Health Financial Systems | MEMORIAL HOSPITAL | LOGANSPORT | In Lie | u of Form CMS-2 | 2552-10 |
|---|-------------------|-----------------------|-----------------------------|--------------------------------|----------------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider CCN: 15-0072 | Peri od: From 01/01/2020 | Worksheet D-1 | |
| | | | | Date/Time Pre 8/2/2021 10:5 | pared: 7 am |
| | | Title XVIII | Hospi tal | PPS | |
| Cost Center Description | | | | | |
| | | | | 1. 00 | |

| Dest Center Description Part All PROVIDER COMPONENTS | | | Title XVIII | Hospi tal | 8/2/2021 10: 5 PPS | / alli | | |
|--|--------|---|-------------------------------|-------------------|-----------------------|--------|--|--|
| NAME | | Cost Center Description | | • | | | | |
| Impart Int Tours Impart Int | | DADT I ALL DROWLDED COMPONENTS | | | 1. 00 | | | |
| Inpatient days (including private room days and swing-bed days, excluding newborn) | | | | | | | | |
| Private room days (excluding swing-bed and observation bed days) 4.00 Seni-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed Sir type inpatient days (including private room days) through December 31 of the cost part of the cost reporting period (if calendary ear, enter 0 on this line) 7.00 Total swing-bed Sir type inpatient days (including private room days) through December 31 of the cost reporting period (if calendary ear, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary ear, enter 0 on this line) 9.00 Total inpatient days (including private room days) after December 31 of the cost reporting period (if calendary ear, enter 0 on this line) 9.00 Total inpatient days (including private room days) after December 31 of the cost reporting period (if calendary ear, enter 0 on this line) 10.00 Sking-bed Sir type inpatient days applicable to the Program (excluding swing-bed and national system of the cost reporting period (if calendary ear, enter 0 on this line) 11.00 Sking-bed Sir type inpatient days applicable to title XVIII only (including private room days) after December 31 or the cost reporting period (if calendary ear, enter 0 on this line) 12.00 Sking-bed Sir type inpatient days applicable to title XVIII only (including private room days) 13.00 through December 31 or the cost reporting period (if calendary ear, enter 0 on this line) 14.00 Medically necessary private room days applicable to title XVIII only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Miscally incender 31 or the cost reporting period (if calendary ear, enter 0 on this line) 17.00 Sking-bed Sir type inpatient days applicable to services through December 31 of the cost reporting period (if calendary ear, enter 0 on this line) 18.00 Miscally incenders 31 or the cost reporting period (if calendary ear, enter 0 on this line) 18.00 Miscally incenders 31 or | 1.00 | | s, excluding newborn) | | 5, 216 | 1.00 | | |
| do not complete this line. 4. 05 Semi-private room days (excluding swing-bed and observation bed days) 5. 00 Total swing-bod SR type inpatient days (including private room days) after December 31 of the cost partial register of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bod SR type inpatient days (including private room days) after December 31 of the cost partial register of the cost of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bod SR type inpatient days (including private room days) sthrough December 31 of the cost of reporting period (if calendar year, enter 0 on this line) 8. 00 Total swing-bod SR type inpatient days (including private room days) after December 31 of the cost o | | | | | | | | |
| Semi-private room days (excluding swinp-bed MP type inpatient days (including private room days) through December 31 of the cost 0.5.00 Total swinp-bed MP type inpatient days (including private room days) after December 31 of the cost 0.5.00 Total swinp-bed MP type inpatient days (including private room days) after December 31 of the cost 0.5.00 Total swinp-bed NP type inpatient days (including private room days) after December 31 of the cost 0.5.00 Total swinp-bed NP type inpatient days (including private room days) after December 31 of the cost 0.5.00 Total swinp-bed NP type inpatient days (including private room days) after December 31 of the cost 0.5.00 Total inpatient days including private room days) after December 31 of the cost 0.5.00 Total inpatient days including private room days applicable to the Program (excluding swinp-bed and 0.5.00 Total inpatient days applicable to 11 to XVIII only (including private room days) 0.5.00 Total inpatient days applicable to 11 to XVIII only (including private room days) 0.5.00 Total inpatient days applicable to 11 to XVIII only (including private room days) 0.5.00 Swinp-bed NP type inpatient days applicable to 11 to XVIII only (including private room days) 0.5.00 Swinp-bed NP type inpatient days applicable to 11 to XVIII only (including private room days) 0.5.00 Swinp-bed NP type inpatient days applicable to 11 to XVIII only (including private room days) 0.5.00 Swinp-bed NP type inpatient days applicable to 11 to XVIII only (including private room days) 0.5.00 Swinp-bed NP type inpatient days applicable to 11 to XVIII only (including private room days) 0.5.00 Swinp-bed NP type inpatient days applicable to 11 to XVIII only (including private room days) 0.5.00 Swinp-bed NP type inpatient days applicable to 11 to XVIII only (including private room days) 0.5.00 Swinp-bed NP type inpatient days applicable to 11 to XVIII only 0.5.00 Swinp-bed MP type inpatient days applicable to 5 ervices through December 31 of the cost reporting period 0.5.00 Swinp-bed Swinp-bed Swinp-be | 3. 00 | | | | | | | |
| Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost operating period in the cost operating period if calendar year, enter 0 on this line) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost operating period if calendar year, enter 0 on this line) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost operating period (if calendar year, enter 0 on this line) Total inpatient days including private room days) after December 31 of the cost operating period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and 1,343 g.o.) Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and 1,343 g.o.) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) Including private room days (including private room days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) Including private room days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) Including private room days) Swing-bed SNF type inpatient days (including private room days) Including private room days) Including private room days (including private room days) Swing-bed SNF type inpatient days (including private room days) Including private room days (including swing-bed SNF services applicable to the Program (excluding swing-bed days) Including swing-bed SNF services applicable to the Program (exclud | 4 00 | · · | ed days) | | 4 262 | 4 00 | | |
| Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of total swing-bed NF type inpatient days (including private room days) through December 31 of the cost of total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of through December 31 of the cost reporting period (in patient days) (including private room days) after December 31 of the cost reporting period (in patient days) (including private room days) (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting Decem | | | | er 31 of the cost | | • | | |
| reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) on through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 SNF type inpatient days applicable to titles V or XIX only (including private room days) 16.00 SNF type inpatient days applicable to titles V or XIX only (including private room days) 17.00 SNF type inpatient days applicable to titles V or XIX only (including private room days) 18.00 SNF type inpatient days applicable to titles V or XIX only (including private room days) 18.00 SNF type days (title V or XIX only) 18.00 SNF type applicable to the Program (excluding swing-bed days) 18.00 SNF type days (title V or XIX only) 18.00 SNF type days (title V or XIX only) 18.00 SNF type days (title V or XIX only) 18.00 SNF type days (title V or XIX only) 18.00 SNF type days (title V or XIX only) 18.00 SNF type days (title V or XIX only) | | | | | _ | | | |
| Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of reporting period (if calendar year, enter 0 on this line) of Total inpatient days including private room days) after December 31 of the cost of reporting period (if calendar year, enter 0 on this line) of Total inpatient days including private room days applicable to the Program (excluding swing-bed and 1, 343 - 0.0 for the program (excluding swing-bed and 1, 343 - 0.0 swing-bed SNF type inpatient days applicable to the Program (excluding private room days) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost (see instructions) the declar reporting period (see instructions) the declar reporting period (see instructions) the services after December 31 of the cost (see instructions) the declar reporting period (see instructions) the services after December 31 of the cost (see instructions) the services after December 31 of the cost reporting period (line (see instructions)) through December 31 of the cost reporting period (line (see instructions)) the services after December 31 of the cost reporting period (line (see instructions)) the service of s | 6.00 | | om days) after December | 31 of the cost | 0 | 6.00 | | |
| reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see Instructions) 12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see Instructions) 13. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) of through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) of the cost reporting period (if calendar year, enter 0 on this line) 16. 00 Investry days (title V or XIX only) of the cost reporting period (if calendar year, enter 0 on this line) 17. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) of 15. 00 18. 00 Redically necessary private room days applicable to services through December 31 of the cost reporting period (including private room days) of 15. 00 18. 00 Redical or acto for swing-bed SNF services applicable to services after December 31 of the cost of 16. 00 19. 00 Medical or acto for swing-bed SNF services applicable to services after December 31 of the cost of 16. 00 19. 00 Medical or acto for swing-bed SNF services applicable to services after December 31 of the cost of 16. 00 20. 00 Medical or actor for swing-bed SNF services through December 31 of the cost reporting period (line reporting period (line swing-bed cost applicable to SNF type services thr | 7. 00 | | m davs) through December | 31 of the cost | 0 | 7.00 | | |
| reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to titlet XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to titlet XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to titlet XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 13.00 Swing-bed NF type inpatient days applicable to titlet XVIII only (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) applicable to the Program (excluding swing-bed days) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 17.00 Nursery days (title V or XIX only) 0 17.00 Nursery days (title V or XIX only) 0 17.00 Nursery days (title V or XIX only) 0 17.00 Nursery days (title V or XIX only) 0 18.00 reporting period (including total days only total days on | | | ,g | | | | | |
| 1,342 9.00 | 8.00 | | m days) after December 3 | 31 of the cost | 0 | 8. 00 | | |
| newborn days) (see instructions) 10. 00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 10. 00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 10. 00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 11. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12. 00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 13. 00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 14. 00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 15. 00 Total nursery days (title V or XIX only) 16. 00 Nursery days (title V or XIX only) 17. 00 Medicare rate for swing-bed SWF services applicable to services after December 31 of the cost 18. 00 Medicare rate for swing-bed SWF services applicable to services after December 31 of the cost 19. 00 Medicare rate for swing-bed SWF services applicable to services after December 31 of the cost 19. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Swing-bed cost applicable to SWF type services after December 31 of the cost reporting period (line of x x x x x x x x x x x x x x x x x | 9 00 | | o the Program (excluding | swing-bod and | 1 3/13 | 9 00 | | |
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| 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room cost differential (line 32 minus line 33) 35.00 Average per diem private room cost differential (line 32 minus line 33) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 987, 801) Average per diem private room cost differential (line 3 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 987, 801) Average per diem private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 987, 801) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | 0.4.00 | | | | | | | |
| 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 34 x line 35) 30.00 Agusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see | 24.00 | | r 31 of the cost reporti | ng period (line | 0 | 24.00 | | |
| 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average pri vate room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 987, 801) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 987, 801) 38.00 Ajusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) | 25. 00 | , | 31 of the cost reporting | period (line 8 | 0 | 25. 00 | | |
| 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9. 00 Pri vate room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32. 00 Average private room per diem charge (line 29 + line 3) 33. 00 Average semi-private room per diem charge (line 30 + line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 9. 00 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 987, 801) Adjusted general inpatient routine service cost per diem (see instructions) 10. 00 | | · | | | | | | |
| PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 9.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions) 32.00 Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 987, 801) 37.00 General inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 79.00 Program general inpatient routine service cost per diem (see instructions) 10.00 Average per diem private room cost differential (line 8, 987, 801) 38.00 Average per diem private room cost differential (line 8, 987, 801) 39.00 Program general inpatient routine service cost per diem (see instructions) 10.00 Average per diem private room cost diem (see instructions) 10.00 Average per diem private room cost diem (see instructions) 10.00 Average per diem private room cost diem (see instructions) 11.00 Average per diem private room cost diem (see instructions) 12.00 Average per diem private room cost diem (see instructions) 13.00 Average per diem private room cost diem (see instructions) 14.00 Average per diem private room cost diem (see instructions) 15.00 Average per diem private room cost diem (see instructions) 17.723.12 Average per diem private room cost diem (see instructions) 17.723.12 Average per diem private room cost diem charge (line 30 + line 28) 27.314,150 Average per diem p | | , , | (line 21 minus line 24) | | | 1 | | |
| 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 987, 801) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 50 Concept of the charges of the | 27.00 | | (TTHE 21 III HUS TTHE 26) | | 8, 987, 801 | 27.00 | | |
| 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37.00 x line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29.00 29.00 29.00 30.00 31.00 32.00 | 28. 00 | | d and observation bed ch | narges) | 0 | 28. 00 | | |
| 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 36.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 987, 801) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 000 000 000 000 000 000 000 000 0 | 29. 00 | Private room charges (excluding swing-bed charges) | | | | 29. 00 | | |
| 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 987, 801) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 37.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Value of the program (line 14 x line 35) 40.00 Value of the program (line 14 x line 35) 40.00 Value of the program (line 14 x line 35) 40.00 Value of the program (line 14 x line 35) 40.00 Value of the program (line 14 x line 35) 40.00 Value of the program (line 14 x line 35) 40.00 Value of the program (line 14 x line 35) 40.00 Value of the program (line 14 x line 35) 40.00 Value of the program (line 14 x line 35) 40.00 Value of the program (line 14 x line 35) 40.00 Value of the program (line 14 x line 35) | | | Line 20) | | | | | |
| 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 987, 801) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 37.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 33.00 33.00 34.00 35.00 36.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 | | , | ÷ Tine 28) | | | 1 | | |
| 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 987, 801) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 35.00 36.00 37.00 | | | | | | 1 | | |
| 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 987, 801 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 37.00 37.00 37.00 38.00 40.00 | | Average per diem private room charge differential (line 32 mi | nus line 33)(see instrud | ctions) | | 1 | | |
| 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 40.00 | | , | ne 31) | | | 1 | | |
| 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | | , | and private room cost di | fferential (line | | 1 | | |
| PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,723.12 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 2,314,150 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | 37.00 | , | ana private room cost di | riorentiai (IIII | 0,707,001 | 37.00 | | |
| 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,723.12 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 40.00 | | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | | | |
| 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 2,314,150 39.00 40.00 | 20.25 | | | | 4 700 := | 00.00 | | |
| 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) | | | • | | | 1 | | |
| | | , | * | | 0 | 40.00 | | |
| | 41.00 | , | • | | 2, 314, 150 | | | |

| | Financial Systems Marting COST | MEMORIAL HOSPITA | AL LOGANSPORT Provi der C | CN: 15_0072 | In Lie Period: | u of Form CMS-2 Worksheet D-1 | | |
|--|---|--------------------|----------------------------|--------------------|-------------------|----------------------------------|------------------|--|
| COMPUT | ATION OF INPATIENT OPERATING COST | | Provider C | | rom 01/01/2020 | | | |
| | | | | | Го 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | | |
| | Cost Contar Decemintion | Total | | XVIII Average Per | Hospi tal | PPS | | |
| | Cost Center Description | Total Inpatient | Total Inpatient | Diem (col. 1 | Program Days | Program Cost (col. 3 x | | |
| | | Cost | Days | ÷ col . 2) | | col . 4) | | |
| 42 00 | NURSERY (title V & XIX only) | 1.00 | 2.00 | 3.00 | 4.00 | 5. 00 | 42. 00 | |
| | Intensive Care Type Inpatient Hospital Units | | | | | | 1 | |
| 43. 00 44. 00 | INTENSIVE CARE UNIT | 1, 956, 753 | 455 | 4, 300. 5 | 166 | 713, 893 | 43.00 | |
| 45. 00 | BURN INTENSIVE CARE UNIT | | | | | | 45. 00 | |
| | SURGICAL INTENSIVE CARE UNIT | | | | | | 46. 00 | |
| 47. 00 | OTHER SPECIAL CARE (SPECIFY) Cost Center Description | | | | | | 47.00 | |
| | <u> </u> | | | | | 1. 00 | | |
| 48. 00 | Program inpatient ancillary service cost (Wk | | | ono) | | 2, 948, 931 | | |
| 49.00 | Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS | 41 through 48)(| see mstructi | 0115) | | 5, 976, 974 | 49.00 | |
| 50.00 | Pass through costs applicable to Program inp | atient routine | services (fro | m Wkst. D, sum | of Parts I and | 390, 471 | 50.00 | |
| 51. 00 | | natient ancillar | rv services (f | rom Wkst D s | um of Parts II | 121, 150 | 51.00 | |
| 01.00 | and IV) | | y 301 11 003 (1 | rom witst. b, c | idiii or rarts rr | 121,100 | 01.00 | |
| 52. 00 53. 00 | Total Program excludable cost (sum of lines | , | alated non | velelan anastt | otict and | 511, 621 | | |
| 53.00 | Total Program inpatient operating cost exclumedical education costs (line 49 minus line | | erated, non-pn | ysician anesti | letist, and | 5, 465, 353 | 53.00 | |
| | TARGET AMOUNT AND LIMIT COMPUTATION | , | | | | _ | | |
| 54. 00 55. 00 | Program di scharges Target amount per di scharge | | | | | 0 0. 00 | | |
| 56. 00 | Target amount (line 54 x line 55) | | | | | 0.00 | 1 | |
| 57. 00 | Difference between adjusted inpatient operat | line 53) | 0 | | | | | |
| 58. 00 59. 00 | Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re | 0.00 | | | | | | |
| 07.00 | market basket | | | | | | | |
| 60. 00 61. 00 | | | | | | | | |
| 01.00 | 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 | | • | , , | 3 | _ | | |
| | Relief payment (see instructions) Allowable Inpatient cost plus incentive paym | nent (see instru | ıcti ons) | | | 0 0 | | |
| PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See | | | | | | | 00.00 | |
| 64. 00 | 0 | 64.00 | | | | | | |
| 65. 00 | instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos | sts after Decemb | per 31 of the | cost reporting | period (See | 0 | 65.00 | |
| 66. 00 | instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi | no costs (lino | 64 plus lino | 65) (+i +l o VVI I | Lonly) For | 0 | 66.00 | |
| 00.00 | CAH (see instructions) | ne costs (Title | 04 prus rine | 05)(title xvii | i diliy). Toi | | 00.00 | |
| 67. 00 | Title V or XIX swing-bed NF inpatient routin | ne costs through | December 31 | of the cost re | porting period | 0 | 67.00 | |
| 68. 00 | (line 12 x line 19) Title V or XIX swing-bed NF inpatient routin | ne costs after D | December 31 of | the cost repo | rting period | 0 | 68. 00 | |
| | (line 13 x line 20) | | | | | | (0.00 | |
| 69.00 | Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N | | • | | | 0 | 69.00 | |
| 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 70 ÷ line | 2) | | | 71.00 | |
| 73. 00 | Medically necessary private room cost applic | , | n (line 14 x l | ine 35) | | | 73.00 | |
| 74.00 | Total Program general inpatient routine serv | | | | | | 74.00 | |
| 75. 00 | Capital-related cost allocated to inpatient 26, line 45) | routine service | e costs (trom | worksneet B, F | art 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 | | cost limitation | n (line 78 mir | us line 79) | | 80.00 | |
| 81. 00 82. 00 | Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I | | 1) | | | | 81. 00 82. 00 | |
| 83.00 | Reasonable inpatient routine service costs (| | * . | | | | 83.00 | |
| 84.00 | Program inpatient ancillary services (see in | | ,,,, | | | | 84.00 | |
| 85. 00 86. 00 | Utilization review - physician compensation Total Program inpatient operating costs (sum | | | | | | 85. 00 86. 00 | |
| | PART IV - COMPUTATION OF OBSERVATION BED PAS | S THROUGH COST | | | | | | |
| 87. 00 88. 00 | Total observation bed days (see instructions Adjusted general inpatient routine cost per | * | - line 2) | | | 954 1, 723. 12 | 1 | |
| | Observation bed cost (line 87 x line 88) (se | | , | | | 1, 643, 856 | 1 | |
| | | ŕ | | | ' | • | • | |

| 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 01/01/2020 To 12/31/2020 | | pared: 7 am |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observation | |
| | | (from line | column 2 | Observati on | Bed Pass | |
| | | 21) | | Bed Cost | Through Cost | |
| | | | | (from line | (col. 3 x | |
| | | | | 89) | col. 4) (see | |
| | | | | | instructions) | |
| | 1. 00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | | | | | |
| 90.00 Capital -related cost | 1, 250, 973 | 8, 987, 801 | 0. 13918 | 6 1, 643, 856 | 228, 802 | 90.00 |
| 91.00 Nursing School cost | 0 | 8, 987, 801 | 0.00000 | 0 1, 643, 856 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 8, 987, 801 | 0.00000 | 0 1, 643, 856 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 8, 987, 801 | 0. 00000 | 0 1, 643, 856 | 0 | 93. 00 |

| Health Financial Systems | MEMORIAL HOSPITAL | LOGANSPORT | In Lieu | u of Form CMS-2 | 2552-10 |
|---|-------------------|------------------------|-----------------------------|--------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provi der CCN: 15-0072 | Peri od: From 01/01/2020 | Worksheet D-1 | |
| | | | To 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | |
| | | Title XIX | Hospi tal | Cost | |
| Cost Center Description | | | | | |
| | | | | 1. 00 | |
| PART I - ALL PROVIDER COMPONENTS | | | | | |
| INPATIENT DAYS | | | | | Ī |

| | | Title XIX | Hospi tal | Cost | |
|------------------|---|---------------------------|-------------------|------------------|------------------|
| | Cost Center Description | | | 1 00 | |
| | PART I - ALL PROVIDER COMPONENTS | | | 1. 00 | |
| | INPATIENT DAYS | | | | |
| 1.00 | Inpatient days (including private room days and swing-bed day | (s, excluding newborn) | | 5, 216 | 1.00 |
| 2.00 | Inpatient days (including private room days, excluding swing- | bed and newborn days) | | 5, 216 | 2.00 |
| 3.00 | Private room days (excluding swing-bed and observation bed days | ays). If you have only pr | ivate room days, | 0 | 3. 00 |
| 4 00 | do not complete this line. | | | 4 2/2 | 4 00 |
| 4. 00 5. 00 | Semi-private room days (excluding swing-bed and observation between Total swing-bed SNF type inpatient days (including private ro | | r 31 of the cost | 4, 262 0 | 4. 00 5. 00 |
| 3.00 | reporting period | | | | |
| 6.00 | Total swing-bed SNF type inpatient days (including private ro | oom days) after December | 31 of the cost | 0 | 6. 00 |
| | reporting period (if calendar year, enter 0 on this line) | | | _ | |
| 7. 00 | Total swing-bed NF type inpatient days (including private rooreporting period | om days) through December | 31 of the cost | 0 | 7. 00 |
| 8. 00 | Total swing-bed NF type inpatient days (including private roo | om davs) after December 3 | 1 of the cost | 0 | 8. 00 |
| 0.00 | reporting period (if calendar year, enter 0 on this line) | daye, arter becomber e | | · · | 0.00 |
| 9.00 | Total inpatient days including private room days applicable t | to the Program (excluding | swing-bed and | 322 | 9. 00 |
| 10.00 | newborn days) (see instructions) | | | 0 | 10.00 |
| 10. 00 | Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc | | oom days) | 0 | 10. 00 |
| 11. 00 | Swing-bed SNF type inpatient days applicable to title XVIII of | | oom days) after | 0 | 11. 00 |
| | December 31 of the cost reporting period (if calendar year, e | enter 0 on this line) | | | |
| 12. 00 | Swing-bed NF type inpatient days applicable to titles V or XI | X only (including privat | e room days) | 0 | 12. 00 |
| 13. 00 | through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI | Y only (including privat | o room days) | 0 | 13. 00 |
| 13.00 | after December 31 of the cost reporting period (if calendar y | | | U | 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) | | | 985 | |
| 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 | cos through Docombor 21 o | f the cost | 0.00 | 17. 00 |
| 17.00 | reporting period | ces through becember 31 o | i the cost | 0.00 | 17.00 |
| 18. 00 | Medicare rate for swing-bed SNF services applicable to service | ces after December 31 of | the cost | 0.00 | 18. 00 |
| | reporting period | | | | |
| 19. 00 | Medicaid rate for swing-bed NF services applicable to service | es through December 31 of | the cost | 0. 00 | 19. 00 |
| 20. 00 | reporting period Medicaid rate for swing-bed NF services applicable to service | es after December 31 of t | he cost | 0. 00 | 20. 00 |
| 20.00 | reporting period | arter becomber 57 or t | ne cost | 0.00 | 20.00 |
| 21.00 | Total general inpatient routine service cost (see instruction | ns) | | 8, 987, 801 | 21.00 |
| 22. 00 | Swing-bed cost applicable to SNF type services through Decemb | per 31 of the cost report | ing period (line | 0 | 22. 00 |
| 23. 00 | 5 x line 17) Swing-bed cost applicable to SNF type services after December | 21 of the cost reportin | a ported (line A | 0 | 23. 00 |
| 23.00 | x line 18) | 31 of the cost reportin | g period (iiile d | U | 23.00 |
| 24.00 | | er 31 of the cost reporti | ng period (line | 0 | 24. 00 |
| | 7 x line 19) | | | | |
| 25. 00 | | 31 of the cost reporting | period (line 8 | 0 | 25. 00 |
| 26. 00 | x line 20) Total swing-bed cost (see instructions) | | | 0 | 26. 00 |
| | General inpatient routine service cost net of swing-bed cost | (line 21 minus line 26) | | 8, 987, 801 | |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | , | | | |
| | General inpatient routine service charges (excluding swing-be | ed and observation bed ch | arges) | | 28. 00 |
| | Pri vate room charges (excluding swing-bed charges) | | | 0 | |
| 30. 00 31. 00 | Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 | ÷ line 28) | | 0. 000000 | 30. 00 31. 00 |
| 32. 00 | Average private room per diem charge (line 29 ÷ line 3) | . 11116 20) | | 0.00 | |
| 33.00 | Average semi-private room per diem charge (line 30 ÷ line 4) | | | 0.00 | 33.00 |
| 34.00 | Average per diem private room charge differential (line 32 mi | | tions) | 0.00 | 34. 00 |
| 35.00 | Average per diem private room cost differential (line 34 x li | ne 31) | | 0.00 | |
| 36. 00 37. 00 | Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost | and private room cost di | fferential (line | 0 8, 987, 801 | 36.00 37.00 |
| 37.00 | 27 minus line 36) | and private room cost dr | rielential (IIIIe | 0, 701, 001 | 37.00 |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ | | | | |
| | Adjusted general inpatient routine service cost per diem (see | | | 1, 723. 12 | |
| 39.00 | Program general inpatient routine service cost (line 9 x line | • | | 554, 845 0 | 39. 00 40. 00 |
| 41.00 | Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39 | | | 554, 845 | |
| 55 | 1 | | 1 | 33., 310 | |

| | Financial Systems M TATION OF INPATIENT OPERATING COST | EMORIAL HOSPITA | L LOGANSPORT | CN: 15-0072 | In Lie | u of Form CMS-2 Worksheet D-1 | |
|--|---|----------------------------|-----------------------------|---|----------------------------------|--------------------------------------|--|
| | | | | | From 01/01/2020 To 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | |
| | Cost Center Description | Total Inpatient Cost | Total Inpati ent Days | e XIX Average Per Diem (col. 1 ÷ col. 2) | Hospital Program Days | Program Cost (col. 3 x col. 4) | 7 dili |
| 42. 00 | NURSERY (title V & XIX only) | 1. 00 617, 787 | 2. 00 985 | 3. 00 627. 1 | 4. 00 9 0 | 5. 00 | 42.00 |
| 43. 00 44. 00 45. 00 46. 00 47. 00 | Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description | 1, 956, 753 | 455 | 4, 300. 5 | 6 0 | 0 | 43. 00 44. 00 45. 00 46. 00 47. 00 |
| 10.00 | · | | | | | 1.00 | 40.00 |
| 48. 00 49. 00 | Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines | | | ons) | | 582, 989 1, 137, 834 | 1 |
| F0 00 | PASS THROUGH COST ADJUSTMENTS | , , | | , | C David L | | |
| 50. 00 | Pass through costs applicable to Program inpa | atient routine | services (froi | m Wkst. D, sun | n of Parts I and | 0 | 50.00 |
| 51.00 | Pass through costs applicable to Program inpagnd IV) | atient ancillar | y services (f | rom Wkst. D, s | sum of Parts II | 0 | 51.00 |
| 52.00 | Total Program excludable cost (sum of lines! | | | | | 0 | |
| 53. 00 | Total Program inpatient operating cost exclude medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION | | lated, non-phy | ysician anesth | netist, and | 0 | 53.00 |
| | Program di scharges | | | | | | 54.00 |
| | Target amount per discharge Target amount (line 54 x line 55) | | | | | 0.00 | 55. 00 56. 00 |
| 57. 00 | Difference between adjusted inpatient operation | ing cost and ta | rget amount (| line 56 minus | line 53) | 0 | 57.00 |
| 58. 00 59. 00 | 1 3 1 | norting period | endina 1006 i | undated and co | omnounded by the | 0 00 | 58. 00 59. 00 |
| | market basket | | - | | simpounded by the | 0. 00 | |
| | 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) | | | | | | 60.00 |
| 62. 00 63. 00 | Allowable Inpatient cost plus incentive payme | ent (see instru | ctions) | | | 0 | 62. 00 63. 00 |
| 64. 00 | PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See | | | | | | 64.00 |
| 65. 00 | instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos | ts after Decemb | er 31 of the (| cost reporting | period (See | 0 | 65. 00 |
| 66. 00 | <pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient roution CAH (see instructions)</pre> | ne costs (line | 64 plus line | 65)(title XVII | I only). For | 0 | 66. 00 |
| 67. 00 | Title V or XIX swing-bed NF inpatient routing (line 12 x line 19) | · · | | | | 0 | |
| | 3.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) | | | | | | 68. 00 69. 00 |
| 09.00 | Total title V or XIX swing-bed NF inpatient of PART III - SKILLED NURSING FACILITY, OTHER NU | | | | | 0 | 09.00 |
| 70. 00 71. 00 | Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of | | | | 1 | | 70. 00 71. 00 |
| 72.00 | Program routine service cost (line 9 x line | 71) | | • | | | 72.00 |
| 73. 00 74. 00 | Medically necessary private room cost applications and program general inpatient routine services. | | | | | | 73. 00 74. 00 |
| 75. 00 | | | | | | | 75. 00 |
| 76. 00 77. 00 | Program capital related costs (line 75 ÷ line Program capital related costs (line 9 x line | | | | | | 76. 00 77. 00 |
| | 00 Program capital-related costs (line 9 x line 76) 00 Inpatient routine service cost (line 74 minus line 77) | | | | | | 78.00 |
| 79. 00 80. 00 | | | | | | | 79. 00 80. 00 |
| 81.00 | 00 Inpatient routine service cost per diem limitation | | | | | | 81.00 |
| 82. 00 83. 00 | | | | | | | 82. 00 83. 00 |
| 84.00 | Program inpatient ancillary services (see in | structions) | ŕ | | | | 84. 00 |
| | Utilization review - physician compensation Total Program inpatient operating costs (sum | • | | | | | 85. 00 86. 00 |
| | PART IV - COMPUTATION OF OBSERVATION BED PASS | S THROUGH COST | . 50g., 60 <i>)</i> | | | | |
| 87. 00 88. 00 | Total observation bed days (see instructions) Adjusted general inpatient routine cost per of | | line 2) | | | 954 1, 723. 12 | 87. 00 88. 00 |
| | Observation bed cost (line 87 x line 88) (see | | - - / | | | 1, 643, 856 | |

| 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 01/01/2020 To 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | pared: 7 am |
| | | Ti tl | e XIX | Hospi tal | Cost | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observation | |
| | | (from line | column 2 | Observati on | Bed Pass | |
| | | 21) | | Bed Cost | Through Cost | |
| | | | | (from line | (col. 3 x | |
| | | | | 89) | col. 4) (see | |
| | | | | | instructions) | |
| | 1. 00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | | | | | |
| 90.00 Capital -related cost | 1, 250, 973 | 8, 987, 801 | 0. 13918 | 6 1, 643, 856 | 228, 802 | 90.00 |
| 91.00 Nursing School cost | 0 | 8, 987, 801 | 0.00000 | 0 1, 643, 856 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 8, 987, 801 | 0.00000 | 0 1, 643, 856 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 8, 987, 801 | 0. 00000 | 0 1, 643, 856 | 0 | 93. 00 |

| NPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Heal th | Financial Systems MEMORIA | L HOSPITAL LOGANSPORT | | In Lie | eu of Form CMS-2 | 2552-10 |
|--|---------|--|-----------------------|-------------|----------------------------------|-------------------|---------|
| Title XVIII Hospital PPS Title XVIII Program Costs (col. 1 x col. 2) Title XVIII Program Costs (col. 1 x col. 2) Title XVIII To Charges Title XVIII Program Costs (col. 1 x col. 2) Title XVIII Title XVIII Title XVIII Program Costs (col. 1 x col. 2) Title XVIII T | | | | CN: 15-0072 | Peri od: | Worksheet D-3 | |
| Cost Center Description Ratio of Cost Inpatient Program Costs (col. 1) Col. 1 X Col. 2) | | | | | From 01/01/2020 To 12/31/2020 | Date/Time Pre | |
| NPATIENT ROUTINE SERVICE COST CENTERS | | | Title | XVIII | Hospi tal | PPS | |
| INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3 | | Cost Center Description | | | | | |
| INPATI ENT ROUTI NE SERVICE COST CENTERS 1.00 2.00 3.00 | | | | To Charges | | | |
| IMPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3 | | | | | Charges | | |
| INPATIENT ROUTI NE SERVICE COST CENTERS 3.155, 360 30.00 | | | | 1.00 | 0.00 | | |
| 30. 00 | | INDATION DOUTING CODY OF COCT CONTEDC | | 1.00 | 2.00 | 3.00 | |
| 31, 00 03100 INTENSI VE CARE UNIT 339, 271 31, 00 04300 NURSERY 425, 094 | 20.00 | | | 1 | 2 155 270 | | 20.00 |
| 43.00 | | | | | | | |
| NOTICE N | | | | | 339, 271 | | |
| SOLOD ODGOOD DERRATI NG ROOM D. 296715 D. 425,094 50.00 52.00 52.00 DELIVERY ROOM & LABOR ROOM D. 452975 D. 0 O. 52.00 DELIVERY ROOM & LABOR ROOM D. 452975 D. 0 O. 57.00 D. 57 | 43.00 | | | | | | 43.00 |
| 52. 00 05200 DELIVERY ROM & LABOR ROOM 0.452975 0 0.7 52. 00 53. 00 05300 AMESTHESI OLOGY 0.107067 70, 205 77. 517 53. 00 05400 RADI OLOGY-DI AGNOSTI C 0.281025 391, 585 110, 045 54. 00 54. 00 55. 00 05700 CT SCAN 0.000000 0 0 0 57. 00 58. 00 05900 CARDII AC CATHETERI ZATI ON 0.000000 0 0 0 59. 00 05900 CARDII AC CATHETERI ZATI ON 0.000000 0 0 0 59. 00 06. 00 | 50 00 | | | 0.2967 | 15 1 432 669 | 425 094 | 50.00 |
| 53.00 05300 ANESTHESI OLOGY 0.107067 70, 205 7, 517 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.281025 391, 585 110, 045 54.00 05700 CT SCAN 0.000000 0 0.57.00 55.00 05700 CT SCAN 0.000000 0 0 0.57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 0 0 0.57.00 58.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0.59.00 0.000000 0 0 0.00000 0 0 | | | | | | | • |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.281025 391, 585 110, 045 54. 00 57. 00 05700 0.5700 0.5900 0.5800 0.5900 0.5800 0.5900 0.5800 0.5900 0.5800 0.5900 0.5800 0.5900 | | | | | | _ | |
| 57. 00 05700 CT SCAN 0.000000 0 0 0 57. 00 | | | | | | | |
| 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 0 0 58. 00 05900 0.000000 0 0 0.59. 00 0.000000 0 0 0.59. 00 0.000000 0 0 0.59. 00 0.000000 0 0 0.59. 00 0.000000 0 0 0.59. 00 0.000000 0 0 0.59. 00 0.000000 0 0 0.59. 00 0.000000 0 0 0.59. 00 0.000000 0 0 0.59. 00 0.000000 0 0 0.59. 00 0.000000 0 0 0.59. 00 0.000000 0 0 0.59. 00 0.000000 0 0 0.59. 00 0.000000 0 0.59. 00 0.000000000000000000000000000000 | 57.00 | | | | | | |
| 60. 00 06000 LABORATORY 0. 280373 1, 224, 120 343, 210 60. 00 63. 00 65. 00 06500 BLOOD STORING, PROCESSING & TRANS. 0. 135819 162, 785 22, 109 63. 00 65. 00 06500 RESPIRATORY THERAPY 0. 340695 1, 620, 305 552, 030 65. 00 06600 PHYSI CAL THERAPY 0. 491836 167, 916 82, 587 66. 00 06900 CARDI ACR EHIAB 1. 790097 0 0. 69. 01 06901 CARDI ACR EHIAB 1. 790097 0 0. 69. 01 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 28657 609, 102 217, 093 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 28657 609, 102 217, 093 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 260860 2, 780, 740 628, 670 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 262460 21, 548 5, 655 76. 00 03450 NUCLEAR MEDI CINE - DI AGNOSTI C 0. 148321 388, 974 57, 693 76. 00 03450 NUCLEAR MEDI CINE - DI AGNOSTI C 0. 281192 0 0. 3450 NUCLEAR MEDI CINE - DI AGNOSTI C 0. 231192 0 0. 90. 01 09000 CLI NI C 0. 3450 NUCLEAR MEDI CINE - DI AGNOSTI C 0. 231192 0 0. 90. 01 09000 NUOLD CARE 0. 231192 0 0. 90. 01 09000 NUOLD CARE 0. 231192 0 0. 90. 01 09000 NUOLD CARE 0. 231192 0 0. 90. 01 09000 NUOLD CARE 0. 241518 676, 269 230, 958 91. 00 09000 NUOLD CARE 0. 451423 27, 940 12, 613 92. 00 09000 MBULANCE SERVI CES 0. 09000 MBULANCE SERVI CES 0. 09000 MBULANCE SERVI CES 0. 09000 NUOLD CARE 0. 09100 NUOLD CARE 0. 0910 | 58.00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | | | | 0 | 58.00 |
| 63. 00 | 59.00 | 05900 CARDI AC CATHETERI ZATI ON | | 0. 00000 | 00 | 0 | 59.00 |
| 65. 00 | 60.00 | 06000 LABORATORY | | 0. 2803 | 73 1, 224, 120 | 343, 210 | 60.00 |
| 66. 00 | 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | | 0. 1358 | 19 162, 785 | 22, 109 | 63.00 |
| 69. 00 06900 CARDI AC REHAB 0. 224605 272, 140 61, 124 69. 00 69. 01 06901 CARDI AC REHAB 1. 790097 0 0 69. 01 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 382621 670, 119 256, 402 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 226080 2, 780, 740 628, 670 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 226080 2, 780, 740 628, 670 73. 00 03450 NUCLEAR MEDI CINE - DI AGNOSTI C 0. 148321 388, 974 57, 693 76. 00 03480 ONCOLOGY 0. 262460 21, 548 5, 655 76. 01 0000 09000 CLI NI C 0. 208657 0. 226080 0. 262460 0. 21, 548 5, 655 76. 01 0000 09000 CLI NI C 0. 208657 0. 231192 0 0 0 0. 208657 0. 2 | 65.00 | | | | | | |
| 69. 01 06901 CARDI AC REHAB 1.790097 0 0 69. 01 | | | | | | | |
| 71. 00 | | | | | | 61, 124 | |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 208657 609, 102 127, 093 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 226080 2, 780, 740 628, 670 73. 00 76. 00 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0. 148321 388, 974 57, 693 76. 00 76. 01 03480 ONCOLOGY 0. 262460 21, 548 5, 655 70. 01 0700 CLINIC 0. 0. 262460 21, 548 5, 655 70. 01 0900 CLINIC 0. 0. 231192 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. | | | | | | _ | |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 226080 2, 780, 740 628, 670 73. 00 76. 00 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0. 148321 388, 974 57, 693 76. 00 76. 01 03480 ONCOLOGY 0. 262460 21, 548 5, 655 76. 01 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 4. 709065 5, 549 26, 131 90. 00 90. 01 09001 WOUND CARE 0. 231192 0 0 0 90. 01 91. 00 09100 EMERGENCY 0. 341518 676, 269 230, 958 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 451423 27, 940 12, 613 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 | | | | | | | |
| 76. 00 | | | | | | | |
| 76. 01 03480 ONCOLOGY 0. 262460 21, 548 5, 655 76. 01 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 4. 709065 5, 549 26, 131 90. 00 90. 01 O9001 WOUND CARE 0. 231192 0 0 0 90. 01 90. 01 O9100 EMERGENCY 0. 341518 676, 269 230, 958 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 451423 27, 940 12, 613 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 09500 AMBULANCE SERVICES 10, 521, 966 2, 948, 931 200. 00 091. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 | | | | | | | • |
| OUTPATIENT SERVICE COST CENTERS O O O O O O O O O | | | | l . | · · | · · | |
| 90. 00 | 76. 01 | | | 0. 26240 | 50 21,548 | 5, 655 | 76.01 |
| 90. 01 09001 WOUND CARE 0. 231192 0 0 90. 01 91. 00 09100 EMERGENCY 0. 341518 676, 269 230, 958 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 451423 27, 940 12, 613 92. 00 09500 AMBULANCE SERVICES 95. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 10, 521, 966 2, 948, 931 200. 00 201. 0 | 00 00 | | | 4 7000 | 45 5 540 | 26 121 | 00.00 |
| 91. 00 09100 EMERGENCY 0.341518 676, 269 230, 958 91. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.451423 27, 940 12, 613 92. 00 000 | | | | | | | |
| 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0. 451423 27, 940 12, 613 92. 00 | | | | l . | | _ | |
| OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 10, 521, 966 2, 948, 931 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 | | | | | | | |
| 95. 00 | 72.00 | | | 0. 4314. | 21, 740 | 12,013 | 1 /2.00 |
| 200.00 Total (sum of lines 50 through 94 and 96 through 98) 10,521,966 2,948,931 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 | 95. 00 | | | | | | 95. 00 |
| 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 | | | uah 98) | | 10, 521, 966 | 2, 948, 931 | |
| | | | | | 0 | , , , , , , , , , | 1 |
| | | | , , | | 10, 521, 966 | | • |

| Health Financial Systems MEMORIAL HOS | SPITAL LOGANSPORT | | In Lio | u of Form CMS-2 | 2552 10 |
|---|-------------------|------------------------------|---|--|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provi der CC | CN: 15-0072 | Period: From 01/01/2020 To 12/31/2020 | Worksheet D-3 | epared: |
| | Title | e XIX | Hospi tal | Cost | |
| Cost Center Description | | Ratio of Cos To Charges | 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 | | | 430, 665 | | 30.00 |
| 31. 00 03100 INTENSIVE CARE UNIT | | | 26, 480 | | 31.00 |
| 43. 00 04300 NURSERY | | | 147, 276 | | 43.00 |
| ANCILLARY SERVICE COST CENTERS | | 0.20201 | 0 201 050 | 00.007 | |
| 50. 00 05000 OPERATING ROOM | | 0. 29281 | | | |
| 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY | | 0. 45297 0. 1070 <i>6</i> | | | |
| 53. 00 05300 ANESTHESTOLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C | | 0. 10706 | | 1, 812 | |
| 57. 00 05700 CT SCAN | | 0. 00000 | | 6, 124 0 | |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | | 0. 00000 | | 0 | 1 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | | 0. 00000 | | 0 | 1 |
| 60. 00 06000 LABORATORY | | 0. 28037 | | 37, 031 | |
| 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. | | 0. 13581 | | 2, 717 | |
| 65. 00 06500 RESPI RATORY THERAPY | | 0. 34069 | | 31, 618 | |
| 66. 00 06600 PHYSI CAL THERAPY | | 0. 49183 | | 1, 993 | |
| 69. 00 06900 ELECTROCARDI OLOGY | | 0. 22460 | | 966 | |
| 69. 01 06901 CARDI AC REHAB | | 1. 79009 | | 0 | 1 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0. 38262 | | 39, 293 | |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT | | 0. 20865 | | 0,72,0 | 1 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | | 0. 22608 | | 54, 495 | |
| 76. 00 03450 NUCLEAR MEDICINE - DIAGNOSTIC | | 0. 14832 | | 2, 453 | |
| 76. 01 03480 0NC0L0GY | | 0. 26246 | | 0 | 1 |
| OUTPATIENT SERVICE COST CENTERS | | | | | |
| 90. 00 09000 CLI NI C | | 4. 67523 | 60, 602 | 283, 329 | 90.00 |
| 90. 01 09001 WOUND CARE | | 0. 23119 | | 0 | |
| 91. 00 09100 EMERGENCY | | 0. 34151 | | 16, 285 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 0. 45142 | | | |
| OTHER REIMBURSABLE COST CENTERS | | | | | |
| 95. 00 09500 AMBULANCE SERVICES | | | | | 95.00 |
| 200 00 Total (sum of Lines EO through 04 and 04 through 0 | 201 | | 1 001 425 | E02 000 | |

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)

582, 989 200. 00 201. 00 202. 00

1, 091, 435

1, 091, 435

200. 00 201. 00

202.00

| Health Financial Systems MEMORIAL HOSPITAL | LOGANSPORT | | In Lie | u of Form CMS-2 | 2552-10 |
|--|-------------|---------------|------------------|-----------------------------|------------------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provi der C | | Peri od: | Worksheet D-3 | |
| | | 2011 45 11070 | From 01/01/2020 | D . (T) D | |
| | Component | CCN: 15-U072 | To 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | pared: |
| | Ti †I | e XIX | Swing Beds - SNF | | 7 aiii |
| Cost Center Description | | Ratio of Cos | | Inpatient | |
| μ | | To Charges | Program | Program Costs | |
| | | | Charges | (col. 1 x | |
| | | | ŭ . | col . 2) | |
| | | 1.00 | 2.00 | 3. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | | | 0 | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | | | 0 | 1 | 31.00 |
| 43. 00 04300 NURSERY | | | 0 | <u> </u> | 43.00 |
| ANCILLARY SERVICE COST CENTERS | | | | | |
| 50. 00 05000 OPERATING ROOM | | 0.00000 | | _ | 50.00 |
| 52. 00 05200 DELI VERY ROOM & LABOR ROOM | | 0.00000 | | 1 | |
| 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C | | 0.00000 | | 0 | 53. 00 54. 00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN | | 0.00000 | | 0 | 54.00 |
| 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) | | 0.00000 | | 0 | 58.00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | | 0.00000 | | | 59.00 |
| 60. 00 06000 LABORATORY | | 0.00000 | | 0 | 60.00 |
| 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. | | 0.00000 | | 0 | 63.00 |
| 65. 00 06500 RESPI RATORY THERAPY | | 0.00000 | | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | | 0. 00000 | | 0 | 66.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | | 0. 00000 | | l o | 69.00 |
| 69. 01 06901 CARDI AC REHAB | | 0.00000 | | 0 | 69. 01 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0. 00000 | | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | | 0. 00000 | | 0 | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | | 0. 00000 | 00 | 0 | 73.00 |
| 76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC | | 0. 00000 | 00 | 0 | 76.00 |
| 76. 01 03480 ONCOLOGY | | 0. 00000 | 00 | 0 | 76. 01 |
| OUTPATIENT SERVICE COST CENTERS | | | | | |
| 90. 00 09000 CLINIC | | 0.00000 | 00 0 | 0 | |
| 90. 01 09001 WOUND CARE | | 0. 00000 | | 0 | 90. 01 |
| 91. 00 09100 EMERGENCY | | 0. 00000 | | 1 | 91.00 |
| 92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) | | 0.00000 | 00 0 | 0 | 92.00 |
| OTHER RELIDEARIE COST CENTERS | | | | | I |

0

95.00 0 200. 00 201. 00 202. 00

91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS

95.00 | O9500 | AMBULANCE SERVICES |
200.00 | Total (sum of lines 50 through 94 and 96 through 98) |
201.00 | Less PBP Clinic Laboratory Services-Program only charges (line 61) |
202.00 | Net charges (line 200 minus line 201)

| Health Financial Systems | MEMORIAL HOSPITAL LOGANSPORT | In Lie | u of Form CMS-2552-10 |
|---|------------------------------|-----------------|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-007 | From 01/01/2020 | Worksheet E Part A Date/Time Prepared: 8/2/2021 10:57 am |
| | | | |

| PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS 1.00 | | | | | 8/2/2021 10:5 | 7 am |
|--|--------|--|------------------------|------------------|---------------|--------|
| PART A - INPATIENT MOSPITAL SERVICES LINGER IPPS 0 1.00 DISC Amounts other than outli er payments for discharges occurring prior to October 1 (see 2, 245, 682 1.01 1.076, 393 1.02 1.02 1.02 1.03 1.04 1.076, 393 1.02 1.02 1.03 1.04 1.076, 393 1.02 1.03 1.04 1.076, 393 1.02 1.03 1.04 1.076, 393 1.02 1.03 1.04 1.076, 393 1.02 1.076, 393 1.02 1.076, 393 1.02 1.076, 393 1.02 1.076, 393 1.02 1.076, 393 1.02 1.076, 393 1.02 1.076, 393 1.02 1.076, 393 1.02 1.076, 393 1.02 1.076, 393 1.02 1.076, 393 1.02 1.076, 393 1.02 1.076, 393 1.02 1.076, 393 1.02 1.076, 393 1.02 1.076, 393 1.076 | | | Title XVIII | Hospi tal | PPS | |
| 1.00 BRK Amounts other than Out Payments 0 1.00 | | | | | 1. 00 | |
| Book amounts other than outlier payments for discharges occurring only to Ctober 1 (see 2,245,602 1.01 Instructions) 1.02 Book amounts other than outlier payments for discharges occurring on after October 1 (see 1,076,393 1.02 1.03 1. | | | | | | |
| 1.02 BRC amounts other than outlier payments for discharges occurring on or after October 1 (see instructions) 1.03 BRC for rederal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1.04 | | DRG amounts other than outlier payments for discharges occurring | g prior to October 1 (| see | - | |
| 1.03 1066 for Federal specific operating payment for World 4 BPCI for discharges occurring prior to October 1 1.03 1.056 instructions 1.03 1.056 instructions 1.03 1.057 1.0 | 1. 02 | DRG amounts other than outlier payments for discharges occurring | g on or after October | 1 (see | 1, 076, 393 | 1. 02 |
| 0.000 0.00 | 1. 03 | DRG for federal specific operating payment for Model 4 BPCI for | di scharges occurri ng | prior to October | 0 | 1. 03 |
| 2.00 Outlier payments for discharges. (see Instructions) | 1. 04 | DRG for federal specific operating payment for Model 4 BPCI for | di scharges occurri ng | on or after | 0 | 1. 04 |
| 2.02 2.03 Dutilier payments for discharges cocurring prior to October 1 (see instructions) 2.5,070 2.03 | | Outlier payments for discharges. (see instructions) | | | 0 | |
| 2.4 out 1 cp payments for discharges occurring on or after October 1 (see instructions) 22, 491 2.04 3.00 Managed Care S limit latted Payments 3.0 3.00 3.00 Managed Care S limit latted Payments 3.0 3.00 3.01 Managed Care S limit latted Payments 3.0 3.00 3.02 Managed Care S limit latted divided by number of days in the cost reporting period (see instructions) 3.0 3.00 5.00 FTE count for all logathic and osteopathic programs for the most recent cost reporting period ending or or before 12/31/1996 (see instructions) 3.00 3.00 6.00 FTE count for all logathic and osteopathic programs that meet the criteria for an add-on to the cap for or before 12/31/1996 (see instructions) 3.00 3.00 7.01 | 2. 02 | Outlier payment for discharges for Model 4 BPCI (see instruction | ns) | | 0 | 2. 02 |
| Managed Care Simulated Payments 0 3.00 | 2.03 | Outlier payments for discharges occurring prior to October 1 (se | ee instructions) | | 25, 070 | 2.03 |
| Red days available divided by number of days in the cost reporting period (see instructions) 39.39 4.00 | | | (see instructions) | | 22, 491 | |
| Indirect Medical Education Adjustment Count for all lopathic and osteopathic programs for the most recent cost reporting period ending or or before 12/31/1996, (see Instructions) Count for all lopathic 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) Count for all lopathic 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) Count for all lopathic 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) Count for all lopathic and osteopathic programs for a count for increase or decrease) to the FTE count for all lopathic and osteopathic programs for a spot and 67 FR 5009 (August 1, 2002) Counter 5 500 of ACA (See Instructions) Counter 5 5500 of ACA (See Instructions) Counter type all lowable FTE count for the prior year. Counter type all lowable FTE count for the prior year. Counter type all lowable FTE count for the prior year. Counter 5 500 of ACA (See Instructions) Counter type all lowable FTE count for the prior year. Counter type all lowable FTE count for the prior year. Counter type all lowable FTE count for the prior year. Counter type all lowable FTE count for the prior year. Counter type all lowable FTE count for the prior year. Counter type all lowable FTE count for the prior year. Counter type all lowa | | | | | - | |
| 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) | 4. 00 | | ng period (see instru | ctions) | 39. 39 | 4.00 |
| 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) 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 0.00 7.00 7.01 ACA \$5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the 0.00 7.00 | 5. 00 | FTE count for allopathic and osteopathic programs for the most i | recent cost reporting | period ending on | 0.00 | 5. 00 |
| ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1) | 6. 00 | 1 1 9 | criteria for an add-c | n to the cap for | 0. 00 | 6. 00 |
| Agl Justment (Increase or decrease) to the FTE count for all lopathic and osteopathic programs for artificated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(v), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). | | • | | | | |
| 1998), and 67 FR 50009 (August 1, 2002). | 8. 00 | Adjustment (increase or decrease) to the FTE count for allopathi | | | 0. 00 | 8. 00 |
| report straddles July 1, 2011, see instructions. 8.02 Re amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions) 9.00 1.00 | 8 01 | 1998), and 67 FR 50069 (August 1, 2002). | | | 0.00 | 8 01 |
| under § \$506 of ACA. (see instructions) 0.00 under § \$506 of ACA. (see instructions) 0.00 9.00 9.00 sin of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions) 0.00 9.00 11.00 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 10.00 12.00 Current year allowable FTE (see instructions) 0.00 11.00 13.00 Total allowable FTE count for the prior year. 0.00 13.00 14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997. 0.00 13.00 15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 Adjustment for residents in initial years of the program 0.00 15.00 18.00 Adjusted rolling average FTE count 0.00 17.00 18.00 Adjusted rolling average FTE count 0.00 0.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 19.00 21.00 Enter the lesse of lines 19 or 20 (see instructions) 0.000000 20.00 22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.000000 20.00 23.00 (F(f)(i)(i)(c)). <td< td=""><td></td><td>report straddles July 1, 2011, see instructions.</td><td></td><td></td><td></td><td></td></td<> | | report straddles July 1, 2011, see instructions. | | | | |
| 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 10.00 | | under § 5506 of ACA. (see instructions) | | | 0. 00 | 9. 00 |
| 12.00 Current year allowable FTE (see instructions) 0.00 12.00 13.00 10.10 | 10. 00 | | t year from your recor | ds | 0. 00 | 10.00 |
| 13.00 Total all owable FTE count for the prior year. 0.00 13.00 14.00 Total all owable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero. 0.00 14.00 | | | | | | |
| 14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 0.00 14.00 15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 Adjustment for residents in initial years of the program 0.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjusted rolling average FTE count 0.00 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 0.000000 20.00 Prior year resident to bed ratio (see instructions) 0.000000 0.000000 0.000000 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 0.000000 0.000000 22.01 IME payment adjustment (see instructions) 0.22.00 0.00 0.000000 0.00 0.000000 0.00 | | , , , , , , , , , , , , , , , , , , , | | | | |
| Otherwise enter zero. Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 20 | | · | | | | |
| 15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 16.00 16.00 17.00 17.00 17.00 18.00 18.00 18.00 19 | 14. 00 | | ended on or after Sep | tember 30, 1997, | 0.00 | 14.00 |
| 16. 00 Adj ustment for residents in initial years of the program 0.00 16.00 17. 00 Adj ustment for residents displaced by program or hospital closure 0.00 17.00 18. 00 Adj ustment for residents displaced by program or hospital closure 0.00 17.00 18. 00 Adj ustment for residents displaced by program or hospital closure 0.00 17.00 19. 00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 20. 00 Prior year resident to bed ratio (see instructions) 0.000000 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 22. 00 IME payment adj ustment (see instructions) 0.000000 22. 01 IME payment adj ustment – Managed Care (see instructions) 0.000000 22. 01 IME payment adj ustment for the Add-on for § 422 of the MMA 23. 00 (f)(1)(iv)(C). 0.000000 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 25. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 IME payments adjustment factor. (see instructions) 0.000000 28. 01 IME payment adjustment factor. (see instructions) 0.000000 29. 00 IME add-on adjustment amount - Managed Care (see instructions) <t< td=""><td>15.00</td><td></td><td></td><td></td><td>0. 00</td><td>15.00</td></t<> | 15.00 | | | | 0. 00 | 15.00 |
| 18. 00 Adjusted rolling average FTE count 0.00 18. 00 19. 00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 20.00 20. 00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22. 01 IME payment adjustment (see instructions) 0.000000 22.00 1 IME payment adjustment – Managed Care (see instructions) 0.00 22.01 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.00 23.00 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). 0.00 24.00 25.00 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 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 amount (see instructions) 0.000000 27.00 28. 01 IME add-on ad | | | | | 0.00 | 16.00 |
| 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) 0.2000 22.01 IME payment adjustment - Managed Care (see instructions) 0.22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.00 23.00 (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 a | 17.00 | Adjustment for residents displaced by program or hospital closu | re | | 0. 00 | 17.00 |
| 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 0.000000 21.00 0.000000 21.00 0.000000 21.00 0.000000 21.00 0.000000 21.00 0.000000 22.00 0.000000 22.00 0.0000000 0.0000000 0.0000000 0.00000000 | | , | | | | |
| 21.00 Enter the lesser of lines 19 or 20 (see instructions) 22.00 IME payment adjustment (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 Indirect Medical Education Adjustment for the Add-on for § 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) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount (see instructions) 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) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days (see instructions) 20.00 SUm of lines 30 and 31 20.00 Allowable disproportionate share percentage (see instructions) 21.00 0 33.00 22.01 Allowable disproportionate share percentage (see instructions) | | | | | | |
| 22.00 IME payment adjustment (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 2 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 2 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 2 O (f) (1) (iv) (C). 2 O (in FTE Resident Count Over Cap (see instructions) 2 O (in FTE Resident Count Over Cap (see instructions) 2 O (in FTE Resident Count Over Cap (see instructions) 2 O (in FTE Resident Count Over Cap (see instructions) 2 O (in FTE Resident Count Over Cap (see instructions) 2 O (in FTE Resident Count Over Cap (see instructions) 2 O (in FTE Resident Count Over Cap (see instructions) 2 O (in FTE Resident Count Over Cap (see instructions) 2 O (in FTE Resident Count Over Cap (see instructions) 2 O (in FTE Resident Count Over Cap (see instructions) 2 O (in FTE Resident Count Over Cap (see instructions) 3 O (in FTE Resident Count Over Cap (see instructions) 4 O (in FTE Resident Count Over Cap (see instructions) 5 O (in FTE Resident Count Over Cap (see instructions) 6 O (in FTE Resident Count Over Cap (see instructions) 7 O (in FTE Resident Count Over Cap (see instructions) 8 O (in FTE Resident Count Over Cap (see instructions) 9 O (in FTE Resident Count Over Cap (see instructions) 9 O (in FTE Resident Count Over Cap (see instructions) 9 O (in FTE Resident Count Over Cap (see instructions) 9 O (in FTE Resident Count Over Cap (see instructions) 9 O (in FTE Resident Count Over Cap (see instructions) 9 O (in FTE Resident Count Over Cap (see instructions) 9 O (in FTE Resident Count Over Cap (see instructions) 9 O (in FTE Resident Count Over Cap (see instructions) 9 O (in FTE Resident Count Over Cap (see instructions) 9 O (in FTE Resident Count Over Cap (see instructions) 9 O (in FTE Resident Count Over Cap (see instructions) 9 O (in FTE Resident Count Over Cap (see instructions) 9 O (in FTE Resident Count Over Cap (see instructions) | | | | | | |
| 22. 01 IME payment adjustment - Managed Care (see instructions) 1. Indi 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 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 | | | | | | |
| Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 O.00 (f)(1)(iv)(C). 1 ME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see O.00 25.00 instructions) Resident to bed ratio (divide line 25 by line 4) O.000000 26.00 IME payments adjustment factor. (see instructions) IME payments adjustment amount (see instructions) IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions) IME payment (sum of lines 22 and 28) 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 Allowable disproportionate share percentage (see instructions) 12.00 33.00 | | | | | | |
| (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions) 10.00 24.00 24.00 25.00 26.00 0.000000 26.00 0.000000 27.00 28.01 0.000000 27.00 28.01 29.00 29.01 29.01 29.01 29.01 29.01 29.01 29.01 29.01 29.01 20.02 20.03 20.03 20.03 20.04 | 22.01 | Indirect Medical Education Adjustment for the Add-on for § 422 c | of the MMA | | 0 | 22.01 |
| 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions) 25.00 Condition 24 (see of line 24 (see of li | 23. 00 | | t cap slots under 42 C | FR 412. 105 | 0.00 | 23. 00 |
| instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions) 20.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 20.00 Constitution (sie instructions) 30.00 Allowable disproportionate share percentage (see instructions) | | | £ ! 22 ! | 24 (| | |
| 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) 0.00 Disproportionate Share Adjustment 0.00 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4.58 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 19. 04 31. 00 32. 00 Sum of lines 30 and 31 23. 62 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 12. 00 33. 00 | | i nstructi ons) | wer of line 23 or line | 24 (see | | |
| 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 30.00 Allowable disproportionate share percentage (see instructions) | | | | | | |
| 28.01 IME add-on adjustment amount - Managed Care (see instructions) 7 | | | | | | |
| 29.00 Total IME payment (sum of lines 22 and 28) 0 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4.58 30.00 Percentage of Medicaid patient days (see instructions) 19.04 31.00 32.00 Sum of lines 30 and 31 23.62 32.00 31.00 Allowable disproportionate share percentage (see instructions) 12.00 33.00 | | · · · · · · · · · · · · · · · · · · · | | | | |
| 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 32. 01 Disproportionate Share Adjustment 4. 58 30. 00 4. 58 30. 00 29. 01 | | | | | | |
| 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4.58 30.00 31.00 Percentage of Medicaid patient days (see instructions) 4.58 30.00 31.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 4.58 30.00 19.04 31.00 21.00 32.00 32.00 33.00 | | Total IME payment - Managed Care (sum of lines 22.01 and 28.01) | | | | |
| 31.00Percentage of Medicaid patient days (see instructions)19.0431.0032.00Sum of lines 30 and 3123.6232.0033.00Allowable disproportionate share percentage (see instructions)12.0033.00 | 30.00 | | ent days (see instruc | tions) | 4, 58 | 30, 00 |
| 32.00 Sum of Lines 30 and 31 23.62 32.00 33.00 Allowable disproportionate share percentage (see instructions) 12.00 33.00 | | | (000 1.1.011 00 | / | | |
| 33.00 Allowable disproportionate share percentage (see instructions) 12.00 33.00 | | | | | | |
| 34.00 Disproportionate share adjustment (see instructions) 99,663 34.00 | | | | | | |
| | 34.00 | Disproportionate share adjustment (see instructions) | | | 99, 663 | 34.00 |

| | Financial Systems MEMORIAL HOSPITAL | | | u of Form CMS-2 | 2552-10 |
|------------------|--|---------------------------|----------------------------|-------------------------|------------------|
| CALCUL | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0072 | Period: From 01/01/2020 | Worksheet E Part A | |
| | | | To 12/31/2020 | Date/Time Pre | |
| | | Title XVIII | Hospi tal | 8/2/2021 10: 5 PPS | / am |
| | | | Prior to 10/1 | | |
| | | | 1. 00 | 2. 00 | |
| 35. 00 | Uncompensated Care Adjustment Total uncompensated care amount (see instructions) | | 8, 350, 599, 096 | 8, 290, 014, 521 | 35. 00 |
| 35. 00 | Factor 3 (see instructions) | | 0. 000097346 | 0. 000104522 | 35. 00 35. 01 |
| 35. 02 | Hospital uncompensated care payment (If line 34 is zero, ente | er zero on this line) (se | | 866, 489 | 35. 02 |
| | instructions) | | | | |
| 35. 03 | Pro rata share of the hospital uncompensated care payment amount Total uncompensated care (sum of columns 1 and 2 on line 35.0 | | 608, 562 826, 965 | 218, 403 | 35. 03 36. 00 |
| 30.00 | Additional payment for high percentage of ESRD beneficiary di | | | | 30.00 |
| 40.00 | Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 6 | | 0 | | 40.00 |
| 44.00 | instructions) | | | | 44 00 |
| 41. 00 | Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6 instructions) | 583, 684 an 685. (See | 0 | | 41. 00 |
| 41. 01 | | DRGs 652, 682, 683, 68 | 1 0 | | 41. 01 |
| | an 685. (see instructions) | | | | |
| 42.00 | Divide line 41 by line 40 (if less than 10%, you do not quali | | 0.00 | | 42.00 |
| 43. 00 | Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68 instructions) | 32, 683, 684 an 685. (se | 9 0 | | 43. 00 |
| 44.00 | Ratio of average length of stay to one week (line 43 divided | by line 41 divided by 7 | 0. 000000 | | 44.00 |
| | days) | | | | |
| 45. 00 46. 00 | Average weekly cost for dialysis treatments (see instructions | | 0.00 | | 45.00 |
| 47.00 | Total additional payment (line 45 times line 44 times line 41 Subtotal (see instructions) | 1.01) | 4, 296, 264 | | 46. 00 47. 00 |
| 48. 00 | Hospital specific payments (to be completed by SCH and MDH, s | small rural hospitals | 5, 120, 917 | | 48. 00 |
| | only. (see instructions) | · | | | |
| | | | | Amount 1.00 | |
| 49. 00 | Total payment for inpatient operating costs (see instructions | 5) | | 5, 120, 917 | 49. 00 |
| 50.00 | Payment for inpatient program capital (from Wkst. L, Pt. I ar | |) | 262, 552 | |
| 51.00 | Exception payment for inpatient program capital (Wkst. L, Pt. | | | 0 | 51.00 |
| 52. 00 53. 00 | Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment | ne 49 see instructions) | | 0 | 52. 00 53. 00 |
| 54. 00 | Special add-on payments for new technologies | | | 104, 193 | 54.00 |
| 54.01 | | | | 0 | 54. 01 |
| 55.00 | Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 | • | | 0 | 55.00 |
| 56. 00 57. 00 | Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I | | through 25) | 0 | 56. 00 57. 00 |
| 58. 00 | Ancillary service other pass through costs from Wkst. D, Pt. | | in ough 35). | 0 | 58.00 |
| 59.00 | Total (sum of amounts on lines 49 through 58) | , , | | 5, 487, 662 | |
| 60.00 | Primary payer payments | | | 28, 215 | |
| 61. 00 62. 00 | Total amount payable for program beneficiaries (line 59 minus | s line 60) | | 5, 459, 447 492, 712 | 61. 00 62. 00 |
| 63. 00 | Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries | | | | 63.00 |
| | Allowable bad debts (see instructions) | | | 47, 479 | |
| 65.00 | Adjusted reimbursable bad debts (see instructions) | | | 30, 861 | 65.00 |
| 66.00 | Allowable bad debts for dual eligible beneficiaries (see inst | tructions) | | 47, 479 4, 995, 836 | 66.00 |
| 68. 00 | 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) | | | | 67. 00 68. 00 |
| 69.00 | Outlier payments reconciliation (sum of lines 93, 95 and 96). | | | 0 | 69.00 |
| 70.00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0 | 70.00 |
| 70. 50 | Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration | ration) adjustment (see | ınstructions) | 0 | 70. 50 |
| 70. 87 70. 88 | SCH or MDH volume decrease adjustment (contractor use only) | | | 0 | 70. 87 70. 88 |
| 70. 89 | Pioneer ACO demonstration payment adjustment amount (see inst | tructions) | | | 70.89 |
| 70. 90 | HSP bonus payment HVBP adjustment amount (see instructions) | | | 0 | 70. 90 |
| 70. 91 70. 92 | HSP bonus payment HRR adjustment amount (see instructions) | | | 0 | 70. 91 |
| 70. 92 70. 93 | , | | | 0 -248 | 70. 92 70. 93 |
| | HRR adjustment amount (see instructions) | | | 0 | 70. 94 |
| 70. 95 | Recovery of accelerated depreciation | | | 0 | 70. 95 |
| | | | | | |

| Health Financial Systems | MEMORIAL HOSPITAL L | _OGANSPORT | | In Lie | u of Form CMS-2 | 2552-10 |
|--|-----------------------|--------------|-------------|--|---|---------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | | Provi der CC | CN: 15-0072 | Peri od: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Date/Time Pre 8/2/2021 10:5 | |
| | | Title | XVIII | Hospi tal | PPS | |
| | | | FFY | (уууу) | Amount | |
| | | | | 0 | 1. 00 | |
| 70 96 Low volume adjustment for federal fiscal | year (yyyy) (Enter in | column Ω | • | 2020 | 501 567 | 70 96 |

| | | | | To 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | |
|---|--|--------------|---------------|------------------|----------------------------------|---|
| | | Title | : XVIII | Hospi tal | PPS | 7 (411) |
| | | | | (уууу) | Amount | |
| | | | | 0 | 1. 00 | |
| 70. 96 | 3 (5555) | n column 0 | 20 | 020 | 591, 567 | 70. 96 |
| 70. 97 | the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter i | | 20 | 021 | 298, 521 | 70. 97 |
| 70.00 | the corresponding federal year for the period ending on or af | ter 10/1) | | | 0 | 70.00 |
| 70. 98 70. 99 | Low Volume Payment-3 | | | | 0 42, 434 | |
| 70. 99 | HAC adjustment amount (see instructions) Amount due provider (line 67 minus lines 68 plus/minus lines | 60 8 70) | | | 5, 843, 242 | 1 |
| 71.00 | Sequestration adjustment (see instructions) | 07 & 70) | | | 38, 565 | 1 |
| 71. 01 | Demonstration payment adjustment amount after sequestration | | | | 0 | 1 |
| 71. 03 | Seguestration adjustment-PARHM pass-throughs | | | | O | 71.03 |
| 72. 00 | Interim payments | | | | 5, 870, 198 | |
| 72. 01 | Interim payments-PARHM | | | | 2, 2, 2, | 72. 01 |
| 73.00 | Tentative settlement (for contractor use only) | | | | 0 | 73.00 |
| 73. 01 | Tentative settlement-PARHM (for contractor use only) | | | | | 73. 01 |
| 74. 00 | Balance due provider/program (line 71 minus lines 71.01, 71.073) |)2, 72, and | | | -65, 521 | 74.00 |
| 74.01 | Balance due provider/program-PARHM (see instructions) | | | | | 74. 01 |
| 75. 00 | Protested amounts (nonallowable cost report items) in accorda | nce with | | | 173, 947 | 75.00 |
| | CMS Pub. 15-2, chapter 1, §115.2 | | | | | |
| | TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) | | | | | |
| 90. 00 | Operating outlier amount from Wkst. E, Pt. A, line 2, or sum | of 2.03 | | | 0 | 90.00 |
| 01 00 | plus 2.04 (see instructions) | | | | 0 | 01 00 |
| 91.00 | Capital outlier from Wkst. L, Pt. I, line 2 Operating outlier reconciliation adjustment amount (see instr | untiana) | | | 0 | |
| 92. 00 93. 00 | Capital outlier reconciliation adjustment amount (see instruc | , | | | 0 | |
| 94.00 | The rate used to calculate the time value of money (see instruc | | | | 0. 00 | |
| 95. 00 | Time value of money for operating expenses (see instructions) | | | | 0.00 | 1 |
| 96. 00 | Time value of money for capital related expenses (see instruc | | | | 0 | 1 |
| | | , , , , , | | Prior to 10/1 | On/After 10/1 | |
| | | | | 1.00 | 2. 00 | |
| | HSP Bonus Payment Amount | | | | | |
| 100.00 | HSP bonus amount (see instructions) | | | 0 | 0 | 100. 00 |
| 101 00 | HVBP Adjustment for HSP Bonus Payment | | | 0.000000000 | 0.000000000 | 101 00 |
| | HVBP adjustment factor (see instructions) |) () | | 0.0000000000 | 0. 0000000000 | 101.00 |
| 102.00 | HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment | 15) | | J U | 0 | 102.00 |
| 103 00 | HRR adjustment factor (see instructions) | | | 0.0000 | 0. 0000 | 103 00 |
| | HRR adjustment amount for HSP bonus payment (see instructions | (;) | | 0.0000 | | 104.00 |
| | Rural Community Hospital Demonstration Project (§410A Demonst | ration) Adiu | ustment | <u> </u> | | 1.000 |
| 200.00 | Is this the first year of the current 5-year demonstration pe | | | | | 200.00 |
| | Century Cures Act? Enter "Y" for yes or "N" for no. | | | | | |
| | Cost Reimbursement | | | | | |
| | Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin | ne 49) | | | | 201.00 |
| | Medicare discharges (see instructions) | | | | | 202.00 |
| 203.00 | Case-mix adjustment factor (see instructions) | | | | | 203. 00 |
| | Computation of Demonstration Target Amount Limitation (N/A in | i first year | of the curren | it 5-year demons | tration | |
| 204.00 | period) | | | | | 204.00 |
| | Medicare target amount Case-mix adjusted target amount (line 203 times line 204) | | | | | 205.00 |
| | Medicare inpatient routine cost cap (line 202 times line 205) | | | | | 206.00 |
| 200.00 | Adjustment to Medicare Part A Inpatient Reimbursement | | | | | 200.00 |
| 207.00 | Program reimbursement under the §410A Demonstration (see inst | ructions) | | | | 207. 00 |
| | | , | | 1 | | 208.00 |
| 208. U | Medicare Part A inpatient service costs (from Wkst. E, Pt. A, | line 59) | | | | |
| | Medicare Part A inpatient service costs (from Wkst. È, Pt. A, Adjustment to Medicare IPPS payments (see instructions) | 11ne 59) | | | | 209.00 |
| 209.00 | | line 59) | | | | |
| 209. 00 210. 00 | Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) | ŕ | | | | 209. 00 |
| 209. 00 210. 00 211. 00 | 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 | , | | | | 209. 00 210. 00 |
| 209. 00 210. 00 211. 00 212. 00 | 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 | , | | | | 209. 00 210. 00 211. 00 212. 00 |
| 209. 00 210. 00 211. 00 212. 00 213. 00 | 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 Low-volume adjustment (see instructions) | 211) | | | | 209. 00 210. 00 211. 00 212. 00 213. 00 |
| 209. 00 210. 00 211. 00 212. 00 213. 00 | 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) | mbursement) | | | 209. 00 210. 00 211. 00 212. 00 |

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2020 Part A Exhi bi t 4 Date/Ti me Prepared: 8/2/2021 10:57 am Provider CCN: 15-0072

| | | | | | | | 8/2/2021 10:5 | ל am |
|------------------|--|-------------------------|-----------------------------|-------------------------|--------------------------|------------------------------|----------------------------|--------|
| | | | | | XVIII | Hospi tal | PPS | |
| | | W/S E, Part A line | Amounts (from E, Part A) | Pre/Post Entitlement | Period Prior to 10/01 | Peri od On/After 10/01 | Total (Col 2 through 4) | |
| | | 0 | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| 1. 00 | DRG amounts other than outlier payments | 1. 00 | 0 | 0 | _ | 0 | 0 | |
| 1. 01 | DRG amounts other than outlier payments for discharges occurring prior to October 1 | 1. 01 | 2, 245, 682 | 0 | 2, 245, 682 | | 2, 245, 682 | 1.01 |
| 1. 02 | DRG amounts other than outlier payments for discharges occurring on or after October | 1. 02 | 1, 076, 393 | 0 | | 1, 076, 393 | 1, 076, 393 | 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 discharges (see instructions) | 2. 00 | | | | | | 2.00 |
| 2. 01 | Outlier payments for discharges for Model 4 BPCI | 2. 02 | 0 | 0 | 0 | 0 | 0 | 2. 01 |
| 2. 02 | Outlier payments for discharges occurring prior to | 2. 03 | 25, 070 | 0 | 25, 070 | | 25, 070 | 2. 02 |
| 2. 03 | October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see | 2. 04 | 22, 491 | 0 | | 22, 491 | 22, 491 | 2. 03 |
| 3. 00 | instructions) Operating outlier reconciliation | 2. 01 | 0 | 0 | 0 | 0 | 0 | 3. 00 |
| 4. 00 | Managed care simulated payments | 3. 00 | 0 | 0 | 0 | 0 | 0 | 4. 00 |
| | Indirect Medical Education Adj | ustment | | | | | | |
| 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. 01 | IME payment adjustment for managed care (see instructions) | 22. 01 | 0 | 0 | 0 | 0 | 0 | 6. 01 |
| | Indirect Medical Education Adj | | | | | | | |
| 7. 00 | IME payment adjustment factor (see instructions) | 27. 00 | 0. 000000 | 0. 000000 | | | | 7.00 |
| 8. 00 | IME adjustment (see instructions) | 28. 00 | 0 | 0 | _ | 0 | 0 | |
| 8. 01 | IME payment adjustment add on for managed care (see instructions) | 28. 01 | 0 | 0 | 0 | 0 | 0 | 8. 01 |
| 9. 00 | Total IME payment (sum of lines 6 and 8) | 29. 00 | 0 | 0 | 0 | 0 | 0 | 9. 00 |
| 9. 01 | Total IME payment for managed care (sum of lines 6.01 and 8.01) | 29. 01 | 0 | 0 | 0 | 0 | 0 | 9. 01 |
| | Disproportionate Share Adjustm | | | | | | | |
| 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 | 99, 663 | 0 | 67, 371 | 32, 292 | 99, 663 | 11.00 |
| 11. 01 | Uncompensated care payments Additional payment for high pe | 36.00 rcentage of ES | 826, 965 RD beneficiary | 0 di scharges | 608, 562 | 218, 403 | 826, 965 | 11. 01 |
| 12. 00 | Total ESRD additional payment (see instructions) | 46. 00 | 0 | 0 | 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, 296, 264 5, 120, 917 | 0 | | | | |
| 15. 00 | (see instructions) Total payment for inpatient operating costs (see instructions) | 49. 00 | 5, 120, 917 | 0 | 3, 467, 158 | 1, 653, 759 | 5, 120, 917 | 15.00 |

| LOW VO | LUME CALCULATION EXHIBIT 4 | | | Provi der CO | | Peri od: From 01/01/2020 To 12/31/2020 | Worksheet E Part A Exhibi Date/Time Pre 8/2/2021 10:5 | 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 | Peri od On/After 10/01 | Total (Col 2 through 4) | |
| | | 0 | 1. 00 | 2.00 | 3.00 | 4, 00 | 5. 00 | |
| 16. 00 | Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) | 50. 00 | 262, 552 | 0 | 180, 05 | | 262, 552 | 16.00 |
| 17. 00 | Special add-on payments for new technologies | 54. 00 | 104, 193 | 0 | | 0 104, 193 | 104, 193 | |
| 17. 01 17. 02 | Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs | 68. 00 | 0 | 0 | | 0 0 | 0 | 17. 01 17. 02 |
| 18. 00 | Capital outlier reconciliation adjustment amount (see instructions) | | 0 | 0 | | 0 0 | О | 18. 00 |
| 19.00 | · | | | 0 | 3, 647, 21 | 4 1, 840, 448 | 5, 487, 662 | 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 | 1. 00 1. 01 | 250, 417 0 | 0 | 174, 52 | 8 75, 889 0 0 | 250, 417 0 | |
| 21. 00 21. 01 | Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments | 2. 00 2. 01 | 12, 135 0 | 0 | 5, 52 | 8 6, 607 0 0 | 12, 135 0 | 21. 00 21. 01 |
| 22. 00 | Indirect medical education percentage (see instructions) | 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 | 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 | 0 | 25. 00 |
| 26. 00 | Total prospective capital payments (see instructions) | 12. 00 | 262, 552 | 0 | 180, 05 | 6 82, 496 | 262, 552 | 26. 00 |
| | | W/S E, Part A | (Amounts to | | | | | |
| | | line 0 | E, Part A) 1.00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| 27. 00 | Low volume adjustment factor | U | 1.00 | 2.00 | 0. 16219 | _ | 3.00 | 27. 00 |
| 28. 00 | Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line) | 70. 96 | | | 591, 56 | | 591, 567 | |
| 29. 00 | Low volume adjustment (transfer amount to Wkst. E, Pt. A, line) | 70. 97 | | | | 298, 521 | 298, 521 | 29. 00 |
| 100.00 | Transfer low volume adjustments to Wkst. E, Pt. A. | | Y | | | | | 100. 00 |

Provider CCN: 15-0072

Peri od:

From 01/01/2020

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Part A Exhibit 5

Date/Time Prepared: 12/31/2020 8/2/2021 10:57 am Hospi tal Title XVIII Period to Total (cols. Wkst. E, Pt. Amt. from Period on Wkst. E, Pt. 10/01 after 10/01 A. line 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 2, 245, 682 2, 245, 682 2, 245, 682 1.01 discharges occurring prior to October 1 1 02 DRG amounts other than outlier payments for 1 02 1,076,393 1,076,393 1,076,393 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 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 2.01 **BPCI** 2.02 25,070 25,070 25,070 2.02 Outlier payments for discharges occurring 2.03 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 22, 491 22, 491 22, 491 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 C 0 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 0.000000 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 5.00 (see instructions) 6.00 IME payment adjustment (see instructions) 22.00 0 6.00 C 6.01 IME payment adjustment for managed care (see 22.01 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8.00 IME adjustment (see instructions) 28.00 0 0 8.00 0 IME payment adjustment add on for managed 0 28 01 C 0 8 01 8 01 0 care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 10.00 Allowable disproportionate share percentage 33.00 0.1200 0.1200 0.1200 (see instructions) 11.00 Di sproporti onate share adjustment (see 34.00 99,663 67, 371 32, 292 99, 663 11.00 instructions) Uncompensa<u>ted care payments</u> 11.01 36 00 826, 965 608, 562 218, 403 826, 965 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment (see 12.00 46.00 12.00 instructions) 4, 296, 264 47.00 2, 946, 685 1.349.579 13.00 Subtotal (see instructions) 4, 296, 264 13.00 14.00 Hospital specific payments (completed by SCH 48.00 5, 120, 917 3, 467, 158 1, 653, 759 5, 120, 917 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 15 00 49 00 5 120 917 3 467 158 1 653 759 5, 120, 917 15 00 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 262, 552 180, 056 82, 496 262, 552 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 104, 193 0 104, 193 104, 193 17.00 Net organ acquisition cost 17.01 17.01 17.02 Credits received from manufacturers for 68.00 0 0 Λ 17.02 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 18.00 amount (see instructions) 19.00 SUBTOTAL 3, 647, 214 1, 840, 448 5, 487, 662 19.00

| olth Financial Systems | MEMORIAL HOSPITAL LOGANSPORT | In Lieu of Form CMS-2552-10 |
|------------------------|------------------------------|-----------------------------|
| | ****** | |

| Health Financial Systems | MEMORIAL HOSPIT | AL LOGANSPORT | | In Lie | u of Form CMS-2 | 2552-10 |
|--|-------------------------|----------------------------------|---------|---|--------------------------------|---------|
| HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA | ATION EXHIBIT 5 | | | Period: From 01/01/2020 To 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | pared: |
| | | | XVIII | Hospi tal | PPS | |
| | Wkst. L, line | (Amt. from Wkst. L) | | | | |
| | 0 | 1. 00 | 2.00 | 3. 00 | 4. 00 | |
| 20.00 Capital DRG other than outlier | 1. 00 | 250, 417 | 174, 52 | 8 75, 889 | 250, 417 | 20.00 |
| 20.01 Model 4 BPCI Capital DRG other than outlier | 1. 01 | 0 | | 0 | 0 | 20. 01 |
| 21.00 Capital DRG outlier payments | 2. 00 | 12, 135 | 5, 52 | 8 6, 607 | 12, 135 | 21.00 |
| 21.01 Model 4 BPCI Capital DRG outlier payments | 2. 01 | 0 | | 0 | 0 | 21. 01 |
| 22.00 Indirect medical education percentage (see instructions) | 5. 00 | 0. 0000 | 0.000 | 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 | 0.000 | 0. 0000 | | 24. 00 |
| 25.00 Disproportionate share adjustment (see | 11. 00 | 0 | | 0 0 | 0 | 25. 00 |
| instructions) 26.00 Total prospective capital payments (see | 12. 00 | 262, 552 | 180, 05 | 6 82, 496 | 262, 552 | 26. 00 |
| i nstructi ons) | W | (1) | | | | |
| | Wkst. E, Pt. A, line | (Amt. from Wkst. E, Pt. A) | | | | |
| | 0 | 1. 00 | 2.00 | 3.00 | 4. 00 | |
| 27. 00 | | | | | | 27. 00 |
| 28.00 Low volume adjustment prior to October 1 | 70. 96 | 591, 567 | 591, 56 | 7 | 591, 567 | 28. 00 |
| 29.00 Low volume adjustment on or after October 1 | 70. 97 | 298, 521 | | 298, 521 | 298, 521 | 29. 00 |
| 30.00 HVBP payment adjustment (see instructions) | 70. 93 | -248 | 4, 59 | 7 -4, 845 | -248 | 30.00 |
| 30.01 HVBP payment adjustment for HSP bonus payment (see instructions) | 70. 90 | 0 | | 0 0 | 0 | 30. 01 |
| 31.00 HRR adjustment (see instructions) | 70. 94 | 0 | | 0 | 0 | 31.00 |
| 31.01 HRR adjustment for HSP bonus payment (see instructions) | 70. 74 | ő | | 0 0 | ő | 31.00 |
| THIST detroils) | | | | | (Amt. to | |
| | | | | | Wkst. E, Pt. | |
| | | | | | A) | |
| | 0 | 1.00 | 2.00 | 3.00 | 4. 00 | |
| 32.00 HAC Reduction Program adjustment (see | 70. 99 | | 42, 43 | | | 32.00 |
| instructions) 100.00 Transfer HAC Reduction Program adjustment to | , | Y | | | | 100.00 |
| Wkst. E, Pt. A. | | | | | | |

| Health Financial Systems | MEMORIAL HOSPITAL L | LOGANSPORT | In Lieu | of Form CMS-2552-10 |
|---|---------------------|------------------------|--|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | | Provi der CCN: 15-0072 | Peri od: From 01/01/2020 To 12/31/2020 | Worksheet E Part B Date/Time Prepared: 8/2/2021 10:57 am |
| | | | | |

| | | Title XVIII | Hospi tal | 8/2/2021 10: 5 PPS | 7 am |
|----------------|--|----------------------|------------------|------------------------|------------------|
| | | | noop: rai | | |
| | DADT D. MEDICAL AND OTHER HEALTH CERVICES | | | 1. 00 | |
| 1. 00 | PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) | | | 12, 737 | 1.00 |
| 2. 00 | Medical and other services (see First detrons) | ;) | | 11, 131, 134 | 2.00 |
| 3. 00 | OPPS payments | • • | | 9, 273, 670 | |
| 4.00 | Outlier payment (see instructions) | | | 87, 617 | 4.00 |
| 4. 01 | Outlier reconciliation amount (see instructions) | | | 0 | |
| 5.00 | Enter the hospital specific payment to cost ratio (see instruction | ıs) | | 0. 000 | 1 |
| 6. 00 7. 00 | Line 2 times line 5 | | | 0.00 | |
| 8. 00 | Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions) | | | 0.00 | 1 |
| 9. 00 | Ancillary service other pass through costs from Wkst. D, Pt. IV, c | col. 13. line 200 | | 0 | 9.00 |
| 10.00 | Organ acquisitions | | | 0 | ı |
| 11. 00 | Total cost (sum of lines 1 and 10) (see instructions) | | | 12, 737 | 11.00 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | | |
| 12. 00 | Reasonable charges | | | 56, 322 | 12.00 |
| 13.00 | Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 6 | , 9) | | 0 50, 322 | 1 |
| 14. 00 | Total reasonable charges (sum of lines 12 and 13) | ''') | | 56, 322 | ı |
| | Customary charges | | | · | |
| 15.00 | Aggregate amount actually collected from patients liable for payme | | | 0 | |
| 16. 00 | Amounts that would have been realized from patients liable for pay | ment for services o | on a chargebasis | 0 | 16. 00 |
| 17. 00 | had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000) | | | 0. 000000 | 17.00 |
| 18. 00 | Total customary charges (see instructions) | | | 56, 322 | |
| 19. 00 | Excess of customary charges over reasonable cost (complete only if | line 18 exceeds li | ne 11) (see | 43, 585 | |
| | instructions) | | , , | • | |
| 20.00 | Excess of reasonable cost over customary charges (complete only if | line 11 exceeds li | ne 18) (see | 0 | 20.00 |
| 21 00 | instructions) | | | 10 707 | 21 00 |
| 21.00 | Lesser of cost or charges (see instructions) Interns and residents (see instructions) | | | 12, 737 0 | 21. 00 22. 00 |
| | Cost of physicians' services in a teaching hospital (see instructi | ons) | | Ö | • |
| 24. 00 | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) | | | 9, 361, 287 | |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | | |
| 25. 00 | Deductibles and coinsurance amounts (for CAH, see instructions) | | | 0 | |
| 26.00 | Deductibles and Coinsurance amounts relating to amount on line 24 | | | 1, 915, 609 | 1 |
| 27. 00 | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus instructions) | the sum of fittes 22 | and 23] (See | 7, 458, 415 | 27. 00 |
| 28. 00 | Direct graduate medical education payments (from Wkst. E-4, line 5 | 50) | | 0 | 28. 00 |
| 29.00 | ESRD direct medical education costs (from Wkst. E-4, line 36) | , | | 0 | 29. 00 |
| 30.00 | Subtotal (sum of lines 27 through 29) | | | 7, 458, 415 | 1 |
| 31.00 | Primary payer payments | | | 1, 866 | |
| 32.00 | Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) | | | 7, 456, 549 | 32.00 |
| 33.00 | Composite rate ESRD (from Wkst. I-5, line 11) | | | 0 | 33.00 |
| | Allowable bad debts (see instructions) | | | 137, 056 | |
| | Adjusted reimbursable bad debts (see instructions) | | | 89, 086 | • |
| | Allowable bad debts for dual eligible beneficiaries (see instructi | ons) | | 137, 056 | • |
| 37.00 | Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R | | | 7, 545, 635 | 37.00 |
| 39.00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0 | 1 |
| 39. 50 | Pioneer ACO demonstration payment adjustment (see instructions) | | | | 39.50 |
| 39. 97 | Demonstration payment adjustment amount before sequestration | | | 0 | ı |
| | Partial or full credits received from manufacturers for replaced d | levices (see instruc | ctions) | 0 | |
| 39. 99 | RECOVERY OF ACCELERATED DEPRECIATION | | | 0 | |
| 40.00 | Subtotal (see instructions) Sequestration adjustment (see instructions) | | | 7, 545, 530 49, 800 | • |
| 40. 01 | Demonstration payment adjustment amount after sequestration | | | 49,800 | 40.01 |
| | Sequestration adjustment-PARHM pass-throughs | | | | 40. 03 |
| | Interim payments | | | 7, 485, 768 | ı |
| | Interim payments-PARHM | | | | 41.01 |
| 42.00 | Tentative settlement (for contractors use only) | | | 0 | |
| 42. 01 | Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions) | | | 9, 962 | 42. 01 43. 00 |
| 43. 00 | Balance due provider/program-PARHM (see instructions) | | | 7, 702 | 43.00 |
| 44. 00 | Protested amounts (nonallowable cost report items) in accordance w | vith CMS Pub. 15-2. | chapter 1, | 0 | 1 |
| | §115. 2 | · | · . | | |
| 00 =: | TO BE COMPLETED BY CONTRACTOR | | | | |
| | Original outlier amount (see instructions) | | | 0 | |
| | Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money | | | 0 0. 00 | |
| | Time Value of Money (see instructions) | | | 0.00 | 1 |
| | Total (sum of lines 91 and 93) | | | - | 94.00 |
| | | | | ' | |

Health Financial Systems MEMORI ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared: Provi der CCN: 15-0072

| | | | | 10 12/31/2020 | 8/2/2021 10:5 | |
|----------------|---|------------|------------|---------------|-------------------------|----------------|
| | | 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 | | 5, 808, 49 | 8 | 7, 405, 538 | 1. 00 |
| 2.00 | Interim payments payable on individual bills, either | | | 0 | 0 | 2.00 |
| | submitted or to be submitted to the contractor for | | | | | |
| | services rendered in the cost reporting period. If none, | | | | | |
| | write "NONE" or enter a zero | | | | | |
| 3. 00 | List separately each retroactive lump sum adjustment | | | | | 3.00 |
| | amount based on subsequent revision of the interim rate | | | | | |
| | for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | | | | | |
| | Program to Provider | | | | | |
| 3. 01 | ADJUSTMENTS TO PROVIDER | 12/31/2020 | 61, 70 | 0 12/31/2020 | 80, 230 | 3. 01 |
| 3. 02 | ADDUSTMENTS TO TROVIDER | 12/31/2020 | | 0 12/31/2020 | 00, 230 | 3. 01 |
| 3. 03 | | | | Ö | 0 | 3. 03 |
| 3. 04 | | | | 0 | l o | 3. 04 |
| 3. 05 | | | | o | 0 | 3. 05 |
| | Provider to Program | | | - | _ | |
| 3.50 | ADJUSTMENTS TO PROGRAM | | | 0 | 0 | 3.50 |
| 3.51 | | | | 0 | 0 | 3. 51 |
| 3. 52 | | | | 0 | 0 | 3. 52 |
| 3. 53 | | | | 0 | 0 | 3. 53 |
| 3. 54 | | | 1 | 0 | 0 | 3. 54 |
| 3. 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines | | 61, 70 | 0 | 80, 230 | 3. 99 |
| | 3. 50-3. 98) | | 5 070 40 | | 7 405 740 | |
| 4. 00 | Total interim payments (sum of lines 1, 2, and 3.99) | | 5, 870, 19 | 8 | 7, 485, 768 | 4. 00 |
| | (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) | | | | | |
| | TO BE COMPLETED BY CONTRACTOR | | | | | |
| 5. 00 | List separately each tentative settlement payment after | | | | | 5. 00 |
| 3.00 | desk review. Also show date of each payment. If none, | | | | | 3.00 |
| | write "NONE" or enter a zero. (1) | | | | | |
| | Program to Provider | | • | · | | |
| 5.01 | TENTATI VE TO PROVI DER | | | 0 | 0 | 5. 01 |
| 5. 02 | | | | 0 | 0 | 5. 02 |
| 5. 03 | | | | 0 | 0 | 5. 03 |
| | Provi der to Program | | | _ | _ | |
| 5. 50 | TENTATIVE TO PROGRAM | | | 0 | 0 | 5. 50 |
| 5. 51 | | | | 0 | 0 | 5. 51 |
| 5. 52 5. 99 | Subtatal (aum of lines E 01 E 40 minus cum of lines | | | 0 | 0 | 5. 52 5. 99 |
| 5. 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) | | | U | ا | 5. 99 |
| 6. 00 | Determined net settlement amount (balance due) based on | | | | | 6. 00 |
| . 01 | the cost report. (1) | | | | 0.040 | / 01 |
| 6. 01 | SETTLEMENT TO PROCEAM | | 45.50 | 1 | 9, 962 | 6. 01 |
| 6. 02 | SETTLEMENT TO PROGRAM | | 65, 52 | | 7 405 720 | 6. 02 |
| 7. 00 | Total Medicare program liability (see instructions) | | 5, 804, 67 | Contractor | 7, 495, 730 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 Lieu | u of Form CMS- | 2552-10 |
|---------|--|--------------------------|----------------------------------|----------------|---------|
| CALCUL | ATION OF REIMBURSEMENT SETTLEMENT FOR HIT | Provi der CCN: 15-0072 | Peri od: | Worksheet E- | 1 |
| | | | From 01/01/2020 To 12/31/2020 | | enared· |
| | | | 127 017 2020 | 8/2/2021 10: | |
| | | Title XVIII | Hospi tal | PPS | |
| | | | | 1.00 | |
| | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS | | | 1. 00 | |
| | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO | N | | | |
| 1. 00 | Total hospital discharges as defined in AARA §4102 from Wkst | | e 14 | | 1.00 |
| 2. 00 | Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, | | | | 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 | | WI+ C 2 D+ I | | 6.00 |
| 7. 00 | CAH only - The reasonable cost incurred for the purchase of line 168 | certified Hil technology | WKSt. 5-2, 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 | n (see instructions) | | | 10.00 |
| | INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH | | | | |
| | Initial/interim HIT payment adjustment (see instructions) | | | | 30.00 |
| | Other Adjustment (specify) | 11 | | | 31.00 |
| 32.00 | Balance due provider (line 8 (or line 10) minus line 30 and | line 31) (see instructio | ns) | | 32.00 |

| Health Financial Systems | MEMORIAL HOSPITAL | LOGANSPORT | In Lieu | u of Form CMS-2552-10 |
|---|-------------------|---|--|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT - | SWI NG BEDS | Provider CCN: 15-0072 Component CCN: 15-U072 | Peri od: From 01/01/2020 To 12/31/2020 | Worksheet E-2 Date/Time Prepared: 8/2/2021 10:57 am |

| | | Component CCN: 15-00/2 | 10 12/31/2020 | 8/2/2021 10:5 | |
|----------------|--|--------------------------|-------------------|---------------|------------|
| | | Title XIX | Swing Beds - SNF | PPS | |
| | | | Part A | Part B | |
| | COMPUTATION OF NET COST OF COVERED SERVICES | | 1. 00 | 2. 00 | |
| | Inpatient routine services - swing bed-SNF (see instructions) | | ol | | 1.0 |
| 00 | Inpatient routine services - swing bed-NF (see instructions) | | o | | 2.0 |
| 00 | Ancillary services (from Wkst. D-3, col. 3, line 200, for Part | A, and sum of Wkst. D, | O | | 3. |
| | Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swin | | | | |
| | i nstructi ons) | | | | |
| 01 | Nursing and allied health payment-PARHM (see instructions) | | | | 3. |
| .00 | Per diem cost for interns and residents not in approved teachi | ng program (see | 0. 00 | | 4.0 |
| 00 | instructions) | | | | _ |
| 00 | Program days Interns and residents not in approved teaching program (see in | etructions) | 0 | | 5. 6. |
| 00 | Utilization review - physician compensation - SNF optional met | | | | 7. |
| 00 | Subtotal (sum of lines 1 through 3 plus lines 6 and 7) | nou on y | | | 8. |
| 00 | Primary payer payments (see instructions) | | | | 9. |
| 0.00 | Subtotal (line 8 minus line 9) | | o | | 10. |
| 1. 00 | Deductibles billed to program patients (exclude amounts applic | able to physician | O | | 11. |
| | professional services) | . 3 | | | |
| 2. 00 | Subtotal (line 10 minus line 11) | | 0 | | 12. |
| 3. 00 | Coinsurance billed to program patients (from provider records) | (excl ude coi nsurance | 0 | | 13. |
| | for physician professional services) | | | | ١ |
| | 80% of Part B costs (line 12 x 80%) | | 0 | | 14. |
| | Subtotal (see instructions) | | 0 | | 15. |
| | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | ` | U | | 16. |
| | Pioneer ACO demonstration payment adjustment (see instructions Rural community hospital demonstration project (§410A Demonstr | • | | | 16. 16. |
| 3. 33 | adjustment (see instructions) | atron) payment | | | 10. |
| 5. 99 | Demonstration payment adjustment amount before sequestration | | | | 16. |
| | Allowable bad debts (see instructions) | | | | 17. |
| | Adjusted reimbursable bad debts (see instructions) | | o | | 17. |
| | Allowable bad debts for dual eligible beneficiaries (see instr | uctions) | O | | 18. |
| 9. 00 | Total (see instructions) | | О | | 19. |
| 9. 01 | Sequestration adjustment (see instructions) | | 0 | | 19. |
| 9. 02 | Demonstration payment adjustment amount after sequestration) | | 0 | | 19. |
| 9. 03 | Sequestration adjustment-PARHM pass-throughs | | | | 19. |
| 1 | Interim payments | | 0 | | 20. |
| - 1 | Interim payments-PARHM | | | | 20. |
| - 1 | Tentative settlement (for contractor use only) | | U | | 21. |
| 1. 01 2. 00 | Tentative settlement-PARHM (for contractor use only) Balance due provider/program (line 19 minus lines 19.01, 20, a | nd 21) | 0 | | 22. |
| 2. 00 | Balance due provider/program-PARHM (see instructions) | 110 21) | ١ | | 22. |
| 3. 00 | Protested amounts (nonallowable cost report items) in accordan | ce with CMS Pub. 15-2. | 0 | | 23. |
| | chapter 1, §115.2 | | | | |
| | Rural Community Hospital Demonstration Project (§410A Demonstr | ation) Adjustment | | | |
| | Is this the first year of the current 5-year demonstration per | iod under the 21st | | | 200. |
| | Century Cures Act? Enter "Y" for yes or "N" for no. | | | | |
| | Cost Reimbursement | | | | |
| 31.00 | Medicare swing-bed SNF inpatient routine service costs (from W | kst. D-1, Pt. II, line | | | 201. |
| 22 00 | 66 (title XVIII hospital)) | Wko+ D 2 col 2 lis | | | 202 |
| J2. UU | Medicare swing-bed SNF inpatient ancillary service costs (from 200 (title XVIII swing-bed SNF)) | I WKSt. D-3, COI. 3, III | ie | | 202. |
| J3 UU | Total (sum of lines 201 and 202) | | | | 203. |
| | Medicare swing-bed SNF discharges (see instructions) | | | | 204. |
| | Computation of Demonstration Target Amount Limitation (N/A in | first year of the curre | ent 5-vear demons | | 1204. |
| | peri od) | et year er the earle | nit o jour domono | | |
| 05.00 | Medicare swing-bed SNF target amount | | | | 205. |
| 06.00 | Medicare swing-bed SNF inpatient routine cost cap (line 205 ti | mes line 204) | | | 206. |
| ĺ | Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs | ement | | | |
| 7. 00 | Program reimbursement under the §410A Demonstration (see instr | uctions) | | | 207. |
| 00 .80 | Medicare swing-bed SNF inpatient service costs (from Wkst. E-2 | , col. 1, sum of lines | 1 | | 208. |
| | and 3) | | | | |
| - 1 | Adjustment to Medicare swing-bed SNF PPS payments (see instruc | tions) | | | 209. |
| 10. 00 | Reserved for future use | | | | 210. |
| | Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare swing-bed SNF PPS payment (line 2 | 00 plus 11== 2422 (| | | 215. |
| 1 . 00 | | | | | |

| Health Financial Systems | MEMORIAL HOSPITAL LOGANSPORT | In Lieu of Form CMS-2552 | | |
|---|------------------------------|--------------------------|---|--|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0072 | From 01/01/2020 | Worksheet E-3 Part VII Date/Time Prepared: 8/2/2021 10:57 am | |

| | | | 10 12/31/2020 | 8/2/2021 10:5 | pareu: 7 am |
|--------|---|-------------------------|---------------|---------------|----------------|
| | | Title XIX | Hospi tal | Cost | |
| | | | Inpatient | Outpati ent | |
| | | | 1. 00 | 2. 00 | |
| | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI | CES FOR TITLES V OR XI | X SERVICES | | |
| | COMPUTATION OF NET COST OF COVERED SERVICES | | | | 1 |
| 1.00 | Inpati ent hospi tal /SNF/NF servi ces | | 1, 137, 834 | | 1.00 |
| 2.00 | Medical and other services | | | 0 | 2.00 |
| 3.00 | Organ acquisition (certified transplant centers only) | | 0 | | 3.00 |
| 4.00 | Subtotal (sum of lines 1, 2 and 3) | | 1, 137, 834 | 0 | 4.00 |
| 5.00 | Inpatient primary payer payments | | 0 | | 5.00 |
| 6.00 | Outpatient primary payer payments | | | 0 | 6.00 |
| 7.00 | Subtotal (line 4 less sum of lines 5 and 6) | | 1, 137, 834 | 0 | 7.00 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | | 1 |
| | Reasonabl e Charges | | | | 1 |
| 8.00 | Routine service charges | | 647, 948 | | 8.00 |
| 9.00 | Ancillary service charges | | 1, 091, 435 | 0 | 9.00 |
| 10.00 | Organ acquisition charges, net of revenue | | 0 | | 10.00 |
| 11.00 | Incentive from target amount computation | | 0 | | 11.00 |
| 12.00 | Total reasonable charges (sum of lines 8 through 11) | | 1, 739, 383 | 0 | 12.00 |
| | CUSTOMARY CHARGES | | | | |
| 13.00 | Amount actually collected from patients liable for payment for s | services on a charge | 0 | 0 | 13.00 |
| | basi s | | | | |
| 14.00 | Amounts that would have been realized from patients liable for p | | 0 ا | 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, 739, 383 | 0 | |
| 17. 00 | Excess of customary charges over reasonable cost (complete only | if line 16 exceeds | 601, 549 | 0 | 17.00 |
| | line 4) (see instructions) | | | _ | |
| 18. 00 | Excess of reasonable cost over customary charges (complete only | if line 4 exceeds line | 9 0 | 0 | 18.00 |
| 40.00 | 16) (see instructions) | | | | 40.00 |
| 19.00 | Interns and Residents (see instructions) | | 0 | 0 | |
| 20.00 | Cost of physicians' services in a teaching hospital (see instruc | | 1 127 024 | 0 | |
| 21. 00 | Cost of covered services (enter the lesser of line 4 or line 16) | | 1, 137, 834 | 0 | 21.00 |
| 22 00 | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co Other than outlier payments | mipreted for PPS provid | ol | 0 | 22. 00 |
| | | | | 0 | |
| | Program capital payments | | | U | 24.00 |
| | Capital exception payments (see instructions) | | | | 25.00 |
| | | | | 0 | |
| 27. 00 | Subtotal (sum of lines 22 through 26) | | | 0 | |
| 28. 00 | Customary charges (title V or XIX PPS covered services only) | | | 0 | |
| 29.00 | Titles V or XIX (sum of lines 21 and 27) | | 1, 137, 834 | 0 | |
| 27.00 | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | 1, 107, 001 | | 27.00 |
| 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) | | 1, 137, 834 | 0 | |
| | Deducti bl es | | 0 | 0 | |
| 33. 00 | | | 0 | 0 | |
| 34.00 | Allowable bad debts (see instructions) | | 0 | 0 | |
| | Utilization review | | o | | 35.00 |
| 36.00 | Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3 | 33) | 1, 137, 834 | 0 | 36, 00 |
| | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | • | 0 | 0 | 37.00 |
| 38.00 | Subtotal (line 36 ± line 37) | | 1, 137, 834 | 0 | 38.00 |
| | | | 0 | | 39.00 |
| | Total amount payable to the provider (sum of lines 38 and 39) | | 1, 137, 834 | 0 | 40.00 |
| 41.00 | Interim payments | | 854, 482 | 0 | 41.00 |
| 42.00 | Balance due provider/program (line 40 minus line 41) | | 283, 352 | 0 | 42.00 |
| 43.00 | Protested amounts (nonallowable cost report items) in accordance | e with CMS Pub 15-2, | 0 | 0 | 43.00 |
| | chapter 1, §115.2 | | | | 1 |

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

Provider CCN: 15-0072 Peri od: Worksheet G From 01/01/2020 12/31/2020 Date/Time Prepared: only) 8/2/2021 10:57 am General Fund Speci fi c Endowment Plant Fund Purpose Fund Fund 1.00 2.00 4.00 3.00 CURRENT ASSETS Cash on hand in banks 29, 305, 668 0 0 0 1.00 0 0 Temporary investments 0 2.00 0 Notes receivable 0 0 3 00 0 Accounts receivable 80, 505, 236 0 4.00 3, 414, 889 0 0 0 5.00 Other receivable ol Allowances for uncollectible notes and accounts receivable -58, 707, 580 0 0 6.00 o 1, 748, 984 0 7 00 0 Inventory 0 Prepaid expenses 1,087,342 0 0 8.00 0 Other current assets 0 9.00 Due from other funds 0 ol 0 10.00 Total current assets (sum of lines 1-10) 57, 354, 539 0 0 0 11.00 FIXED ASSETS Land 205.783 0 0 0 12.00 Land improvements 0 0 0 13.00 838.517 οĺ -482, 630 Accumulated depreciation 0 14.00 Bui I di ngs o 65, 043, 987 0 0 15.00 Accumulated depreciation -40, 627, 644 0 0 16.00

1.00 2.00 3 00 4.00 5.00 6.00 7 00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 0 0 0 0 Leasehold improvements 17.00 17.00 0 0 18 00 Accumulated depreciation 0 18 00 Fixed equipment 7, 611, 191 19.00 19.00 0 0 20.00 Accumulated depreciation -4, 035, 485 0 0 0 20.00 0 108, 602 21.00 Automobiles and trucks 0 21.00 22.00 Accumulated depreciation -105, 908 0 22.00 23.00 Major movable equipment 48, 764, 305 0 0 0 0 23.00 Accumulated depreciation 0 24.00 -26, 159, 224 0 24.00 0 25.00 Minor equipment depreciable 0 25.00 Accumulated depreciation 0 0 26.00 26.00 0 0 27.00 HIT designated Assets 0 0 27.00 C 0 28.00 Accumulated depreciation 0 0 28.00 0 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 Total fixed assets (sum of lines 12-29) 30.00 51, 161, 494 0 0 0 30.00 OTHER ASSETS 31 00 31.00 Investments 3, 393, 369 0 0 0 0 32.00 Deposits on Leases 0 0 32.00 0 0 33.00 Due from owners/officers 0 33.00 o 34.00 Other assets 13, 185, 386 0 34.00 0 Total other assets (sum of lines 31-34) 0 0 35.00 16, 578, 755 0 35.00 Total assets (sum of lines 11, 30, and 35) 125, 094, 788 36.00 0 0 0 36.00 CURRENT LIABILITIES 37 00 14 360 852 0 0 n 37 00 Accounts payable 0 0 38.00 Salaries, wages, and fees payable 1,820,455 0 38.00 Payroll taxes payable 0 0 0 39.00 39.00 40.00 Notes and Loans payable (short term) 1, 971, 687 0 0 40.00 0 o Deferred income 0 41 00 41 00 C 0 42.00 Accelerated payments C 42.00 43.00 Due to other funds 0 0 0 43.00 Other current liabilities ol 44.00 1.383.836 0 0 44.00 0 Total current liabilities (sum of lines 37 thru 44) 45.00 19, 536, 830 0 0 45.00 ONG TERM LIABILITIES Mortgage payable 0 0 0 46.00 46,00 0 0 Notes payable 0 47.00 47.00 C 48.00 Unsecured Loans 0 0 0 48.00 Other long term liabilities 33, 224, 843 0 0 49.00 49.00 0 Total long term liabilities (sum of lines 46 thru 49) 33, 224, 843 0 ol 0 50.00 50.00 51.00 Total liabilities (sum of lines 45 and 50) 52, 761, 673 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 72, 333, 115 52.00 0 Specific purpose fund 53.00 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) 72, 333, 115 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 125, 094, 788 0 0 0 60.00

MCRI F32 - 16. 10. 172. 3

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0072

Peri od: Worksheet G-1 From 01/01/2020 To 12/31/2020 Date/Time Prepared:

8/2/2021 10:57 am General Fund Special Purpose Fund Endowment Fund 5.00 1. 00 3. 00 4.00 2.00 1.00 Fund balances at beginning of period 72, 687, 109 0 1.00 Net income (loss) (from Wkst. G-3, line 29) -353, 994 2.00 2.00 3 00 Total (sum of line 1 and line 2) 72, 333, 115 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 Subtotal (line 3 plus line 10) 72, 333, 115 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 000000 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 72, 333, 115 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 Total (sum of line 1 and line 2) 0 3.00 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 C Total deductions (sum of lines 12-17) 18.00 0 18.00 Fund balance at end of period per balance 0 0 19.00 sheet (line 11 minus line 18)

| Peri od: | Worksheet G-2 | From 01/01/2020 | Parts | & II | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems MEM STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0072

| | | | То | 12/31/2020 | Date/Time Pre 8/2/2021 10:5 | |
|--------|---|---|-----|---------------|---|--------|
| | Cost Center Description | I npati ent | | Outpati ent | Total | / aiii |
| | oost oonton bood (ptron | 1.00 | | 2.00 | 3. 00 | |
| | PART I - PATIENT REVENUES | | | | 2. 22 | |
| | General Inpatient Routine Services | | | | | |
| 1.00 | Hospi tal | 8, 575, 3 | 239 | | 8, 575, 239 | 1.00 |
| 2.00 | SUBPROVI DER - I PF | | | | .,, | 2.00 |
| 3.00 | SUBPROVIDER - IRF | | | | | 3.00 |
| 4. 00 | SUBPROVI DER | | | | | 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 | | | | | 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) | 8, 575, 1 | 239 | | 8, 575, 239 | 10.00 |
| | Intensive Care Type Inpatient Hospital Services | | | | -,, | |
| 11. 00 | INTENSIVE CARE UNIT | 1, 030, | 532 | | 1, 030, 632 | 11.00 |
| 12.00 | CORONARY CARE UNIT | | | | | 12.00 |
| 13.00 | BURN INTENSIVE CARE UNIT | | | | | 13.00 |
| 14.00 | SURGICAL INTENSIVE CARE UNIT | | | | | 14.00 |
| 15. 00 | OTHER SPECIAL CARE (SPECIFY) | | | | | 15.00 |
| 16. 00 | Total intensive care type inpatient hospital services (sum of lines | 1, 030, | 332 | | 1, 030, 632 | 16.00 |
| | 11-15) | , | | | , , | |
| 17.00 | Total inpatient routine care services (sum of lines 10 and 16) | 9, 605, | 371 | | 9, 605, 871 | 17.00 |
| 18.00 | Ancillary services | 28, 058, | | 135, 127, 081 | 163, 185, 823 | 18.00 |
| 19.00 | Outpati ent servi ces | 2, 188, | | 25, 608, 659 | 27, 796, 829 | 19.00 |
| 20.00 | RURAL HEALTH CLINIC | | 0 | o | 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 | ol | 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 | NONREI MBURSABLE | 8. : | 264 | 8, 556, 812 | 8, 565, 076 | 27.00 |
| 27. 01 | PRO FEES | 455, | | 15, 523, 499 | 15, 979, 396 | 27. 01 |
| 28. 00 | Total patient revenues (sum of lines 17-27)(transfer column 3 to Wk | | | 184, 816, 051 | 225, 132, 995 | 28.00 |
| | G-3, line 1) | | | .,, | , | |
| | PART II - OPERATING EXPENSES | | | | | |
| 29.00 | Operating expenses (per Wkst. A, column 3, line 200) | | | 99, 008, 369 | | 29.00 |
| 30.00 | ADD (SPECIFY) | | 0 | | | 30.00 |
| 31.00 | | | 0 | | | 31.00 |
| 32.00 | | | 0 | | | 32.00 |
| 33.00 | | | 0 | | | 33.00 |
| 34.00 | | | 0 | | | 34.00 |
| 35.00 | | | 0 | | | 35.00 |
| 36.00 | Total additions (sum of lines 30-35) | | | o | | 36.00 |
| 37.00 | DEDUCT (SPECIFY) | | 0 | | | 37.00 |
| 38.00 | | | 0 | | | 38.00 |
| 39.00 | | | 0 | | | 39.00 |
| 40.00 | | | 0 | | | 40.00 |
| 41.00 | | | 0 | | | 41.00 |
| 42.00 | Total deductions (sum of lines 37-41) | | | o | | 42.00 |
| 43.00 | Total operating expenses (sum of lines 29 and 36 minus line 42)(tra | nsfer | | 99, 008, 369 | | 43.00 |
| | to Wkst. G-3, line 4) | | | | | |
| | | | | | | |

| ∐oal +k | Financial Systems MEMORIAL HC | OSPITAL LOGANSPORT | In Lio | u of Form CMS-2 | 0552 10 |
|---------|--|------------------------|-----------------|-----------------|---------|
| | MENT OF REVENUES AND EXPENSES | Provi der CCN: 15-0072 | Peri od: | Worksheet G-3 | |
| SIMIL | MENT OF REVENUES THIS EXTENSES | 11001461 001. 10 0072 | From 01/01/2020 | WOT KSHEET & & | |
| | | | To 12/31/2020 | | |
| | | | | 8/2/2021 10:5 | / am |
| | | | | 1 00 | |
| 1. 00 | Total notions revenues (from What C.2 Port I column | 2 Line 20) | | 1. 00 | 1. 00 |
| 2.00 | Total patient revenues (from Wkst. G-2, Part I, column | | | 225, 132, 995 | |
| | Less contractual allowances and discounts on patients' | accounts | | 142, 095, 348 | |
| 3.00 | Net patient revenues (line 1 minus line 2) | 1: 42) | | 83, 037, 647 | 3.00 |
| 4.00 | Less total operating expenses (from Wkst. G-2, Part II | | | 99, 008, 369 | |
| 5. 00 | Net income from service to patients (line 3 minus line | 4) | | -15, 970, 722 | 5. 00 |
| / 00 | OTHER I NCOME | | | 0 | / 00 |
| 6.00 | Contributions, donations, bequests, etc | | | 0 | 6.00 |
| 7.00 | Income from investments | | | 0 | 7.00 |
| 8. 00 | Revenues from telephone and other miscellaneous commun | ication services | | 0 | |
| 9.00 | Revenue from television and radio service | | | 0 | ,, 00 |
| 10.00 | Purchase di scounts | | | 0 | 10.00 |
| 11.00 | Rebates and refunds of expenses | | | 0 | 11.00 |
| 12.00 | Parking lot receipts | | | 0 | 12.00 |
| 13.00 | Revenue from Laundry and Linen service | | | 0 | 13.00 |
| | Revenue from meals sold to employees and guests | | | 0 | 14.00 |
| | Revenue from rental of living quarters | | | 0 | 15.00 |
| | Revenue from sale of medical and surgical supplies to | other than patients | | 0 | 16.00 |
| | Revenue from sale of drugs to other than patients | | | 0 | 17. 00 |
| 18. 00 | Revenue from sale of medical records and abstracts | | | 0 | 18. 00 |
| | Tuition (fees, sale of textbooks, uniforms, etc.) | | | 0 | 19.00 |
| 20. 00 | Revenue from gifts, flowers, coffee shops, and canteen | | | 0 | 20.00 |
| 21. 00 | Rental of vending machines | | | 0 | 21.00 |
| 22. 00 | Rental of hospital space | | | 0 | 22.00 |
| 23.00 | Governmental appropriations | | | 0 | 23.00 |
| 24.00 | OTHER REVENUE | | | 1, 720, 755 | |
| | I NVESTMENT I NCOME | | | 539, 608 | |
| | COVI D-19 PHE Funding | | | 13, 356, 365 | |
| 25 00 | Total other income (sum of lines 6.24) | | | 15 616 720 | 25 00 |

24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

25.00

26.00 0 27.00 0 28.00 -353, 994 29. 00

15, 616, 728

-353, 994

| CALCUL | ATION OF CAPITAL PAYMENT | Provi der CCN: 15-0072 | Peri od: From 01/01/2020 To 12/31/2020 | | pared: 7 am |
|----------------|--|---------------------------|--|----------|----------------|
| | | Title XVIII | Hospi tal | PPS | |
| | | | | | |
| | PART I - FULLY PROSPECTIVE METHOD | | | 1. 00 | |
| | CAPITAL FEDERAL AMOUNT | | | | |
| 1.00 | Capital DRG other than outlier | | | 250, 417 | 1.0 |
| 1. 01 | Model 4 BPCI Capital DRG other than outlier | | | 0 | 1.0 |
| 2. 00 | Capital DRG outlier payments | | | 12, 135 | 2.0 |
| 2. 01 | Model 4 BPCI Capital DRG outlier payments | | | 0 | 2.0 |
| 3. 00 | Total inpatient days divided by number of days in the cost i | reporting period (see ins | tructions) | 13. 75 | 3.0 |
| 1. 00 | Number of interns & residents (see instructions) | 3 1 | , | 0.00 | |
| 5. 00 | Indirect medical education percentage (see instructions) | | | 0.00 | |
| . 00 | Indirect medical education adjustment (multiply line 5 by th 1.01) (see instructions) | ne sum of lines 1 and 1.0 | 1, columns 1 and | 0 | 6.0 |
| . 00 | Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions) | patient days (Worksheet | E, part A line | 0. 00 | 7.0 |
| 3. 00 | Percentage of Medicaid patient days to total days (see insti | ructions) | | 0.00 | 8.0 |
| 9. 00 | Sum of lines 7 and 8 | 46 (1 0113) | | 0.00 | |
| 10.00 | Allowable disproportionate share percentage (see instruction | ns) | | 0.00 | |
| 11. 00 | Disproportionate share adjustment (see instructions) | .5) | | 0.00 | 11.0 |
| 12.00 | Total prospective capital payments (see instructions) | | | 262, 552 | 12.0 |
| | | | | 1.00 | |
| | PART II - PAYMENT UNDER REASONABLE COST | | | | |
| 1. 00 | Program inpatient routine capital cost (see instructions) | | | 0 | 1.0 |
| 2. 00 | Program inpatient ancillary capital cost (see instructions) | | | 0 | 2.0 |
| 3.00 | Total inpatient program capital cost (line 1 plus line 2) | | | 0 | 3.0 |
| 4. 00 | Capital cost payment factor (see instructions) | | | 0 | 4.0 |
| 5. 00 | Total inpatient program capital cost (line 3 x line 4) | | | 0 | 5.0 |
| | | | | 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 circumstan | nces (see instructions) | | 0 | 2.0 |
| 3. 00 1. 00 | Net program inpatient capital costs (line 1 minus line 2) | | | 0 | 3. 0 4. 0 |
| i. 00 5. 00 | Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) | | | 0.00 | 5.0 |
| b. 00 | Percentage adjustment for extraordinary circumstances (see i | instructions) | | 0. 00 | |
| . 00 | Adjustment to capital minimum payment level for extraordinar | | x line 6) | 0.00 | 7.0 |
| . 00 | Capital minimum payment level (line 5 plus line 7) | y circumstances (iffle 2 | X 11110 0) | 0 | |
| 9. 00 | Current year capital payments (from Part I, line 12, as appl | licable) | | 0 | 0.0 |
| 0.00 | Current year comparison of capital minimum payment level to | | less line 9) | 0 | 10.0 |
| 11. 00 | Carryover of accumulated capital minimum payment level over | | | 0 | 11.0 |
| | Worksheet L, Part III, line 14) | | , | | |
| 12 00 | Not comparison of capital minimum payment lovel to capital | | 1 | | |

12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)

14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period

(if line 12 is negative, enter the amount on this line)

15.00 Current year allowable operating and capital payment (see instructions)

16.00 Current year operating and capital costs (see instructions)

17.00 | Current year exception offset amount (see instructions)

0 12.00 0 13.00 0 14.00

0 15.00

0 16.00

0 17.00