SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1	2	SI GNATURE STATEMENT	
Sherri	Gehlhausen	T	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2 Signatory Printed Name	Sherri Gehl hausen			2
3 Signatory Title	CFO			3
4 Date	(Dated when report is electronica			4

provided in compliance with such laws and regulations.

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	·	1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-71, 119	-47, 097	0	15, 783	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - 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
10.00	EXPRESS MEDICAL CENTER I	0		0		0	10.00
10.01	FAMILY HEALTH CARE II	0		0		0	10.01
200.00	Total	0	-71, 119	-47, 097	0	15, 783	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.

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX	MEMORIAL HOSPIT				Peri od:		of For Workshe		
						From 01/01/ To 12/31/		Part I Date/Ti	me Pre	epared
	1.00	2.00		3.00			4.00	5/27/20	22 1:4	17 pm
	Hospital and Hospital Health Care Co			3.00			4.00			
00	Street: 1101 MI CHI GAN AVENUE	PO Box:	7 n Cod	a. 4604	7					1.0
00	City: LOGANSPORT	State: IN Component Name	Zip Cod CCN	CBSA		ty: CASS Date	Payme	nt Syst	em (P,	2.0
			Number	Numbe		Certi fi ed	T,	0, or	N)	
		1.00	2.00	3.00	4.00	5.00	V 6.00	XVIII 7.00		-
	Hospital and Hospital-Based Componer		2.00	<u> </u>	4.00	5.00	0.00	7.00	0.00	
00	Hospi tal	MEMORIAL HOSPITAL	150072	9991	5 1	07/01/1966	N	Р	0	3.0
00	Subprovider - IPF	LOGANSPORT								4.0
00	Subprovider - IRF									5.0
00	Subprovider - (Other)		154070		_				-	6.0
00 00	Swing Beds – SNF Swing Beds – NF	SWING BED - SNF	150072	9991	5	05/14/2008	N	Р	Р	7.
00	Hospital-Based SNF									9.
. 00	Hospital-Based NF									10.
. 00	Hospital -Based OLTC									11.
. 00	Hospital-Based HHA Separately Certified ASC									12.
. 00	Hospi tal -Based Hospi ce									14.
. 00	Hospital-Based Health Clinic – RHC	LOGANSPORT MEMORIAL	158561	9991	5	05/25/2021	N	0	0	15.
. 01	Hospital-Based Health Clinic - RHC	EXPRESS MEDICAL LOGANSPORT FAMILY	158563	9991	5	05/19/2021	N	0	0	15.
		HEALTH CARE	100000						Ū	
	Hospital -Based Health Clinic - FQHC									16.
. 00 . 00	Hospital-Based (CMHC) I Renal Dialysis									17. 18.
	Other									19.
						From:		To		_
00	Cost Reporting Period (mm/dd/yyyy)					1.00		2. C 12/31/		20.
	Type of Control (see instructions)					9	021	12/01/	2021	21.
					1 00	2.00		2.0	0	-
	Inpatient PPS Information				1.00	2.00		3. C	10	
. 00	Does this facility qualify and is it				Y	N				22.0
	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo			R						
	facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo	or yes or "N" for no.								
01	Did this hospital receive interim ur				Y	Y				22.
	cost reporting period? Enter in colu the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N	l" for no for the portio	n of the	cost						
00	reporting period occurring on or aft				N					0.00
02	Is this a newly merged hospital that payments to be determined at cost re				Ν	N				22.
	Enter in column 1, "Y" for yes or "N									
	cost reporting period prior to Octob									
	or "N" for no, for the portion of th October 1.	ne cost reporting period	on or ar	ter						
03	Did this hospital receive a geograph	nic reclassification fro	m urban t	o	Ν	N		Ν		22.
	rural as a result of the OMB standar	ds for delineating stat	istical a	reas						
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportir									
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or aft									
	Does this hospital contain at least counted in accordance with 42 CFR 41									
	yes or "N" for no.	2. rooj. Enter in corumn	0, 1 1							
04	Did this hospital receive a geograph				Ν	N		N		22.
	rural as a result of the revised OME adopted by CMS in FY 2021? Enter in									
	for the portion of the cost reportir									
		no for the nortion of t	he cost							
	in column 2, "Y" for yes or "N" for		ructions)							
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft	er October 1. (see inst				1				1
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least	er October 1. (see inst 100 but not more than 4	99 beds (
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft	er October 1. (see inst 100 but not more than 4	99 beds (
. 00	in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	er October 1. (see inst 100 but not more than 4 2.105)? Enter in colum edicaid days on lines 24	99 beds (in 3, "Y" and/or 2	for 5		3 N				23. (
. 00	in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date	er October 1. (see inst 100 but not more than 4 2.105)? Enter in colum edicaid days on lines 24 of admission, 2 if cens	99 beds (in 3, "Y" and/or 2 us days,	for 5 or 3		3 N				23.0
00	in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	er October 1. (see inst 100 but not more than 4 2.105)? Enter in colum edicaid days on lines 24 of admission, 2 if cens of identifying the days	99 beds (in 3, "Y" and/or 2 us days, in this	for 5 or 3		3 N				23.

	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D		OGANSPORT Provider CC	N: 15-0072	Pe	eri od:		1	orm CM sheet S	
							1/2021 1/2021		/Time F	Prepared :47 pm
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Me Me	ut-of State di cai d i gi bl e npai d	Medica HMO da		Other Medicai days	d
		1.00	2.00	3.00		4.00	5.00)	6.00	_
4.00	in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		755			0 0		988		0 24.0
	out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.									
						Urban/Ri 1. C			of Geo 2.00	gr
6.00	Enter your standard geographic classification (not w	age) status	at the be	ginning of	the	1.0	2		∠.00	26.0
7.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassif	age) status or "2" for r	ural. If a	d of the cc pplicable,	st		2			27.0
5.00	If this is a sole community hospital (SCH), enter the	e number of	periods S	CH status i	n		1			35.0
	effect in the cost reporting period.					Begi nn	ni ng:	Er	ndi ng:	
	Entry and include herization and and include of COU	tatua Cula		24 6		1.0		-	2.00	
	Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), enter	es.				01/01/	0		31/2021	36. 37.
7. 01	accordance with FY 2016 OPPS final rule? Enter "Y" f									37.
3. 00	instructions) If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number of	es of MDH st	atus. If I	1 2 2 1 2						
	enter subsequent dates.	of periods i								38.0
		of periods i				Y/I			Y/N	38.
9.00	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i	il payment a), (ii), or the mileage	n excess o djustment (iii)? En requireme	f one and for low vol ter in colu nts in	ımn	Y/I 1. C Y	00		Y/N 2.00 Y	
	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)	il payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Ente	n excess o djustment (iii)? En requireme in column t? Enter " r "Y" for	f one and for low vol ter in colu nts in 2 "Y" for y Y" for yes	ımn ves or	1. C	00		2.00 Y Y	38. (
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo	il payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Ente	n excess o djustment (iii)? En requireme in column t? Enter " r "Y" for	f one and for low vol ter in colu nts in 2 "Y" for y Y" for yes	ımn ves or	1. C Y	00 V	XVI	2.00 Y Y	39. (40. (X_
	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital	I payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Ente . (see inst	n excess o djustment (iii)? En requireme in column t? Enter " ructions)	f one and for low vol ter in colu nts in 2 "Y" for y Y" for yes yes or "N"	imn ves or for	1. C Y N	V 1.00	XVI	2.00 Y Y	39. (40. (X_
). 00	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme	I payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Ente . (see inst	n excess o djustment (iii)? En requireme in column t? Enter " ructions)	f one and for low vol ter in colu nts in 2 "Y" for y Y" for yes yes or "N"	imn ves or for	1. C Y N	V 1.00	XVI	2.00 Y Y 11 X12 D0 3.0	39. 40. <u>X</u>
). 00 5. 00	<pre>Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octoon no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks</pre>	I payment a), (ii), or the mileage ii)? Enter on adjustmer ber 1. Ente . (see inst ent for disp	n excess o djustment (iii)? En requireme in column t? Enter " ructions) roportiona extraordin	f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums	or for accestant	1.C Y N cordance	V 1.00	XVI 2. (2.00 Y Y <u>11 X1</u> 20 3.0	39. 40. <u>X</u> 45.
0. 00 6. 00 6. 00 7. 00	enter subsequent dates. Does this facility qualify for the inpatient hospital s in accordance with 42 CFR §412.101(b)(2)(i1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octor no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excours pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital payment	I payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Ente . (see inst ent for disp ception for ct. L, Pt. I capital? E	n excess o djustment (iii)? En requireme in column rt? Enter " ructions) roportiona extraordin II and Wks	f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N	imn or for a acc tan I	1.0 Y N cordance ces through or no.	00 V 1.00 N	XVI D 2. (2.00 Y Y 11 X12 DO 3.0 N N N N	39. 40. <u>X</u> 45. 46. 47.
0.00 .00 .00 .00	enter subsequent dates. Does this facility qualify for the inpatient hospital s in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octor no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excours pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital payment reaching Hospitals Is this a hospital involved in training residents in approved GME payment, and are you are impacted by CR 11642 (or appli)	I payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Enter . (see inst ent for disp ception for it. L, Pt. I capital? Enter " n approved C ise to column rograms in cable CRs)	n excess o djustment (iii)? En requireme in column r" "Y" for ructions) roportiona extraordin II and Wks nter "Y fo Y" for yes ME program 1 is "Y",	f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen	Imn ves or for i acu i stand l' fo no stand l' fo stand l' fo stand l' fo stand l' fo stand l' stand l' stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stand stan	1.0 Y N cordance ces through or no. or yes o spi tal i mate	DO V 1. OC N N N N N T	XVI 2.(N N N	2.00 Y Y 11 X12 DO 3.0 N N N N	39. 40. 40. 45. 46. 47. 48.
5. 00 5. 00 5. 00 7. 00 3. 00 5. 00	enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octoon on in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excours for the facility eligible for additional payment excours for the facility electing full federal capital payment Teaching Hospitals Is this a new hospital under 42 CFR §412.300(b) PPS Is this a new hospital involved in training residents in approved GME pyear, and are you are impacted by CR 11642 (or appli Enter "Y" for yes; otherwise, enter "N" for no in colum	I payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Enter . (see inst ent for disp caption for it. L, Pt. I capital? Enter " capital? Enter " napproved C e to column rograms in cable CRs) olumn 2. period duri or yes or "N th of this Y", complet	n excess o djustment (iii)? En requireme in column at? Enter "' rr "Y" for ructions) roportiona extraordin II and Wks inter "Y fo Y" for yes ME program 1 is "Y", the prior MA direct ng which r " for no i cost repor e Workshee	f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or in for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period	Imn or for a acc l stand l s hos s ul t r e n app If	1.0 Y Y N cordance ces through or no. or yes o spital imate duction? proved column Enter "Y	DO V 1.00 N N N N N N 1	XVI 2.(N N N	2.00 Y Y 11 X12 DO 3.0 N N N N	39. 40. <u>X</u> 45. 46. 47.
5. 00 5. 00 5. 00 7. 00 5. 00 7. 00	enter subsequent dates. Does this facility qualify for the inpatient hospital sin accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octor no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is this a hospital involved in training residents in approved GME pyear, and are you are impacted by CR 11642 (or applier for yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for no in column 1. For column 2, if the respons was involved in training residents in approved GME pyear, and are you are impacted by CR 11642 (or applier for yes or "N" for no in column 2. If column 2 is "	I payment a), (ii), or the mileage ii)? Enter on adjustmer ber 1. Enter . (see inst ent for disp ception for ct. L, Pt. I capital? E tt? Enter " approved C e to columr programs in cable CRS olumn 2. period duri or yes or "N of this Y", complet I, if appli	n excess o djustment (iii)? En requireme in column t? Enter " r"Y" for ructions) roportiona extraordin II and Wks nter "Y fo Y" for yes ME program 1 is "Y", the prior MA direct ng which r " for no i cost repor e Workshee cable. or physici	f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period t E-4. If c	Imn ves or for in acc itani l" fic n acc itani "" fic n acc itani "" fic n acc itani "" fic n acc itani "" fic "" fic	1.0 Y N cordance ces through or no. or yes o spital imate duction? proved column Enter "Y mn 2 is	DO V 1.00 N N N N N N 1	XVI 2.(N N N	2.00 Y Y 11 X12 DO 3.0 N N N N	39. 40. 45. 45. 46. 47. 48. 56.

Health Financial Systems MEMORIAL	HOSPI TA	LOGANSPORT		In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ТА	Provider C	CN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Pre 5/27/2022 1:4	pared:
			NAHE 413.85 Y/N	5 Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in col	85? (s umn 1. CR) NAHE	see If column 1	N			60.00
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 	Ν			0.00	0.00	61.00
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						
61.02 Enter the current year total unweighted primary care 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 Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	(1.10
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 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Ser						
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct		d in this cost	t reporting p	eriod for which	0.00	62.00
62.01 Énter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	a Teachi 11 Teachi	see instructio		to your hospital	0.00	62.01
63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, completing	ettings	during this o			N	63.00

	Financial Systems AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION D	ATA Provider Co		eri od:	u of Form CMS-2 Worksheet S-2	
					rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre 5/27/2022 1:4	
				Unweighted	Unweighted	Ratio (col.	
				FTEs Nonprovider	FTEs in Hospital	1/ (col . 1 + col . 2))	
				Site	nospi tai		
				1.00	2.00	3.00	1
	Section 5504 of the ACA Base Yea			-This base yea	r is your cost	reporti ng	
~~	period that begins on or after J			0.00	0.00	0,000000	
00	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ror settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.0
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
		U U	C C	FTEs	FTEs in	3/ (col. 3 +	
				Nonprovi der	Hospi tal	col. 4))	
			0.00	Site	1.00		-
00	Enter in column 1, if line 63	1.00	2.00	3.00	4.00 0.00	5.00 0.000000	
	is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
				Nonprovi der	Hospi tal	col. 2))	
				Si te 1.00	2.00	3.00	-
	Section 5504 of the ACA Current	Year FTF Residents i	n Nonprovider Setting				
	beginning on or after July 1, 20			go Encourve			
. 00	Enter in column 1 the number of FTEs attributable to rotations c Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. Try care resident 3 the ratio of	0.00	0.00	0. 000000	66. C
		Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs	FTEs in	3/ (col. 3 +	
				Nonprovi der	Hospi tal	col. 4))	
		1.00	2.00	Si te 3.00	4.00	5.00	-
. 00	Enter in column 1, the program	1.00	2.00	0.00			67.0
	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						

	Financial Systems MEMORIAL HOSPITAL LOGANSPORT	In	Li eu	of Form	n CMS-2	2552-10
HOSPI T		eriod: rom 01/01/2 o 12/31/2	021 F	Vorkshe Part I Date/Tii	me Pre	pared:
				2.00		7 pm
70 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub		N	2.00	0.00	70.00
	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in				0	71.00
/1.00	recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teac program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for Column 3: If column 2 is Y, indicate which program year began during this cost reportin (see instructions)	no. (see hi ng no.			0	71.00
75 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	I	N			75.00
	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in	the meet	IN		0	76.00
70.00	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	78.00
				1.0	0	
	Long Term Care Hospi tal PPS					
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 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? Er	nter	N N		80.00 81.00
	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section		no.	N		85.00 86.00
87.00	<pre>\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.</pre>			Ν		87.00
		V 1.00		XI X 2. 0		
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N		Y		90.00
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in	N		Y		91.00
92.00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see			Ν		92.00
93.00	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	Ν		Ν		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		Ν		94.00
	If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N		0.0 N	0	95.00 96.00
	If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	0. 00 Y		0. 0 Y	0	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		Y		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	Y		Y		98.02
98. 03	for title V, and in column 2 for title XIX. 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	N		Ν		98.03
98.04	for title V, and in column 2 for title XIX. 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	N		Ν		98.04
98. 05	in column 2 for title XIX. 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	Y		Y		98.05
98.06	column 2 for title XIX. 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.	Y		Y		98.06
105 -	Rural Providers					
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N N				105.00 106.00
107.00	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&R	N				107.00
	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 L&Rs in an approved medical education program in the CAH's excluded LPF and/or LRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					

Health Financial Systems MEMORIAL HOSPITA	AL LOGANSPORT		In Lieu	of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		eriod: com 01/01/2021 o 12/31/2021	Worksheet S- Part I Date/Time Pr 5/27/2022 1:	repared:
			V 1.00	XI X	_
108.00 Is this a rural hospital qualifying for an exception to the	CRNA fee sche	edul e? See 42	1.00 N	2.00	108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	
	1. 00	2.00	Speech 3.00	4.00	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
110 00 Did this bestitel sectoristic the Dural Community Harrist	- Demonstrasti	an and ant (SA	104	1.00 N	110.00
110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no. I	f yes,	N	110.00
			1.00	2.00	_
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.	ost reporting olumn 1 is Y, rticipating ir	period? Enter enter the column 2.	N		111.00
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Hea demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 i in column 2, the date the hospital began participating in t demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable.	period? s "Y", enter he	N			112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes o	r "N" for no	N			0115.00
in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1.	B, or E only) 93" percent (includes				
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.00
117.00 Is this facility legally-required to carry malpractice insu	rance? Enter	Y			117.00
"Y" for yes or "N" for no. 118.00 is the malpractice insurance a claims-made or occurrence po if the policy is claim-made. Enter 2 if the policy is occur		1			118.00
		Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	3.00	0118.01
		020,000	-		
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein.			1.00 N	2.00	118.02
119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.	n column 1, "\ ualifies for t	(" for yes or he Outpatient	Ν	Y	119.00 120.00
121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.	antable device	es charged to	Y		121.00
122.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.			Ν		122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f	or yes and "N"	for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, e	nter the certi	fication date			126.00
in column 1 and termination date, if applicable, in column	2.				
127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column	2.				127.00
128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column	2.				128.00
129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2.	er the certifi	cation date in			129.00

SPITAL AND HOSPITAL HEALTH CARE COMPLE		TAL LOGANSPORT Provider CC	N: 15-0072	Peri od:	:	u of Form CMS Worksheet S-	
				From O	1/01/2021 2/31/2021	Part I Date/Time Pr 5/27/2022 1:	repared
					1.00	2.00	-
0.00 f this is a Medicare certified pa	increas transplant center	r, enter the cer	tification		1.00	2.00	130.
date in column 1 and termination of 1.00	itestinal transplant cen	ter, enter the ce	erti fi cati d	n			131.
date in column 1 and termination of 2.00			cation dat	e			132.
in column 1 and termination date,	if applicable, in column	n 2.					100
 3. 00 Removed and reserved 4. 00 If this is an organ procurement or and termination date, if applicabl All Providers 		the OPO number i	n column 1				133. 134.
40.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, N chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs							140.
are claimed, enter in column 2 the 1.00		<u>er. (see Enstruc</u> .00	tions)		3.00		
If this facility is part of a chai	n organization, enter o	n lines 141 thro	ugh 143 the	e name an		of the home	
office and enter the home office of	contractor name and cont Contractor's Name:	ractor number.	Control	ctor's Nu	mbor		111
1.00Name: 2.00Street:	PO Box:		Contrac	Stor S Nu			141.
3. 00 Ci ty:	State:		Zip Coo	de:			143.
						1.00	-
4.00 Are provider based physicians' cos	sts included in Workshee	t A?				Y	144.
					1.00	2.00	_
5.00 f costs for renal services are cl	aimed on Wkst. A. Line	74, are the costs	s for		1.00	2.00	145.
inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N" 5.00 Has the cost allocation methodolog	lude Medicare utilization for no in column 2. Ny changed from the previ	on for this cost iously filed cos [:]	reporting t report?		N		146.
Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/c		. 15-2, chapter 4	40, §4020)	IT			
						1 00	_
		r ves or "N" for	no.			1.00 N	147.
7.00Was there a change in the statisti 3.00Was there a change in the order of	cal basis? Enter "Y" for allocation? Enter "Y" f	for yes or "N" fo	or no.	°or no.			148.
7.00Was there a change in the statisti 3.00Was there a change in the order of	cal basis? Enter "Y" for allocation? Enter "Y" f	for yes or "N" fo Enter "Y" for ye Part A	or no. es or "N" f Part B		itle V	N N Title XIX	148.
7.00Was there a change in the statisti 3.00Was there a change in the order of 9.00Was there a change to the simplifi	cal basis? Enter "Y" for allocation? Enter "Y" f ed cost finding method?	for yes or "N" for Enter "Y" for ye Part A 1.00	or no. es or "N" f Part B 2.00	Т	3.00	N N Title XIX 4.00	148.
7.00Was there a change in the statisti 8.00Was there a change in the order of	cal basis? Enter "Y" for allocation? Enter "Y" f ed cost finding method? der that qualifies for	for yes or "N" for Enter "Y" for ye Part A 1.00 an exemption from	or no. es or "N" f Part B 2.00 m the appli	cation c	3.00 of the low	N N Title XIX 4.00 er of costs	148
2.00 Was there a change in the statisti 3.00 Was there a change in the order of 3.00 Was there a change to the simplific Does this facility contain a provior or charges? Enter "Y" for yes or ' 5.00 Hospital	cal basis? Enter "Y" for allocation? Enter "Y" f ed cost finding method? der that qualifies for	for yes or "N" for Enter "Y" for ye Part A 1.00 an exemption fro ponent for Part A N	or no. es or "N" f Part B 2.00 m the appli and Part D N	cation c	3.00 of the low 2 CFR §41 N	N N Title XIX 4.00 er of costs 3.13) N	148. 149. 155.
7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplific Does this facility contain a provior or charges? Enter "Y" for yes or ' 5.00 Hospital 5.00 Subprovider - IPF	cal basis? Enter "Y" for allocation? Enter "Y" f ed cost finding method? der that qualifies for	for yes or "N" for Enter "Y" for ye Part A 1.00 an exemption fro onent for Part A N N	or no. es or "N" f Part B 2.00 m the appli and Part I N N	cation c	3.00 of the low 12 CFR §41 N N	N N Title XIX 4.00 er of costs 3.13) N	148. 149. 149. 155. 156.
7.00Was there a change in the statisti 8.00Was there a change in the order of 9.00Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or ' 5.00Hospital 5.00Subprovider - IPF 7.00Subprovider - IRF	cal basis? Enter "Y" for allocation? Enter "Y" f ed cost finding method? der that qualifies for	for yes or "N" for Enter "Y" for ye Part A 1.00 an exemption fro ponent for Part A N	or no. es or "N" f Part B 2.00 m the appli and Part D N	cation c	3.00 of the low 2 CFR §41 N	N N Title XIX 4.00 er of costs 3.13) N	148 149 155 155 156 157
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2.00 Was there a change in the statisti 3.00 Was there a change in the order of 3.00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or " 5.00 Hospital 5.00 Subprovider - IPF 5.00 Subprovider - IRF 5.00 SUBPROVIDER 5.00 SNF 5.00 HOME HEALTH AGENCY	cal basis? Enter "Y" for allocation? Enter "Y" f ed cost finding method? der that qualifies for	for yes or "N" for Enter "Y" for yes Part A 1.00 an exemption from ionent for Part A N N N	or no. es or "N" f Part B 2.00 m the appli and Part D N N N N N	cation c	3.00 of the low I2 CFR §41 N N N N	N N Title XIX 4.00 er of costs 3.13) N N N N N	148. 149. 155. 155. 156. 157. 158. 159. 160.
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7. 00Was there a change in the statisti 8. 00Was there a change in the order of 9. 00Was there a change to the simplifi Does this facility contain a provion or charges? Enter "Y" for yes or ' 5. 00Hospital 5. 00Subprovider - IPF 7. 00Subprovider - IRF 8. 00SUBPROVIDER 9. 00SNF 0.00SNF 0.00HOME HEALTH AGENCY 1. 00CMHC Multicampus	cal basis? Enter "Y" for fallocation? Enter "Y" f ed cost finding method? der that qualifies for N" for no for each comp	for yes or "N" for Enter "Y" for yes Part A 1.00 an exemption from ionent for Part A N N N N N	or no. es or "N" f Part B 2.00 m the appli and Part I N N N N N N	T i cati on c 3. (See 4	3.00 of the low 12 CFR §41 N N N N N N	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160. 161.
7. 00Was there a change in the statisti 8. 00Was there a change in the order of 9. 00Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or ' 5. 00Hospital 5. 00Subprovider - IPF 7. 00Subprovider - IRF 8. 00SUBPROVIDER 9. 00SNF 0. 00HOME HEALTH AGENCY 1. 00CMHC Multicampus 5. 00Is this hospital part of a Multica	cal basis? Enter "Y" for fallocation? Enter "Y" f ed cost finding method? der that qualifies for N" for no for each comp	for yes or "N" for Enter "Y" for yes Part A 1.00 an exemption from ionent for Part A N N N N N	or no. es or "N" f Part B 2.00 m the appli and Part I N N N N N N	T i cati on c 3. (See 4	3.00 of the low 12 CFR §41 N N N N N N	N N Title XIX 4.00 er of costs 3.13) N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160. 161.
7. 00Was there a change in the statisti 8. 00Was there a change in the order of 9. 00Was there a change to the simplifi Does this facility contain a provion or charges? Enter "Y" for yes or ' 5. 00Hospital 5. 00Subprovider - IPF 7. 00Subprovider - IRF 8. 00SUBPROVIDER 9. 00SNF 0.00SNF 0.00HOME HEALTH AGENCY 1. 00CMHC Multicampus	cal basis? Enter "Y" for fallocation? Enter "Y" f ed cost finding method? der that qualifies for N" for no for each comp	for yes or "N" for Enter "Y" for yes Part A 1.00 an exemption from ionent for Part A N N N N N	or no. es or "N" f Part B 2.00 m the appli and Part I N N N N N N N N N N N	T i cati on c 3. (See 4	3.00 of the low 12 CFR §41 N N N N N N	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160. 161.
.00 Was there a change in the statisti .00 Was there a change in the order of .00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or ' .00 Hospital .00 Subprovider - IPF .00 Subprovider - IRF .00 SUBPROVIDER .00 SUBPROVIDER .00 HOME HEALTH AGENCY .00 CMHC Multicampus .00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	cal basis? Enter "Y" for fallocation? Enter "Y" f ed cost finding method? der that qualifies for N" for no for each comp mpus hospital that has o	for yes or "N" for Enter "Y" for ye Part A 1.00 an exemption fro nonent for Part A N N N N N N N N	or no. es or "N" f Part B 2.00 m the appli and Part I N N N N N N N N N N N	T i cati on c 3. (See 4	3.00 of the low 12 CFR §41 N N N N N BSAS?	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N T.00 FTE/Campus 5.00	148 149 155 156 157 158 159 160 161 165 165
 2.00 Was there a change in the statisti 3.00 Was there a change in the order of 00 Was there a change to the simplifi Does this facility contain a provior charges? Enter "Y" for yes or '5.00 Hospital 0.00 Subprovider - IPF 0.00 Subprovider - IRF 3.00 SUBPROVIDER 0.00 SNF 0.00 HOME HEALTH AGENCY 0.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	cal basis? Enter "Y" for fallocation? Enter "Y" for ed cost finding method? der that qualifies for N" for no for each comp mpus hospital that has on Name	for yes or "N" for Enter "Y" for yes Part A 1.00 an exemption from ionent for Part A N N N N N N N N N N N N N	or no. es or "N" f Part B 2.00 m the appli and Part I N N N N N N N N N N N N N	T i cati on c 3. (See 4 ferent C Zi p Code	3.00 of the low 12 CFR §41 N N N N N BSAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N T.00 FTE/Campus 5.00	148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
2.00 Was there a change in the statisti 3.00 Was there a change in the order of 5.00 Was there a change to the simplifi Does this facility contain a provion or charges? Enter "Y" for yes or ' 5.00 Hospital 5.00 Subprovider - IPF 7.00 Subprovider - IPF 7.00 SUBPROVIDER 5.00 SUBPROVIDER 5.00 SUBPROVIDER 5.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 5.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	cal basis? Enter "Y" for fallocation? Enter "Y" for ed cost finding method? der that qualifies for N" for no for each comp mpus hospital that has on Name	for yes or "N" for Enter "Y" for yes Part A 1.00 an exemption from ionent for Part A N N N N N N N N N N N N N	or no. es or "N" f Part B 2.00 m the appli and Part I N N N N N N N N N N N N N	T i cati on c 3. (See 4 ferent C Zi p Code	3.00 of the low 12 CFR §41 N N N N N BSAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N S C O O.C	148. 149. 155. 156. 157. 158. 159. 160. 161. 165.
2.00 Was there a change in the statisti 3.00 Was there a change in the order of 5.00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or ' 5.00 Hospital 5.00 Subprovider - IPF 5.00 Subprovider - IRF 5.00 SUBPROVIDER 5.00 SUBPROVIDER 5.00 HOME HEALTH AGENCY 5.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 5.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for N" for no for each comp mpus hospital that has on Name 0 0 0 0 0 0 0 0 0 0 0 0 0	for yes or "N" for Enter "Y" for yes Part A 1.00 an exemption from ionent for Part A N N N N N N N N N N N N N	or no. es or "N" f Part B 2.00 m the appli and Part I N N N N N N N N N N N N N	T Cation c 3. (See 4 Ferent C Zip Code 3.00	3.00 of the low 12 CFR §41 N N N N N BSAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 00 166.
2. 00 Was there a change in the statisti 3. 00 Was there a change in the order of 5. 00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or ' 5. 00 Hospital 0. 00 Subprovider - 1PF 0. 00 Subprovider - 1RF 0. 00 SUBPROVIDER 0. 00 SNF 0. 00 HOME HEALTH AGENCY . 00 CMHC Multicampus 0. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for N" for no for each comp impus hospital that has or Name 0 0 0 0 0 0 0 0 0 0 0 0 0	for yes or "N" for Enter "Y" for yes Part A 1.00 an exemption from in connent for Part A N N N N N N N N N N N N N	or no. es or "N" f Part B 2.00 m the appli and Part I N N N N N N N N N N N N N	T Cation c 3. (See 4 Cation c 3. (See 4 Cation c Cation c	3.00 of the low 12 CFR §41 N N N N N BSAS? CBSA 4.00	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N S C O O.C	148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 00 166.
 7. 00 Was there a change in the statisti 3. 00 Was there a change in the order of 9. 00 Was there a change to the simplifi Does this facility contain a provior charges? Enter "Y" for yes or " 5. 00 Hospital 6. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 0. 00 HOME HEALTH AGENCY 1. 00 CMHC Multicampus 5. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 	cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for N" for no for each comp impus hospital that has on Name 0 0 0 0 0 0 0 0 0 0 0 0 0	for yes or "N" for Enter "Y" for yes Part A 1.00 an exemption from onent for Part A N N N N N N N N N N N N N	or no. es or "N" f Part B 2.00 m the appli and Part I N N N N N N N N N N N N N	T Cation c 3. (See 4 Cation c 3. (See 4 Cation c Cation c	3.00 of the low 12 CFR §41 N N N N N BSAS? CBSA 4.00	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 165. 00 166.
7. 00 Was there a change in the statisti 8. 00 Was there a change in the order of 9. 00 Was there a change to the simplifi Does this facility contain a provion or charges? Enter "Y" for yes or ' 5. 00 Hospital 5. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 9. 00 SNF 9. 00 HOME HEALTH AGENCY 1. 00 CMHC Multicampus 5. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 7. 00 Is this provider a meaningful user 8. 00 If this provider is a CAH (line 10)	cal basis? Enter "Y" for fallocation? Enter "Y" for ed cost finding method? der that qualifies for N" for no for each comp mpus hospital that has on Name 0 0 0 0 0 0 0 0 0 0 0 0 0	for yes or "N" for Enter "Y" for yes Part A 1.00 an exemption fro ionent for Part A N N N N N N N N N N N N N	or no. es or "N" f Part B 2.00 m the appli and Part I N N N N N N N N N N N N N	T ication c 3. (See 4 Ferent C Zip Code 3. 00	3.00 of the low 12 CFR §41 N N N N BSAs? CBSA 4.00 r the	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 00 166.

Health Financial Systems	MEMORIAL HOSPITAL	LOGANSPORT	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA			Worksheet S-2 Part I	
			To 12/31/2021	Date/Time Pre 5/27/2022 1:4	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR begin period respectively (mm/dd/yyyy)	nning date and ending da	te for the reporting			170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provide	er have any days for indi	viduals enrolled in	N	0	171.00
section 1876 Medicare cost plans repo	orted on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column	1. If column 1 is yes, e	nter the number of sectio	n		
1876 Medicare days in column 2. (see	instructions)				

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet S- Part II Date/Time Pr 5/27/2022 1:	epared
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	lforall NO r	esponses. En	ter all dates in	the	
	COMPLETED BY ALL HOSPITALS					_
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	e heainning of	the cost	N		1.0
. 00	reporting period? If yes, enter the date of the change in o					1.
		•	Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	N			2.0
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe relationships? (see instructions)	offices, drug der or its of the board	N			3. (
			Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	°or Compiled,	Y	A		4. (
. 00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5. (
				Y/N	Legal Oper.	_
	Approved Educational Activities			1.00	2.00	_
. 00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2. If yes i	s the provid	er N		6.0
. 00	is the legal operator of the program?	2. 11 yes, 1	s the provide			0.
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve	he N		7. (8. (
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	graduate medi	cal educatio	n N		9.0
0.00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated c	is.		N		10. (
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	Ν		11.
					Y/N 1.00	
2 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	S SPP instruc	tions		Y	12.0
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	N	13.0
4.00		ents waived? I	fyes, see i	nstructions.	N	14.0
5 00	Bed Complement Did total beds available change from the prior cost reporti	ng portod2 lf	NOS COO LO	structions	N	15.
5.00	The form beds available change from the piron cost report	<u> </u>	t A		t B	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	Y	03/22/2022	Y Y	03/22/2022	16.
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Ν		Ν		17.
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19.

Health Financial Systems	3
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MEMORIAL HOSPITAL LOGANSPORT

In Lieu of Form CMS-2552-10

	FINANCIAL Systems MEMORIAL HUSPI			III LIE	u or Form CM3-	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CO	CN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre 5/27/2022 1:4	epared:
		Descri	ption	Y/N	Y/N	
		(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	Ν	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS	HOSPI TALS)			
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	e due to apprais	sals made dur	ing the cost	Ν	23.00
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during	this cost re	porting period?	Ν	24.00
25.00	Have there been new capitalized leases entered into during instructions.	Ν	25.00			
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	the cost reporti	ng period? I	f yes, see	Ν	26.00
27.00	Has the provider's capitalization policy changed during the copy.	ne cost reportin	ng period? If	yes, submit	Ν	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	Ν	28.00			
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst	eserve Fund)	Ν	29.00		
30.00	Has existing debt been replaced prior to its scheduled mat instructions.		debt? If yes	, see	Ν	30.00
31.00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? If yes	, see	Ν	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se	ervices furnishe	ed through co	ntractual	N	32.00
	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap	ructions.				33.00
55.00	no, see instructions.			tive bruuring: Ti	IN	33.00
24 00	Provider-Based Physicians Are services furnished at the provider facility under an a	rrangement with	n nrovi dor ha	cod physicians?	N	34.00
	If yes, see instructions.	0				
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		N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs Were home office costs claimed on the cost report?			N		24 00
	Were nome office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	roparod by the	homo offica?	N N		36.00
37.00	If yes, see instructions.	biepared by the	nome office:	IN		37.00
38.00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year er	fice different d of the home of	from that of	N		38.00
39.00	If line 36 is yes, did the provider render services to oth see instructions.			, N		39.00
40.00	If line 36 is yes, did the provider render services to the instructions.	e home office?	lf yes, see	Ν		40.00
		1.	00	2.	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
	respectivel y.					
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LL	С			42.00
43.00	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

Heal th	Financial Systems	MEMORIAL HOSPITA	L LOGANSPOR	Т		In Lieu	u of Form CMS-2	2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 15-0072		i od:	Worksheet S-2	
					Froi To	m 01/01/2021 12/31/2021	Part II Date/Time Pre	nared
					10	12/ 51/ 2021	5/27/2022 1:4	
				3.00				
	Cost Report Preparer Contact Information							
	Enter the first name, last name and the t		I RECTOR					41.00
	held by the cost report preparer in column	ns 1, 2, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the cost	st report						42.00
	preparer.							
	Enter the telephone number and email addre							43.00
	report preparer in columns 1 and 2, respe-	ctively.						

	Financial Systems M AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	EMORIAL HOSPITA	Provi der C	CN: 15 0072	Peri od:	u of Form CMS-2 Worksheet S-3	
IUSPI I	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider Co	CN. 15-0072	From 01/01/2021	Part I	
					To 12/31/2021	Date/Time Pre 5/27/2022 1:4	
						I/P Days /	
						0/P Visits /	
						Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	32	11, 68	30 0. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						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, 6	0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	5	1, 8:	25 0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00 13.00	OTHER SPECIAL CARE (SPECIFY) NURSERY	43.00				0	12.00 13.00
14.00	Total (see instructions)	43.00	37	13, 50	0. 00		13.00
15.00	CAH visits		57	13, 50	0.00	0	15.00
16.00	SUBPROVIDER - IPF					0	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
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	EXPRESS MEDI CAL CENTER	88.00				0	26.00
26.01	FAMILY HEALTH CARE	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00	37			0	26.25 27.00
27.00	Total (sum of lines 14-26)		37			0	
28.00 29.00	Observation Bed Days Ambulance Trips						28.00 29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days (see first detron)						31.00
32.00	Labor & delivery days (see instructions)		5	1, 8	25		32.00
32.00	Total ancillary labor & delivery room		0	1, 0.			32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33 01	LTCH site neutral days and discharges						33.01

HOSPI	Financial Systems M AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0072	In Lie Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part I Date/Time Pre 5/27/2022 1:4	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	1, 395	276	4, 22	20		1.00
2.00	for the portion of LDP room available beds) HMO and other (see instructions)	644	1, 733				2.00
3.00 4.00	HMO IPF Subprovider HMO IRF Subprovider	0	0				3.00
4.00 5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0		0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 395	276	4, 22	20		7.00
8.00	INTENSIVE CARE UNIT	192	0	60	2		8.00
9.00	CORONARY CARE UNIT						9.0
0.00	BURN I NTENSI VE CARE UNI T						10.0
11.00 12.00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECIAL CARE (SPECI FY)						11.0
12.00	NURSERY		0	98	2		12.0
14.00	Total (see instructions)	1, 587	276	5, 80	-	579.83	
15.00	CAH vi si ts	1, 307	2,0	5, 60	0.00	577.05	15.0
6.00	SUBPROVIDER - IPF	J.	Ű		0		16.0
7.00	SUBPROVIDER - IRF						17.0
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY						22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00 4.10	HOSPICE HOSPICE (non-distinct part)				0		24.0
25.00	CMHC - CMHC				0		24.1
26.00	EXPRESS MEDICAL CENTER	0	0		0 0.00	0.00	
26.01	FAMILY HEALTH CARE	0	0		0 0.00		
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
27.00	Total (sum of lines 14-26)				0.00	579.83	27.0
28.00	Observation Bed Days		9	60	00		28.0
29.00	Ambulance Trips	0					29.0
30.00	Employee discount days (see instruction)				0		30.0
31.00	Employee discount days - IRF				0		31.0
32.00	Labor & delivery days (see instructions)	0	10	56			32.0
32.01	Total ancillary labor & delivery room outpatient days (see instructions)				0		32.0
33.00	LTCH non-covered days	0					33.0
	LTCH site neutral days and discharges	0					33.0

	Financial Systems M AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	EMORIAL HOSPITAL AL DATA	Provi der C	CN: 15-0072	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2021	Part I	
					To 12/31/2021	Date/Time Pre 5/27/2022 1:4	
		Full Time		Di s	charges		
	Company	Equi val ents	T: +1 - 1/	Title XVIII	Title XIX	Total All	
	Component	Nonpai d Workers	Title V			Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	44	42 61	1, 421	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2.00	for the portion of LDP room available beds) HMO and other (see instructions)			1.	412		2.00
3.00	HMO I PF Subprovi der				412		3.00
4.00	HMO I RF Subprovi der				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 11.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0, 00	0	4	12 61	1, 421	14.00
15.00	CAH visits						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 21.00	NURSING FACILITY OTHER LONG TERM CARE						20.00
21.00	HOME HEALTH AGENCY						21.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	EXPRESS MEDICAL CENTER	0.00					26.00
26.01	FAMILY HEALTH CARE	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 28.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days Ambulance Trips						28.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days (see first detroit)						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

SPI T	AL WAGE INDEX INFORMATION			Provider C	CN: 15-0072	Period: From 01/01/2021	Worksheet S-3 Part II	
						To 12/31/2021		par
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	A-6) 3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
00	Total salaries (see instructions)	200.00	42, 171, 203	-262, 623	41, 908, 580	0 1, 194, 231. 00	35.09	1
00	Non-physician anesthetist Part A		0	0	(0.00	0.00	
00	Non-physician anesthetist Part B		0	0	(0.00	0.00	:
00	- Physician-Part A - Administrative		358, 029	0	358, 029	7 1, 743. 00	205. 41	'
01 00	Physicians - Part A - Teaching Physician and Non Physician-Part B		0 8, 733, 544	0	(8, 733, 54	0 0. 00 4 62, 911. 00		
00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	(0.00	0.00	0
00	Interns & residents (in an approved program)	21.00	0	0	(0.00	0.00	
01	Contracted interns and residents (in an approved programs)		0	0	(0.00	0.00	
00	Home office and/or related organization personnel		0	0	(0.00	0.00	
00 . 00	SNF Excluded area salaries (see instructions)	44.00	0 7, 585, 712	0 -39, 152	(7, 546, 56	0.00 0 170,297.00		
00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		5, 257, 125	0	5, 257, 12	5 59, 972. 00	87.66	1
00	Care Contract Labor: Top Level management and other management and administrative		0	0		0.00	0.00	1:
00	services Contract Labor: Physician-Part		69, 131	0	69, 13 ⁻	1 788.00	87. 73	1
00	A - Administrative Home office and/or related organization salaries and		0	0	(0.00	0. 00	1
	wage-related costs Home office salaries		0	0	(0.00		
02 00	Related organization salaries Home office: Physician Part A		0 0	0		0.00 0.00		
00	- Administrative Home office and Contract		0	0	(0.00	0.00	1
01	Physicians Part A - Teaching Home office Physicians Part A - Teaching		0	0	(0.00	0.00	1
. 02	Home office contract Physicians Part A - Teaching		0	0	(0.00	0.00	1
00	WAGE-RELATED COSTS Wage-related costs (core) (see		10, 339, 554	0	10, 339, 55	4		1
00	instructions) Wage-related costs (other)							1
00 00	(see instructions) Excluded areas Non-physician anesthetist Part		1, 938, 091 0	0	1, 938, 09 [.] (1		1 2
00	A Non-physician anesthetist Part		0	0	(D		2
	B Physician Part A - Administrative		26, 874	0	26, 87	4		2
00	Physician Part A - Teaching Physician Part B		0 953, 463	0 0	953, 46) 3		2
00 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0 0	0				2 2
50	approved program) Home office wage-related		0	0	(D		2
51	(core) Related organization wage related (core)		0	0	(2
. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	0		D		2

ealth Financial Systems	IVI	ENUKIAL HUSPII	AL LOGANSPORT			u of Form CMS-2	
IOSPITAL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part II Date/Time Pre 5/27/2022 1:4	pared
	Wkst. A Line	Amount	Recl assi fi cat		Paid Hours	Average	
	Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
			Sal ari es	(col.2 ± col.		(col. 4 ÷	
			(from Wkst. A-6)	3)	col. 4	col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.53 Home office: Physicians Part A		0	0		0		25.5
- Teaching - wage-related							
(core)							
OVERHEAD COSTS - DIRECT SALARI			1		-		
26.00 Employee Benefits Department	4.00	335, 448		000711			
7.00 Administrative & General	5.00	4, 112, 081					
8.00 Administrative & General under	-	444, 530	0	444, 53	0 1, 869. 00	237.84	28.
contract (see inst.)							
9.00 Maintenance & Repairs	6.00	0	Ŭ		0 0.00		
30.00 Operation of Plant	7.00	796, 827	0	796, 82			
1.00 Laundry & Linen Service	8.00	0	0		0.00		
2.00 Housekeepi ng	9.00	655, 062	-5, 796	649, 26	6 38, 315. 00	16. 95	
3.00 Housekeeping under contract (see instructions)		0	0		0 0.00	0.00	33.
4.00 Dietary	10.00	418, 318	-345, 873	72, 44	5 5, 316. 00	13.63	34.
5.00 Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.
6.00 Cafeteria	11.00	0	341, 264	341, 26	4 23, 701. 00	14.40	36.
7.00 Maintenance of Personnel	12.00	0	0		0.00	0.00	37.
8.00 Nursing Administration	13.00	890, 426	0	890, 42	6 24, 034. 00	37.05	38.
9.00 Central Services and Supply	14.00	295, 175	0	295, 17	5 16, 782. 00	17.59	39.
0.00 Pharmacy	15.00	688, 010	0	688, 01	0 17, 325. 00	39. 71	40.
1.00 Medi cal Records & Medi cal Records Li brary	16.00	1, 998, 619	-3, 294	1, 995, 32	5 81, 123. 00	24.60	41.
2.00 Social Service	17.00	138, 284	0	138, 28	4 4, 016. 00	34.43	42.
3.00 Other General Service	18.00	0			0.00		

Health Financial Systems MEMORIAL HOSPITAL LOGANSPORT In Lieu o							u of Form CMS-2	2552-10
HOSPI 1	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part III Date/Time Pre 5/27/2022 1:4	pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid 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		33, 882, 189	-262, 623	33, 619, 56	6 1, 133, 189. 00	29.67	1.00
	instructions)							
2.00	Excluded area salaries (see		7, 585, 712	-39, 152	7, 546, 56	0 170, 297. 00	44.31	2.00
	instructions)							
3.00	Subtotal salaries (line 1		26, 296, 477	-223, 471	26, 073, 00	6 962, 892. 00	27.08	3.00
	minus line 2)							
4.00	Subtotal other wages & related		5, 326, 256	0	5, 326, 25	6 60, 760. 00	87.66	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		10, 366, 428	0	10, 366, 42	8 0.00	39. 76	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		41, 989, 161	-223, 471	41, 765, 69	0 1, 023, 652. 00	40.80	6.00
7.00	Total overhead cost (see		10, 772, 780	-32, 322	10, 740, 45	8 417, 916. 00	25.70	7.00
	instructions)							
								•

Heal th	Financial Systems MEMORIAL HOSPITAL	LOGANSPORT	In Lie	u of Form CMS-2	2552-10
	AL WAGE RELATED COSTS	Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Pre 5/27/2022 1:4	pared:
				Amount Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETI REMENT COST				
1.00	401K Employer Contributions			438, 317	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0	6.00
7.00	Employee Managed Care Program Administration Fees			0	7.00
	HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administ			0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrat	or)		9, 114, 531	8.02
8.03	Health Insurance (Purchased)			0	8.03
9.00	Prescription Drug Plan			0	
10.00	Dental, Hearing and Vision Plan			149, 737	10.00
11.00	Life Insurance (If employee is owner or beneficiary)			38, 576	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0	
13.00	Disability Insurance (If employee is owner or beneficiary)			453, 217	
14.00	Long-Term Care Insurance (If employee is owner or beneficiar	y)			14.00
15.00	'Workers' Compensation Insurance			280, 183	
16.00	Retirement Health Care Cost (Only current year, not the extr	aordinary accrual requir	ed by FASB 106.	0	16.00
	Non cumulative portion)				
	TAXES				
	FICA-Employers Portion Only			2, 721, 681	
18.00	Medicare Taxes - Employers Portion Only			0	
19.00	Unemployment Insurance			15, 144	19.00
20.00	State or Federal Unemployment Taxes			0	20.00
	OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost instructions))	Reported on lines 1 thro	ough 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances			0	22.00
23.00	Tuition Reimbursement			46, 595	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			13, 257, 981	24.00
	Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)				25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST Provider CCN: 15-0072 Period: From 01/01/2021 To 12/31/2021 Worksheet S-3 From 01/01/2021 To 12/31/2021 Cost Center Description Contract Labor Benefit Cost Date/Time Prepared: 5/27/2022 1:47 pm Mospital and Hospital -Based Component Identification: 1.00 2.00 100 Total facility's contract labor and benefit cost 5, 257, 125 13, 257, 981 1.00 1.00 Subprovider - 1PF 5, 257, 125 13, 257, 981 2.00 3.00 Subprovider - 1PF 0 0 3.00 6.00 Subprovider - 10F 0 0 0 0 6.00 Subprovider - 10F 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Heal th	Financial Systems	MEMORIAL HOSPITAL	LOGANSPORT	In Lie	u of Form CMS-2	2552-10
Cost Center Description Contract S/27/2022 1: 47 pm PART V - Contract Labor and Benefit Cost Contract Labor Benefit Cost Hospital and Hospital-Based Component I dentification: 1.00 2.00 Total facility's contract labor and benefit cost 5,257,125 13,257,981 1.00 2.00 Hospital 5,257,125 13,257,981 2.00 3.00 Subprovider - 1PF 5,257,125 13,257,981 2.00 4.00 Subprovider - 1RF 0 0 6.00 5.00 Subprovider - 00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 6.00 6.00 6.00 6.00 6.00 7.00 8.00 6.00 7.00 8.00 6.00 7.00 8.00 6.00 7.00 8.00 6.00 7.00 8.00 6.00 7.00 8.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.0	HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0072			
PART V - Contract Labor and Benefit Cost Contract Labor Benefit Cost Hospital and Hospital-Based Component Identification: 1.00 2.00 1.00 Total facility's contract labor and benefit cost 5,257,125 13,257,981 1.00 2.00 Hospital 5,257,125 13,257,981 1.00 2.00 3.00 Subprovider - IPF 5,257,125 13,257,981 2.00 3.00 Subprovider - IPF 0 0 5.00 6.00 Subprovider - (Other) 0 0 6.00 5.00 Subprovider - (Other) 0 0 6.00 6.00 Swing Beds - SNF 0 0 7.00 8.00 Hospital-Based SNF 0 0 7.00 9.00 Hospital-Based NF 0 0 10.00 10.00 Hospital-Based NF 0 0 10.00 10.00 Hospital-Based HHA 10.00 12.00 13.00 11.00 Hospital-Based Health Clinic RHC 0 0 14.01 <							
Cost Center Description Contract Labor Benefit Cost Hospital and Hospital - Based Component Identification: 1.00 2.00 Total facility's contract Labor and benefit cost 5,257,125 13,257,981 1.00 2.00 Hospital 5,257,125 13,257,981 2.00 3.00 Subprovider - IPF 5,257,125 13,257,981 2.00 4.00 Subprovider - IRF 0 0 5.00 5.00 Subprovider - (Other) 0 0 6.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Hospital - Based SNF 0 0 7.00 8.00 Hospital - Based NF 0 0 7.00 9.00 Hospital - Based NF 0 0 10.00 11.00 Hospital - Based NF 10.00 10.00 10.00 11.00 Labor 10.00 10.00 10.00 11.00 12.00 Separately Certified ASC 12.00 13.00 13.00 13.00 <t< td=""><td></td><td></td><td></td><td></td><td>10 12/31/2021</td><td></td><td></td></t<>					10 12/31/2021		
PART V - Contract Labor and Benefit Cost 1.00 2.00 Hospital and Hospital-Based Component Identification: 5,257,125 13,257,981 1.00 1.00 Subprovider - IPF 5,257,125 13,257,981 1.00 3.00 Subprovider - IPF 3.00 4.00 5,257,125 13,257,981 1.00 4.00 Subprovider - IPF 4.00 5,257,125 13,257,981 1.00 5.00 Subprovider - (Other) 0 0 5.00 5.00 5.00 5.00 5.00 5.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 7.00 8.00 9.00 6.00 7.00 8.00 9.00 8.00 9.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00		Cost Center Description		-	Contract		
PART V - Contract Labor and Benefit Cost Hospital and Hospital -Based Component Identification: 1.00 Total facility's contract labor and benefit cost 2.00 3.00 Subprovider - IPF 4.00 5.057,125 13,257,981 2.00 3.00 Subprovider - IPF 4.00 Subprovider - (Other) 6.00 Swing Beds - SNF 0 0 7.00 Swing Beds - NF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 10.00 10.01 10.02 0 0 0 0 0 0 <td< td=""><td></td><td></td><td></td><td></td><td>Labor</td><td></td><td></td></td<>					Labor		
Hospi tal and Hospi tal -Based Component I denti fi cati on: 1.00 Total facility's contract labor and benefit cost 5, 257, 125 13, 257, 981 1.00 2.00 Hospi tal 5, 257, 125 13, 257, 981 2.00 3.00 Subprovi der - I PF 5, 257, 125 13, 257, 981 2.00 4.00 Subprovi der - I RF 0 0 4.00 5.00 Subprovi der - (Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 6.00 8.00 Hospi tal -Based SNF 0 0 0 8.00 9.00 Hospi tal -Based SNF 0 0 0 10.00 10.00 Hospi tal -Based NF 10.00 11.00 10.00 11.00 12.00 11.00 Hospi tal -Based HHA 12.00 13.00 14.01 12.00 13.00 Hospi tal -Based Heal th Clinic RHC 0 0 14.01 15.00 14.00 15.00					1.00	2.00	
1.00 Total facility's contract labor and benefit cost 5, 257, 125 13, 257, 981 1.00 2.00 Hospital 5, 257, 125 13, 257, 981 2.00 3.00 Subprovider - IPF 5, 257, 125 13, 257, 981 3.00 4.00 Subprovider - IRF 0 0 3.00 5.00 Subprovider - (Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 0 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital -Based SNF 0 0 7.00 9.00 Hospital -Based NF 0 0 9.00 10.00 Hospital -Based OLTC 10.00 10.00 10.00 11.00 Hospital -Based HHA 12.00 13.00 12.00 12.00 Hospital -Based Heal th Clinic RHC 0 0 14.00 14.01 Hospital -Based Heal th Clinic RHC 0 0 14.00 14.01 Hospital -Based Heal th Clinic RHC 0 0 14.00 15.00 Hospital -Based Heal th Clinic FQHC 0		PART V - Contract Labor and Benefit Cost					
2.00 Hospi tal 5, 257, 125 13, 257, 981 2.00 3.00 Subprovi der - IPF 3.00 4.00 Subprovi der - IRF 4.00 5.00 Subprovi der - (Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospi tal -Based SNF 0 0 7.00 9.00 Hospi tal -Based NF 0 0 7.00 8.00 Hospi tal -Based NF 0 0 10.00 11.00 Hospi tal -Based HAA 11.00 10.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.0		Hospital and Hospital-Based Component Iden	ti fi cati on:				
3.00 Subprovi der - IPF 3.00 4.00 Subprovi der - IRF 4.00 5.00 Subprovi der - (Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 6.00 0 7.00 8.00 Hospi tal -Based SNF 0 0 7.00 8.00 9.00 8.00 9.00 8.00 9.00 8.00 9.00 9.00 10.00 9.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 <td>1.00</td> <td>Total facility's contract labor and benefi</td> <td>t cost</td> <td></td> <td>5, 257, 125</td> <td>13, 257, 981</td> <td>1.00</td>	1.00	Total facility's contract labor and benefi	t cost		5, 257, 125	13, 257, 981	1.00
4.00 Subprovider - 1RF 4.00 5.00 Subprovider - (Other) 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 6.00 8.00 Hospi tal -Based SNF 0 0 7.00 8.00 Hospi tal -Based NF 0 0 7.00 9.00 Hospi tal -Based OLTC 10.00 10.00 10.00 10.00 10.00 11.00 12.00 Separatel y Certi fied ASC 12.00 13.00 14.02 13.00 14.00 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 <td>2.00</td> <td></td> <td></td> <td></td> <td>5, 257, 125</td> <td>13, 257, 981</td> <td>2.00</td>	2.00				5, 257, 125	13, 257, 981	2.00
5.00 Subprovider - (Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital -Based SNF 0 0 7.00 9.00 Hospital -Based NF 9.00 9.00 10.00 Hospital -Based OLTC 10.00 10.00 11.00 Hospital -Based HHA 11.00 12.00 Separatel y Certified ASC 12.00 13.00 Hospital -Based Heal th Clinic RHC 0 0 14.00 14.01 Hospital -Based Heal th Clinic RHC 1 0 0 14.00 14.01 Hospital -Based Heal th Clinic RHC 1 0 0 14.01 15.00 Hospital -Based Heal th Clinic RHC 1 0 0 14.01 15.00 Hospital -Based -CMHC 15.00 15.00 16.00 17.00 17.00 Renal Dial ysis 17.00 17.00 17.00 17.00							3.00
6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital -Based SNF 0 0 7.00 9.00 Hospital -Based NF 9.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 11.00 12.00 Separatel y Certified ASC 12.00 13.00 Hospital -Based Heal 11.00 12.00 13.00 0 0 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 16.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.0							
7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital -Based SNF 8.00 9.00 Hospital -Based NF 9.00 10.00 Hospital -Based OLTC 10.00 11.00 Hospital -Based HHA 11.00 12.00 Separately Certified ASC 12.00 13.00 Hospital -Based Heal th Clinic RHC 0 14.00 Hospital -Based Heal th Clinic RHC 0 14.01 Hospital -Based Heal th Clinic RHC 1 0 15.00 Hospital -Based Heal th Clinic FQHC 15.00 16.00 Hospital -Based-CMHC 16.00 17.00 Renal Dialysis 17.00					0	0	
8.00 Hospital -Based SNF 8.00 9.00 Hospital -Based NF 9.00 10.00 Hospital -Based OLTC 10.00 11.00 Hospital -Based HHA 11.00 12.00 Separately Certified ASC 12.00 13.00 Hospital -Based Heal th Clinic RHC 0 14.00 Hospital -Based Heal th Clinic RHC 0 14.01 Hospital -Based Heal th Clinic RHC 1 0 15.00 Hospital -Based -CMHC 15.00 17.00 Renal Dialysis 17.00					0	0	
9.00 Hospital -Based NF 9.00 10.00 Hospital -Based OLTC 10.00 11.00 Hospital -Based HHA 11.00 12.00 Separatel y Certified ASC 12.00 13.00 Hospital -Based Heal th Clinic RHC 0 14.01 Hospital -Based Heal th Clinic RHC 1 0 15.00 Hospital -Based Heal th Clinic FQHC 15.00 16.00 Hospital -Based-CMHC 16.00 17.00 Renal Dial ysis 17.00	7.00				0	0	7.00
10.00 Hospital - Based OLTC 10.00 11.00 Hospital - Based HHA 11.00 12.00 Separatel y Certi fied ASC 12.00 13.00 Hospital - Based Hospice 13.00 14.00 Hospital - Based Heal th Clinic RHC 0 0 14.01 Hospital - Based Heal th Clinic RHC 1 0 0 15.00 Hospital - Based Heal th Clinic FQHC 15.00 16.00 17.00 Renal Dial ysis 17.00 17.00							
11.00 Hospital - Based HHA 11.00 12.00 Separatel y Certified ASC 12.00 13.00 Hospital - Based Hospice 13.00 14.00 Hospital - Based Heal th Clinic RHC 0 0 14.01 Hospital - Based Heal th Clinic RHC 1 0 0 15.00 Hospital - Based - Meal th Clinic FQHC 15.00 16.00 17.00 Renal Dial ysis 17.00 17.00							
12.00 Separately Certified ASC 12.00 13.00 Hospital-Based Hospice 13.00 14.00 Hospital-Based Health Clinic RHC 0 0 14.00 14.01 Hospital-Based Health Clinic RHC 1 0 0 14.01 15.00 Hospital-Based Health Clinic FDHC 0 0 14.01 16.00 Hospital-Based-CMHC 15.00 16.00 17.00							
13.00 Hospi tal -Based Hospi ce 13.00 14.00 Hospi tal -Based Heal th Clinic RHC 0 0 14.00 14.01 Hospi tal -Based Heal th Clinic RHC 1 0 0 14.01 15.00 Hospi tal -Based Heal th Clinic FQHC 0 0 14.01 16.00 Hospi tal -Based-CMHC 16.00 17.00 17.00							
14.00Hospital -Based Health Clinic RHC0014.0014.01Hospital -Based Health Clinic RHC 10014.0115.00Hospital -Based Health Clinic FQHC15.0015.0016.00Hospital -Based-CMHC16.0017.00							
14. 01Hospital -Based Health Clinic RHC 1014. 0115. 00Hospital -Based Health Clinic FQHC15. 0016. 00Hospital -Based-CMHC16. 0017. 00Renal Dialysis17. 00							
15.00 Hospital-Based Health Clinic FQHC 15.00 16.00 Hospital-Based-CMHC 16.00 17.00 Renal Dialysis 17.00					0	-	
16.00 Hospital-Based-CMHC 16.00 17.00 Renal Dialysis 17.00					0	0	
17.00 Renal Dialysis 17.00							
18.00 Other 0 0 18.00		3					
	18.00	Other			0	0	18.00

Heal th	Financial Systems M	IEMORIAL HOSPI	TAL LOGANSPORT		In Lie	eu of Form CMS-	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period: From 01/01/2021	Worksheet S-8	3
			Component		To 12/31/2021		
					RHC I	Cost	
					1	. 00	
1 00	Clinic Address and Identification					<u></u>	1 00
1.00	Street		Ci	ty	3400 E MARKET State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		LOGANSPORT		11	46947	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for ru	ral or "U" for	urban		1.00	3.00
	<i></i>				Award	Date	
				1	. 00	2.00	
4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)		1		1	4.00
4.00 5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6.00	Health Services for the Homeless (Section 34)				6.00
7.00	Appalachian Regional Commission						7.00
8.00 9.00	Look-Alikes OTHER (SPECIFY)						8.00 9.00
9.00	UTILK (SFECITT)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h				N	0	10.00
	yes or "N" for no in column 1. If yes, indica 2.(Enter in subscripts of line 11 the type o						
	hours.)	i otnor oporta	eron(o) and the	oporating			
			nday		nday	Tuesday	
		from 1.00	to 2.00	from 3.00	to 4.00	from 5.00	
	Facility hours of operations (1)	1.00	2.00	5.00	4.00	5.00	
11.00		12:00	18: 00	08: 30	19: 00	08: 30	11.00
					1.00	0.00	
12.00	Have you received an approval for an exception	on to the pro	ductivity stand	ard?	1.00	2.00	12.00
	Is this a consolidated cost report as define				N	0	13.00
	30.8? Enter "Y" for yes or "N" for no in col						
	number of providers included in this report. numbers below.	List the name	es of all provi	ders and			
				Provid	ler name	CCN number	
				1	. 00	2.00	
14.00	RHC/FQHC name, CCN number	Y/N	V	XVIII	VIV		14.00
		1. 00	2.00	3.00	XI X 4.00	Total Visits 5.00	
15.00	Have you provided all or substantially all		2.00	0.00	1.00	0.00	15.00
	GME cost? Enter "Y" for yes or "N" for no in						
	column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)		Col	l Inty		<u> </u>	
			4.	00			
2.00	City, State, ZIP Code, County	. .	CASS				2.00
		Tuesday		esday to		rsday to	
		to 6.00	from 7.00	to 8.00	<u>from</u> 9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19: 00	08: 30	19:00	08: 30	19:00	11.00

Health Financial Systems	MEMORIAL HOSPIT	AL LOGANSPORT		In Lieu	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-0072	Period: From 01/01/2021	Worksheet S-8	
		Component	CCN: 15-8561		Date/Time Pre 5/27/2022 1:4	
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)			_			
11. 00 CLINIC	08: 30	19: 00	10: 00	18: 00		11.00

Heal th	Financial Systems M	IEMORIAL HOSPIT	AL LOGANSPORT		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	
			Component		From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 1:4	
					RHC II	Cost	
					1.	00	
	Clinic Address and Identification						1.00
1.00	Street		Ci	ty		01 MICHIGAN AVE State ZIP Code	
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		LOGANSPORT		IN	46947	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for	urban		0	3.00
					Award	Date	
	Source of Federal Funds			1	. 00	2.00	
4.00 5.00 6.00 7.00 8.00 9.00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A Health Services for the Homeless (Section 34 Appalachian Regional Commission Look-Alikes OTHER (SPECIFY)	ct)			1		4.00 5.00 6.00 7.00 8.00 9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h yes or "N" for no in column 1. If yes, indic. 2. (Enter in subscripts of line 11 the type o hours.)	ate number of	other operatio	ns in column	N		10.00
			nday		nday	Tuesday	
		from 1.00	to 2.00	from 3.00	4.00	from 5.00	
	Facility hours of operations (1)	1.00	2.00	5.00	4.00	5.00	
11.00	CLINIC	12: 00	18: 00	08: 30	19: 00	08: 30	11.00
					1.00	2.00	
	Have you received an approval for an excepting Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colu number of providers included in this report. numbers below.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N		12.00 13.00
					ler name	CCN number	
14,00	RHC/FQHC name, CCN number				. 00	2.00	14.00
		Y/N	V	XVIII	XI X	Total Visits	
15.00	llava vau pravidad all, ar aubatanti allu all	1.00	2.00	3.00	4.00	5.00	15.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
				inty	_		
2.00	City, State, ZIP Code, County		4. CASS	00			2.00
2. 50	,	Tuesday		esday	Thur	sday	
		to	from 7.00	to	from	to	
	Facility hours of operations (1)	6.00	7.00	8.00	9.00	10.00	
11.00		19: 00	08: 30	19: 00	08: 30	19: 00	11.00

Health Financial Systems	MEMORIAL HOSPIT	AL LOGANSPORT		In Lieu	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-0072	Period: From 01/01/2021	Worksheet S-8	;
		Component	CCN: 15-8563	To 12/31/2021	Date/Time Pre 5/27/2022 1:4	
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)			_			
11.00 CLINIC	08: 30	19:00	10: 00	18: 00		11.00

Heal th	Financial Systems	MEMORIAL HOSPITAL	LOGANSPORT		In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE		Provider CO	CN: 15-0072	Peri od:	Worksheet S-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 1:4	
						1.00	
	Uncompensated and indigent care cos	st computation				1.00	
1.00	Cost to charge ratio (Worksheet C,	Part I line 202 column 3 d	livided by li	ine 202 colum	n 8)	0. 303455	1.00
	Medicaid (see instructions for each	n line)					
2.00	Net revenue from Medicaid	naverata fram Madi asi dQ				8, 316, 617	2.00
3.00 4.00	Did you receive DSH or supplemental If line 3 is yes, does line 2 inclu		ntal navmont	ts from Medic	ai d2	Y Y	3.00 4.00
4.00 5.00	If line 4 is no, then enter DSH and					0	5.00
6.00	Medi cai d charges	a or suppremental payments	i i olir medi edi	, a		40, 868, 138	
7.00	Medicaid cost (line 1 times line 6))				12, 401, 641	
8.00	Difference between net revenue and < zero then enter zero)	costs for Medicaid program	n (line 7 mir	nus sum of li	nes 2 and 5; if	4, 085, 024	8.00
	Children's Health Insurance Program	n (CHIP) (see instructions	for each lir	ne)			
	Net revenue from stand-alone CHIP					0	
	Stand-alone CHIP charges	line 10)				0	
	Stand-alone CHIP cost (line 1 times Difference between net revenue and) (line 11 mi	inus lino 0:	if < zero then		11.00
12.00	enter zero)	costs for stand-arone chin		rnus rrne y,	ri < zero then		12.00
	Other state or local government inc	ligent care program (see ir	nstructions f	for each line)	I	
	Net revenue from state or local ind					0	
14.00	Charges for patients covered under 10)	state or local indigent ca	are program ((Not included	in lines 6 or	0	
	State or local indigent care progra					0	
16.00	Difference between net revenue and	costs for state or local i	ndigent care	e program (li	ne 15 minus line	0	16.00
	<u>13; if < zero then enter zero)</u> Grants, donations and total unreimb	nursed cost for Medicaid (`HIP and stat	te/local indi	gent care progra	ams (see	
	instructions for each line)				gent care progra	1113 (300	
17.00	Private grants, donations, or endow	wment income restricted to	fundi ng char	rity care		0	17.00
	Government grants, appropriations of					0	
19.00	Total unreimbursed cost for Medicai 8, 12 and 16)	d , CHIP and state and loo	cal indigent	care program	s (sum of lines	4, 085, 024	19.00
				Uni nsured	Insured	Total (col. 1	
				patients 1.00	patients 2.00	+ col . 2) 3.00	
	Uncompensated Care (see instruction	ns for each line)		1.00	2.00	3.00	
	Chari ty care charges and uninsured (see instructions)		°acility	2, 029, 96	03 0	2, 029, 963	20.00
21.00	· · ·	ty care and uninsured disc	counts (see	616, 00	02 0	616, 002	21.00
22.00	Payments received from patients for charity care	r amounts previously writte	en off as		0 0	0	22.00
23.00	Cost of charity care (line 21 minus	s line 22)		616, 00	02 0	616, 002	23.00
						1.00	
24.00	Does the amount on line 20 column 2	2, include charges for pati	ent days bey	yond a length	of stay limit	N	24.00
25.00	imposed on patients covered by Medi If line 24 is yes, enter the charge			t care progra	m's length of	0	25.00
24 00	stay limit Total had dobt expense for the enti	re beenitel complex (coe i	netructione'	\ \		8, 160, 191	24 00
	Total bad debt expense for the enti Medicare reimbursable bad debts for					108, 824	
	Medicare allowable bad debts for th		•			167, 421	
	Non-Medicare bad debt expense (see			/		7, 992, 770	
	Cost of non-Medicare and non-reimbu		expense (see	instructions)	2, 484, 043	
	Cost of uncompensated care (line 23	• •				3, 100, 045	
31.00	Total unreimbursed and uncompensate	ed care cost (line 19 plus	line 30)			7, 185, 069	31.00

RECLAS	Financial Systems M SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	EMORIAL HOSPITAL F EXPENSES	Provi der CC		eriod:	u of Form CMS-2 Worksheet A	2552-10
				Fi Te	rom 01/01/2021 p 12/31/2021	Date/Time Pre 5/27/2022 1:4	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Recl assi fi cat i ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS		5, 498, 914	5, 498, 914	-1,051,343	4, 447, 571	1.00
1.00	00101 MOB		0,470,714	0,470,714	223, 692	223, 692	
1.02	00102 OPS		0	0	147, 326	147, 326	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	335, 448	13, 570, 565	13, 906, 013	0	13, 906, 013	
5.00	00500 ADMINISTRATIVE & GENERAL	4, 112, 081	5, 953, 333	10, 065, 414	515, 689	10, 581, 103	
7.00 3.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	796, 827 0	1, 987, 976 215, 672	2, 784, 803 215, 672	208, 581 0	2, 993, 384 215, 672	•
9.00 9.00	00900 HOUSEKEEPING	655, 062	162, 483	817, 545	0	817, 545	
10.00	01000 DI ETARY	418, 318	312, 074	730, 392	-595, 854	134, 538	
11.00	01100 CAFETERI A	0	0	0	595, 854	595, 854	•
13.00	01300 NURSING ADMINISTRATION	890, 426	106, 461	996, 887	0	996, 887	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	295, 175	266, 625	561, 800	-42, 284	519, 516	
15.00	01500 PHARMACY	688, 010	207, 144	895, 154	0	895, 154	
16.00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	1, 998, 619 138, 284	5, 273, 119 31, 534	7, 271, 738 169, 818	0	7, 271, 738 169, 818	
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	130, 204	31, 334	109, 010	0	109,010	17.00
30.00	03000 ADULTS & PEDI ATRI CS	4, 396, 485	342, 534	4, 739, 019	-966, 158	3, 772, 861	30.00
31.00	03100 I NTENSI VE CARE UNI T	894, 005	77, 446	971, 451	0	971, 451	
43.00	04300 NURSERY	0	1, 698	1, 698	380, 320	382, 018	43.00
	ANCI LLARY SERVI CE COST CENTERS	5 070 050	0.074.454	7 45 4 740			1
50.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	5, 378, 259	2, 076, 454 0	7, 454, 713	0 505 020	7, 454, 713	
52.00 53.00	05300 ANESTHESI OLOGY	0	2, 379, 382	0 2, 379, 382	585, 838 0	585, 838 2, 379, 382	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 318, 802	920, 991	2, 379, 382	0	2, 239, 793	
57.00	05700 CT SCAN	0	0	2,207,170	0	2,207,170	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	•
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
50.00	06000 LABORATORY	0	4, 048, 057	4, 048, 057	0	4, 048, 057	1
53.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	218, 062	218, 062	0	218, 062	•
55.00 56.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	985, 630 997, 285	200, 495 77, 190	1, 186, 125 1, 074, 475	0	1, 186, 125 1, 074, 475	•
59.00	06900 ELECTROCARDI OLOGY	266, 905	103, 069	369, 974	0	369, 974	•
59.01	06901 CARDI AC REHAB	307, 265	19, 966		0	327, 231	•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 430, 778	4, 430, 778	-1, 941, 752	2, 489, 026	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	1, 941, 752	1, 941, 752	
73.00	07300 DRUGS CHARGED TO PATIENTS	40	10, 254, 392	10, 254, 432	0	10, 254, 432	
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	230, 418	452, 715	683, 133	0	683, 133	
76. 01	03480 ONCOLOGY OUTPATIENT SERVICE COST CENTERS	714, 383	1, 732, 388	2, 446, 771	0	2, 446, 771	76.01
38.00	08800 EXPRESS MEDICAL CENTER	1	0	1	0	1	88. 00
	08801 FAMILY HEALTH CARE	1	0	1	0	1	
	09000 CLI NI C	6, 918, 109	551, 056	7, 469, 165	-1, 661	7, 467, 504	
90.01	09001 WOUND CARE	147, 975	603, 182	751, 157	0	751, 157	
91.00	09100 EMERGENCY	1, 701, 678	1, 018, 895	2, 720, 573	0	2, 720, 573	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
/5.00	SPECIAL PURPOSE COST CENTERS			0	V	0	/ /5.00
118.00		34, 585, 491	63, 094, 650	97, 680, 141	0	97, 680, 141]118. OC
	NONREIMBURSABLE COST CENTERS						
	07950 FOUNDATI ON	0	1, 872	1, 872	0		194.OC
		0	0	0	0		194.01
	07952 NONREI MBURSABLE OTHER 07953 PI H		0	0	0		194.02 194.03
	07954 HEALTH COMPANIES	475, 075	137, 013	612, 088	0	612,088	
	07955 PHYSI CI ANS OFFI CE	4, 838, 457	1, 823, 133	6, 661, 590	Ő	6, 661, 590	
194.06	07956 THE ARBORS	0	0	0	0	0	194.06
	07957 PAIN MANAGEMENT	0	0	0	0		194.07
	07958 OPS	0	0	0	0		194.08
$\omega A \cap C$	07959 MHL ROCHESTER HEALTH CENTER	598, 801	47, 269 118, 400		0	646, 070 1, 341, 995	
					()		1194 11
194.10	07961 RHEUMATOLOGY 07960 SPORTS HEALTH	1, 223, 595					
194. 10 194. 11	07961 RHEUMATOLOGY 07960 SPORTS HEALTH 07962 BEHAVIORAL HEALTH CLINIC	1, 223, 595 251, 520 198, 264	33, 408 21, 165	284, 928 219, 429	0	284, 928 219, 429	194.11

	ATION AND ADJUSTMENTS OF TRIAL BALANCE O	<u>EMORIAL HOSPIT</u> F EXPENSES	Provi der CCN:	From C	1/01/2021	t A
					2/31/2021 Date/Time	e Prepared 2 1:47 pm
	Cost Center Description	Adjustments	Net Expenses			
		(See A-8)	For Allocation			
		6.00	7.00			
GENER	AL SERVICE COST CENTERS					
	NEW CAP REL COSTS-BLDG & FIXT	-51, 941	4, 395, 630			1.0
01 00101		0	223, 692			1.0
02 00102	EMPLOYEE BENEFITS DEPARTMENT	0 -74, 655	147, 326 13, 831, 358			1.0
	ADMINISTRATIVE & GENERAL	-3, 187, 138	7, 393, 965			5.0
	OPERATION OF PLANT	-12, 908	2, 980, 476			7.0
	LAUNDRY & LINEN SERVICE	0	215, 672			8.0
	HOUSEKEEPI NG	0	817, 545			9.0
	DIETARY	-30, 448	104, 090			10.0
		-1, 433	594, 421			11.0
	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	-3, 094 -84, 437	993, 793 435, 079			13.0
5.00 01400 5.00 01500		-84, 437	895, 154			14.0
	MEDICAL RECORDS & LIBRARY	-25, 449	7, 246, 289			16.0
	SOCIAL SERVICE	-967	168, 851			17.0
	IENT ROUTINE SERVICE COST CENTERS					
	ADULTS & PEDIATRICS	-1, 262, 442	2, 510, 419			30.0
	INTENSIVE CARE UNIT	0	971, 451			31.0
3.00 04300		0	382, 018			43.0
	LARY SERVICE COST CENTERS	-3, 644, 518	3, 810, 195			50.0
1	DELIVERY ROOM & LABOR ROOM	-3, 044, 518	585, 838			52.0
	ANESTHESI OLOGY	-2, 379, 110	272			53.0
	RADI OLOGY-DI AGNOSTI C	0	2, 239, 793			54.0
	CT SCAN	0	0			57.0
	MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.0
	CARDI AC CATHETERI ZATI ON	0	0			59.0
	LABORATORY BLOOD STORING, PROCESSING & TRANS.	0	4, 048, 057 218, 062			60. 0 63. 0
	RESPIRATORY THERAPY	0	1, 186, 125			65.0
	PHYSI CAL THERAPY	0	1,074,475			66.0
	ELECTROCARDI OLOGY	0	369, 974			69.0
	CARDI AC REHAB	0	327, 231			69.0
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 489, 026			71.0
	IMPL. DEV. CHARGED TO PATIENT	0	1,941,752			72.0
	DRUGS CHARGED TO PATIENTS	-189, 240	10,065,192			73.0
6.00 03450 6.01 03480	NUCLEAR MEDICINE - DIAGNOSTIC	0 -1, 512, 857	683, 133 933, 914			76.0
	TI ENT SERVICE COST CENTERS	1, 512, 057	755, 714			/0.0
	EXPRESS MEDICAL CENTER	0	1			88.0
	FAMILY HEALTH CARE	0	1			88.0
0.00 09000		-6, 750, 773	716, 731			90.0
	WOUND CARE	-681, 762	69, 395			90.0
1.00 09100		-842, 886	1, 877, 687			91.0
	OBSERVATION BEDS (NON-DISTINCT PART)					92.0
	AMBULANCE SERVICES	0	0			95.0
	AL PURPOSE COST CENTERS	0	V			,0.0
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	-20, 736, 058	76, 944, 083			118.0
	IMBURSABLE COST CENTERS	r				
	FOUNDATION	0	1, 872			194.0
94.0107951		0	0			194.0
94.0207952 94.0307953	NONREI MBURSABLE OTHER	0	0			194. 0 194. 0
	HEALTH COMPANIES	0	612, 088			194.0
	PHYSI CLANS OFFICE	0	6, 661, 590			194.0
	THE ARBORS	0	0			194.0
	PAIN MANAGEMENT	0	o			194.0
94. 08 07958		0	0			194.0
	MHL ROCHESTER HEALTH CENTER	0	646, 070			194.0
	RHEUMATOLOGY	0	1, 341, 995			194.1
	SPORTS HEALTH	0	284, 928			194.1
	BEHAVIORAL HEALTH CLINIC TOTAL (SUM OF LINES 118 through 199)	0 -20, 736, 058	219, 429 86, 712, 055			194. 1 200. 0
		-20 /30 058				12001 ()

1.00 1.00 1.00 1.00 1.00 1.00	Cost Center 2. 00 A - CAFETERIA RECLASS CAFETERIA RECLASS CAFETERIA 0 B - 0B RECLASS NURSERY DELIVERY ROOM & LABOR ROOM 0 C - MALPRACTICE INS. RECLASS ADMI NI STRATIVE & GENERAL 0 D - IMPLANT EXPENSE RECLASS IMPL. DEV. CHARGED TO PATIENT	l ncreases Li ne # 3.00 11.00 43.00 52.00 52.00	Sal ary 4. 00 341, 264 341, 264 341, 077 523, 054 864, 131 0 0	Provi der Co 0ther 5.00 254,590 254,590 39,243 62,784 102,027 680,325	Peri od: From 01/01/2021 To 12/31/2021	Worksheet A-6 Date/Time Prepared 5/27/2022 1:47 pm 1.4 1.4 2.4
1.00 1.00 2.00 1.00 1.00	2.00 A - CAFETERI A RECLASS CAFETERI AO B - OB RECLASS NURSERY DELI VERY ROOM & LABOR ROOM O C - MALPRACTI CE INS. RECLASS ADMI NI STRATI VE & GENERAL O D - IMPLANT EXPENSE RECLASS IMPL. DEV. CHARGED TO	Li ne # 3.00 11.00 43.00 52.00	4.00 <u>341,264</u> <u>341,264</u> <u>341,077</u> <u>523,054</u> <u>864,131</u>	5.00 <u>254,590</u> 254,590 <u>39,243</u> <u>62,784</u> 102,027		1.1
1.00 1.00 2.00 1.00 1.00	2.00 A - CAFETERI A RECLASS CAFETERI AO B - OB RECLASS NURSERY DELI VERY ROOM & LABOR ROOM O C - MALPRACTI CE INS. RECLASS ADMI NI STRATI VE & GENERAL O D - IMPLANT EXPENSE RECLASS IMPL. DEV. CHARGED TO	3.00 <u>11.00</u> 43.00 <u>52.00</u>	4.00 <u>341,264</u> <u>341,264</u> <u>341,077</u> <u>523,054</u> <u>864,131</u>	5.00 <u>254,590</u> 254,590 <u>39,243</u> <u>62,784</u> 102,027		1.1
1.00 1.00 2.00 1.00 1.00	A - CAFETERIA RECLASS CAFETERIA 0 B - OB RECLASS NURSERY DELIVERY ROOM & LABOR ROOM 0 C - MALPRACTICE INS. RECLASS ADMINISTRATIVE & GENERAL 0 D - IMPLANT EXPENSE RECLASS IMPL. DEV. CHARGED TO	<u>11. 00</u> 43. 00 <u>52. 00</u>	341, 264 341, 264 341, 077 523, 054 864, 131	_ <u>254, 590</u> 254, 590 39, 243 <u>62, 784</u> 102, 027		1.1
1.00 1.00 2.00 1.00 1.00	CAFETERIA 0 B - OB RECLASS NURSERY DELIVERY ROOM & LABOR ROOM 0 C - MALPRACTICE INS. RECLASS ADMINISTRATIVE & GENERAL 0 D - IMPLANT EXPENSE RECLASS IMPL. DEV. CHARGED TO	43.00	341, 264 341, 077 523, 054 864, 131	254, 590 39, 243 62, 784 102, 027		1.1
1.00 2.00 1.00	0	43.00	341, 264 341, 077 523, 054 864, 131	254, 590 39, 243 62, 784 102, 027		1.1
1.00 2.00 1.00	NURSERY DELIVERY ROOM & LABOR ROOM O C - MALPRACTICE INS. RECLASS ADMINISTRATIVE & GENERAL O D - IMPLANT EXPENSE RECLASS IMPL. DEV. CHARGED TO	<u>52.00</u>	341, 077 52 <u>3, 054</u> 864, 131	39, 243 6 <u>2, 784</u> 102, 027		
1.00 2.00 1.00	NURSERY DELIVERY ROOM & LABOR ROOM O C - MALPRACTICE INS. RECLASS ADMINISTRATIVE & GENERAL O D - IMPLANT EXPENSE RECLASS IMPL. DEV. CHARGED TO	<u>52.00</u>	<u>523, 054</u> 864, 131 0	6 <u>2, 7</u> 84 102, 027		
2.00 [() 1.00	DELI VERY ROOM & LABOR ROOM O C - MALPRACTICE INS. RECLASS ADMI NI STRATI VE & GENERAL O D - IMPLANT EXPENSE RECLASS IMPL. DEV. CHARGED TO	<u>52.00</u>	<u>523, 054</u> 864, 131 0	6 <u>2, 7</u> 84 102, 027		
1.00	0 C - MALPRACTICE INS. RECLASS ADMINISTRATIVE & GENERAL 0 D - IMPLANT EXPENSE RECLASS IMPL. DEV. CHARGED TO		864, 131	102, 027		2.
1.00	ADMI NI STRATI VE & GENERAL O D - IMPLANT EXPENSE RECLASS IMPL. DEV. CHARGED TO	5.00	0			
1.00	ADMI NI STRATI VE & GENERAL O D - IMPLANT EXPENSE RECLASS IMPL. DEV. CHARGED TO	5.00		680 325		
(0 D - IMPLANT EXPENSE RECLASS	5.00		680 325		
ĺ	D - IMPLANT EXPENSE RECLASS		()			1.
	IMPL. DEV. CHARGED TO		9	680, 325		
1.00		72.00	0	1, 941, 752		1.1
1		72.00	0	1, 941, 752		1.1
1		+		1,941,752		
	E - UTILITIES RECLASS		U	1, 741, 752		
-	OPERATION OF PLANT	7.00	0	208, 581		1.1
2.00		0.00	0	200, 301		2.
3.00		0.00	0	0		3.
0.00	<u> </u>			208, 581		0.1
- T	F - DEPRECIATION RECLASS		-1			
	МОВ	1.01	0	223, 692		1.
2.00	OPS	1.02	0	147, 326		2.
C	0			371,018		
1	H - SHORT TERM DISABILITY REC	LASS	· · · ·			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	18, 623		1.
2.00	HOUSEKEEPI NG	9.00	0	5, 796		2.
3.00 [DI ETARY	10.00	0	4, 609		3.
	MEDICAL RECORDS & LIBRARY	16.00	0	3, 294		4.
	ADULTS & PEDIATRICS	30.00	0	28, 458		5.
	OPERATING ROOM	50.00	0	19, 615		6.
	RADI OLOGY-DI AGNOSTI C	54.00	0	10, 439		7.
	RESPI RATORY THERAPY	65.00	0	19, 121		8.
	PHYSICAL THERAPY	66.00	0	1, 797		9.
	ELECTROCARDI OLOGY	69.00	0	3, 786		10.
	ONCOLOGY	76.01	0	14, 937		11.
		90.00	0	68, 527		12.
		91.00	0	24, 469		13.
	HEALTH COMPANIES	194.04	0	1,886		14.
	PHYSICIANS OFFICE	194.05	0	23, 458		15.
16.00	MHL ROCHESTER HEALTH CENTER	1 <u>94.</u> 09		- 13,808		16.
E00 00 0	U Grand Total: Increases		1, 205, 395	262, 623 3, 820, 916		500.

Heal th	Financial Systems	М	EMORIAL HOSPITA	L LOGANSPORT		In Lie	u of Form CMS-2552-10
RECLAS	SI FI CATI ONS			Provider (CCN: 15-0072	Peri od:	Worksheet A-6
						From 01/01/2021	
						To 12/31/2021	Date/Time Prepared: 5/27/2022 1:47 pm
		Decreases					072772022 1.47 pm
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Rei	-	
	6,00	7.00	8.00	9,00	10,00	-	
	A - CAFETERIA RECLASS						
1.00	DI ETARY	10.00	341, 264	254, 590		0	1.00
			341, 264	254, 590		-	
	B - OB RECLASS				I		
1.00	ADULTS & PEDIATRICS	30.00	864, 131	102, 027		0	1.00
2.00		0, 00	0	0		0	2.00
		+	864, 131	102, 027		1	
	C - MALPRACTICE INS. RECLASS	I			1	1	
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	680, 325		12	1.00
	FLXT						
				680, 325		1	
	D - IMPLANT EXPENSE RECLASS				1	•	
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 941, 752		0	1.00
	PATI ENTS						
	0		0	1,941,752		1	
	E - UTILITIES RECLASS						
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	164, 636		0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	42, 284		0	2.00
3.00	CLINIC	90.00	0	1, 661		0	3.00
	0		0	208, 581		7	
	F - DEPRECIATION RECLASS						
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	371, 018		9	1.00
	FIXT						
2.00		0.00	0	0		9	2.00
	0		o	371, 018			
	H - SHORT TERM DI SABILITY REC						
1.00	ADMI NI STRATI VE & GENERAL	5.00	18, 623	0		0	1.00
2.00	HOUSEKEEPING	9.00	5, 796	0		0	2.00
3.00	DI ETARY	10. 00	4, 609	0		0	3.00
4.00	MEDICAL RECORDS & LIBRARY	16. 00	3, 294	0		0	4.00
5.00	ADULTS & PEDIATRICS	30. 00	28, 458	0		0	5.00
6.00	OPERATING ROOM	50.00	19, 615	0		0	6.00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	10, 439	0		0	7.00
8.00	RESPI RATORY THERAPY	65.00	19, 121	0		0	8.00
9.00	PHYSI CAL THERAPY	66.00	1, 797	0		0	9.00
10.00	ELECTROCARDI OLOGY	69.00	3, 786	0		0	10.00
11.00	ONCOLOGY	76.01	14, 937	0		0	11.00
12.00	CLINIC	90.00	68, 527	0		0	12.00
13.00	EMERGENCY	91.00	24, 469	0		0	13.00
14.00	HEALTH COMPANI ES	194.04	1, 886	0		0	14.00
15.00	PHYSI CLANS OFFI CE	194. 05	23, 458	0		0	15.00
16.00	MHL ROCHESTER HEALTH CENTER	1 <u>94.</u> 09	1 <u>3, 8</u> 08	0	L	Q	16.00
	0		262, 623	0		_	
500.00	Grand Total: Decreases		1, 468, 018	3, 558, 293			500.00

ECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC		То	d: 01/01/2021 12/31/2021	Worksheet A-7 Part I Date/Time Prep 5/27/2022 1:4	pared:
				Acqui si ti on	s			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
. 00	Land	205, 783	0		0	0	0	1.0
. 00	Land Improvements	838, 517	0		0	0	0	2.0
. 00	Buildings and Fixtures	65, 043, 978	6, 648, 911		0	6, 648, 911	0	3.0
. 00	Building Improvements	0	0		0	0	0	4.0
. 00	Fixed Equipment	7, 611, 191	617,863		0	617, 863	0	5.0
. 00	Movable Equipment	48, 872, 907	0		0	0	2, 207, 156	6.0
. 00	HIT designated Assets	0	0		0	o	0	7.0
. 00	Subtotal (sum of lines 1-7)	122, 572, 376	7, 266, 774		0	7, 266, 774	2, 207, 156	8.0
. 00	Reconciling Items	0	0		0	0	0	9.0
0.00	Total (line 8 minus line 9)	122, 572, 376	7, 266, 774		0	7, 266, 774	2, 207, 156	
		Endi ng	Fully					
		Bal ance	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
. 00	Land	205, 783	0					1.0
. 00	Land Improvements	838, 517	0					2.0
. 00	Buildings and Fixtures	71, 692, 889	0					3.0
. 00	Building Improvements	0	0					4.0
. 00	Fixed Equipment	8, 229, 054	0					5.0
. 00	Movable Equipment	46, 665, 751	0					6.0
. 00	HIT designated Assets	0	0					7.0
. 00	Subtotal (sum of lines 1-7)	127, 631, 994	0					8.0
. 00	Reconciling Items	0	0					9.0
0.00	Total (line 8 minus line 9)	127, 631, 994	0					10.0

Heal th	Financial Systems	MEMORIAL HOSPITA	AL LOGANSPORT		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2021	Worksheet A-7 Part II	
					To 12/31/2021	Date/Time Pre	
						5/27/2022 1:4	7 pm
			SL	IMMARY OF CAPI	TAL		
	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, COLUN	IN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,057,136	0	639, 326	802, 452	0	1.00
1.01	MOB	0	0	(0 0	0	1.01
1.02	OPS	0	0	(0 0	0	1.02
3.00	Total (sum of lines 1-2)	4,057,136	0	639, 326	802, 452	0	3.00
		SUMMARY OF	F CAPI TAL				
	Cost Center Description	Other	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	IN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	5, 498, 914				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, 498, 914				3.00

Health Financial Systems	IEMORIAL HOSPITA	AL LOGANSPORT		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	eriod: rom 01/01/2021 o 12/31/2021	5/27/2022 1:4	pared:
	COMP	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 NEW CAP REL COSTS-BLDG & FIXT 1.01 MOB 1.02 OPS	127, 631, 994 0	0	127, 631, 994 C	1.000000 0.000000 0.000000	0	1. 00 1. 01 1. 02
3.00 Total (sum of lines 1-2)	127, 631, 994	0	127, 631, 994		0	3.00
		TION OF OTHER (F CAPI TAL	3.00
Cost Center Description	Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS			1		
1.00 NEW CAP REL COSTS-BLDG & FIXT 1.01 MOB	0	0 0		3, 665, 552 223, 692	0	1.00 1.01
1.02 OPS	0	0	0	147, 326	0	1.02
3.00 Total (sum of lines 1-2)	0	SL	IMMARY OF CAPIT		5	3.00
Cost Center Description	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C			1	1		
1.00 NEW CAP REL COSTS-BLDG & FLXT 1.01 MOB	607, 951 0	122, 127 0	C C	0 0	4, 395, 630 223, 692	1. 00 1. 01
1.02 OPS 3.00 Total (sum of lines 1–2)	0 607, 951	0 122, 127	0 0	0	147, 326 4, 766, 648	1.02 3.00

Health Financial Systems ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10 Period: Worksheet A-8

ADJUSTN	MENTS TO EXPENSES			Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021		pared:
			Tc	Expense Classification o /From Which the Amount is		5/27/2022 1: 4	<u>7 pm</u>
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter			W CAP REL COSTS-BLDG & XT	1.00	0	1.00
	2)						
. 01	Investment income - MOB (chapter 2)		OMC)B	1.01	0	1.01
. 02	Investment income - OPS (chapter 2)		0 O F	PS	1.02	0	1.02
	Investment income - CAP REL		0 * *	** Cost Center Deleted **	* 2.00	0	2.00
	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.00
	(chapter 2)						
	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
	Refunds and rebates of	В	-84, 437 CE	NTRAL SERVICES & SUPPLY	14.00	0	5.00
	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.00
	stations excluded) (chapter		Ŭ		0.00	0	7.00
	21) Television and radio service		0		0.00	0	8.00
. 00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
0. 00	Provi der-based physi ci an	A-8-2	-16, 987, 661		0.00	0	
	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
	(chapter 23)		Ŭ		0.00		
	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
	Laundry and linen service	٥	0 -1, 433 CA		0.00 11.00	0	
	Cafeteria-employees and guests Rental of quarters to employee	A	-1, 433 CA	AFEIERIA	0.00	0	
	and others Sale of medical and surgical		0		0.00	0	16.00
	supplies to other than		Ŭ		0.00	Ű	10100
	patients Sale of drugs to other than		0		0.00	0	17.00
	patients		0		0.00	0	10 00
	Sale of medical records and abstracts		0		0.00	0	18.00
	Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
	books, etc.)						
	Vending machines Income from imposition of		0		0.00 0.00	0	
	interest, finance or penalty						
	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22.00
	overpayments and borrowings to repay Medicare overpayments						
3.00	Adjustment for respiratory	A-8-3	ORE	SPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of limitation (chapter 14)						
4.00	Adjustment for physical	A-8-3	0 PH	IYSI CAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
	Utilization review - physicians' compensation		0**	** Cost Center Deleted **	* 114.00		25.00
	(chapter 21)						
	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			W CAP REL COSTS-BLDG & XT	1.00	0	26.00
6. 01	Depreciation - MOB		ОМС)B	1.01	0	
1	Depreciation - OPS Depreciation - CAP REL		0 OF 0 * *	PS ** Cost Center Deleted ***	* 1.02 * 2.00	0	
	COSTS-MVBLE EQUIP					0	
	Non-physician Anesthetist Physicians' assistant		0	** Cost Center Deleted **	* 19.00 0.00	0	28.00 29.00

In Lieu of Form CMS-2552-10 Provi der CCN: 15-0072 Peri od: Worksheet A-8

ADJUS	IMENTS TO EXPENSES				Period: From 01/01/2021	WORKSNEET A-8	
					To 12/31/2021	Date/Time Pre 5/27/2022 1:4	
				Expense Classification or	n Worksheet A		
			Тс	o/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	cost center bescription	(2)	Allouire	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		30.00
	therapy costs in excess of						
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0 AI	DULTS & PEDIATRICS	30.00		30.99
	instructions)						
31.00		A-8-3	0**	** Cost Center Deleted ***	68.00		31.00
	pathology costs in excess of						
	limitation (chapter 14)				0.00	0	
32.00			0		0.00	0	32.00
33.00	Depreciation and Interest OTHER REVENUE - MISCELLANEOUS	В	-33 703 41	DMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OTHER REVENUE - CPR TRAINING	B		URSING ADMINISTRATION	13.00	0	
35.00	HIM MEDICAL RECORDS FEES	B		EDICAL RECORDS & LIBRARY	16.00	0	35.00
37.00	OTHER REVENUE - MED/SURGICAL	B		DULTS & PEDIATRICS	30.00	0	
	SERVI CE	5	0,000,1		00100	0	
38.00	INTEREST INCOME	В	-31, 375 NE	EW CAP REL COSTS-BLDG &	1.00	11	38.00
				I XT			
39.00	DI ETARY REVENUE	В	-30, 448 DI	I ETARY	10.00	0	39.00
10.00	PATI ENT TELEVI SI ONS	A	-1, 575 OF	PERATION OF PLANT	7.00	0	40.00
41.00	PATI ENT TELEPHONES	A		MPLOYEE BENEFITS DEPARTMEN	T 4.00	0	41.00
45.00	PATI ENT TELEPHONES	A		EW CAP REL COSTS-BLDG &	1.00	9	45.00
45 04					F 00	0	45 04
45.01 45.02	PATIENT TELEPHONES	A A		DMINISTRATIVE & GENERAL DMINISTRATIVE & GENERAL	5.00	0	45.01 45.02
15.02	IHA & AHA LOBBYING FEES GIFT SHOP	A		EW CAP REL COSTS-BLDG &	5.00 1.00	9	45.02
+5. 05		A		IXT	1.00	7	45.0
45.04	GIFT SHOP	А		PERATION OF PLANT	7.00	0	45.04
15.05		A		DMI NI STRATI VE & GENERAL	5.00	0	
15.06	TAXES	А		DMINISTRATIVE & GENERAL	5.00	0	
45.07	DONATION EXPENSE	А	-78, 489 AI	DMINISTRATIVE & GENERAL	5.00	0	45.0
45.08	PHYSI CI AN RECRUI TMENT	А	-193, 564 AI	DMINISTRATIVE & GENERAL	5.00	0	45.08
45.09	VENDI NG	A		EW CAP REL COSTS-BLDG &	1.00	9	45.09
45.10	VENDI NG	А		IXT PERATION OF PLANT	7.00	0	45.10
45.10		A		DMINISTRATIVE & GENERAL	5.00	0	
45.12		A		DULTS & PEDIATRICS	30.00	0	45.13
45.14		A		MPLOYEE BENEFITS DEPARTMEN		0	45.14
45.15	340B OFFSET	A		RUGS CHARGED TO PATIENTS	73.00	0	
50.00			-20, 736, 058		. 51 00	0	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			MEMORIAL HOSPITAL LOGANSPORT			In Lieu of Form CMS-2552-10			
PROVI DE	ER BASED PHYSICI	AN ADJUSTMENT		Provider (Period: Worksheet		3-2	
						From 01/01/2021 To 12/31/2021			
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov		
		Identifier	Remuneration	Component	Component		ider Component		
							Hours		
	1.00	2.00	3.00	4.00	5.00	6.00	7.00		
1.00		ADMI NI STRATI VE & GENERAL	22, 888		22, 888	3 211, 500	267	1.00	
2.00	17. 00 SOCI AL SERVI CE		9,000	l o	9,000	211, 500	79	2.00	
3.00	30. 00 ADULTS & PEDI ATRI CS		1, 174, 788						
4.00	50. 00 OPERATING ROOM		3, 783, 947					4.00	
5.00	53. 00 ANESTHESI OLOGY		2, 379, 110						
6.00	54. 00 RADI OLOGY-DI AGNOSTI C		44, 061	0					
7.00	76. 01 ONCOLOGY		1, 512, 857	1, 512, 857					
8.00	90. 00 CLI NI C		6, 808, 325						
9.00				681, 762					
		90. 01 WOUND CARE 91. 00 EMERGENCY							
10.00	91.00		842, 886						
200.00			17, 259, 624					200.00	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost		
		I denti fi er	Limit	Unadjusted RCE			of Malpractice		
				Limit	Conti nui ng	Share of col.	Insurance		
	1.00		0.00	0.00	Education	12	11.00		
1.00	1.00		8.00	9.00	12.00	13.00	14.00	1.00	
1.00		ADMINISTRATIVE & GENERAL	27, 149				-		
2.00	17.00 SOCI AL SERVI CE		8, 033				-		
3.00	30. 00 ADULTS & PEDI ATRI CS		0	, s			3		
4.00	50.00 OPERATI NG ROOM		139, 429	6, 971	(-	0		
5.00	53. 00 ANESTHESI OLOGY		0	0	(-	0		
6.00	54. 00 RADI OLOGY-DI AGNOSTI C		52, 062	2, 603	(0 0	0	6.00	
7.00	76.01 ONCOLOGY		0	0	(0 0	0	7.00	
8.00	90.000		57, 552	2, 878	(0 0	0	8.00	
9.00	90. 01 WOUND CARE		0	0	(0 0	0	9.00	
10.00	91. OO EMERGENCY		0	0	(0 0	0	10.00	
200.00			284, 225	14, 211	(0 0	0	200.00	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment			
		Identifier	Component	Limit	Di sal I owance				
			Share of col.						
			14						
	1.00	2.00	15.00	16.00	17.00	18.00			
1.00	5.00/	ADMINISTRATIVE & GENERAL	0	27, 149		-		1.00	
2.00	17.00 SOCI AL SERVI CE		0	8, 033	96	7 967		2.00	
3.00	30. 00 ADULTS & PEDI ATRI CS		0	0	(1, 174, 788		3.00	
4.00	50. 00 OPERATI NG ROOM		0	139, 429	204, 912	2 3, 644, 518		4.00	
5.00	53. 00 ANESTHESI OLOGY		0	0	(2, 379, 110		5.00	
6.00	54. 00 RADI OLOGY-DI AGNOSTI C		0	52, 062	(6.00	
7.00	76. 01 ONCOLOGY		0	0	(1, 512, 857		7.00	
8.00	90. 00 CLINIC		0	57, 552	48, 729			8.00	
9.00	90. 01 WOUND CARE		0					9.00	
10.00	91. OO EMERGENCY			0 0				10.00	
200.00			0	284, 225				200.00	
200.00	I			1 201,220	201,000		1	200.00	

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS		EMORIAL HOSPITAL LOGANSPORT Provider CCN: 15-0072		CN: 15-0072 P	In Lieu of Form CMS-2552 Period: Worksheet B		
					rom 01/01/2021 o 12/31/2021	Part I Date/Time Prepared: 5/27/2022 1:47 pm	
			CAPITAL RELATED COSTS			572772022 1.4	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	MOB	OPS	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	1.01	1. 02	4.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	4, 395, 630	4, 395, 630				1.00
1.00	00101 MOB	4, 393, 630	4, 395, 030				1.00
1.02	00102 OPS	147, 326	0		147, 326		1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	13, 831, 358	27, 624		0	13, 865, 087	
5.00 7.00	00700 OPERATION OF PLANT	7, 393, 965 2, 980, 476	351, 480 800, 993		0 11, 704	1, 365, 213 265, 751	•
8.00	00800 LAUNDRY & LI NEN SERVI CE	215, 672	14, 037		0	0	1
9.00	00900 HOUSEKEEPI NG	817, 545	31, 425		432	216, 537	•
	01000 DI ETARY 01100 CAFETERI A	104, 090 594, 421	133, 011 64, 290		0	24, 161 113, 815	•
	01300 NURSI NG ADMI NI STRATI ON	993, 793	49, 871		0	296, 967	
14.00	01400 CENTRAL SERVICES & SUPPLY	435, 079	92, 836		0	98, 444	
	01500 PHARMACY	895, 154	47, 306		0	229, 459	•
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	7, 246, 289 168, 851	167, 473 27, 938		0	665, 463 46, 119	•
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	100,001	27,700			10, 117	17.00
	03000 ADULTS & PEDIATRICS	2, 510, 419				1, 168, 588	
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	971, 451 382, 018	118, 840 5, 849			298, 161 113, 753	1
43.00	ANCI LLARY SERVICE COST CENTERS	302,010	5, 649	<u>1</u> 0	0	113,733	43.00
	05000 OPERATING ROOM	3, 810, 195	438, 355		33, 560	1, 787, 167	50.00
	05200 DELIVERY ROOM & LABOR ROOM	585, 838	95, 895		0	174, 444	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	272 2, 239, 793	46, 272 203, 083		0 8, 309	0 436, 353	
	05700 CT SCAN	2,237,773	203,003		0, 307	430, 333	1
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	-	0	0	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0 108, 807	0	0 3, 875	0	
	06300 BLOOD STORING, PROCESSING & TRANS.	4, 048, 057 218, 062	108, 807	6, 686 0	3, 875	0	
	06500 RESPI RATORY THERAPY	1, 186, 125	7, 738	0	0	322, 341	•
	06600 PHYSI CAL THERAPY	1,074,475	124, 306		0	332, 006	•
	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	369, 974 327, 231	10, 775 125, 138		0	87, 753 102, 476	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 489, 026	0		0	0	•
	07200 I MPL. DEV. CHARGED TO PATIENT	1, 941, 752	0		0	0	
	07300 DRUGS CHARGED TO PATIENTS 03450 NUCLEAR MEDICINE - DIAGNOSTIC	10, 065, 192 683, 133	0 16, 489	-	0	13 76 947	73.00 76.00
	03480 ONCOLOGY	933, 914			-	233, 273	
	OUTPATIENT SERVICE COST CENTERS]
	08800 EXPRESS MEDICAL CENTER	1	0	-	0	0	
	08801 FAMILY HEALTH CARE 09000 CLINIC	716, 731	4, 724	-	-	0 2, 284, 403	
	09001 WOUND CARE	69, 395	0	13, 611	0	49, 351	
	09100 EMERGENCY	1, 877, 687	344, 642	0	0	559, 368	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS			1			
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	76, 944, 083	4, 242, 914	153, 254	106, 096	11, 348, 226	118.00
194.00	07950 FOUNDATI ON	1, 872	0	0	0	0	194.00
194.01	07951 MOB	0	0		0	0	194.01
	07952 NONREI MBURSABLE OTHER	0	0	-	0		194.02
	07953 PI H 07954 HEALTH COMPANI ES	0 612, 088	0 51, 400	0	0	0 157, 814	194.03 194.04
	07955 PHYSI CLANS OFFI CE	6, 661, 590	101, 316		0	1, 605, 855	
	07956 THE ARBORS	0	0		0	0	194.06
194.07	07957 PAIN MANAGEMENT 07958 OPS	0	0		0 41, 230		194.07 194.08
	07958 0PS 07959 MHL ROCHESTER HEALTH CENTER	646, 070	0	-	41, 230 ∩	0 195, 102	•
194.10	07961 RHEUMATOLOGY	1, 341, 995	0	28, 093	0	408, 082	•
	07960 SPORTS HEALTH	284, 928	0	0	0	83, 885	
194. 12 200. 00	07962 BEHAVIORAL HEALTH CLINIC Cross Foot Adjustments	219, 429	0	6, 990	0	66, 123	194. 12 200. 00
200.00			0	0	о	0	200.00
202.00	8	86, 712, 055	4, 395, 630	223, 692	147, 326		

	LLOCATION - GENERAL SERVICE COSTS	IEMORIAL HOSPIT	Provider C	F	veriod: rom 01/01/2021 o 12/31/2021	5/27/2022 1:4	epared:
	Cost Center Description	Subtotal	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		4A	5.00	7.00	8.00	9.00	
	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	9, 131, 075 4, 060, 246 229, 709 1, 078, 203 261, 262 772, 526 1, 340, 631 626, 359	9, 131, 075 477, 879 27, 036 126, 901 30, 750 90, 924 157, 788 73, 721	4, 538, 125 13, 628 86, 159 129, 140 62, 419 48, 419	270, 373 0 2, 772 0 0	1, 291, 263 0 0 3, 503	10.00 11.00 13.00
15.00	01500 PHARMACY	1, 171, 919	137, 931				
	01600 MEDICAL RECORDS & LIBRARY	8, 079, 225	950, 901				
17.00	01700 SOCIAL SERVICE	242, 908	28, 590	27, 125	0	0	17.00
31.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04300 NURSERY	4, 462, 724 1, 388, 452 501, 620	525, 249 163, 417 59, 039	115, 381	9, 072	70, 063	31.00
	ANCI LLARY SERVICE COST CENTERS	(0 (0 . 077	711.00/	5 (0.40)	70.400	457 (10	
50.00 52.00 53.00 54.00 57.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	6, 069, 277 856, 177 46, 544 2, 887, 538 0	714, 336 100, 769 5, 478 339, 855 0	93, 104 44, 925 231, 221	0 0 22, 780	48, 344 0 56, 050	52.00 53.00 54.00
58.00 59.00 60.00 63.00	05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0 0 4, 167, 425 218, 062	0 0 490, 493 25, 665	0 150, 893 0	0	0 0 24, 522 0	58.00 59.00 60.00 63.00
65.00 66.00 69.00 69.01 71.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	1, 516, 204 1, 530, 787 482, 571 554, 845 2, 489, 026	178, 453 180, 169 56, 797 65, 304 292, 951	120, 688 72, 269 121, 496	7, 756 0 0	14, 013 31, 528 0	66.00 69.00 69.01
72.00 73.00 76.00	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 03450 NUCLEAR MEDICINE - DIAGNOSTIC 03480 ONCOLOGY	1, 941, 752 10, 065, 205 776, 469 1, 215, 403	228, 538 1, 184, 672 91, 388 143, 049	0 0 16, 009	0	0	73.00 76.00
88.00	OUTPATI ENT SERVICE COST CENTERS 08800 EXPRESS MEDICAL CENTER	1	0	0	0	0	88.00
88. 01 90. 00 90. 01 91. 00	08801 FAMILY HEALTH CARE 09000 CLINIC 09001 WOUND CARE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	, 3, 084, 638 132, 357 2, 781, 697 0	0 363, 053 15, 578 327, 397	0 350, 686 59, 798	0 0 0	0 38, 535 17, 516	88.01 90.00 90.01
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
118.00	NONREI MBURSABLE COST CENTERS	74, 162, 838	7, 654, 071				
194. 01 194. 02	07950 FOUNDATI ON 07951 MOB 07952 NONREI MBURSABLE OTHER	1, 872 7, 362 0	220 866 0	32, 345		0	194.00 194.01 194.02
194.04 194.05 194.06	07953 PIH 07954 HEALTH COMPANIES 07955 PHYSICIANS OFFICE 07956 THE ARBORS 07957 PAIN MANAGEMENT	0 821, 302 8, 396, 754 0 0	0 96, 665 988, 273 0 0	221, 349 0	0 0	14, 013 84, 076 0 0	194.03 194.04 194.05 194.06 194.07
194.09 194.10 194.11 194.12	07958 OPS 07959 MHL ROCHESTER HEALTH CENTER 07961 RHEUMATOLOGY 07960 SPORTS HEALTH 07962 BEHAVI ORAL HEALTH CLINIC	41, 230 841, 172 1, 778, 170 368, 813 292, 542	4, 853 99, 003 209, 285 43, 408 34, 431	0 123, 418 0	0 0 0	0 31, 528 0	194.08 194.09 194.10 194.11 194.12
200.00 201.00 202.00	Negative Cost Centers	0 0 86, 712, 055	0 9, 131, 075	-	-		200. 00 201. 00 202. 00

	Financial Systems N LLOCATION - GENERAL SERVICE COSTS	MEMORIAL HOSPITA	L LOGANSPORT Provider C	CN: 15-0072 P	In Lieu eriod:	u of Form CMS- Worksheet B	2552-10
CUSTF	ILLUCATION - GENERAL SERVICE COSTS		Provider c		rom 01/01/2021	Part I Date/Time Pre 5/27/2022 1:4	
	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	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.00	00101 MOB						1.00
1.02	00102 OPS						1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00
7.00 8.00	00800 LAUNDRY & LINEN SERVICE						7.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY	423, 924					10.00
11.00	01100 CAFETERIA	0	925, 869				11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	22, 388 18, 157		816, 779		13.00
15.00	01500 PHARMACY	0	18, 709		010,777	1, 381, 495	1
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	52, 287		0	0	1
17.00	01700 SOCI AL SERVI CE	0	4, 337	0	0	0	17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	376, 559	93, 678	479, 912	0	0	30.00
30.00	03100 I NTENSI VE CARE UNI T	47, 365	30, 252		0	0	
43.00	04300 NURSERY	0	11, 819		0	0	
	ANCI LLARY SERVICE COST CENTERS	-			-1		
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	122, 721		0	0	
52.00	05300 ANESTHESI OLOGY	0	18, 125	81, 906 0	0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	45, 456		0	0	
57.00	05700 CT SCAN	0	0	0	0	0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	U	0	0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	-	0	0	
65.00	06500 RESPI RATORY THERAPY	0	24, 347	0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	32, 194		0	0	66.00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0	6, 699 13, 691		0	0	69.00 69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13, 071		816, 779	0	1
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	1, 381, 495	1
76. 00 76. 01	03450 NUCLEAR MEDICINE - DIAGNOSTIC 03480 ONCOLOGY	0	6, 583 24, 789		0	0	
70.01	OUTPATIENT SERVICE COST CENTERS	U0	24,707	0	U	0	1 /0.01
88.00	08800 EXPRESS MEDICAL CENTER	0	0	0	0	0	88.00
88.01	08801 FAMILY HEALTH CARE	0	0		0	0	
	09000 CLINIC 09001 WOUND CARE	0	152, 458		0	0 0	
	09100 EMERGENCY	0	3, 061 58, 911		0	0	
			•		_	-	92.00
05 00	OTHER REIMBURSABLE COST CENTERS						1 05 00
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	95.00
118.00		423, 924	760, 662	1, 572, 729	816, 779	1, 381, 495	118.00
	NONREI MBURSABLE COST CENTERS			, , , ,			
	07950 FOUNDATI ON	0	0		0		194.00
	07951 MOB 07952 NONREI MBURSABLE OTHER	0	0	0	0		194.01 194.02
	07952 NUNRET MOURSABLE OTHER 07953 PI H	0	0	0	0		194.02
	07954 HEALTH COMPANIES	0	19, 779	-	0		194.04
194.05	07955 PHYSI CLANS OFFI CE	0	101, 655		О		194.05
	07956 THE ARBORS	0	0	0	0		194.06
	07957 PALN MANAGEMENT 07958 OPS		0	0	0		194.07 194.08
	07959 MHL ROCHESTER HEALTH CENTER	ol	0	0	0		194.08
194.10	07961 RHEUMATOLOGY	o o	25, 131		Ō	0	194.10
	07960 SPORTS HEALTH	0	12, 581		0		194.11
194.12 200.00	07962 BEHAVIORAL HEALTH CLINIC	0	6, 061	0	0	0	194. 12 200. 00
200.00			0	0	0	Ω	200.00
201.00		423, 924	925, 869	1, 572, 729	816, 779	1, 381, 495	202.00
							•

	Financial S	Systems / GENERAL SERVICE COSTS	MEMORIAL HOSPITA	L LOGANSPORT Provider CC	N: 15-0072 P	In Lieu eriod:	i of Form CMS-: Worksheet B	2552-10
CUSTA	LLUCATION -	GENERAL SERVICE COSTS		Provider CC	N. 15-0072 F	rom 01/01/2021	Part I Date/Time Pre 5/27/2022 1:4	epared:
	Cost	Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		NUCE COST CENTEDS	16.00	17.00	24.00	25.00	26.00	-
1.00		AVICE COST CENTERS AP REL COSTS-BLDG & FIXT	T T					1.00
	00500 ADMI N 00700 OPERA	RY						1.01 1.02 4.00 5.00 7.00 8.00 9.00 10.00 11.00
		NG ADMI NI STRATI ON						13.00
	01400 CENTR 01500 PHARM	AL SERVICES & SUPPLY						14.00
16.00		AL RECORDS & LIBRARY	9, 255, 521 0	302, 960				16.00 17.00
		ROUTINE SERVICE COST CENTERS						
	1 1	S & PEDIATRICS	545, 661	237, 996	8, 004, 053 2, 123, 877	0	8,004,053	
	04300 NURSE	SIVE CARE UNIT RY	127, 701 59, 677	35, 466 0	2, 123, 877 698, 329	0	2, 123, 877 698, 329	
101.00		SERVICE COST CENTERS	0,7,0,7,		0,0,02,		0,0,02,	101.00
	05000 OPERA		2, 801, 950	0	11, 055, 757	0	11, 055, 757	
	05200 DELTV 05300 ANEST	ERY ROOM & LABOR ROOM	3, 285 107, 560	0	1, 201, 710 204, 507	0	1, 201, 710 204, 507	
	1 1	LOGY-DI AGNOSTI C	733, 927	0	4, 316, 827	0	4, 316, 827	
	05700 CT SC		0	0	0	0	0	
		TIC RESONANCE IMAGING (MRI)	0	0	0	0	0	
	05900 CARDI 06000 LABOR	AC CATHETERI ZATI ON	0 1, 075, 811	0	0 5, 909, 144	0	0 5, 909, 144	
	1 1	STORING, PROCESSING & TRANS.	34, 948	0	278, 675	0	278, 675	
65.00		RATORY THERAPY	380, 075	0	2, 138, 120	0	2, 138, 120	
		CAL THERAPY	208, 637	0	2,094,244	0	2,094,244	
	06900 ELECT 06901 CARDI	ROCARDI OLOGY	161, 853 24, 672	0	811, 717 780, 008	0	811, 717 780, 008	
	1 1	AL SUPPLIES CHARGED TO PATIENTS	24,072	0	3, 598, 756	0	3, 598, 756	
72.00	07200 I MPL.	DEV. CHARGED TO PATI ENT	0	0	2, 170, 290	О	2, 170, 290	72.00
		CHARGED TO PATIENTS	0	0	12, 631, 372	0	12, 631, 372	
	03450 NUCLE 03480 ONCOL	AR MEDICINE - DIAGNOSTIC	509, 259 528, 294	0	1, 399, 708 2, 165, 172	0	1, 399, 708 2, 165, 172	
70.01		SERVICE COST CENTERS	520, 274		2,103,172	<u> </u>	2,100,172	70.01
88.00		SS MEDICAL CENTER	0	0	1	0	1	88.00
		Y HEALTH CARE	0	0	1	0	1	
	09000 CLI NI 09001 WOUND		548, 657 108, 344	0	4, 538, 027 336, 654	0	4, 538, 027 336, 654	
	09100 EMERG		788, 439	29, 498	4, 761, 376	-	4, 761, 376	
92.00		VATION BEDS (NON-DISTINCT PART)				0		92.00
05 00		BURSABLE COST CENTERS		ol	0	ol	0	
95.00		ANCE SERVICES RPOSE COST CENTERS	0	0	0	0	0	95.00
118.00	SUBTO	TALS (SUM OF LINES 1 through 117) GABLE COST CENTERS	8, 748, 750	302, 960	71, 218, 325	0	71, 218, 325	118.00
	07950 FOUND		0	0	13, 302	0		194.00
	07951 MOB		0	0	40, 573	0		194.01
	07952 NUNRE 07953 PI H	IMBURSABLE OTHER	0	0	0	0		194.02 194.03
		H COMPANIES	0	Ő	1,001,664	0	1, 001, 664	
		CLANS OFFICE	399, 320	0	10, 191, 427	О	10, 191, 427	
	07956 THE A		0	0	0	0		194.06
	07957 PAI N 07958 0PS		0	0	243, 063	0	0 243, 063	194.07 194.08
		OCHESTER HEALTH CENTER	25, 913	0	966, 088	Ő	966, 088	
	07961 RHEUM		65, 273	0	2, 232, 805	0	2, 232, 805	
194.11	07960 SPORT		14 245	0	424, 802	0	424, 802	
10/ 10		IORAL HEALTH CLINIC	16, 265	U	380, 006	0	380, 006	
					Ω		Ω	200.00
194. 12 200. 00 201. 00	Cross	Foot Adjustments ive Cost Centers	0	0	0 0	0		200.00 201.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	MEMORI	<u>AL HUSPITA</u>	AL LOGANSPORT Provider CC		riod: om 01/01/2021	u of Form CMS-2 Worksheet B Part II Date/Time Pre	pared:
			CAPI	TAL RELATED CO	STS	5/27/2022 1:4	
Cost Center Description	Assi	rectly gned New apital ced Costs	NEW BLDG & FIXT	MOB	OPS	Subtotal	
		0	1.00	1.01	1.02	2A	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & 1.01 00101 MOB		0 0 0 0 0 0 0 0 0 0	27, 624 351, 480 800, 993 14, 037 31, 425 133, 011 64, 290 49, 871	6, 105 20, 417 1, 322 0 12, 264 0 0 0	0 0 11, 704 0 432 0 0 0 0	33, 729 371, 897 814, 019 14, 037 44, 121 133, 011 64, 290 49, 871	8.00 9.00 10.00 11.00
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY	,	0 0 0 0	92, 836 47, 306 167, 473 27, 938	0 0 0 0	0 0 0 0	92, 836 47, 306 167, 473 27, 938	15.00 16.00
I NPATI ENT ROUTI NE SERVI CE COST 30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	CENTERS	0 0 0	783, 717 118, 840 5, 849	0 0 0	0 0 0	783, 717 118, 840 5, 849	31.00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROO 53.00 05300 ANESTHESI OLOGY S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S S <		0 0 0 0 0 0	438, 355 95, 895 46, 272 203, 083 0 0 0	0 0 0 0 0 0 0	33, 560 0 0 8, 309 0 0 0 0	471, 915 95, 895 46, 272 211, 392 0 0 0	52.00 53.00 54.00 57.00 58.00 59.00
60.00 06000 LABORATORY 63.00 06300 BLOOD STORING, PROCESSING 65.00 06500 RESPIRATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 69.00 06900 ELECTROCARDIOLOGY 69.01 06901 CARDIAC REHAB 71.00 07100 MEDICAL SUPPLIES CHARGED 72.00 07200 IMPL. 73.00 07300 DRUGS CHARGED TO PATIENTS 76.01 03480 ONCOLOGY	TO PATI ENTS TENT	0 0 0 0 0 0 0 0 0 0 0 0 0	108, 807 0 7, 738 124, 306 10, 775 125, 138 0 0 0 16, 489 0	6,686 0 0 14,069 0 0 0 0 0 0 0	3, 875 0 0 0 0 0 0 0 0 48, 216	119, 368 0 7, 738 124, 306 24, 844 125, 138 0 0 0 16, 489 48, 216	63.00 65.00 66.00 69.00 69.01 71.00 72.00 73.00 76.00
OUTPATI ENT SERVI CE_COST_CENTERS 88. 00 08800 EXPRESS_MEDI CAL_CENTER 88. 01 08801 FAMI LY_HEALTH_CARE 90. 00 09000 CLI NI C 90. 01 09001 WOUND_CARE 91. 00 09100 EMERGENCY 92. 00 052ERVATION_BEDS_(NON-DI SOTTERS) 0THER_REI_MBURSABLE_COST_CENTERS	STINCT PART)	0 0 0 0	0 0 4, 724 0 344, 642	0 0 78, 780 13, 611 0	0 0 0 0	0 0 83, 504 13, 611 344, 642 0	90.01 91.00
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS		0	0	0	0	0	95.00
118.00 SUBTOTALS (SUM OF LINES 1 NONREI MBURSABLE COST CENTERS	through 117)	0	4, 242, 914	153, 254	106, 096	4, 502, 264	1
194. 00 07950 FOUNDATI ON 194. 01 07951 MOB 194. 02 07952 NONREI MBURSABLE OTHER 194. 03 07953 PI H 194. 04 07954 HEALTH COMPANIES 194. 05 07955 PHYSI CI ANS OFFI CE		0 0 0 0 0	0 0 0 51, 400 101, 316	0 7,362 0 0 0 27,993	0 0 0 0 0 0	7, 362 0	
194.06 07956 THE ARBORS 194.07 07957 PAIN MANAGEMENT 194.08 07958 0PS 194.09 07959 MHL ROCHESTER HEALTH CENT 194.10 07961 RHEUMATOLOGY 194.11 07960 SPORTS HEALTH	TER			0 0 0 28, 093 0	0 0 41, 230 0 0 0	0 41, 230 0 28, 093	194.06 194.07 194.08 194.09 194.10 194.11
194. 1207962BEHAVI ORALHEALTHCLINIC200. 00Cross Foot Adjustments201. 00Negative Cost Centers202. 00TOTAL (sum lines 118 throps)	bugh 201)	0	0 0 4, 395, 630	6, 990 0 223, 692	0 0 147, 326	6, 990 0	194. 12 200. 00 201. 00

ALIO2ATIGN OF CAPITAL RELATED COSTS Provider: DOL: 15:007 Provider	Health Financial Systems	MEMORIAL HOSPIT	AL_LOGANSPORT		In Lie	u of Form CMS-	2552-10
Cost Center Description DERVICE Internation Action Defention F & Gransson OPERATIVE P & Gransson OPERATIVE P & Gransson Defention P & Gransson LUMMAY P & LUMMAY F LUMMAY F LUMMAY F LUMMAY F P & Gransson 1.00 Gransson Gransson 6.00 5.00 7.00 6.00 9.00 9.00 1.00 1.00 Gransson Gransson 1.00 1.00 1.00 1.00 1.00 Gransson Gransson 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.	ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	F	rom 01/01/2021	Part II	narod:
DelVERTING E.A. GENERAL PLANT LINEN SERVICE 00 OPTION LINENT 5.00 7.00 8.00 9.00 1.01 ODTOR LARREY OF COST CENTERS 4.00 7.00 8.00 9.00 1.01 ODTOR LARREY OF PERCENTS DEPARTNENT 3.757, 717 1.01 1.01 5.00 7.00 8.00 9.00 1.01 ODTOR MAIN STRATUF & FENERAL 3.757, 717 1.01 5.00 7.00 8.00 9.00 1.00 1.00 ODTOR MAIN STRATUF & FENERAL 2.97 1.11 1.2464 10 6.5, 00 1.00 1.00 DOTOR MAIN STRATUF & FENERAL 2.97 1.14 1.2464 10 1.00 1.00 1.00 DOTOR MAINS RAW INSTRATUF & FENERAL 2.97 1.14 1.1464 10 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00						5/27/2022 1:4	7 pm
Bit Net All STRUCT COST CENTERS 1.00 0.00 0000014/08 1.00 0.00 0000014/08 1.00 0.00 0000014/08 1.00 0.00 0000014/08 1.00 0.00 0000014/08 1.00 0.00 0000014/08 0.00 0.00 0000014/08 0.00 0.00 0000014/08 0.00 0.00 0000014/08 0.00 0.00 0000014/08 0.00 0.00 0000014/08 0.00 0.00 0000014/08 0.00 0.00 0000014/08 0.00 0.00 0000004 0.00 0.00 000004 0.00 0.00 000004 0.00 0.00 000004 0.00 0.00 000004 0.00 0.00 000004 0.00 0.00 00004 0.00 0.00 00004 0.00 0.00 0004004 0.00 <td>Cost Center Description</td> <td>BENEFI TS</td> <td>E & GENERAL</td> <td></td> <td></td> <td>HOUSEKEEPI NG</td> <td></td>	Cost Center Description	BENEFI TS	E & GENERAL			HOUSEKEEPI NG	
1.00 DOTOD INTE CAP FIL CONST. FUEG & FLYT 1.00 1.00 DOTOD AND BELEFET TS DEPARTMENT 33, 200 1.00 DOTOD AND STATURE 1.00 1.00 DOTOD AND STATURE STATURE 0.00 DOTOD ANDRY & LINER SEVICE 0.01111 C2, 505 17, 653 0.00 DOTOD ANDRY & LINER SEVICE 0.01111 C2, 505 17, 653 0.00 DOTOD ANDRY & LINER SEVICE 0.01111 C2, 505 17, 653 0.00 DOTOD ANDRY & LINER SEVICE 2.27 5, 714 181 0.1100 0.01000 HUSEREEPING 3.029 15, 570 0 4.28 14, 00 11.00 DITODO FINAL SEVICE SEVICE 112 1, 173 561 21, 990 553 16, 00 0.01000 HULES & FEDIAL SEVICE SEVICE 112 1, 173 561 21, 990 553 16, 00 174 13, 00 0.01000 HUSEREEFING 777 7, 472 1, 04 716 6, 012 19, 00 13, 00 1428 14, 00		4.00	5.00	7.00	8.00	9.00	
1.22 00102 (PS 1.22 00102 (PS 1.22 00102 (PS 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 00000 1.22 1.22 1.22 1.22 1.22 1.22 1.22 1.22 1.22 1.22 1.22 1.22 1.22 1.22 1.22 1.22 1.22 1.22 1.22 1.22 1.22 1.22 1.22 1.22 1.22 1.22 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>1.00</td></td<>							1.00
4.00 00.000 EMPLOYCE BENEFITS DEPARTMENT 33. 320 4.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 10.00 10.00 5.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00						-	1
5.00 DOSCO JAMINI STRATUTE & GENERAL 3, 320 375, 217 5 5 5 5 5 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 7 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0<		33 729					1
8.00 000000 LAUNDRY & LINEN SERVICE 0 1.111 2.503 8.00 05000 000000 F1.444 101 0.00000 000000 F1.447 101 0.00000 000000 F1.447 101 0.00000 000000000000000000000000000000000000							1
9.00 000000 NUDEKCEP NG 527 5,714 15,840 0 65,702 9,002 10,00000 100000 NUDEKCEP NG 59 1,263 23,244 15,840 0 15,000 10,000 11,000 00000 NUDEKCEP NG 59 1,263 23,244 15,840 0 15,000 11,000 NUEKCEP NG 50,000	7.00 00700 OPERATION OF PLANT	646	19, 635	834, 300			
10.00 01000 DETARY 59 1.2.63 2.3.741 181 0 10.00 11.00 01000 DETRAL SERVICES & SUPPLY 239 3.722 6.483 8.962 0 178 13.00 11.00 01000 DETRAL SERVICES & SUPPLY 239 3.027 0 5.99 0 5.99 0 5.99 0 5.99 0 5.99 0 5.99 0 5.99 0 0 7.00 0 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.00000 0 0 0.00000 0.00000 0.00000 0 0 0 0.000000 0 0 0 0 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>4E 702</td><td></td></td<>						4E 702	
11.00 01100 CAFETERIA 277 3,736 11,45 0 0 0 11.00 13.00 01300 NESING ADMINISTRATION 722 6,483 8,902 0 14.00 14.00 CENTRAL SERVICES & SUPPLY 239 3,029 16,570 0 428 14.00 10.00 01600 NENARMACY 1,588 5,667 17 4,997 0 0 0 0.01 0.00 0.01 0.00 0.01 0.00 0.01 0.00 0.01 0.00 0.01 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
14.00 CENTRAL SERVICES & SUPPLY 229 3.029 16.50 0 428 14.00 15.00 01500 HERCORDS & LIBRARY 1.618 39.071 29.893 0 535 16.00 16.00 01500 HERCORDS & LIBRARY 1.618 39.071 29.893 0 535 16.00 10.00 000.014.15 & PED ATRIC IS 2.942 21.592 139.887 5.814 21.904 30.00 3.00 3.024 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00							1
15. 00 01500 PHARMACY 558 5. 667 8. 444 0 356 15. 00 17. 00 01700 SOCIAL SERVICE 112 1, 175 4, 987 0 0 7. 00 IMPATELYN ROUTINE SERVICE COST CENTERS 112 1, 175 4, 987 0 0 7. 00 30. 00 03000 AULTS & FEDIALRICS 2, 842 21, 582 139, 867 5, 516 21, 943 3. 565 31. 00 30. 00 03000 FEDIALRY SERVICE COST CENTERS 2.1< 212					-		1
16. 00 01600 MEDICAL RECORDS & LIBRARY 1, 418 39, 071 29, 993 0 535 16. 00 10. 00 01000 NUMER SERVICE COST CENTERS 112 1, 175 4, 993 0 0 0 00 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 000000 00000 000000 000000 00000000 000000000000000000000000000000000000					Ű		1
17.00 01700 SOCIAL SERVICE 112 1,175 4,987 0 0 17.00 IMPATEM RUTINE SERVICE COST CENTERS 2,842 21,582 139,887 5,816 21,996 30.00 30.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.0					-		1
30:00 03000 ADULTS & PEDIATRICS 2,642 21,562 139,887 5,616 21,966 30.00 43:00 04300 (NURSISY 277 2,426 1,044 280 143 43.00 43:00 04300 (NURSISY 277 2,426 1,044 280 143 43.00 43:00 04300 (NURSISY 277 2,426 1,044 280 143 43.00 50:00 05000 (PERATING ROOM 4,346 29,351 103,526 4,710 8,021 50.00 52.00 50:00 05300 (NESTINES) (LCCY 0 225 8,259 0 0.65.20 52.00 55.00 55.00 55.00 55.00 55.00 55.00 56.00 55.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.30 66.00 77.40 1.60.46 69.00 72.00 72.00					-		1
31.00 03100 NTESIS VE CARE UNIT 725 6,715 27,212 592 3,566 31.00 AND 03300 NURSERY 277 2,42 1,044 280 143 43.00 NCILLARY SERVICE COST CENTERS			01 500	100.007	5.01/	01.00/	
43. 00 04300 NURSERY 277 2, 426 1, 044 280 143 43. 00 ANCILLARY SERVICE COST CENTES							
MXILLARY SERVICE COST CENTERS 0.00 05000 (DEENTING ROM 4,346 29,351 103,526 4,710 6,021 50,001 52.00 05200 (DELIVERY ROM & LABOR ROM 424 4,140 17,117 0 2,400 52,00 53.00 05300 (DSCOLOCY) LARNOSTI C 1,061 13,964 42,508 1,487 2,852 54,00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
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	202.00 IUTAL (sum Fines 118 through 201)	33, 729	375, 217	834, 300	17, 653	65, 702	202.00

		MEMORIAL HOSPITA	AL LOGANSPORT		In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der C		eriod: rom 01/01/2021	Worksheet B Part II	
					o 12/31/2021	Date/Time Pre	epared:
	Cost Center Description	DI ETARY	CAFETERIA	NURSI NG	CENTRAL	5/27/2022 1:4 PHARMACY	+/ pm
				ADMI NI STRATI O	SERVICES &		
		10.00	11 00	N 12.00	SUPPLY	15.00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	15.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 MOB						1.01
1.02 4.00	00102 OPS 00400 EMPLOYEE BENEFITS DEPARTMENT						1.02
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	158, 255					9.00 10.00
11.00	01100 CAFETERIA	130, 233	79, 778				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	1, 929				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1, 565			(0.040	14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	1, 612 4, 505		-	63, 943 0	1
	01700 SOCIAL SERVICE	0	4, 303			0	1
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30.00	03000 ADULTS & PEDIATRICS	140, 573	8, 072			0	1
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	17, 682 0	2, 607 1, 018			0	
45.00	ANCI LLARY SERVICE COST CENTERS	0	1,010	2, 512	0	0	43.00
50.00	05000 OPERATING ROOM	0	10, 574	24, 008	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 562			0	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0 3, 917	-	-	0	53.00 54.00
57.00	05700 CT SCAN	0	3, 717		-	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	0	0	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0			0	
60.00 63.00	06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0	-	-	0	
65.00	06500 RESPIRATORY THERAPY	0	2, 098			0	65.00
66.00	06600 PHYSI CAL THERAPY	0	2, 774		0	0	1
69.00	06900 ELECTROCARDI OLOGY	0	577		-	0	69.00
69.01	06901 CARDI AC REHAB	0	1, 180			0	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0			0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			63, 943	
76.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	567			0	
76.01	03480 ONCOLOGY OUTPATI ENT SERVICE COST CENTERS	0	2, 136	C	0	0	76.01
88.00	08800 EXPRESS MEDICAL CENTER	0	0	C	0	0	88.00
88.01	08801 FAMILY HEALTH CARE	0	0			0	1
	09000 CLINIC	0	13, 137		Ŭ	0	
	09001 WOUND CARE 09100 EMERGENCY	0	264 5, 076			0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	5,076	11, 525	0	0	91.00
	OTHER REIMBURSABLE COST CENTERS	· ·		1			
95.00	09500 AMBULANCE SERVICES	0	0	0 0	0	0	95.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	158, 255	65, 544	68, 085	114, 667	62 042	118.00
110.00	NONREIMBURSABLE COST CENTERS	156, 255	05, 544	08,085	114,007	03, 943	110.00
	07950 FOUNDATI ON	0	0				194.00
	07951 MOB	0	0				194.01
	07952 NONREI MBURSABLE OTHER 07953 PI H	0	0		-		194.02 194.03
	07953 PTH 07954 HEALTH COMPANIES	0	1, 704	-	-		194.03
	07955 PHYSI CI ANS OFFI CE	0	8, 759		Ŭ,	0	194.05
	07956 THE ARBORS	0	0		0		194.06
	07957 PAIN MANAGEMENT	0	0		0		194.07
	07958 OPS 07959 MHL ROCHESTER HEALTH CENTER	0	0				194.08 194.09
	07951 RHEUMATOLOGY	0	2, 165		0		194.09
194.11	07960 SPORTS HEALTH	0	1, 084	C	0	0	194.11
	07962 BEHAVI ORAL HEALTH CLINIC	0	522	2 O	0	0	194.12
200.00 201.00			0			0	200.00
201.00		158, 255	79, 778	-	114, 667		201.00
			,				•

Heal th	Financial Systems	MEMORIAL HOSPITA	L LOGANSPORT		In Lieu	u of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 01/01/2021	Worksheet B Part II	
				T.		Date/Time Pre	pared:
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	<u>5/27/2022</u> 1:4 Total	7 pm
		16.00	17.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT				[[1.00
	00101 MOB						1.00
	00102 OPS						1.02
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINISTRATIVE & GENERAL						5.00
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
							11.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13.00 14.00
	01400 PHARMACY						15.00
	01600 MEDI CAL RECORDS & LI BRARY	243, 095					16.00
17.00	01700 SOCIAL SERVICE	0	34, 586				17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	14.224	27 1(0	1 10(7//		1 10(7//	20.00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	14, 336 3, 355	27, 169 4, 049	1, 186, 766 185, 260		1, 186, 766 185, 260	
	04300 NURSERY	1, 568	0	14, 917	0	14, 917	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	73, 539	0	729, 990	0	729, 990	
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	86 2, 826	0	125, 230 57, 582	0	125, 230 57, 582	
	05400 RADI OLOGY-DI AGNOSTI C	19, 283	0	296, 464	0	296, 464	
57.00	05700 CT SCAN	0	0	0	0	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 28, 265	0	0 196, 776	0	0 196, 776	59.00 60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	28, 205	0	1,973	0	1,973	
	06500 RESPI RATORY THERAPY	9, 986	0	30, 923	0	30, 923	
	06600 PHYSI CAL THERAPY	5, 482	0	164, 179		164, 179	
	06900 ELECTROCARDI OLOGY	4, 252	0	47, 110	0	47, 110	
	06901 CARDI AC REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	648 0	0	152, 234 126, 704	0	152, 234 126, 704	
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	9, 390	0	9, 390	
	07300 DRUGS CHARGED TO PATIENTS	0	0	112, 654	0	112, 654	
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	13, 380	0	37, 321	0	37, 321	
	03480 ONCOLOGY OUTPATI ENT SERVICE COST CENTERS	13, 880	0	109, 854	0	109, 854	76.01
	08800 EXPRESS MEDICAL CENTER	0	0	0	0	0	88.00
	08801 FAMILY HEALTH CARE	0	0	0	0	0	
	09000 CLINIC	14, 415	0	197, 974		197, 974	
	09001 WOUND CARE 09100 EMERGENCY	2, 847 20, 715	3, 368	29, 366 471, 439		29, 366 471, 439	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	20,710	0,000	171,107	0	171,107	92.00
	OTHER REIMBURSABLE COST CENTERS				I		
	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	229, 781	34, 586	4, 284, 106	0	4, 284, 106	118.00
	NONREI MBURSABLE COST CENTERS	,	,	.,,	-	.,,	
	07950 FOUNDATI ON	0	0	579			194.00
	07951 MOB 07952 NONREI MBURSABLE OTHER	0	0	13, 344 0	0	13, 344	194.01 194.02
	07953 PIH	0	0	0	0		194.02
	07954 HEALTH COMPANIES	0	0	67, 348	0	67, 348	
	07955 PHYSICIANS OFFICE	10, 491	0	238, 042		238, 042	
	07956 THE ARBORS	0	0	0	0		194.06
	07957 PAIN MANAGEMENT 07958 OPS	0	0	0 73, 916	0	0 73, 916	194.07 194.08
	07959 MHL ROCHESTER HEALTH CENTER	681	0	5, 223			194.00
194.10	07961 RHEUMATOLOGY	1, 715	o	65, 858		65, 858	
	07960 SPORTS HEALTH	0	0	3, 072			194.11
	07962 BEHAVI ORAL HEALTH CLINIC	427	0	15, 160 0	0		194.12
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers	0	0	0	0		200. 00 201. 00
201.00	TOTAL (sum lines 118 through 201)	243, 095	34, 586	4, 766, 648	-	4, 766, 648	
'		,			,		

	ancial Systems N ATION - STATISTICAL BASIS	IEMORIAL HOSPITA	LOGANSPORT		Period:	u of Form CMS-2 Worksheet B-1	
					rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/27/2022 1:4	
		CAPI	TAL RELATED CO	STS			
	Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	MOB (SQUARE FEET)	OPS (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliatio n	
CENE		1.00	1.01	1.02	4.00	5A	
1.00 0010 1.01 0010 1.02 0010 4.00 0040 5.00 0050 7.00 0070 8.00 0088 9.00 0090 10.00 0100	RAL SERVICE COST CENTERS 00 NEW CAP REL COSTS-BLDG & FIXT 11 MOB 12 OPS 00 EMPLOYEE BENEFITS DEPARTMENT 00 ADMINISTRATIVE & GENERAL 100 OPERATION OF PLANT 101 HOUSEKEEPING 102 DI ETARY 103 CAFETERIA	195, 407 0 1, 228 15, 625 35, 608 624 1, 397 5, 913 2, 858	44, 997 0 1, 228 4, 107 266 0 2, 467 0 0	27, 643 C 2, 196 C 81 C C	41, 573, 132 4, 093, 458 796, 827 0 649, 266 72, 445	-9, 131, 075 0 0 0 0 0	7.00 8.00 9.00 10.00
13.00 0130 14.00 0140 15.00 0150 16.00 0160 17.00 0170	NO CAPETERTA NO NURSI NG ADMINI STRATI ON NO CENTRAL SERVI CES & SUPPLY NO PHARMACY NO MEDI CAL RECORDS & LI BRARY NO SOCI AL SERVI CE TI ENT ROUTI NE SERVI CE COST CENTERS	2, 838 2, 217 4, 127 2, 103 7, 445 1, 242	0 0 0 0 0		890, 426 295, 175 688, 010 1, 995, 325	0 0 0 0	13.00
30.00 0300	0 ADULTS & PEDIATRICS 10 INTENSIVE CARE UNIT	34, 840 5, 283	0	C		0	
43.00 0430	0 NURSERY LLARY SERVICE COST CENTERS	260	0	C		0	43.00
50.00 0500 52.00 0520 53.00 0530 54.00 0540 57.00 0570 58.00 0580	00 OPERATING ROOM 00 DELIVERY ROOM & LABOR ROOM 00 ANESTHESIOLOGY 100 RADIOLOGY-DIAGNOSTIC 00 CT SCAN 100 MAGNETIC RESONANCE IMAGING (MRI)	19, 487 4, 263 2, 057 9, 028 0 0	0 0 0 0 0 0	6, 297 C C 1, 559 C C C	523, 054 0 1, 308, 363 0 0 0	0 0 0 0 0 0	52.00 53.00 54.00 57.00 58.00
60.00 0600 63.00 0630 65.00 0650 66.00 0660 69.01 0690 71.00 0710 72.00 0722 73.00 0730 76.00 0345	 CARDIAC CATHETERIZATION CABORATORY BLOOD STORING, PROCESSING & TRANS. RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROCARDIOLOGY CARDIAC REHAB MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS NUCLEAR MEDICINE - DIAGNOSTIC ONONCLOGY 	4, 837 0 344 5, 526 479 5, 563 0 0 0 733 0	1, 345 0 0 2, 830 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	C 727 C C C C C C C C C C C C C C C C C	0 966, 509 995, 488 263, 119 307, 265 0 0 40 230, 418		1
OUTF	ATIENT SERVICE COST CENTERS		0	9,047	077, 440	0	76.01
88.01 0880 90.00 0900 90.01 0900 91.00 0910 92.00 0920	00 EXPRESS MEDICAL CENTER 11 FAMILY HEALTH CARE 10 CLINIC 11 WOUND CARE 10 EMERGENCY 10 OBSERVATION BEDS (NON-DISTINCT PART) 10 R REIMBURSABLE COST CENTERS	0 0 210 0 15, 321	0 0 15, 847 2, 738 0		1 6, 849, 582 147, 975	0 0 0 0 0	88.01 90.00 90.01
95.00 0950	O AMBULANCE SERVICES	0	0	С	0	0	95.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	188, 618	30, 828	19, 907	34, 026, 572	-9, 131, 075	118.00
194.000795 194.010795	2 NONREI MBURSABLE OTHER	0 0 0	0 1, 481 0 0		0 0 0 0	0	194.00 194.01 194.02 194.03
194. 04 0795 194. 05 0795 194. 06 0795 194. 07 0795 194. 08 0795	4 HEALTH COMPANIES 5 PHYSICIANS OFFICE 6 THE ARBORS 57 PAIN MANAGEMENT 88 OPS	2, 285 4, 504 0 0	0 0 5, 631 0 0 0	C C C C 7, 736	473, 189 4, 814, 999 0 0 0 0 0 0 0	0 0 0 0 0	194. 04 194. 05 194. 06 194. 07 194. 08
194. 10 0796 194. 11 0796	99 MHL ROCHESTER HEALTH CENTER 11 RHEUMATOLOGY 00 SPORTS HEALTH 12 BEHAVIORAL HEALTH CLINIC Cross Foot Adjustments Negative Cost Centers	0 0 0 0	0 5, 651 0 1, 406		1, 223, 595 251, 520	0 0	194.09 194.10 194.11 194.12 200.00 201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	4, 395, 630	223, 692	147, 326	13, 865, 087		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	22. 494742	4. 971265	5. 329595	0. 333511		203.00

Health Fin	ancial Systems	MEMORIAL HOSPIT	AL LOGANSPORT		In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider C	CN: 15-0072	Period: From 01/01/2021	Worksheet B-1	
					To 12/31/2021		pared: 7 pm
		CAPI	TAL RELATED CO	OSTS			
	Cost Center Description	NEW BLDG &	MOB	OPS	EMPLOYEE	Reconciliatio	
		FLXT	(SQUARE	(SQUARE	BENEFI TS	n	
		(SQUARE	FEET)	FEET)	DEPARTMENT		
		FEET)			(GROSS		
		1.00	1.01	1.00	SALARI ES)		
		1.00	1.01	1.02	4.00	5A	
204.00	Cost to be allocated (per Wkst. B, Part II)				33, 729		204.00
205.00	Unit cost multiplier (Wkst. B, Part				0. 000811		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	I					206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	Financial Systems LOCATION - STATISTICAL BASIS	MEMORIAL HOSPITA	Provider C	CN: 15-0072 P	eriod:	u of Form CMS-: Worksheet B-1	
001 AL				F	rom 01/01/2021		
					o 12/31/2021	Date/Time Pre 5/27/2022 1:4	pared 7 pm
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL (ACCUM.	PLANT (SQUARE	LINEN SERVICE (LAUNDRY)	(HOURS OF SERVICE)	(PATI ENT DAYS)	
		COST)	FEET)		OLIVITOL)	bitto)	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						1 1 0
	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 MOB						1. C
	00102 OPS						1.0
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
. 00	00500 ADMI NI STRATI VE & GENERAL	77, 580, 980					5.C
	00700 OPERATION OF PLANT	4, 060, 246	207, 789				7.0
	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	229, 709	624				8.0
	00900 DI ETARY	1, 078, 203 261, 262	3, 945 5, 913		., = . =	5, 388	9.0 10.0
	01100 CAFETERI A	772, 526	2, 858			0,000	11.0
	01300 NURSING ADMINISTRATION	1, 340, 631	2, 217		5	0	13.0
	01400 CENTRAL SERVICES & SUPPLY	626, 359	4, 127			0	14.0
	01500 PHARMACY	1, 171, 919	2, 103			0	15.0
	01600 MEDICAL RECORDS & LIBRARY	8,079,225	7,445			0	16.0
H-	01700 SOCIAL SERVICE	242, 908	1, 242	0	0	0	17.0
	03000 ADULTS & PEDIATRICS	4, 462, 724	34, 840	95, 217	617	4, 786	30.0
	03100 I NTENSI VE CARE UNI T	1, 388, 452	5, 283			602	
	04300 NURSERY	501, 620	260	4, 577	4	0	43.0
	ANCI LLARY SERVICE COST CENTERS	(0/0 0	05.30		0.00-		50
	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	6,069,277	25, 784			0	50.0 52.0
	05200 DELIVERY ROOM & LABOR ROOM	856, 177 46, 544	4, 263 2, 057			0	52.0
	05400 RADI OLOGY-DI AGNOSTI C	2, 887, 538	10, 587			0	54.0
	05700 CT SCAN	0	0			0	57.0
3. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.0
	05900 CARDI AC CATHETERI ZATI ON	0	0	-	0	0	59.0
	06000 LABORATORY	4, 167, 425	6, 909			0	60.0
	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06500 RESPI RATORY THERAPY	218, 062 1, 516, 204	0 344			0	63.0 65.0
	06600 PHYSI CAL THERAPY	1, 530, 787	5, 526		20	0	66.0
	06900 ELECTROCARDI OLOGY	482, 571	3, 309			0	69.0
9. 01	06901 CARDI AC REHAB	554, 845	5, 563			0	69.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 489, 026	0		0	0	71.(
	07200 IMPL. DEV. CHARGED TO PATIENT	1, 941, 752	0			0	72.0
	07300 DRUGS CHARGED TO PATLENTS 03450 NUCLEAR MEDICINE - DIAGNOSTIC	10, 065, 205 776, 469	0 733			0	73.0 76.0
	03480 ONCOLOGY	1, 215, 403	9, 047			0	76.0
	OUTPATIENT SERVICE COST CENTERS	., = ,	.,	-			
	08800 EXPRESS MEDI CAL CENTER	1	0			0	88.
	08801 FAMILY HEALTH CARE	1	0	0	0	0	
		3, 084, 638	16, 057			0	
	09001 WOUND CARE 09100 EMERGENCY	132, 357 2, 781, 697	2, 738 15, 321		25 160	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,701,077	15, 521	00, 013	100	0	92.
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	0	0	0	0	95.
	SPECIAL PURPOSE COST CENTERS	(5.004.7/0	170.005	000.010	1 (00)		1110
18.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	65, 031, 763	179, 095	289, 013	1, 602	5, 388	1118.1
	07950 FOUNDATI ON	1, 872	0	0	16	0	194.
	07951 MOB	7, 362	1, 481				194.
	07952 NONREI MBURSABLE OTHER	0	0	0			194.
4.03	07953 PI H	0	0	0		0	194.
	07954 HEALTH COMPANIES	821, 302	2, 285				194.
	07955 PHYSI CLANS OFFI CE	8, 396, 754	10, 135		120		194.
	07956 THE ARBORS 07957 PAIN MANAGEMENT	0	0	0	0		194. 194.
	07957 PATN MANAGEMENT 07958 OPS	41, 230	7, 736		40		194. 194.
	07959 MHL ROCHESTER HEALTH CENTER	841, 172	,,,30	0			194.
	07961 RHEUMATOLOGY	1, 778, 170	5, 651		45		194.
4. 11	07960 SPORTS HEALTH	368, 813	0	0		0	194.
	07962 BEHAVI ORAL HEALTH CLINIC	292, 542	1, 406	0	0	0	194.
0.00	Cross Foot Adjustments						200.
1.00	Negative Cost Centers	0 121 075	A E20 105	070 070	1 201 2/2	100 004	201.
02.00	Cost to be allocated (per Wkst. B, Part I)	9, 131, 075	4, 538, 125	270, 373	1, 291, 263	423, 924	202.
03. 00	Unit cost multiplier (Wkst. B, Part I)	0. 117697	21. 840064	0. 935505	700. 631036	78. 679287	203.
	Cost to be allocated (per Wkst. B,	375, 217	834, 300			158, 255	
04.00	Cost to be allocated (per wikst. b,	575,217	001,000			100, 200	201.

Health Financial Systems	MEMORIAL HOSPIT	AL LOGANSPORT		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2021	Worksheet B-1	
				To 12/31/2021	Date/Time Pre 5/27/2022 1:4	
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	E & GENERAL	PLANT	LINEN SERVICE	E (HOURS OF	(PATI ENT	
	(ACCUM.	(SQUARE	(LAUNDRY)	SERVICE)	DAYS)	
	COST)	FEET)				
	5.00	7.00	8.00	9.00	10.00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 004836	4. 015131	0. 06108	0 35.649485	29. 371752	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

			Provider CC		eriod:	Worksheet B-1	
				F T	rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/27/2022 1:4	
	Cost Center Description	CAFETERI A (MAN HOURS)	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS)	CENTRAL SERVICES & SUPPLY (100%	PHARMACY (100% DRUGS)	MEDI CAL RECORDS & LI BRARY (REVENUE)	
		11.00	13.00	SUPPLIES) 14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						1 00
1.01 1.02 4.00 5.00 7.00 8.00 10.00 11.00 13.00 14.00 15.00 14.00 15.00 17.00 17.00 10.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 1	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 MOB 00102 OPS 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINI STRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVICE	857, 377 20, 732 16, 814 17, 325 48, 419 4, 016	322, 282 0 0 0 0 0	100 0 0 0	100 0 0	205, 206, 660 0	1
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	86, 748	98, 343	0	0	12, 098, 106	30.00
31.00	03100 I NTENSI VE CARE UNI T	28, 014	28, 014	0	0	2, 831, 323	31.00
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	10, 945	10, 945	0	0	1, 323, 123	43.00
	05000 OPERATI NG ROOM	113, 643	113, 643	0	0	62, 121, 548	50.00
1	05200 DELIVERY ROOM & LABOR ROOM	16, 784	16, 784	0	0	72, 834	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 42, 093	0	0	0	2, 384, 753 16, 272, 235	
57.00	05700 CT SCAN	0	0	0	0	0	57.00
	05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
	06000 LABORATORY	0	0	0	0	23, 852, 306	
	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0	0	0	774, 839	1
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	22, 546 29, 812	0	0	0	8, 426, 828 4, 625, 797	
69.00	06900 ELECTROCARDI OLOGY	6, 203	0	0	0	3, 588, 510	69.00
	06901 CARDI AC REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	12, 678 0	0	0 100	0	547, 009 0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	1
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	100	0	
	03450 NUCLEAR MEDICINE - DIAGNOSTIC 03480 ONCOLOGY	6, 096 22, 955	0	0	0	11, 291, 024 11, 713, 051	
C	OUTPATIENT SERVICE COST CENTERS	22,700					
	08800 EXPRESS MEDI CAL CENTER 08801 FAMI LY HEALTH CARE	0	0	0 0	0	0	88.00 88.01
	09000 CLINIC	141, 180	0	0	0	12, 164, 536	
	09001 WOUND CARE	2, 835	0	0	0	2, 402, 141	90.01
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	54, 553	54, 553	0	0	17, 480, 848	91.00 92.00
C	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	95.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	704, 391	322, 282	100	100	193, 970, 811	118.00
	NONREI MBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951 MOB	0	0	0	0	0	194.01
	07952 NONREI MBURSABLE OTHER 07953 PI H	0	0	0	0		194.02 194.03
	07953 HEALTH COMPANIES	18, 316	0	0	0		194.03
	07955 PHYSI CI ANS OFFI CE	94, 135	0	0	0	8, 853, 514	
	07956 THE ARBORS 07957 PAIN MANAGEMENT	0	0	0	0		194.06 194.07
194.08	07958 OPS	0	0	0	0	0	194.08
	07959 MHL ROCHESTER HEALTH CENTER 07961 RHEUMATOLOGY	0 23, 272	0	0	0	574, 527 1, 447, 197	
	07960 SPORTS HEALTH	11, 650	0	0	0		194.10
	07962 BEHAVI ORAL HEALTH CLINIC	5, 613	0	0	0	360, 611	
200.00	Cross Foot Adjustments Negative Cost Centers						200.00
	insight to boot boiltors	005 0/0	1, 572, 729	816, 779	1, 381, 495	9, 255, 521	
200.00 201.00 202.00	Cost to be allocated (per Wkst. B,	925, 869	1, 572, 727	010, 779	1, 301, 473	7, 200, 021	202.00
201.00	Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)	925, 869			13, 814. 950000	0. 045103	

Health Financial Systems	MEMORIAL HOSPIT	AL LOGANSPORT		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 1:4	
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)	SUPPLIES)			
	11.00	13.00	14.00	15.00	16.00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 093049	0. 211259	1, 146. 67000	639. 430000	0. 001185	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

	Financial Systems LLOCATION - STATISTICAL BASIS	MEMORIAL HOSPITAL	LOGANSPORT Provider CCN: 15-0072	Peri od:	u of Form CMS Worksheet B	
				From 01/01/2021 To 12/31/2021	Date/Time Pi 5/27/2022 1:	
	Cost Center Description	SOCI AL SERVI CE (HOURS)				
	GENERAL SERVICE COST CENTERS	17.00				
. 00 . 01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 MOB					1.0
. 01	00102 OPS					1.0
00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.0
00	00500 ADMI NI STRATI VE & GENERAL					5. C
00	00700 OPERATION OF PLANT					7.0
00 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG					8.0
	01000 DI ETARY					10.0
	01100 CAFETERI A					11. (
	01300 NURSI NG ADMI NI STRATI ON					13.0
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY					14.0
	01600 MEDICAL RECORDS & LIBRARY					16.0
	01700 SOCIAL SERVICE	8, 884				17.0
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS	6, 979				30.0
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	1,040				31.0 43.0
5.00	ANCI LLARY SERVICE COST CENTERS	0				45.0
	05000 OPERATING ROOM	0				50.0
	05200 DELIVERY ROOM & LABOR ROOM	0				52.0
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0				53.0 54.0
	05700 CT_SCAN	0				57.0
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0				58.0
	05900 CARDI AC CATHETERI ZATI ON	0				59.0
	06000 LABORATORY	0				60.0
	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06500 RESPI RATORY THERAPY	0				63.0 65.0
	06600 PHYSI CAL THERAPY	Ő				66.0
	06900 ELECTROCARDI OLOGY	0				69.0
	06901 CARDI AC REHAB	0				69.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0				71.0
	07300 DRUGS CHARGED TO PATIENTS	0				73.0
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0				76.0
5. 01	03480 ONCOLOGY	0				76.0
00		0				
	08800 EXPRESS MEDICAL CENTER 08801 FAMILY HEALTH CARE	0				88.0 88.0
	09000 CLINIC	0				90.0
	09001 WOUND CARE	0				90. (
	09100 EMERGENCY	865				91.0
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					92.0
5.00	09500 AMBULANCE SERVICES	0				95. (
	SPECIAL PURPOSE COST CENTERS					
8.00		7) 8,884				118.0
4.00	NONREI MBURSABLE COST CENTERS	0				194. (
	07951 MOB	0				194. (
4. 02	07952 NONREI MBURSABLE OTHER	0				194. (
		0				194.0
	07954 HEALTH COMPANI ES 07955 PHYSI CI ANS OFFI CE	0				194.0
	07956 THE ARBORS	0				194.0
4.07	07957 PALN MANAGEMENT	0				194. (
	07958 OPS	0				194. (
	07959 MHL ROCHESTER HEALTH CENTER	0				194.0
	07961 RHEUMATOLOGY 07960 SPORTS HEALTH	0				194. 194.
	07960 SPORTS HEALTH 07962 BEHAVI ORAL HEALTH CLINIC	0				194.
0.00						200.
1.00	Negative Cost Centers					201.0
2.00		302, 960				202. (
	Part I)) 24 10175/				202.4
03.00 04.00) 34. 101756 34, 586				203.0 204.0
	Part II)	54, 550				207.0
	Unit cost multiplier (Wkst. B, Part	3. 893066				205.0

Health Financial Systems	MEMORIAL HOSPITA	L LOGANSPORT	In Lieu	u of Form CMS-255	52-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0072	Period: From 01/01/2021	Worksheet B-1	
			To 12/31/2021	Date/Time Prepa 5/27/2022 1:47	
Cost Center Description	SOCI AL				
	SERVI CE				
	(HOURS)				
	17.00				
206.00 NAHE adjustment amount to be allocated				20	06.00
(per Wkst. B-2)					
207.00 NAHE unit cost multiplier (Wkst. D,				20	07.00
Parts III and IV)					

ΟΜΡυτΑ	TION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/27/2022 1:4	parec 7 pm
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	NPATIENT ROUTINE SERVICE COST CENTERS		1	1			4
	D3000 ADULTS & PEDIATRICS	8,004,053		8,004,05		8,004,053	
	D3100 INTENSIVE CARE UNIT	2, 123, 877		2, 123, 87		2, 123, 877	
	D4300 NURSERY	698, 329		698, 32	.9 0	698, 329	43.
	ANCILLARY SERVICE COST CENTERS		1	1	_		4
	D5000 OPERATING ROOM	11, 055, 757		11, 055, 75		11, 260, 669	
	D5200 DELIVERY ROOM & LABOR ROOM	1, 201, 710		1, 201, 71		1, 201, 710	
	D5300 ANESTHESI OLOGY	204, 507		204, 50		204, 507	
	05400 RADI OLOGY-DI AGNOSTI C	4, 316, 827		4, 316, 82		4, 316, 827	
	D5700 CT SCAN	0			0 0	0	
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	
	05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	
	D6000 LABORATORY	5, 909, 144		5, 909, 14	4 0	5, 909, 144	
	D6300 BLOOD STORING, PROCESSING & TRANS.	278, 675		278, 67	5 0	278, 675	63.
5.00 0	06500 RESPI RATORY THERAPY	2, 138, 120	0	2, 138, 12	0 0	2, 138, 120	65.
	D6600 PHYSI CAL THERAPY	2,094,244	0	2, 094, 24	4 0	2, 094, 244	66.
	D6900 ELECTROCARDI OLOGY	811, 717		811, 71	7 0	811, 717	69.
	D6901 CARDI AC REHAB	780, 008		780, 00		780, 008	69.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 598, 756		3, 598, 75	6 0	3, 598, 756	71.
	07200 IMPL. DEV. CHARGED TO PATIENT	2, 170, 290		2, 170, 29	0 0	2, 170, 290	72.
3.00 0	07300 DRUGS CHARGED TO PATIENTS	12, 631, 372		12, 631, 37	2 0	12, 631, 372	73.
6.00	D3450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 399, 708		1, 399, 70	0 8	1, 399, 708	76.
6.01	D3480 ONCOLOGY	2, 165, 172		2, 165, 17	2 0	2, 165, 172	76.
	DUTPATIENT SERVICE COST CENTERS						
	08800 EXPRESS MEDI CAL CENTER	1			1 0	1	88.
8.01 0	D8801 FAMILY HEALTH CARE	1			1 0	1	88.
	D9000 CLINIC	4, 538, 027		4, 538, 02	48, 729	4, 586, 756	90.
	D9001 WOUND CARE	336, 654		336, 65		336, 654	
	D9100 EMERGENCY	4, 761, 376		4, 761, 37	6 0	4, 761, 376	91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	996, 354		996, 35	4	996, 354	
	OTHER REIMBURSABLE COST CENTERS						
5.00 0	09500 AMBULANCE SERVI CES	0			0 0		
00.00	Subtotal (see instructions)	72, 214, 679	0	72, 214, 67	253, 641	72, 468, 320	200.
01.00	Less Observation Beds	996, 354		996, 35	4	996, 354	
02.00	Total (see instructions)	71, 218, 325	0	71, 218, 32	253, 641	71, 471, 966	202

		MEMORIAL HOSPIT				u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/27/2022 1:4	epared: 47 pm
				XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
-	INPATIENT ROUTINE SERVICE COST CENTERS				÷		
30.00	03000 ADULTS & PEDIATRICS	6, 898, 860		6, 898, 86	50		30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 578, 705		1, 578, 70)5		31.00
43.00	04300 NURSERY	1, 322, 606		1, 322, 60	06		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5, 695, 891	33, 941, 976	39, 637, 86	0. 278919	0. 000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 957, 430	71, 624	2, 029, 05	0. 592251	0.00000	52.00
53.00	05300 ANESTHESI OLOGY	293, 383	2,091,370	2, 384, 75	0. 085756	0.00000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1,022,142	15, 213, 156	16, 235, 29	0. 265891	0.00000	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
	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.000000	0.00000	
	06000 LABORATORY	3, 844, 799	20,007,499	23, 852, 29		0.00000	
	06300 BLOOD STORING, PROCESSING & TRANS.	422, 673	611, 904			0. 000000	
	06500 RESPI RATORY THERAPY	5, 286, 984	2,241,094			0.000000	
	06600 PHYSI CAL THERAPY	413, 175	4, 197, 222			0.000000	
	06900 ELECTROCARDI OLOGY	715, 170	4, 690, 221	5, 405, 39		0.000000	
	06901 CARDI AC REHAB	0	547,009			0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 277, 675	4, 497, 105			0. 000000	
	07200 I MPL. DEV. CHARGED TO PATIENT	1, 335, 461	9, 119, 517			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	14, 858, 851	43, 978, 775			0, 000000	•
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 142, 862	10, 148, 162			0.000000	
	03480 ONCOLOGY	397	11, 320, 685			0.000000	
70.01	OUTPATIENT SERVICE COST CENTERS	0,1	11, 020, 000	11, 021, 00	0.171201	0.00000	/ /0.01
88.00	08800 EXPRESS MEDICAL CENTER	0	0		0		88.00
	08801 FAMILY HEALTH CARE	0	0		0		88.01
	09000 CLINIC	125, 963	2,924,398	3, 050, 36	0	0.00000	
	09001 WOUND CARE	6, 931	1, 632, 278			0.000000	
	09100 EMERGENCY	1, 884, 712	16, 545, 007			0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	203, 353	624, 575			0. 000000	
	OTHER REIMBURSABLE COST CENTERS	200, 300	027, 373	027, 72	1.203431	0.00000	, ,2.00
	09500 AMBULANCE SERVICES	0	0		0 0.000000	0, 000000	95.00
200.00		50, 288, 023	184, 403, 577			0.000000	200.00
200.00		00,200,020	.01, 100, 077	201,071,00			200.00
201.00		50, 288, 023	184, 403, 577	234, 691, 60	00		201.00
202.00		00,200,020	.01, 100, 011	201,071,00			1-02.00

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pr 5/27/2022 1:	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS	· ·				
30.00	03000 ADULTS & PEDIATRICS					30.0
31.00	03100 I NTENSI VE CARE UNI T					31.0
	04300 NURSERY					43.0
	ANCI LLARY SERVI CE COST CENTERS					
0.00	05000 OPERATING ROOM	0, 284089				50.0
	05200 DELIVERY ROOM & LABOR ROOM	0. 592251				52.
	05300 ANESTHESI OLOGY	0. 085756				53.
	05400 RADI OLOGY-DI AGNOSTI C	0. 265891				54.
	05700 CT SCAN	0. 203891				57.
		0. 000000				58.
	05800 MAGNETIC RESONANCE IMAGING (MRI)					
	05900 CARDI AC CATHETERI ZATI ON	0.000000				59.
	06000 LABORATORY	0. 247739				60.
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 269361				63.
	06500 RESPI RATORY THERAPY	0. 284019				65.
	06600 PHYSI CAL THERAPY	0. 454244				66.
	06900 ELECTROCARDI OLOGY	0. 150168				69.
	06901 CARDI AC REHAB	1. 425951				69.
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 623185				71.
2.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 207584				72.
3.00	07300 DRUGS CHARGED TO PATIENTS	0. 214682				73.
6.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 123966				76.
6.01	03480 ONCOLOGY	0. 191251				76.
	OUTPATIENT SERVICE COST CENTERS					
8.00	08800 EXPRESS MEDI CAL CENTER					88.
8.01	08801 FAMILY HEALTH CARE					88.
	09000 CLINIC	1. 503676				90.
	09001 WOUND CARE	0. 205376				90.
	09100 EMERGENCY	0. 258353				91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 203431				92.
2.00	OTHER REIMBURSABLE COST CENTERS	1.200401				- '2'
5 00	09500 AMBULANCE SERVICES	0.000000				95.
200. 00		0.000000				200.
200. 00 201. 00						200.
	Less ubservation beus					1201.

OMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/27/2022 1:4	epared 7 pm
			Titl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26) 1.00	Therapy Limit Adj.	Total Costs	RCE Di sal I owance 4.00	Total Costs	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	03000 ADULTS & PEDIATRICS	8,004,053		8,004,05	2	8, 004, 053	20 (
	03100 INTENSIVE CARE UNIT	2, 123, 877		2, 123, 87		2, 123, 877	
	04300 NURSERY	698, 329		698, 32		698, 329	
	ANCI LLARY SERVICE COST CENTERS	090, 329	1	090, 32	9 0	090, 329	43.1
	05000 OPERATING ROOM	11, 055, 757		11,055,75	204, 912	11, 260, 669	50.0
	05200 DELIVERY ROOM & LABOR ROOM	1, 201, 710		1, 201, 71		1, 201, 710	
	05300 ANESTHESI OLOGY	204, 507		204, 50		204, 507	
	05400 RADI OLOGY-DI AGNOSTI C	4, 316, 827		4, 316, 82		4, 316, 827	
	05700 CT SCAN	4, 310, 027		4, 510, 02	0 0	4, 310, 027	
	05800 MAGNETIC RESONANCE IMAGING (MRI)				0 0	0	
	05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	
	06000 LABORATORY	5, 909, 144		5, 909, 14		5, 909, 144	
	06300 BLOOD STORING, PROCESSING & TRANS.	278, 675		278, 67		278, 675	
	06500 RESPIRATORY THERAPY	2, 138, 120				2, 138, 120	
	06600 PHYSI CAL THERAPY	2,094,244		2,094,24		2,094,244	
	06900 ELECTROCARDI OLOGY	811, 717		811, 71		811, 717	
	06901 CARDI AC REHAB	780, 008		780, 00		780, 008	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 598, 756		3, 598, 75		3, 598, 756	
	07200 IMPL. DEV. CHARGED TO PATIENT	2, 170, 290		2, 170, 29		2, 170, 290	
3.00	07300 DRUGS CHARGED TO PATIENTS	12, 631, 372		12, 631, 37	2 0	12, 631, 372	73.
6.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 399, 708	5	1, 399, 70	0 8	1, 399, 708	76.
6.01	03480 ONCOLOGY	2, 165, 172		2, 165, 17	2 0	2, 165, 172	76.
	OUTPATIENT SERVICE COST CENTERS						
8.00	08800 EXPRESS MEDI CAL CENTER	1			1 0	1	88.
8.01	08801 FAMILY HEALTH CARE	1			1 0	1	88.
0.00	09000 CLINIC	4, 538, 027		4, 538, 02	48, 729	4, 586, 756	90.
0. 01	09001 WOUND CARE	336, 654		336, 65	64 0	336, 654	90.
	09100 EMERGENCY	4, 761, 376		4, 761, 37	6 0	4, 761, 376	91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	996, 354		996, 35		996, 354	92.
	OTHER REIMBURSABLE COST CENTERS						
5.00	09500 AMBULANCE SERVICES	C			0 0		
00.00	Subtotal (see instructions)	72, 214, 679	0	72, 214, 67	253, 641	72, 468, 320	200.
01.00	Less Observation Beds	996, 354		996, 35		996, 354	
02.00	Total (see instructions)	71, 218, 325	0	71, 218, 32	25 253, 641	71, 471, 966	202.

		LEMORTAL HOST IN	AL LOGANSPORT			u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CO	JN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/27/2022 1:4	epared: 47 pm
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA 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	6, 898, 860		6, 898, 86	50		30.00
31.00	03100 INTENSIVE CARE UNIT	1, 578, 705		1, 578, 70	05		31.00
	04300 NURSERY	1, 322, 606		1, 322, 60			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5, 695, 891	33, 941, 976	39, 637, 86	0. 278919	0,00000	50.00
	05200 DELIVERY ROOM & LABOR ROOM	1,957,430	71, 624			0.000000	
	05300 ANESTHESI OLOGY	293, 383	2,091,370			0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	1,022,142	15, 213, 156			0.000000	
	05700 CT SCAN	0	0,210,100	10,200,2	0 0.000000	0.000000	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0.000000	0.000000	
	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.000000	0. 000000	
	06000 LABORATORY	3, 844, 799	20,007,499	23, 852, 29		0. 000000	
	06300 BLOOD STORING, PROCESSING & TRANS.	422, 673	20, 007, 499 611, 904			0. 000000	
	06500 RESPIRATORY THERAPY	422, 073 5, 286, 984				0. 000000	
			2,241,094				
	06600 PHYSI CAL THERAPY	413, 175	4, 197, 222			0.00000	
	06900 ELECTROCARDI OLOGY	715, 170	4, 690, 221	5, 405, 39		0.00000	
	06901 CARDI AC REHAB	0	547,009			0.00000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 277, 675	4, 497, 105			0.00000	
	07200 IMPL. DEV. CHARGED TO PATIENT	1, 335, 461	9, 119, 517			0.00000	
	07300 DRUGS CHARGED TO PATIENTS	14, 858, 851	43, 978, 775			0.00000	
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	1, 142, 862	10, 148, 162			0.00000	
76.01	03480 ONCOLOGY	397	11, 320, 685	11, 321, 08	32 0. 191251	0.00000	76.01
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			1		
	08800 EXPRESS MEDICAL CENTER	0	0		0 0.000000	0. 000000	88.00
88.01	08801 FAMILY HEALTH CARE	0	0		0 0.000000	0.00000	88.01
	09000 CLINIC	125, 963	2, 924, 398	3, 050, 36	51 1. 487702	0.00000	90.00
90.01	09001 WOUND CARE	6, 931	1, 632, 278	1, 639, 20	0. 205376	0. 000000	90.01
91.00	09100 EMERGENCY	1, 884, 712	16, 545, 007	18, 429, 71	0. 258353	0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	203, 353	624, 575			0.00000	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	0		0 0.000000	0.00000	95.00
200.00		50, 288, 023	184, 403, 577	234, 691, 60			200.00
201.00							201.00
				234, 691, 60	1		202.00

Health Financial Systems	MEMORIAL HOSPITAL			u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/27/2022 1:47 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 I NTENSI VE CARE UNI T				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 RESPI RATORY THERAPY	0.000000			65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000			66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
69. 01 06901 CARDI AC REHAB	0. 000000			69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				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
OUTPATI ENT SERVI CE COST CENTERS				
88. 00 08800 EXPRESS MEDICAL CENTER	0. 000000			88.00
88. 01 08801 FAMILY HEALTH CARE	0. 000000			88.01
90. 00 09000 CLINIC	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)				92.00
OTHER REIMBURSABLE COST CENTERS	0.000000			/2.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.00
200.00 Subtotal (see instructions)	0.000000			200.00
201.00 Less Observation Beds				201.00

Health Financial Systems	MEMORIAL HOSPIT	AL LOGANSPORT		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	CAPITAL COSTS	Provider C		Peri od:	Worksheet D	
				rom 01/01/2021	Part I	
				To 12/31/2021	Date/Time Pre 5/27/2022 1:4	pared:
		Titlo	XVIII	Hospi tal	PPS	/ pili
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
cost center bescription	Rel ated Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.	Aujustilient	Related Cost	Days	col. 4)	
	B, Part II,		(col. 1 -		COI. 4)	
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTE		2.00	0.00	1.00	0.00	
30. 00 ADULTS & PEDIATRICS	1, 186, 766	0	1, 186, 766	4, 820	246.22	30.00
31.00 INTENSIVE CARE UNIT	185, 260		185, 260			
43. 00 NURSERY	14, 917		14, 917			•
200.00 Total (lines 30 through 199)	1, 386, 943		1, 386, 943			200.00
Cost Center Description	Inpatient	I npati ent	.,	-,,		
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTE	RS					
30.00 ADULTS & PEDIATRICS	1, 395	343, 477				30.00
31.00 INTENSIVE CARE UNIT	192	59, 086				31.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	1, 587	402, 563				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CON: 15-0072 Period: To Worksheet D From 0101/2021 Worksheet D To Period: 12/31/2021 Worksheet D To Period: To Period: To <tho< th=""><th>Health Financial Systems</th><th>MEMORIAL HOSPIT</th><th>AL LOGANSPORT</th><th></th><th>In Lie</th><th>u of Form CMS-2</th><th>2552-10</th></tho<>	Health Financial Systems	MEMORIAL HOSPIT	AL LOGANSPORT		In Lie	u of Form CMS-2	2552-10
Cost Center Description Capital Related Cost (from Wsst. b, col. 26) Title XVIII Hospital (col. 1, - col. 8) Date/Time Prepared: 5/27/2022 1:47 pm (col. mn 3 x) 50.00 Cost Center Description Capital Related Cost (from Wsst. b, col. 26) Total Charges (rom Wst. col. 8) Capital (col. 2, - col. 2) Capital (col. 1, - col. 8) Capital (col. 2, - col. 2) Capital (col. 1, - col. 8) Capital (col. 2, - col. 2) 50.00 05000 MACHTIC NG NOM 729, 990 39, 637, 867 0.018416 1, 263, 997 23, 278 50.00 51.00 05000 MACHTIC RESONACE IMAGINGT (MRI) 0 0.000000 0 0.52.00 52.00 05000 CARDIAC CATHIETER 12ATI 0N 0 0.000000 0 0.58.00 0.000000 0 0.59.00<	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C				
ANCI LLARY SERVICE COST CENTERS Capit al Related Cost (From Wkst. B, Part II, col. 26) Title XVIII Total Corress (From Wkst. Col. 26) Total Corress (Col. 1 col. 26) Capit al Col. 26) Capit al Col. 26) Capit al Col. 20 Capit al Col. 20 <td></td> <td></td> <td></td> <td></td> <td>From 01/01/2021</td> <td></td> <td></td>					From 01/01/2021		
Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 26) Title XVIII Hospital Cost Post Program (col. 1+ col. 2) Hospital Program (col. 1+ col. 2) Hospital Program (col. 1+ col. 2) Post Program (col. 1+ col. 2) ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 055000 [OPERATI NG ROM 729,990 39,637,867 0.018416 1,263,997 23,278 50.00 52.00 05300 ANESTHESIOLOGY 57,582 2,384,753 0.02416 59,120 1,428 53.00 53.00 05000 (ARDI OLOGY-DI AGNOSTI C 296,644 16,235,298 0.018260 386,995 7,667 54.00 59.00 05900 (ARDI AC CATHERRI ZATI M 0 0 0.000000 0 0 0.000000 0 0.59.00 66.00 06600 PHYSICAL THERIZATION 0 0.000000 0 0 0.000000 0 0					10 12/31/2021	Date/lime Pre	pared:
Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 26) Total Charges (C, Part I, col. 8) Ratio of Cost to Charges (col. 1 + col. 26) Inpatient Charges (col. 1 + col. 26) Capital Cost (col. 1 + col. 26) Cost (col. 1 + col. 26) Inpatient (col. 1 + col. 26) Capital Cost (col. 1 + col. 26) Cost (col. 1 + col. 26) 50.00 05000 OPERATING ROM 729,990 39, 637, 867 0.018416 1, 263,997 23, 278 50.00 50.00 05000 OPENATING ROM 125, 230 2, 029, 054 0.04116 59, 120 1, 428 53.00 50.00 05000 ACRDIC CHARGE NOSTIC 296, 464 16, 235, 298 0.018260 386, 995 7, 651.00 59, 00 50.00 05000 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0.000000 0 0.58, 00 60.00 060000 BLOOD STORIN			Title	XVIII	Hospi tal		7 pili
Rel ated Cost (from Wkst. B. Part II, col. 26) Rel ated Cost (c) C, Part I, col. 26) Program (col. 1 + col. 2) Column 3 x Column 4) ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 (DPERATI NG ROM 729.990 39.637,867 0.018416 1.263.997 23.278 50.00 52.00 05200 (DELIVERY ROM & LABOR ROM 125,230 2.029.054 0.061718 0 0 52.00 53.00 05300 (DST C SCAN 0 54.00 57.00 5000 (CT SCAN 0 0 0 0 57.00 58.00 05800 (ARDI AC CATHERERIZATI ON 0 0 0 0 0 0 0 0 58.00 05800 (ARDI AC CATHERERIZATI ON 0 0 0 0 58.00 05600 (ARDI AC CATHERERIZATI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Cost Center Description	Capi tal					
ANCI LLARY SERVICE COST CENTERS (from Wkst. B, Part II, col. 2) C, Part I, col. 2) (col. 1)+ col. 2) Charges col umn 4) 50.00 05000 0PENATI NC ROOM 729,990 3,00 4.00 5.00 52.00 052000 DELVERY ROM & LABOR ROOM 729,990 3,04,37,867 0.018416 1,263,997 23,278 50.00 53.00 05300 ALBOR ROOM 125,230 2,029,064 0.61718 0 0 52.00 53.00 53.00 53.00 53.00 05300 ALMORY PROM & LABOR ROOM 125,230 2,029,064 0.61718 0 0 52.00 50.00 55.00 55.00 50.00 55.00 05000 (AROARCHTI C RESONANCE I MAGI NG (MRI) 0 0 0.000000 0 0 57.00 50.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 0 0.000000 0 59.00 59.00 59.00 50.00 59.00 59.00 50.00 59.00 59.00 50.00 59.00 59.00 <							
B. Part II, col 26) col 20 col 20 col 20 col 20 col 20 ANCILLARY SERVICE COST CENTERS - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -							
col. 26) 1.00 2.00 3.00 4.00 5.00 50.00 05000 DPERATI NG ROOM 729,990 3,9,637,867 0.018416 1,263,997 23,278 50.00 52.00 52.00 DS2000 DELVERY ROOM & LABOR ROOM 125,230 2,029,054 0.01718 0 0 52.00 53.00 DS300 NESTHESI OLOGY 57,582 2,384,753 0.024146 59,120 1,428 53.00 54.00 D5700 CT SCAN 0 0 0.000000 0 57.00 59.00 05700 CT SCAN 0 0 0.000000 0 0 59.00 50.00 DS600 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0.000000 0 59.00 50.00 DS600 DROIN DSPRING, RPROCESSI NG & TRANS. 1,973 1.034,577 0.0014018 1,893,102 7,777 65.00 60.00 O6500 RESPI RATORY THERAPY 164,179 4,610,397 0.035611 189,686					J		
ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATING ROOM 729,990 39,637,867 0.018416 1,263,997 23,278 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 125,230 2,029,054 0.061718 0 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 296,464 16,235,298 0.018260 386,995 7,067 54.00 57.00 05500 CT SCAN 0 0 0.000000 0 0 58.00 58.00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0 0 0.000000 0 0 59.00 60.00 06300 LABOR TORY 196,776 23,852,298 0.001907 111,927 213 63.00 61.00 O6300 DAGOD ANDRING, PROCESSING & TRANS. 1,973 1,034,577 0.001907 111,927 213 63.00 65.00 OE500 RESPI RATORY THERAPY 130,923 7,777 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
50.00 05000 0PERATI NC ROOM 729,990 39,637,867 0.018416 1,263,997 23,278 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 125,230 2,029,054 0.061718 0 0 52.00 53.00 05300 ANESTHESI DLOCY 57,582 2,384,753 0.024146 59,120 1,428 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 296,464 16,235,298 0.018260 386,995 7,067 54.00 55.00 05500 CARDI AC CATHETERI ZATI ON 0 0 0.000000 0 58.00 05.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0.000000 0 058.00 05.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0.000000 0 058.00 0.00250 1,212,138 10,000 0.00 0 0.058.00 0.00250 1,212,138 10,000 0.00 0 0.058.00 0.0021480 164,179 4,610,397 0.335611 189,686 6,755 66.00 0.6600 PHYSI CAL THERAPY 162,774,780 0			2.00	3.00	4.00	5.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM 125,230 2,029,054 0.061718 0 52.00 53.00 05300 ANESTHESI OLOGY 57,582 2,384,753 0.024146 59,120 1,428 53.00 54.00 05400 RADI LOGY - DI AGNOSTI C 296,464 16,235,298 0.018260 386,995 7,667 54.00 55.00 05500 CT SCAN 0 0 0 0.000000 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0.000000 0 58.00 60.00 06000 LABORATORY 196,776 23,852,298 0.004205 1,212,138 10,000 60.00 65.00 06500 RESPI RATORY THERAPY 196,776 23,852,298 0.004108 1,893,102 7,777 65.00 66.00 06500 RESPI RATORY THERAPY 136,179 4,613,397 0.004108 1,893,102 7,777 65.00 69.00 06900 LECTROCARDI OLOGY 47,110 5,405,391 0.0089715 326,509 2,846 69.01 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 11	ANCILLARY SERVICE COST CENTERS						
53.00 05300 ANESTHESI OLOGY 57,582 2,384,753 0.024146 59,120 1,428 53.00 54.00 O5400 RADI OLOGY-DI AGNOSTI C 296,464 16,235,298 0.018260 386,995 7,067 54.00 58.00 O5500 CT SCAN 0 0.000000 0 0 58.00 59.00 O5500 CATHETERI ZATION 0 0 0.0002000 0 58.00 60.00 CABONATARY 196,776 23,852,298 0.004120 1,11,927 213 63.00 65.00 06500 RESPI RATORY THERAPY 30,923 7,528,078 0.004108 1,893,102 7,777 65.00 66.00 O6900 LABORATORY 164,179 4,610,397 0.035611 189,866 6,755 66.00 67.00 OF900 CARDIAC REHAB 152,234 547,009 0.278303 0 69.01 69.01 69.01 O6901 CARDIAC REHAB 152,234 547,09 0.21941 432,436 9,488 11.00 71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 112	50.00 05000 OPERATI NG ROOM	729, 990	39, 637, 867	0. 01841	6 1, 263, 997	23, 278	50.00
54.00 05400 RADI OLOGY - DI AGNOSTI C 296, 464 16, 235, 298 0.018260 386, 995 7, 067 54.00 57.00 05700 CT SCAN 0 0 0.000000 0 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0.000000 0 58.00 59.00 CARDI AC CATHETERI ZATI ON 0 0 0.000000 0 59.00 60.00 LABORATORY 196, 776 23, 852, 298 0.008250 1, 212, 138 10, 000 60.00 65.00 06500 RESPI RATORY THERAPY 196, 776 23, 852, 298 0.008250 1, 212, 138 10, 000 60.00 66.00 C6500 RESPI RATORY THERAPY 30, 923 7, 528, 078 0.004108 1, 893, 102 7, 777 65.00 69.00 CACH THERAPY 164, 179 4, 610, 397 0.035611 189, 686 6, 755 66.00 69.00 CARDI AC REHAB 152, 234 547, 009 0.278303 0 69.01 72.00 IMPL DEV. CHARGED TO PATI ENT 12, 654 58, 837, 62	52.00 05200 DELIVERY ROOM & LABOR ROOM	125, 230	2, 029, 054	0. 06171	8 0	0	52.00
57.00 05700 CT SCAN 0 0 0.000000 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0.000000 0 58.00 59.00 CARDIA C. CATHETERIZATION 0 0 0.000000 0 0 58.00 60.00 06000 LABORATORY 196,776 23,852,298 0.008250 1,212,138 10,000 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 1,973 1,034,577 0.001907 111,927 213 63.00 65.00 06500 RESPI RATORY THERAPY 30,923 7,528,078 0.004108 1,893,102 7,777 65.00 66.00 06600 PHYSI CAL THERAPY 164,179 4,610,397 0.035611 189,686 6,755 66.00 69.01 06901 CARDI AC REHAB 152,234 547,009 0.278303 0 0 69.01 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 112,654 58,837,626 0.001915 4,175,739 7,997 73.00 73.00 03450 NUCLEA	53.00 05300 ANESTHESI OLOGY	57, 582	2, 384, 753	0. 02414	6 59, 120	1, 428	53.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0.000000 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0.000000 0 0 59.00 60.00 LABORATORY 196,776 23,852,298 0.008250 1,212,138 10,000 60.00 65.00 06500 RESPI RATORY HEAPY 30,923 7,528,078 0.004108 1,893,102 7,777 65.00 66.00 06900 ELECTROCARDI OLOGY 47,110 5,405,391 0.008715 326,509 2,846 69.00 69.01 06900 IECTROCARDI OLOGY 47,110 5,405,391 0.008715 326,509 2,846 69.00 69.01 06901 CARDI AC REHAB 152,234 547,009 0.278303 0 69.01 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 126,704 5,774,780 0.0021941 432,436 9,488 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 112,654 58.837,626 0.00115 4,175,739 7,997 73.00	54. 00 05400 RADI OLOGY-DI AGNOSTI C	296, 464	16, 235, 298	0. 01826	0 386, 995	7,067	54.00
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0.000000 0 0 59.00 60.00 06000 LABORATORY 196,776 23,852,298 0.008250 1,212,138 10,000 60.00 63.00 06000 Stood BESPI RATORY THERAPY 30,923 7,528,078 0.004108 1,893,102 7,777 65.00 66.00 06600 PHYSI CAL THERAPY 164,179 4,610,397 0.035611 189,686 6,755 66.00 69.00 06900 ELECTROCARDI OLOGY 47,110 5,405,391 0.008715 326,509 2,846 69.00 69.01 OARDI AC REHAB 152,234 547,009 0.278303 0 0 69.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 126,704 5,774,780 0.021941 432,436 9,488 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 112,654 58,837,626 0.001915 4,175,739 79,977 76.00 74.00 03460 NUCLEAR MEDI CI NE - DI AGNOSTI C 37,321 11,291,024 0.003305 434,862	57.00 05700 CT SCAN	0	0	0. 00000	0 0	0	57.00
60.00 06000 LABORATORY 196,776 23,852,298 0.008250 1,212,138 10,000 60.00 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 1,973 1,034,577 0.001907 111,927 213 63.00 65.00 06500 RESPI RATORY THERAPY 30,923 7,528,078 0.004108 1,893,102 7,777 65.00 66.00 06600 PHYSI CAL THERAPY 164,179 4,610,397 0.035611 189,686 6,755 66.00 69.00 06900 ELECTROCARDI OLOGY 47,110 5,405,391 0.008715 326,509 2,846 69.00 69.01 06901 CARDI AC REHAB 152,234 547,009 0.278303 0 0 69.01 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 9,390 10,454,978 0.00898 455,823 409 72.00 73.00 07300 DRUGS CHARGED TO PATI ENT 9,390 10,454,978 0.009703 0 0 73.00 76.00 76.01 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 37,321 11,291,024	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0. 00000	0 0	0	58.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 1,973 1,034,577 0.001907 111,927 213 63.00 65.00 06500 RESPIRATORY THERAPY 30,923 7,528,078 0.004108 1,893,102 7,777 65.00 66.00 06600 PHYSI CAL THERAPY 164,179 4,610,397 0.035611 189,686 6,755 66.00 69.00 G6900 ELECTROCARDI OLOGY 47,110 5,405,391 0.008715 326,509 2,846 69.00 69.01 OA900 ELECTROCARDI OLOGY 47,110 5,405,391 0.008715 326,509 2,846 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 126,704 5,774,780 0.021941 432,436 9,488 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 112,654 58,837,626 0.001915 4,175,739 7,997 73.00 76.00 03450 INUCLEAR MEDI CI NE - DI AGNOSTI C 37,321 11,221,082 0.009703 0 0 76.01 04340 INCOLOGY 109,854 11,321,082 0.009703 0 0 <	59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000	0 0	0	59.00
65.00 06500 RESPI RATORY THERAPY 30,923 7,528,078 0.004108 1,893,102 7,777 65.00 66.00 06600 PHYSI CAL THERAPY 164,179 4,610,397 0.035611 189,686 6,755 66.00 69.01 06900 ELECTROCARDI OLOGY 47,110 5,405,391 0.008715 326,509 2,846 69.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 122,734 547,009 0.278303 0 0 69.01 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 126,704 5,774,780 0.0021941 432,436 9,488 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 112,654 58,837,626 0.001915 4,175,739 7,997 73.00 76.01 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 37,321 11,291,024 0.003305 434,862 1,437 76.00 04500 NOCOLOGY 109,854 11,321,082 0.00700 0 0 76.01 04501 FAMI LY HEALTH CARE 0 0 0.000000 0 88.0	60. 00 06000 LABORATORY	196, 776	23, 852, 298	0. 00825	i0 1, 212, 138	10, 000	60.00
66.00 06600 PHYSI CAL THERAPY 164, 179 4, 610, 397 0.035611 189, 686 6, 755 66.00 69.00 06900 ELECTROCARDI OLOGY 47, 110 5, 405, 391 0.008715 326, 509 2, 846 69.00 69.01 06901 CARDI AC REHAB 152, 234 547, 009 0.278303 0 69.01 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 126, 704 5, 774, 780 0.021941 432, 436 9, 488 1.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 112, 654 58, 837, 626 0.001915 4, 1757 7, 997 73.00 73.00 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 37, 321 11, 291, 024 0.003305 434, 862 1, 437 76.00 04880 08800 EXPRESS MEDI CAL CENTER 0 0 0.000000 0 0 88.01 90.00 09000 CLI NI C 197, 974 3, 050, 361 0.064902 0 0 00.00 0 90.01 90.01 09001 WOUND CARE 29, 366 1, 639, 209 <td< td=""><td>63.00 06300 BLOOD STORING, PROCESSING & TRANS.</td><td>1, 973</td><td>1, 034, 577</td><td>0. 00190</td><td>111, 927</td><td>213</td><td>63.00</td></td<>	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 973	1, 034, 577	0. 00190	111, 927	213	63.00
69.00 06900 ELECTROCARDI OLOGY 47, 110 5, 405, 391 0.008715 326, 509 2, 846 69.00 69.01 06901 CARDI AC REHAB 152, 234 547, 009 0.278303 0 0 69.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 126, 704 5, 774, 780 0.021941 432, 436 9, 488 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 9, 390 10, 454, 978 0.000898 455, 823 409 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 112, 654 58, 837, 626 0.001915 4, 175, 739 7, 997 73.00 76.00 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 37, 321 11, 291, 024 0.003305 434, 862 1, 437 76.00 76.01 03480 ONCOLOGY 109, 854 11, 321, 082 0.009703 0 0 69.00 0 08801 FAMI LY HEALTH CARE 0 0 0.000000 0 88.01 90.00 09000 CLI NI C 197, 974 3, 050, 361 0.064902 0	65.00 06500 RESPI RATORY THERAPY	30, 923	7, 528, 078	0.00410	1, 893, 102	7,777	65.00
69.01 06901 CARDI AC REHAB 152, 234 547,009 0.278303 0 0 69.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 126,704 5,774,780 0.021941 432,436 9,488 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 9,390 10,454,978 0.000898 455,823 409 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 112,654 58,837,626 0.001915 4,175,739 7,997 73.00 76.00 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 37,321 11,291,024 0.003305 434,862 1,437 76.00 0.4000GY 03480 NUCLEAR MEDI CAL CENTER 0 0 0.009703 0 0 0 0 04880 FAMI LY HEALTH CARE 0 0 0.000000 0 0 88.00 88.01 08801 FAMI LY HEALTH CARE 0 0 0.000000 0 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.	66. 00 06600 PHYSI CAL THERAPY	164, 179	4, 610, 397	0. 03561	1 189, 686	6, 755	66.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 126,704 5,774,780 0.021941 432,436 9,488 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 9,390 10,454,978 0.000898 455,823 409 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 112,654 58,837,626 0.001915 4,175,739 7,997 73.00 76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC 37,321 11,291,024 0.003305 434,862 1,437 76.00 0017041 ONCOLOGY 000 0000030 0 0 0 0 0 0 0017041 EXPRESS MEDI CAL CENTER 0 0 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <	69. 00 06900 ELECTROCARDI OLOGY	47, 110	5, 405, 391	0. 00871	5 326, 509	2, 846	69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 9,390 10,454,978 0.000898 455,823 409 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 112,654 58,837,626 0.001915 4,175,739 7,997 73.00 76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC 37,321 11,291,024 0.003305 434,862 1,437 76.00 76.01 03480 ONCOLOGY 109,854 11,321,082 0.009703 0 0 76.00 0UTPATIENT SERVICE COST CENTERS 0 0 0.000000 0 0 88.00 88.00 08801 FAMILY HEALTH CARE 0 0 0.000000 0 88.01 90.00 09000 CLINIC 197,974 3,050,361 0.064902 0 90.00 90.01 09001 WOUND CARE 29,366 1,639,209 0.017915 5,689 102 90.01 91.00 09100 EMERGENCY 471,439 18,429,719 0.025580 850,311 21,751 91.00 92.00 092000 OBSERVATION BEDS (NON-DI ST	69. 01 06901 CARDI AC REHAB	152, 234	547,009	0. 27830	03 0	0	69.01
73.00 07300 DRUGS CHARGED TO PATIENTS 112,654 58,837,626 0.001915 4,175,739 7,997 73.00 76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC 37,321 11,291,024 0.003305 434,862 1,437 76.00 76.01 03480 ONCOLOGY 109,854 11,321,082 0.009703 0 0 76.01 00TPATIENT SERVICE COST CENTERS 0 0 0.000000 0 0 88.00 88.00 08800 EXPRESS MEDICAL CENTER 0 0 0.000000 0 88.01 90.00 09000 CLINIC 197,974 3,050,361 0.064902 0 90.00 90.01 09001 WOUND CARE 29,366 1,639,209 0.017915 5,689 102 90.01 91.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 147,730 827,928 0.178433 84,198 15,024 92.00 0 09200 OBSERVATION BEDS (NON-DI STINCT PART) 147,730 827,928 0.178433 84,198 15,024 92.00 0THER REI MBURSABLE COST CENTERS	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	126, 704	5, 774, 780	0. 02194	432, 436	9, 488	71.00
76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC 37,321 11,291,024 0.003305 434,862 1,437 76.00 76.01 03480 ONCOLOGY 109,854 11,321,082 0.009703 0 0 76.01 0UTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0 0 88.00 88.00 08800 EXPRESS MEDICAL CENTER 0 0 0.000000 0 88.01 90.00 09000 CLINIC 197,974 3,050,361 0.064902 0 90.00 90.01 09001 WOUND CARE 29,366 1,639,209 0.017915 5,689 102 90.01 91.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 147,439 18,429,719 0.025580 850,311 21,751 91.00 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 147,730 827,928 0.178433 84,198 15,024 92.00 0THER REI MBURSABLE COST CENTERS 0 095.00 MBULANCE SERVICES 95.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	9, 390	10, 454, 978	0.00089	455, 823	409	72.00
76. 01 03480 ONCOLOGY 109, 854 11, 321, 082 0.009703 0 76. 01 OUTPATI ENT SERVICE COST CENTERS 0 0 0.009703 0 0 76. 01 88. 00 08800 EXPRESS MEDI CAL CENTER 0 0 0.000000 0 88. 00 88. 01 08801 FAMI LY HEALTH CARE 0 0 0.000000 0 88. 01 90. 00 09000 CLI NI C 197, 974 3, 050, 361 0.064902 0 90. 00 90. 01 09001 WOUND CARE 29, 366 1, 639, 209 0.017915 5, 689 102 90. 01 91. 00 09100 EMERGENCY 471, 439 18, 429, 719 0.025580 850, 311 21, 751 91. 00 92.00 OBSERVATION BEDS (NON-DI STINCT PART) 147, 730 827, 928 0.178433 84, 198 15, 024 92. 00 0THER REI MBURSABLE COST CENTERS	73.00 07300 DRUGS CHARGED TO PATIENTS	112, 654	58, 837, 626	0. 00191	5 4, 175, 739	7, 997	73.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 EXPRESS MEDICAL CENTER 0 0.000000 0 88.00 88.01 08801 FAMILY HEALTH CARE 0 0 0.000000 0 88.01 90.00 09000 CLI NI C 197, 974 3, 050, 361 0.064902 0 90.00 90.01 09001 WOUND CARE 29, 366 1, 639, 209 0.017915 5, 689 102 90.01 91.00 09100 EMERGENCY 471, 439 18, 429, 719 0.025580 850, 311 21, 751 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 147, 730 827, 928 0.178433 84, 198 15, 024 92.00 OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	37, 321	11, 291, 024	0.00330	434, 862	1, 437	76.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 EXPRESS MEDICAL CENTER 0 0.000000 0 88.00 88.01 08801 FAMILY HEALTH CARE 0 0 0.000000 0 88.01 90.00 09000 CLI NI C 197, 974 3, 050, 361 0.064902 0 90.00 90.01 09001 WOUND CARE 29, 366 1, 639, 209 0.017915 5, 689 102 90.01 91.00 09100 EMERGENCY 471, 439 18, 429, 719 0.025580 850, 311 21, 751 91.00 92.00 OBSERVATION BEDS (NON-DI STINCT PART) 147, 730 827, 928 0.178433 84, 198 15, 024 92.00 OTHER REI MBURSABLE COST CENTERS UTHER UMURACE SERVICES 95.00 95.00 95.00 95.00 95.00 95.00	76. 01 03480 ONCOLOGY	109, 854	11, 321, 082	0. 00970	03 0	0	76.01
88.01 08801 FAMILY HEALTH CARE 0 0 0.000000 0 088.01 90.00 09000 CLINIC 197,974 3,050,361 0.064902 0 0 90.00 90.01 09000 USUND CARE 29,366 1,639,209 0.017915 5,689 102 90.01 91.00 09100 EMERGENCY 471,439 18,429,719 0.025580 850,311 21,751 91.00 92.00 09520VATION BEDS (NON-DISTINCT PART) 147,730 827,928 0.178433 84,198 15,024 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC 197, 974 3, 050, 361 0. 064902 0 0 90. 00 90. 01 09001 WOUND CARE 29, 366 1, 639, 209 0. 017915 5, 689 102 90. 01 91. 00 09100 EMERGENCY 471, 439 18, 429, 719 0. 025580 850, 311 21, 751 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 147, 730 827, 928 0. 178433 84, 198 15, 024 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 95. 00 95. 00 95. 00	88.00 08800 EXPRESS MEDI CAL CENTER	0	0	0.00000	0 0	0	88.00
90. 01 09001 WOUND CARE 29, 366 1, 639, 209 0. 017915 5, 689 102 90. 01 91. 00 09100 EMERGENCY 471, 439 18, 429, 719 0. 025580 850, 311 21, 751 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 147, 730 827, 928 0. 178433 84, 198 15, 024 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 95. 00	88.01 08801 FAMILY HEALTH CARE	0	0	0.00000	0 0	0	88.01
91.00 09100 EMERGENCY 471, 439 18, 429, 719 0. 025580 850, 311 21, 751 91. 00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 147, 730 827, 928 0. 178433 84, 198 15, 024 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 950.00	90. 00 09000 CLINIC	197, 974	3, 050, 361	0.06490	02 0	0	90.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 147, 730 827, 928 0. 178433 84, 198 15, 024 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	90. 01 09001 WOUND CARE	29, 366	1, 639, 209	0. 01791	5 5, 689	102	90.01
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	91.00 09100 EMERGENCY	471, 439	18, 429, 719	0. 02558	80 850, 311	21, 751	91.00
95.00 09500 AMBULANCE SERVICES 95.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	147, 730	<u>827,</u> 928	0.17843	83 84, 198	15 <u>,</u> 024	92.00
200.00 Total (lines 50 through 199) 3,044,893 224,891,429 11,882,532 115,572 200.00							
	200.00 Total (lines 50 through 199)	3, 044, 893	224, 891, 429		11, 882, 532	115, 572	200.00

Health Financial Systems	MEMORIAL HOSPI	TAL	LOGANSPORT		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERV	/ICE OTHER PASS THROUGH CC)STS			Period: From 01/01/2021 To 12/31/2021	5/27/2022 1:4	epared: 17 pm
			Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng		Nursi ng	Allied Healt	h Allied Health	All Other	
	Program		Program	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdowr	n	÷	Adjustments		Educati on	
	Adjustments			2		Cost	
	1A		1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST C	ENTERS	_					
30. 00 03000 ADULTS & PEDI ATRI CS		0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT		o	0		0 0	0	31.00
43. 00 04300 NURSERY		0	0		0 0	0	43.00
200.00 Total (lines 30 through 19	9)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed	T	otal Costs	Total Patien	t Per Diem	Inpatient	
	Adjustment		um of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see		through 3,		col. 6)		
	i nstructi ons		nus col. 4)		0011 0)		
	4,00		5.00	6,00	7.00	8,00	
INPATIENT ROUTINE SERVICE COST C							
30. 00 03000 ADULTS & PEDIATRICS		0	0	4, 82	0 0.00	1, 395	30.00
31.00 03100 INTENSIVE CARE UNIT			0	60			
43. 00 04300 NURSERY			0	98			
200.00 Total (lines 30 through 19	9)		0	6, 40			200.00
Cost Center Description	Inpati ent			0,10	-	1,007	200100
	Program						
	Pass-Through						
	Cost (col. 7						
	x col. 8)						
	9.00	-					
INPATIENT ROUTINE SERVICE COST C							
30. 00 03000 ADULTS & PEDIATRICS		0					30.00
31.00 03100 INTENSIVE CARE UNIT		o					31.00
43. 00 04300 NURSERY		0					43.00
200.00 Total (lines 30 through 19	9)	0					200.00
		-1					

Health Financial Systems	MEMORIAL HOSPIT	AL LOGANSPORT			In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PAS	S Provider C	CN: 15-0072	Peri od:		Worksheet D	
THROUGH COSTS				From 01/0		Part IV	
				To 12/3	1/2021	Date/Time Pre 5/27/2022 1:4	pared: 7 nm
		Title	XVIII	Hospi t	al	PPS	<u>, bui</u>
Cost Center Description	Non Physician	Nursi ng	Nursi ng			Allied Health	
	Anesthetist	Program	Program	Post-Ste	epdown		
	Cost	Post-Stepdown	_	Adjustm	nents		
		Adjustments					
	1.00	2A	2.00	3A		3.00	
ANCI LLARY SERVI CE COST CENTERS	1		1				
50.00 05000 OPERATING ROOM	0	0		0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
53.00 05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
57.00 05700 CT SCAN	0	0		0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE 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
	0	0		0	0	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
69. 01 06901 CARDI AC REHAB	0	0		0	0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0			0	0	0	71.00 72.00
72.00 07200 TMPL. DEV. CHARGED TO PATTENT 73.00 07300 DRUGS CHARGED TO PATTENTS	0			0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATTENTS 76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0			0	0	0	73.00
76. 01 03480 ONCOLOGY	0			0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS	0	0		0	U	0	70.01
88. 00 08800 EXPRESS MEDICAL CENTER	0	0		0	0	0	88.00
88. 01 08801 FAMILY HEALTH CARE	0			0	0	0	88.01
90. 00 09000 CLINIC	0			0	0	0	90.00
90. 01 09001 WOUND CARE	0	0		0	0	0	90.01
91. 00 09100 EMERGENCY	0	0		0	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	Ŭ	0	92.00
OTHER REIMBURSABLE COST CENTERS			1	-			
95. 00 09500 AMBULANCE SERVICES							95.00
200.00 Total (lines 50 through 199)	0	0		0	0	0	200.00
		•		·			

Health Financial Systems	MEMORIAL HOSPIT	AL LOGANSPORT		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C	CN: 15-0072	Period:	Worksheet D	
THROUGH COSTS				From 01/01/2021 To 12/31/2021		nared
				10 12/51/2021	5/27/2022 1:4	
			XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum o		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
		5.00	(instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS				0 00 (07 0/7	0.00000	
50. 00 05000 OPERATING ROOM	0	0		0 39, 637, 867		
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 2, 029, 054		
53. 00 05300 ANESTHESI OLOGY	0	0		0 2, 384, 753		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 16, 235, 298		
57.00 05700 CT SCAN	0	0		0 0	0. 000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0 00	0. 000000	
	0	0		0 23, 852, 298		
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0		0 1,034,577		
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0		0 7, 528, 078		
				0 4, 610, 397		
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB				0 5, 405, 391 0 547, 009		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				0 5, 774, 780		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS				0 10, 454, 978		
73.00 07300 DRUGS CHARGED TO PATIENTS				0 10, 454, 978		
73.00 07300 DRUGS CHARGED TO PATTENTS 76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC				0 58, 837, 626		
76.01 03480 ONCOLOGY		-		0 11, 321, 082		
OUTPATIENT SERVICE COST CENTERS	0	0		0 11, 321, 062	0.00000	70.01
88. 00 08800 EXPRESS MEDICAL CENTER	0	0		0 0	0. 000000	88.00
88. 01 08801 FAMILY HEALTH CARE	0	0			0. 000000	
90. 00 109000 CLINIC	0	0		0 3, 050, 361		
90. 01 09001 WOUND CARE				0 1, 639, 209		
91. 00 09100 EMERGENCY		0		0 18, 429, 719		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0 827, 928		
OTHER REIMBURSABLE COST CENTERS	0	0	1	0 027, 920	0.00000	72.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 224, 891, 429		200.00
		1 0	I	224,071,427	I	200.00

Health Financial Systems	MEMORIAL HOSPITA	L LOGANSPORT		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0072	Period:	Worksheet D	
THROUGH COSTS				From 01/01/2021 To 12/31/2021	Part IV Date/Time Pre	narod
				10 12/31/2021	5/27/2022 1:4	
		Title	XVIII	Hospi tal	PPS	i
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS			1		-	
50.00 05000 OPERATING ROOM	0.000000	1, 263, 997		0 6, 275, 787		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	-	
53. 00 05300 ANESTHESI OLOGY	0.000000	59, 120		0 341,036		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	386, 995		0 2, 671, 911		54.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	1 212 120		0 1 004 210	0	59.00
60.00 06000 LABORATORY 63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	1, 212, 138		0 1, 994, 318		60.00 63.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 65.00 06500 RESPIRATORY THERAPY	0. 000000	111, 927		0 86, 935		63.00
	0. 000000	1, 893, 102		0 531,016		
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	0. 000000	189, 686 326, 509				66.00 69.00
69. 01 06900 ELECTROCARDI 0L0GY 69. 01 06901 CARDI AC REHAB	0. 000000	320, 509 0		0 1, 123, 617 0 166, 207		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	432, 436		0 798, 167		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	432, 436 455, 823		0 2,057,139		72.00
72.00 07200 TMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	455, 823 4, 175, 739		0 2,057,139		72.00
76. 00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000	4, 175, 739 434, 862		0 2, 856, 264		76.00
76.01 03480 ONCOLOGY	0. 000000	434, 802		0 2, 422, 497		76.00
OUTPATIENT SERVICE COST CENTERS	0.000000	0		0 2,422,497	0	70.01
88. 00 08800 EXPRESS MEDICAL CENTER	0. 000000	0		0 0	0	88.00
88. 01 08801 FAMILY HEALTH CARE	0. 000000	0		0 0	-	88.01
90. 00 09000 CLINIC	0. 000000	0		0 565, 114	-	90.00
90. 01 09001 WOUND CARE	0. 000000	5,689		0 469, 023		90.01
91. 00 09100 EMERGENCY	0. 000000	850, 311		0 2, 950, 332		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	84, 198		0 212,690		92.00
OTHER REIMBURSABLE COST CENTERS	0.000000	0., 170		- 2.2,070		1.2.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		11, 882, 532		0 37, 422, 520	0	200.00

	MEMORIAL HOSPIT			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0072	Period: From 01/01/2021	Worksheet D	
				To 12/31/2021	Part V Date/Time Pre	nared
				10 12/01/2021	5/27/2022 1:4	7 pm
		Title	× XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9	2.00	(see inst.)	(see inst.)	F 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0. 278919	6, 275, 787		0 0	1, 750, 436	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 278919			0 0		
53. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0. 592251			0 0	29, 246	
53. 00 105300 ANESTHESTOLOGY 54. 00 105400 RADI OLOGY-DI AGNOSTI C	0. 265891			0 0	29, 246 710, 437	53.00
57. 00 05700 CT SCAN	0. 205891			0 0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			0 0	0	59.00
60. 00 106000 LABORATORY	0. 247739			0 0	494, 070	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 269361			0 0	23, 417	•
65. 00 06500 RESPIRATORY THERAPY	0. 284019			0 0	150, 819	•
66. 00 06600 PHYSI CAL THERAPY	0. 454244			0 0	14, 569	
69. 00 06900 ELECTROCARDI OLOGY	0. 150168			0 0	168, 731	•
69. 01 06901 CARDI AC REHAB	1. 425951			0 0	237,003	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 623185			0 0	497,406	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 207584			0 0	427, 029	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 214682			15 83, 535		
76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 123966			0 0	354,080	•
76.01 03480 ONCOLOGY	0. 191251			0 0		
OUTPATIENT SERVICE COST CENTERS		,				1
88.00 08800 EXPRESS MEDICAL CENTER						88.00
88.01 08801 FAMILY HEALTH CARE						88.01
90. 00 09000 CLINIC	1. 487702	565, 114		0 48	840, 721	90.00
90.01 09001 WOUND CARE	0. 205376	469, 023		0 0	96, 326	90.01
91.00 09100 EMERGENCY	0. 258353	2, 950, 332		0 0	762, 227	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 203431	212, 690		0 0	255, 958	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0. 000000			0		95.00
200.00 Subtotal (see instructions)		37, 422, 520	4	45 83, 583	9, 823, 711	
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		37, 422, 520	4	15 83, 583	9, 823, 711	202.00

Health Financial Systems	MEMORIAL HOSPIT	AL LOGANSPORT		In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-0072	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pr 5/27/2022 1:	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.) 7.00	-			
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				
50. 00 05000 OPERATI NG ROOM	0	0				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 05800 MAGNETIC RESONANCE IMAGING (MRI)	0					58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	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 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
69. 01 06901 CARDI AC REHAB	0	0				69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	10	17, 933				73.00
76.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0				76.00
76.01 03480 ONCOLOGY	0	0				76.01
OUTPATIENT SERVICE COST CENTERS			1			
88.00 08800 EXPRESS MEDICAL CENTER						88.00
88.01 08801 FAMILY HEALTH CARE						88.01
90. 00 09000 CLINIC	0					90.00
90.01 09001 WOUND CARE	0	0	•			90.01
91.00 09100 EMERGENCY	0		1			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES	0					95.00
200.00 Subtotal (see instructions)	10					95.00 200.00
201.00 Less PBP Clinic Lab. Services-Program	10	10,004				200.00
Only Charges	0					201.00
202.00 Net Charges (line 200 - line 201)	10	18,004				202.00
	1		1			1202.00

COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0072	Peri od:	Worksheet D-1	
			From 01/01/2021 To 12/31/2021	Date/Time Pre	pared:
		T 111, 2001, 11		5/27/2022 1:4	7 pm
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	cost center bescription			1.00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS]
1.00	Inpatient days (including private room days and swing-bed day			4, 820	1.00
2.00	Inpatient days (including private room days, excluding swing-	-bed and newborn days)		4, 820	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3.00
	do not complete this line.				
1.00	Semi-private room days (excluding swing-bed and observation b			4, 220	4.00
. 00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decemb	er 31 of the cost	0	5.00
. 00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6.00
. 00	Total swing-bed NF type inpatient days (including private roo reporting period	om days) through Decembe	r 31 of the cost	0	7.00
8. 00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	8.00
. 00	Total inpatient days including private room days applicable t newborn days) (see instructions)	to the Program (excludin	g swing-bed and	1, 395	9.00
0.00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		room days)	0	10.00
1. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e	only (including private	room days) after	0	11.00
2.00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.00
3.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)				
4.00	Medically necessary private room days applicable to the Progr			0	14.00
5.00	Total nursery days (title V or XIX only)	all (excluding swing bed	udys)	0	15.00
	Nursery days (title V or XIX only)			0	
0.00	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31	of the cost	0,00	17.00
	reporting period				
8.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost	0.00	18.00
9.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 o	f the cost	0.00	19.00
0. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of	the cost	0.00	20.00
1.00	Total general inpatient routine service cost (see instruction	าร)		8,004,053	21.00
2.00	Swing-bed cost applicable to SNF type services through Decemb 5×1 ine 17)		ting period (line		
3.00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reporti	ng period (line 6	0	23.00
4.00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24.0

23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,004,053	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	8,004,053	37.00
	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)	1, 660. 59	38.00
	Program general inpatient routine service cost (line 9 x line 38)	2, 316, 523	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2, 316, 523	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	MEMORIAL HOSPITA	Provider C	CN: 15-0072	Period:	u of Form CMS- Worksheet D-	
					From 01/01/2021		
					To 12/31/2021	Date/Time Pro	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total	Average Per Diem (col.		Program Cost	
		Inpatient Cost	Inpatient Days	÷ col. 2)		(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	NURSERY (title V & XIX only)	0	0	0. (000	() 42.
	Intensive Care Type Inpatient Hospital Ur INTENSIVE CARE UNIT		602	3, 528. (03 192	677, 382	2 43.
	CORONARY CARE UNIT	2, 123, 877	602	3, 528. 0	192	077, 382	43.
	BURN I NTENSI VE CARE UNI T						45.
. 00	SURGICAL INTENSIVE CARE UNIT						46.
. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost	(Wkst. D-3, col. 3,	line 200)			3, 107, 019	9 48.
	Total Program inpatient costs (sum of li			ons)		6, 100, 924	4 49.
	PASS THROUGH COST ADJUSTMENTS					100 5/	
. 00	Pass through costs applicable to Program III)	inpatient routine :	services (fro	m Wkst. D, su	m of Parts I and	402, 563	3 50.
. 00	Pass through costs applicable to Program	inpatient ancillar	v services (f	rom Wkst D	sum of Parts II	115, 572	2 51
	and IV)	r	,				
	Total Program excludable cost (sum of li					518, 135	
. 00	Total Program inpatient operating cost e		ated, non-ph	ysician anest	hetist, and	5, 582, 789	9 53
	medical education costs (line 49 minus) TARGET AMOUNT AND LIMIT COMPUTATION	The 52)					
	Program di scharges					(54
	Target amount per discharge					0.00	55 0
	Target amount (line 54 x line 55)				11	(
	Difference between adjusted inpatient op Bonus payment (see instructions)	erating cost and tai	rget amount (line 56 minus	line 53)		D 57 D 58
	Lesser of lines 53/54 or 55 from the cos	t reporting period (ending 1996	updated and c	ompounded by the		
	market basket	e ropor en ig por rou -	sharing 1770,				
	Lesser of lines 53/54 or 55 from prior years					0.00	
. 00	If line 53/54 is less than the lower of					(0 61
	which operating costs (line 53) are less amount (line 56), otherwise enter zero (s (TINES 54 X	60), or 1% c	in the target		
. 00	Relief payment (see instructions)					(62
. 00	Allowable Inpatient cost plus incentive	payment (see instru	ctions)			(5 63
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine	anata thursunk Daar			ing and (Car		
. 00	instructions)(title XVIII only)	costs through Decer	nder 31 of th	e cost report	ing period (see		64
5. 00	Medicare swing-bed SNF inpatient routine	costs after Decemb	er 31 of the	cost reportin	g period (See	(0 65
	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient re	outine costs (line o	64 plus line	65)(title XVI	II only). For	() 66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient ro	utine costs through	December 31	of the cost r	eporting period		0 67
	(line 12 x line 19)		becchiber of		opor tring porrod		
. 00	Title V or XIX swing-bed NF inpatient ro	utine costs after De	ecember 31 of	the cost rep	orting period	() 68
9.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatio	opt routing costs (o 49)			0 69
	PART III - SKILLED NURSING FACILITY, OTHE						5 07
	Skilled nursing facility/other nursing facili)		70
	Adjusted general inpatient routine servi		ne 70 ÷ line	2)			71
	Program routine service cost (line 9 x li Medically peopsary private room cost ap	,	(line 14 v l	no 25)			72
. 00	Medically necessary private room cost ap Total Program general inpatient routine :		•				73
	Capital -related cost allocated to inpatio	-			Part II, column		75
	26, line 45)		-				
	Per diem capital -related costs (line 75 -	-					76
	Program capital-related costs (line 9 x Inpatient routine service cost (line 74 m	-					77
	Aggregate charges to beneficiaries for e	-	rovi der recor	ds)			79
	Total Program routine service costs for	•	ost limitatio	n (line 78 mi	nus line 79)		80
	Inpatient routine service cost per diem		, ,				81
	Inpatient routine service cost limitation Reasonable inpatient routine service cost						82
	Program inpatient ancillary services (see		-,				84
	Utilization review - physician compensat		ns)				85
. 00	Total Program inpatient operating costs	(sum of lines 83 th					86
	PART IV - COMPUTATION OF OBSERVATION BED					100	1 07
. 00	Total observation bed days (see instruct Adjusted general inpatient routine cost		line 2)			600 1, 660. 59	
3.00	Adjusted deneral indatient routine rosi						

Health Financial Systems	MEMORIAL HOSPIT	AL LOGANSPORT		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 1:4	pared: 7 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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, 186, 766	8,004,053	0. 14827	1 996, 354	147, 730	90.00
91.00 Nursing Program cost	0	8,004,053	0.00000	0 996, 354	0	91.00
92.00 Allied health cost	0	8,004,053	0.00000	0 996, 354	0	92.00
93.00 All other Medical Education	0	8,004,053	0.00000	996, 354	0	93.00

Heal th Financial	Systems		
COMPUTATION OF I	NPATI ENT	OPERATI NG	COST

MEMORI AL	HOSPI TAL	LOGANSPORT	

In Lieu of Form CMS-2552-10

	Financial Systems MEMORIAL HOSPITAL	LOGANSPORT	In Lie	u of Form CMS-2	2552-
OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0072	Period:	Worksheet D-1	
			From 01/01/2021 To 12/31/2021	Date/Time Pre	nare
			10 12/31/2021	5/27/2022 1:4	7 pm
		Title XIX	Hospi tal	Cost	
	Cost Center Description				
				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed day			4, 820	1.
00	Inpatient days (including private room days, excluding swing-			4, 820	2.
00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	orivate room days,	0	3.
	do not complete this line.				
00	Semi-private room days (excluding swing-bed and observation b			4, 220	
00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decemb	per 31 of the cost	0	5.
00	reporting period	and dave) ofter December	21 of the east	0	
00	Total swing-bed SNF type inpatient days (including private re	Join days) after December	31 OF the COST	0	6.
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	am days) through Docombo	or 21 of the cost	0	7.
00	reporting period	Sill days) thi ough beceilibe	er si or the cost	0	/.
00	Total swing-bed NF type inpatient days (including private roo	am days) after Decomber	21 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line)	Sill days) al ter beceniber	ST OF THE COST	0	0.
00	Total inpatient days including private room days applicable t	to the Program (excludin	na swina bed and	276	9.
00	newborn days) (see instructions)		ig swillig bed and	270	· · ·
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private	room days)	0	10.
	through December 31 of the cost reporting period (see instruc		(dayo)		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private	room davs) after	0	11.
	December 31 of the cost reporting period (if calendar year, e			-	
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		ate room days)	0	12.
	through December 31 of the cost reporting period	5 (5)			
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including priva	ate room days)	0	13
	after December 31 of the cost reporting period (if calendar y				
. 00	Medically necessary private room days applicable to the Progr			0	14
. 00	Total nursery days (title V or XIX only)		3	983	15
. 00	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost	0.00	17
	reporting period	-			
8.00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	f the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 c	of the cost	0.00	19
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
~ ~	reporting period	、 、		0 004 050	
	Total general inpatient routine service cost (see instruction			8,004,053	
. 00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost repor	ting period (line	0	22
	5 x line 17)				
8.00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23
00	x line 18)			0	24
. 00	Swing-bed cost applicable to NF type services through December 7×1 (ine 19)	er 31 of the cost report	ing period (line	0	24
00		21 of the cost reportin	a pariod (line 9	0	25
. 00	Swing-bed cost applicable to NF type services after December	31 OF the cost reportin	ig period (Time 8	0	25
5.00	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, 004, 053	
. 00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT	(The 21 minus The 20)		0,004,033	21
. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed o	harges)	0	28
. 00	Private room charges (excluding swing-bed charges)		indi geo)	0	
. 00	Semi-private room charges (excluding swing bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27)	÷line 28)		0. 000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 2) + line 3)			0.00	
. 00	Average per diem private room charge differential (line 32 mi	inus line 33)(see instru	uctions)	0.00	
. 00	Average per diem private room cost differential (line 34 x li			0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	- /		0	
	General inpatient routine service cost net of swing-bed cost	and private room cost o	lifferential (line		
. 00	27 minus line 36)			.,,	- /
. 00					1
. 00	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
. 00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see			1, 660. 59	38
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	e instructions)		1, 660. 59 458, 323	
3.00 9.00 9.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see	e instructions) e 38)			39

	I Financial Systems M TATION OF INPATIENT OPERATING COST	EMORIAL HOSPIT	AL LOGANSPORT	°N: 15-0072 F	In Lie Period:	u of Form CMS- Worksheet D-1	
COMID				F	rom 01/01/2021 o 12/31/2021		epared:
			Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpati ent Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00		1.00	2.00	3.00	4.00	5.00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	698, 329	983	710. 41	0	0	42.00
43.00		2, 123, 877	602	3, 528. 03	0	0	43.00
44.00							44.00
45.00							45.00
	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)						46.00 47.00
47.00	Cost Center Description						47.00
	-					1.00	
48.00	5 1 5					361, 212	
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	819, 535	49.00				
50.00		atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.00
51.00		atient ancilla	ry services (f	rom Wkst. D, s	um of Parts II	0	51.00
52.00	and IV) .00 Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anesth	etist, and	0	
	medical education costs (line 49 minus line	52)					
54.00	TARGET AMOUNT AND LIMIT COMPUTATION					0	54.00
55.00	Program di scharges Target amount per di scharge						55.00
56.00	5						56.00
57.00	, , , , , , , , , , , , , , , , , , ,	ing cost and ta	arget amount (line 56 minus	line 53)	0	
58.00 59.00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting ported	onding 1004	undated and co	mounded by the	0.00	
39.00	market basket	por tring period	enurny 1990,	upuateu anu co	inpounded by the	. 0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, u	pdated by the	market basket		0.00	60.00
61.00						0	61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		ts (lines 54 x	60), or 1% of	the target		
62.00						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
(1 . 00	PROGRAM INPATIENT ROUTINE SWING BED COST	ta thursuah Daar				0	
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	emper 31 of th	e cost reporti	ng period (see	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ber 31 of the	cost reporting	period (See	0	65.00
((00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For					0	
66.00	CAH (see instructions)	ne costs (IIne	64 prus rine	b5)(title XVII	i oniy). For	0	66.00
67.00		e costs through	h December 31	of the cost re	porting period	0	67.00
	(line 12 x line 19)					_	
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after l	December 31 of	the cost repo	rting period	0	68.00
69.00	· · · · · · · · · · · · · · · · · · ·	0	69.00				
	PART III - SKILLED NURSING FACILITY, OTHER N						
70.00	Skilled nursing facility/other nursing facil						70.00
71.00 72.00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		inne 70 ÷ inne	2)			71.00
73.00	5		m (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 (from	Norksheet B, P	art II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00		,		-1 - 2			78.00
79.00 80.00	55 5 5				us line 70)		79.00
81.00	Inpatient routine service cost per diem limi				ac 1110 17)		81.00
82.00			1)				82.00
83.00	Reasonable inpatient routine service costs (ns)				83.00
84.00 85.00	Program inpatient ancillary services (see in		one)				84.00
85.00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85.00 86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
87.00	Total observation bed days (see instructions					600	
88.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•				1, 660. 59	
20 00)			996, 354	1 20 14

Health Financial Systems	MEMORIAL HOSPITAL LOGANSPORT			In Lieu of Form CMS-2552-10				
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1			
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 1:4	pared: 7 pm		
		Titl	Title XIX		Cost			
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on			
		(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, 186, 766	8,004,053	0. 14827	1 996, 354	147, 730	90.00		
91.00 Nursing Program cost	0	8,004,053	0.00000	0 996, 354	0	91.00		
92.00 Allied health cost	0	8,004,053	0.00000	0 996, 354	0	92.00		
93.00 All other Medical Education	0	8, 004, 053	0.00000	996, 354	0	93.00		

	LOGANSPORT Provider CCN: 15-0072		In Lieu of Form CM Period: Worksheet		
			From 01/01/2021	WOT KSHEET D 5	
			To 12/31/2021	Date/Time Pre	pare
	Titlo	XVIII	Hospi tal	5/27/2022 1:47 PPS	
Cost Center Description	nue	Ratio of Cos		Inpatient	
Cost Center Description		To Charges		Program Costs	
		10 charges	Charges	(col. 1 x	
			chai yes	col. 2)	
		1.00	2.00	3.00	<u> </u>
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00 03000 ADULTS & PEDIATRICS			1, 826, 055		1 30.
I. 00 03100 I NTENSI VE CARE UNI T			390, 080		31.
3. 00 04300 NURSERY					43.
ANCI LLARY SERVI CE COST CENTERS					
D. 00 05000 OPERATI NG ROOM		0. 2840	39 1, 263, 997	359, 088	50.
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 5922	51 0	0	52.
3. 00 05300 ANESTHESI OLOGY		0. 0857	56 59, 120	5, 070	53
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2658	91 386, 995	102, 898	54
7. 00 05700 CT SCAN		0.0000	0 00	0	57
3. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000	0 00	0	58
9. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000	0 00	0	59
D. 00 06000 LABORATORY		0. 2477	39 1, 212, 138	300, 294	60
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2693	61 111, 927	30, 149	63
5. 00 06500 RESPI RATORY THERAPY		0. 2840	1, 893, 102	537, 677	65
5. 00 06600 PHYSI CAL THERAPY		0. 4542	44 189, 686	86, 164	66
9. 00 06900 ELECTROCARDI OLOGY		0. 1501	68 326, 509	49, 031	69
9. 01 06901 CARDI AC REHAB		1. 4259	51 0	0	69
I. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0. 6231	85 432, 436	269, 488	71
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 2075	84 455, 823	94, 622	72
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2146	82 4, 175, 739	896, 456	73
5.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 1239	66 434, 862	53, 908	
5. 01 03480 ONCOLOGY		0. 1912	51 0	0	76
OUTPATIENT SERVICE COST CENTERS					
3. 00 08800 EXPRESS MEDI CAL CENTER		0.0000		0	
B. 01 08801 FAMILY HEALTH CARE		0.0000	00	0	88
D. 00 09000 CLINIC		1. 5036	76 0	0	90
0. 01 09001 WOUND CARE		0. 2053			
. 00 09100 EMERGENCY		0. 2583		219, 680	91
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 20343	31 84, 198	101, 326	92
OTHER REIMBURSABLE COST CENTERS					
5. 00 09500 AMBULANCE SERVICES					95
00.00 Total (sum of lines 50 through 94 and 96 through 98)			11, 882, 532	3, 107, 019	
01.00 Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		0		201
02.00 Net charges (line 200 minus line 201)			11, 882, 532		202.

alth Financial Systems MEMORIAL HOSPITAL LOG IPATIENT ANCILLARY SERVICE COST APPORTIONMENT Pr		N: 15-0072	Peri od:	u of Form CMS-2 Worksheet D-3	
VPATIENT ANGILLART SERVICE CUST APPORTIONMENT	ovider cc	N. 13-0072	From 01/01/2021	WOLKSHEEL D-3	
			To 12/31/2021	Date/Time Pre	pare
			10 12/01/2021	5/27/2022 1:4	7 pm
	Title	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
· ·		To Charges	Program	Program Costs	
		Ũ	Charges	(col. 1 x	
			Jan Jan	col. 2)	
	ľ	1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00 03000 ADULTS & PEDI ATRI CS			449, 572		30.
I. 00 03100 I NTENSI VE CARE UNI T			77, 939		31.
3. 00 04300 NURSERY			35, 130		43.
ANCI LLARY SERVI CE COST CENTERS	I				1
D. OO O5000 OPERATING ROOM		0. 2789	271, 398	75, 698	1 50.
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0.59225		83	
3. 00 05300 ANESTHESI OLOGY		0.08575		1, 129	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 26589		5,602	
7. 00 05700 CT SCAN		0.0000		0,002	
B. OO OSSOO MAGNETIC RESONANCE IMAGING (MRI)		0.00000		0	58
0. 00 05900 CARDIAC CATHETERIZATION		0.00000		0	59
0. 00 06000 LABORATORY				-	60
3. 00 06300 LABORATORT 3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 24773 0. 26936		27, 591 3, 079	
5. 00 06500 RESPIRATORY THERAPY		0. 2840		31, 491	65
6. 00 06600 PHYSI CAL THERAPY		0.45424		2,055	
P. 00 06900 ELECTROCARDI OLOGY		0. 15016		1, 100	
P. 01 06901 CARDI AC REHAB		1. 42595		0	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 62318		0	
. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 20758		0	72
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 21468	32 323, 522	69, 454	
0. 00 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 12396	24, 663	3, 057	76
0. 01 03480 ONCOLOGY		0. 19125	51 0	0	76
OUTPATIENT SERVICE COST CENTERS					
8. 00 08800 EXPRESS MEDICAL CENTER		0.0000	0 0	0	88
. 01 08801 FAMILY HEALTH CARE		0.0000	0 0	0	88
0. 00 09000 CLINIC		1.48770	86, 031	127, 988	90
0. 01 09001 WOUND CARE		0.20537	76 0	0	90
. 00 09100 EMERGENCY		0. 25835	48, 614	12, 560	91
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1.20343		325	
OTHER REIMBURSABLE COST CENTERS			2.0	020	1
. 00 09500 AMBULANCE SERVICES					95
0.00 Total (sum of lines 50 through 94 and 96 through 98)			1, 034, 396	361, 212	
11.00 Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		1,004,070	501, 212	200
22.00 Net charges (line 200 minus line 201)			1, 034, 396		201
2.00 piver charges (The 200 millios The 201)	I		1, 034, 390		1202

	inancial Systems MEMORIAL HOSPITAL		01 45 0070	D		u of Form CMS-2	
NPATTEN	IT ANCI LLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0072		iod: m 01/01/2021	Worksheet D-3	
		Component	CCN: 15-U072	To	12/31/2021	Date/Time Pre	pare
						5/27/2022 1:4	7 pr
		liti	e XIX		ng Beds - SNF		
	Cost Center Description		Ratio of Cos		Inpati ent	Inpatient	
			To Charges		5	Program Costs	
					Charges	(col. 1 x	
			1.00		2.00	<u>col. 2)</u> 3.00	
11	NPATIENT ROUTINE SERVICE COST CENTERS		1.00		2.00	5.00	
	3000 ADULTS & PEDI ATRI CS						30
	3100 I NTENSI VE CARE UNI T						31
	4300 NURSERY						43
	NCILLARY SERVICE COST CENTERS		1				
0.00 05	5000 OPERATING ROOM		0.0000	00	0	0	50
2.00 05	5200 DELIVERY ROOM & LABOR ROOM		0.0000	00	0	0	52
3.00 05	5300 ANESTHESI OLOGY		0.0000	00	0	0	53
4.00 05	5400 RADI OLOGY-DI AGNOSTI C		0.0000	00	0	0	54
7.00 05	5700 CT SCAN		0.0000	00	0	0	57
3. 00 05	5800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000	00	0	0	58
9.00 05	5900 CARDI AC CATHETERI ZATI ON		0.0000	00	0	0	59
0. 00	6000 LABORATORY		0.0000		0	0	60
3.00 00	6300 BLOOD STORING, PROCESSING & TRANS.		0.0000	00	0	0	63
5.00 00	6500 RESPI RATORY THERAPY		0.0000	00	0	0	65
6.00 06	6600 PHYSI CAL THERAPY		0.0000	00	0	0	66
9.00 00	6900 ELECTROCARDI OLOGY		0.0000	00	0	0	69
9.01 00	6901 CARDI AC REHAB		0.0000	00	0	0	69
1.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000	00	0	0	71
	7200 IMPL. DEV. CHARGED TO PATIENT		0.0000	00	0	0	72
	7300 DRUGS CHARGED TO PATIENTS		0.0000	00	0	0	73
6.00 03	3450 NUCLEAR MEDICINE - DIAGNOSTIC		0.0000	00	0	0	76
	3480 ONCOLOGY		0.0000	00	0	0	76
OL	JTPATIENT SERVICE COST CENTERS						
3. 00 08	8800 EXPRESS MEDI CAL CENTER		0.0000	00	0	0	88
3. 01 08	8801 FAMILY HEALTH CARE		0.0000	00	0	0	88
0.00	9000 CLINIC		0.0000	00	0	0	90
0. 01 09	9001 WOUND CARE		0.0000	00	0	0	90
. 00 09	9100 EMERGENCY		0.0000	00	0	0	91
. 00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART)		0.0000	00	0	0	92
OT	THER REIMBURSABLE COST CENTERS						
	9500 AMBULANCE SERVI CES						95
00.00	Total (sum of lines 50 through 94 and 96 through 98)		1		0	0	200
01.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)			0		201
02.00	Net charges (line 200 minus line 201)		1		0		202

	Financial Systems MEMORIAL HOSPITAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	u of Form CMS-: Worksheet E Part A Date/Time Pre 5/27/2022 1:4	epared:
		Title XVIII	Hospi tal	PPS	
				1.00	
. 00 . 01	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ing prior to October 1	(see	0 2, 552, 809	
. 02	DRG amounts other than outlier payments for discharges occurr	5 .		919, 463	
. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI f	prior to October	0	1.0	
. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	on or after	0	1.0	
. 00 . 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount		0	2.0 2.0	
. 02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	
. 03	Outlier payments for discharges occurring prior to October 1			69, 036	
. 04	Outlier payments for discharges occurring on or after October	1 (see instructions)		41, 992	
. 00 . 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repo	orting period (see instr	uctions)	0 40. 36	
. 00	Indirect Medical Education Adjustment	iting period (see misti		40.30	4.0
. 00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	st recent cost reporting	period ending or	0.00	5.0
. 00	FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e)				
. 00 . 01	MMA Section 422 reduction amount to the IME cap as specified ACA \S 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.	0.00 0.00			
. 00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).	0.00	8. C		
. 01	The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	0.00	8.0		
. 02	The amount of increase if the hospital was awarded FTE cap sl under § 5506 of ACA. (see instructions)	0.00	8.0		
. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	0.00			
0.00 1.00 2.00	FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)	ent year from your reco	ras	0.00 0.00 0.00	11.0
3.00	Total allowable FTE count for the prior year.			0.00	
4.00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ear ended on or after Se	ptember 30, 1997,	0.00	
5.00	Sum of lines 12 through 14 divided by 3.			0.00	
6.00	Adjustment for residents in initial years of the program				16.0
7.00 8.00	Adjustment for residents displaced by program or hospital clo Adjusted rolling average FTE count	osure		0.00	17.0 18.0
	Current year resident to bed ratio (line 18 divided by line 4	H).		0.000000	
0.00	Prior year resident to bed ratio (see instructions)			0. 000000	
1.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
2.00	IME payment adjustment (see instructions)			0	
2.01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42 Number of additional elementics and ectoapathics LME Efficiency		CED 412 105	0 00	
3.00 4.00	Number of additional allopathic and osteopathic IME FTE resid (f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)	ient cap stots under 42	ылк 412.1U5	0.00	
5.00	If the amount on line 24 is greater than -0-, then enter the instructions)	lower of line 23 or lin	e 24 (see	0.00	
6.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	
7.00	IME payments adjustment factor. (see instructions)			0.000000	
8.00	IME add-on adjustment amount (see instructions)	•)		0	
8.01 9.00	IME add-on adjustment amount - Managed Care (see instructions Total IME payment (sum of lines 22 and 28)	»)		0	
9.00 9.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0 Disproportionate Share Adjustment	01)		0	
0. 00	Percentage of SSI recipient patient days to Medicare Part A p	oatient days (see instru	ctions)	3. 07	30.0
1.00	Percentage of Medicaid patient days (see instructions)	,	,	31.69	
2.00	Sum of lines 30 and 31			34.76	
3.00	Allowable disproportionate share percentage (see instructions			12.00	33.0

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2021	Worksheet E Part A	
					norod
			To 12/31/2021	Date/Time Pre 5/27/2022 1:4	pareu: 7 pm
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment		9 200 014 E21	7 102 009 710	25 0
35.00 35.01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0. 000104522	7, 192, 008, 710 0. 000082848	35.0 35.0
35. 01 35. 02	Hospital uncompensated care payment (If line 34 is zero, ent	er zero on this line) (se		595, 844	35.0
0.02	instructions)		000,407	373, 044	55.0
35.03	Pro rata share of the hospital uncompensated care payment am	ount (see instructions)	648, 086	150, 185	35.0
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.	03)	798, 271		36.0
	Additional payment for high percentage of ESRD beneficiary di	ischarges (lines 40 throu	gh 46)		
10.00	Total Medicare discharges (see instructions)		0		40.0
11.00	Total ESRD Medicare discharges (see instructions)		0		41.0
11.01	Total ESRD Medicare covered and paid discharges (see instruc		0		41.0
12.00	Divide line 41 by line 40 (if less than 10%, you do not qual	ity for adjustment)	0.00		42.0
13.00 14.00	Total Medicare ESRD inpatient days (see instructions) Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		43.0 44.0
4.00	days)	by The 41 divided by 7	0.000000		44.0
15.00	Average weekly cost for dialysis treatments (see instruction	s)	0.00		45.0
16.00	Total additional payment (line 45 times line 44 times line 4	-	0		46.0
17.00	Subtotal (see instructions)		4, 485, 739		47.0
18.00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	5, 286, 412		48.0
	only. (see instructions)				
				Amount	
19.00	Total payment for inpatient operating costs (see instruction	5)		1.00 5,286,412	49.0
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a	-		278, 051	50. C
51.00	Exception payment for inpatient program capital (Wkst. L, Pt			0	51.0
52.00	Direct graduate medical education payment (from Wkst. E-4, I			0	52.0
53.00	Nursing and Allied Health Managed Care payment			0	53.0
54.00	Special add-on payments for new technologies			389, 191	54.0
54.01	Islet isolation add-on payment			0	54.C
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line			0	55.C
56.00	Cost of physicians' services in a teaching hospital (see int			0	56.0
57.00 58.00	Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt.		nrougn 35).	0	57.0 58.0
59.00	Total (sum of amounts on lines 49 through 58)	rv, cor. In the 200)		5, 953, 654	
50.00	Primary payer payments			5, 551	60.0
51.00	Total amount payable for program beneficiaries (line 59 minu:	s line 60)		5, 948, 103	
52.00	Deductibles billed to program beneficiaries	,		500, 819	
53.00	Coinsurance billed to program beneficiaries			742	63.0
64.00	Allowable bad debts (see instructions)			24, 800	64.0
5.00	Adjusted reimbursable bad debts (see instructions)			16, 120	65.0
6.00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		24, 800	66.0
57.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			5, 462, 662	67.0
8.00	Credits received from manufacturers for replaced devices for Outline normatic received for an (our of lines 02, 05 and 0()			0	68.0
9.00 0.00	Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. (FOI SCH SEE THSTIUCTION	5)	0	69. (70. (
0.50	Rural Community Hospital Demonstration Project (§410A Demons	tration) adjustment (see	instructions)	0	70.
0.87	Demonstration payment adjustment amount before sequestration			0	70.
70.88	SCH or MDH volume decrease adjustment (contractor use only)			Ő	70.8
70.89	Pioneer ACO demonstration payment adjustment amount (see ins	tructions)			70.8
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 9
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 9
70. 92	Bundled Model 1 discount amount (see instructions)			0	70.
70.93	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			-11, 585 0	
70.93					70.9

alth Financial Systems MEMORI. LCULATION OF REIMBURSEMENT SETTLEMENT	AL HOSPITAL LOGANSPORT Provider C	CN: 15-0072	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2021 To 12/31/2021	Part A Date/Time Pre 5/27/2022 1:4	pare 7 pm
	Title	XVIII	Hospi tal	PPS	, b
		FF\	(уууу)	Amount	
96 Low volume adjustment for federal fiscal year (yy	yy) (Enter in column O		0 2021	<u>1.00</u> 714,176	70.
the corresponding federal year for the period price	or to 10/1)				
0.97 Low volume adjustment for federal fiscal year (yy the corresponding federal year for the period end			2022	270, 062	
98 Low Volume Payment-3 99 HAC adjustment amount (see instructions)				0 18, 207	70. 70.
. 00 Amount due provider (line 67 minus lines 68 plus/r	minus lines 69 & 70)			6, 417, 108	
. 01 Sequestration adjustment (see instructions)				0	71
. 02 Demonstration payment adjustment amount after sequ	uestration			0	71.
.03 Sequestration adjustment-PARHM pass-throughs					71
.00 Interim payments				6, 488, 227	72
2.01 Interim payments-PARHM					72.
0.00 Tentative settlement (for contractor use only)				0	73.
5.01 Tentative settlement-PARHM (for contractor use onl 6.00 Balance due provider/program (line 71 minus lines				-71, 119	
73)	/1.01, /1.02, /2, and			-71,117	/ 4
.01 Balance due provider/program-PARHM (see instructio	ons)				74
.00 Protested amounts (nonallowable cost report items)) in accordance with			241, 477	75
CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96		1		0	00
.00 Operating outlier amount from Wkst. E, Pt. A, line plus 2.04 (see instructions)	e 2, 01 Sull 01 2.03			0	90
.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91
.00 Operating outlier reconciliation adjustment amount	t (see instructions)			0	92
.00 Capital outlier reconciliation adjustment amount (0	93
.00 The rate used to calculate the time value of money	y (see instructions)			0.00	
. 00 Time value of money for operating expenses (see in				0	95
.00 Time value of money for capital related expenses	(see Instructions)		Prior to 10/1	0 0 / After 10/1	96
			1.00	2.00	
HSP Bonus Payment Amount					
0.00 HSP bonus amount (see instructions)			0	0	100
HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions)			0.000000000	0.000000000	101
2.00 HVBP adjustment amount for HSP bonus payment (see	instructions)		0.0000000000000000000000000000000000000		102
HRR Adjustment for HSP Bonus Payment			V	0	102
3.00 HRR adjustment factor (see instructions)			0.0000	0.0000	103
4.00 HRR adjustment amount for HSP bonus payment (see i	nstructions)		0	0	104
Rural Community Hospital Demonstration Project (§4					
0.00 Is this the first year of the current 5-year demor		the 21st			200
Century Cures Act? Enter "Y" for yes or "N" for no	Э				
Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1,	Pt II line 49)				201
2.00 Medicare discharges (see instructions)					202
					203
		of the curr	ent 5-year demons	tration	
	tion (N/A in first year				
3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitat period)	tion (N/A in first year				204
 OO Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitat period) OO Medicare target amount 					
 3. 00 <u>Case-mix adjustment factor (see instructions)</u> Computation of Demonstration Target Amount Limitat period) 4. 00 Medicare target amount 5. 00 Case-mix adjusted target amount (line 203 times li 	ne 204)				
 3. 00 <u>Case-mix adjustment factor (see instructions)</u> Computation of Demonstration Target Amount Limitat period) 4. 00 Medicare target amount 5. 00 Case-mix adjusted target amount (line 203 times li 6. 00 Medicare inpatient routine cost cap (line 202 time) 	ne 204) es line 205)				
 Constructions Computation of Demonstration Target Amount Limitat period) OM Medicare target amount OM Medicare inpatient routine cost cap (line 202 times Adjustment to Medicare Part A Inpatient Reimbursen 	ne 204) es line 205) ment				206
 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitat period) OM Medicare target amount OM Adjusted target amount (line 203 times li 6.00 Medicare inpatient routine cost cap (line 202 time Adjustment to Medicare Part A Inpatient Reimbursen OM Program reimbursement under the §410A Demonstration 	ne 204) es line 205) ment on (see instructions)				206 207
 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitat period) OM Medicare target amount OM Adjustment to Medicare part A Inpatient Reimbursen OM Adjustment to Medicare Part A Inpatient Reimbursen OM Medicare Part A inpatient service costs (from Wkst 	ne 204) es line 205) ment on (see instructions) t. E, Pt. A, line 59)				205 206 207 208 209
 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitat period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times li 6.00 Medicare inpatient routine cost cap (line 202 time Adjustment to Medicare Part A Inpatient Reimbursen 7.00 Program reimbursement under the §410A Demonstratio 8.00 Medicare Part A inpatient service costs (from Wkst 9.00 Adjustment to Medicare IPPS payments (see instruct 0.00 Reserved for future use 	ne 204) es line 205) nent on (see instructions) t. E, Pt. A, line 59) tions)				206 207 208 209 210
 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitat period) OM Medicare target amount OM Case-mix adjusted target amount (line 203 times li 6.00 Medicare inpatient routine cost cap (line 202 time Adjustment to Medicare Part A Inpatient Reimbursen 7.00 Program reimbursement under the §410A Demonstration 8.00 Medicare Part A inpatient service costs (from Wksi 9.00 Adjustment to Medicare IPPS payments (see instruct 0.00 Reserved for future use Total adjustment to Medicare IPPS payments (see instruct 	ne 204) es line 205) nent on (see instructions) t. E, Pt. A, line 59) tions)				206 207 208 209 210
 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitat period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times li 6.00 Medicare inpatient routine cost cap (line 202 time Adjustment to Medicare Part A Inpatient Reimbursen 7.00 Program reimbursement under the §410A Demonstration 8.00 Medicare Part A inpatient service costs (from Wksi 9.00 Adjustment to Medicare IPPS payments (see instruction) 0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see information) 	ne 204) es line 205) nent on (see instructions) t. E, Pt. A, line 59) tions) nstructions)				206 207 208 209 210 211
 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitat period) 44.00 Medicare target amount 55.00 Case-mix adjusted target amount (line 203 times li 66.00 Medicare inpatient routine cost cap (line 202 time Adjustment to Medicare Part A Inpatient Reimbursen Adjustment to Medicare Part A Inpatient Reimbursen 77.00 Program reimbursement under the §410A Demonstration 88.00 Medicare Part A inpatient service costs (from Wksi 99.00 Adjustment to Medicare IPPS payments (see instruct 0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see in Comparision of PPS versus Cost Reimbursement 2.00 Total adjustment to Medicare Part A IPPS payments 	ne 204) es line 205) nent on (see instructions) t. E, Pt. A, line 59) tions) nstructions)				206 207 208 209 210 211
 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitat period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times li 6.00 Medicare inpatient routine cost cap (line 202 time Adjustment to Medicare Part A Inpatient Reimbursen 7.00 Program reimbursement under the §410A Demonstration 8.00 Medicare Part A inpatient service costs (from Wksi 9.00 Adjustment to Medicare IPPS payments (see instruction) 0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see information) 	ne 204) es line 205) nent on (see instructions) t. E, Pt. A, line 59) tions) nstructions) (from line 211)	mbursement)			206 207 208 209 210 211

N VC	Financial Systems DLUME CALCULATION EXHIBIT 4		IEMORI AL HOSPI T	Provider C	-	Period: From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 1:4	t 4 parec
		line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	0n/After 10/01	PPS Total (Col 2 through 4)	
0.0		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier payments	1.00	0	0		0 0	0	1.0
01	DRG amounts other than outlier payments for discharges	1.01	2, 552, 809	0	2, 552, 80	9	2, 552, 809	1.
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	919, 463	0		919, 463	919, 463	1.
03	1 DRG for Federal specific operating payment for Model 4 BPCl occurring prior to	1. 03	0	0		D	0	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.
00	Outlier payments for	2.00						2.
01	discharges (see instructions) Outlier payments for discharges for Model 4 BPCI	2.02	0	0	(o o	0	2.
)2	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	69, 036	0	69, 03	6	69, 036	2.
)3	Outlier payments for discharges occurring on or after October 1 (see	2.04	41, 992	0		41, 992	41, 992	2.
00	instructions) Operating outlier reconciliation	2.01	0	0	(o o	0	3.
00	Managed care simulated payments Indirect Medical Education Adju	3.00	0	0		0 0	0	4.
00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0.00000	0.00000		5.
0	A, line 21 (see instructions) IME payment adjustment (see instructions)	22.00	0	0		o o	0	6.
)1	IME payment adjustment for managed care (see	22.01	0	0		0 0	0	6.
	instructions) Indirect Medical Education Adju	istment for th	e Add-on for Se	ection 422 of	the MMA		<u> </u>	
0	IME payment adjustment factor (see instructions)	27.00	0. 000000			0. 000000		7
0	IME adjustment (see instructions)	28.00	0	0		0 0	-	
)1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0		0 0	0	8
)0)1	Total IME payment (sum of lines 6 and 8) Total IME payment for managed	29. 00 29. 01	0	0			-	
, 1	care (sum of lines 6.01 and 8.01)		0					
00	Disproportionate Share Adjustmo Allowable disproportionate share percentage (see	ant 33.00	0. 1200	0. 1200	0. 120	0. 1200		10.
00	instructions) Disproportionate share adjustment (see instructions)	34.00	104, 168	0	76, 58	4 27, 584	104, 168	11.
01	Uncompensated care payments Additional payment for high per	36.00 rcentage of ES	798, 271 RD beneficiary	0 di scharges	648, 08	6 150, 185	798, 271	11.
00	Total ESRD additional payment	46.00	0	0	(0 C	0	12.
00 00	(see instructions) Subtotal (see instructions) Hospital specific payments	47.00 48.00	4, 485, 739 5, 286, 412	0 0				
	(completed by SCH and MDH, small rural hospitals only.) (see instructions)							
00	Total payment for inpatient operating costs (see instructions)	49.00	5, 286, 412	0	3, 928, 61	5 1, 357, 797	5, 286, 412	15

	Financial Systems	r	MEMORIAL HOSPIT	Provider C	CN: 15-0072	Peri od:	u of Form CMS-: Worksheet E	2002-1
						From 01/01/2021 To 12/31/2021	Part A Exhibi Date/Time Pre 5/27/2022 1:4	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prio to 10/01	r Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4, 00	5.00	
6.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	278, 051	0			278, 051	16.0
7.00	Special add-on payments for new technologies	54.00	389, 191	0	269, 8	91 119, 300	389, 191	
17.01	Net organ aquisition cost							17.0
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	0	17.C
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	18.0
19.00	SUBTOTAL			0	4, 403, 00	60 1, 550, 594	5, 953, 654	19.0
		W/S L, line	(Amounts from L)					
	T	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	253, 654 0	0 0	188, 1	19 65, 535 0 0	253, 654 0	
21.00	Capital DRG outlier payments	2.00	24, 397	0	16, 43	35 7, 962	24, 397	21.0
21. 01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0		0 0	0	
2.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0. 0000				22.0
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23. (
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.000	0. 0000		24.0
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25.0
26.00	Total prospective capital payments (see instructions)	12.00	278, 051	0	204, 5	54 73, 497	278, 051	26.0
		W/S E, Part A	•					
		line	E, Part A)	2.00	2.00	4.00	F 00	
00 70	Low volume adjustment frater	0	1.00	2.00	3.00	4.00	5.00	27 /
27.00 28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0. 1622(714, 1		714, 176	27.0 28.0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				270, 062	270, 062	29.0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. (

	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2021 To 12/31/2021		pared
	· · · · · · · · · · · · · · · · · · ·		Title		Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
)0)1	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1.00 1.01	2, 552, 809	2, 552, 80		2, 552, 809	1. (1. (
)2	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges ensure of the October 1	1. 02	919, 463		919, 463	919, 463	1.
3	discharges occurring on or after October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1.
)4	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.
00	Outlier payments for discharges (see instructions)	2.00					2.
)1	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2.
)2	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	69, 036	69, 03	6	69, 036	2.
)3	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	41, 992		41, 992	41, 992	2.
00 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0		0 0 0 0	0	3. 4.
0	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 00000	0 0. 000000		5.
0	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22. 00 22. 01	0 0		0 0 0 0	0	6. 6.
	instructions) Indirect Medical Education Adjustment for the	Add on for S	oction 122 of t	bo MMA			
0	IME payment adjustment factor (see	27.00	0. 000000	0. 00000	0 0. 000000		7.
0 1	IME adjustment (see instructions) IME payment adjustment add on for managed	28. 00 28. 01	0 0		0 0 0 0	0 0	8. 8.
0	care (see instructions) Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.
1	Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment	29.01	0		0 0	0	9.
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1200	0. 120	0 0. 1200		10.
00	Disproportionate share adjustment (see instructions)	34.00	104, 168	76, 58	4 27, 584	104, 168	11.
01	Uncompensated care payments Additional payment for high percentage of ESF			648, 08		798, 271	
	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	47.00 48.00	4, 485, 739 5, 286, 412	3, 346, 51 3, 928, 61		4, 485, 739 5, 286, 412	
00	Total payment for inpatient operating costs (see instructions)	49.00	5, 286, 412	3, 928, 61	5 1, 357, 797	5, 286, 412	15.
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	278, 051	204, 55		278, 051	
00	Special add-on payments for new technologies Net organ acquisition cost	54.00	389, 191	269, 89		389, 191	17.
02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0		17. 18.
00	Capital outlier reconciliation adjustment	93.00	0		0 0		

	EMORIAL HOSPIT			In Lie	u of Form CMS-:	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Exhibi Date/Time Pre 5/27/2022 1:4	pared:
		Title	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	253, 654	188, 11		253, 654	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	
21.00 Capital DRG outlier payments	2.00	24, 397	16, 43	7,962	24, 397	
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	21,011	107 10	0 0	21,077	
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 instructions)	11.00	0		0 0	0	25.00
26.00 Total prospective capital payments (see instructions)	12.00	278, 051	204, 55	54 73, 497	278, 051	26.00
	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt. A)				
	0	1.00	2.00	3.00	4.00	
27.00						27.00
28.00 Low volume adjustment prior to October 1	70.96	714, 176	714, 17	76	714, 176	28.00
29.00 Low volume adjustment on or after October 1	70.97	270, 062		270, 062	270, 062	29.00
30.00 HVBP payment adjustment (see instructions)	70. 93	-11, 585	-11, 58	35 0	-11, 585	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31.00 HRR adjustment (see instructions)	70.94	0		0 0	0	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
					(Amt. to Wkst. E, Pt. A)	
	0	1.00	2.00	3.00	4,00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 18, 207	18, 207	32.00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E. Pt. A.		Y				100.00

	Financial Systems MEMORIAL HOSPITAL ATION OF REIMBURSEMENT SETTLEMENT	LOGANSPORT Provider CCN: 15-0072	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
CALCUL		FI OVI del CCN. 13-0072	From 01/01/2021 To 12/31/2021		
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)	+:>		18, 014	
2.00 3.00	Medical and other services reimbursed under OPPS (see instruc OPPS payments	TI ONS)		9, 823, 711 9, 908, 969	
4.00	Outlier payment (see instructions)			166, 509	
4.01	Outlier reconciliation amount (see instructions)			0	
5.00 6.00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	ictions)		0.000	1
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	1
8.00	Transitional corridor payment (see instructions)			0	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	IV, col. 13, line 200		0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			18, 014	1
	COMPUTATION OF LESSER OF COST OR CHARGES			· ·	1
12 00	Reasonable charges Ancillary service charges			83, 628	1 1 2 00
12.00 13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		03, 020	
14.00	Total reasonable charges (sum of lines 12 and 13)			83, 628	14.00
15 00	Customary charges				1 1 5 00
15.00 16.00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for			0	
101.00	had such payment been made in accordance with 42 CFR §413.13(en a onargobaero	, i i i i i i i i i i i i i i i i i i i	
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00 19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	lvifline 18 exceeds l	ine 11) (see	83, 628 65, 614	
17.00	instructions)			00,011	
20.00	Excess of reasonable cost over customary charges (complete on instructions)	ly if line 11 exceeds l	ine 18) (see	0	20.00
21.00	Lesser of cost or charges (see instructions)			18, 014	21.00
22.00	Interns and residents (see instructions)			0	
23.00 24.00	Cost of physicians' services in a teaching hospital (see inst Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ructions)		0 10, 075, 478	
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			10, 073, 478	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instruction			0	
26.00 27.00	Deductibles and Coinsurance amounts relating to amount on lin Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			1, 961, 625 8, 131, 867	
27.00	instructions)	prus the sum of Trifes 2		0, 131, 007	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, I			0	
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 8, 131, 867	
31.00	Primary payer payments			1, 012	
32.00	Subtotal (line 30 minus line 31)			8, 130, 855	32.00
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. 1-5, line 11)	CES)		0	33.00
	Allowable bad debts (see instructions)			142, 621	
35.00	Adjusted reimbursable bad debts (see instructions)			92, 704	
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	ructions)		142, 621 8, 223, 559	
38.00	MSP-LCC reconciliation amount from PS&R			76	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	is)		0	39.50 39.97
39.97	Partial or full credits received from manufacturers for repla	ced devices (see instru	ctions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION	· ·		0	39.99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			8, 223, 483 0	
40. 01 40. 02	Demonstration payment adjustment amount after sequestration			0	
	Sequestration adjustment-PARHM pass-throughs			_	40.03
41.00	Interim payments			8, 270, 580	
41.01 42.00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41.01 42.00
42.01	Tentative settlement-PARHM (for contractor use only)				42.01
43.00	Balance due provider/program (see instructions)			-47, 097	
43.01 44.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2.	chapter 1.	0	43.01 44.00
	§115. 2		- p		
90.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
	The rate used to calculate the Time Value of Money				92.00
93.00 94.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00 94.00
				, 0	

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	F	Period: From 01/01/2021 To 12/31/2021	5/27/2022 1:4	pared:
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3, 00	4,00	
1.00	Total interim payments paid to provider		6, 488, 227	7	8, 134, 916	1.00
2.00	Interim payments payable on individual bills, either		()	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		(12/08/2021	135, 664	3.01
3. 02			()	0	3.02
3. 03			()	0	3.03
3.04			(0	3.04
3.05)	0	3.05
	Provider to Program			1		
3.50	ADJUSTMENTS TO PROGRAM		(0	3.50
3.51			(0	3.51
3.52 3.53			(0	3.52 3.53
3.53			(0	3.53
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines		(135, 664	3.99
0. 77	3, 50-3, 98)			,	100,001	0.7
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		6, 488, 227	7	8, 270, 580	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5.01	TENTATI VE TO PROVIDER		(0	5.01
5.02			(Ő	5.02
5.03			(0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		()	0	5.50
5.51			(0	5.51
5.52			(0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		()	0	5.99
4 00	5.50-5.98)					4 00
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		(0	6.01
6. 02	SETTLEMENT TO PROGRAM		71, 119		47,097	6.02
7.00	Total Medicare program liability (see instructions)		6, 417, 108		8, 223, 483	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(2.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0072 Period: W	Worksheet E-1				
	Part II				
To 12/31/2021 D	Date/Time Prep 5/27/2022 1:4				
Ti tle XVIII Hospi tal	PPS	pin_			
	1.00				
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00			
2.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost		2.00			
reporting periods beginning on or after 10/01/2013, line 32)					
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00 4.00			
4.00 Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost					
reporting periods beginning on or after 10/01/2013, line 32)					
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 line 20		6.00			
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00			
8.00 Calculation of the HIT incentive payment (see instructions)		8.00			
9.00 Sequestration adjustment amount (see instructions)		9.00			
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)		10.00			
I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH					
30.00 Initial/interim HIT payment adjustment (see instructions)		30.00			
31.00 Other Adjustment (specify)		31.00			
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00			

CULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-0072	Period:	Worksheet E-2	2
	Component CCN: 15-U072	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 1:4	epare 47 pr
	Title XIX	Swing Beds - SNF		_
		Part A	Part B	+
COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	-
0 Inpatient routine services - swing bed-SNF (see instructions)		0		1 1.
0 Inpatient routine services - swing bed-NF (see instructions)		0		2
0 Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A, and sum of Wkst. D,	0		3.
Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing	g-bed pass-through, see	e		
instructions)				
Nursing and allied health payment-PARHM (see instructions)				3
0 Per diem cost for interns and residents not in approved teaching	ng program (see	0.00		4
instructions)		0		
0 Program days 0 Interns and residents not in approved teaching program (see ins	structions)	0		5
0 Utilization review - physician compensation - SNF optional meth		0		7
0 Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0		8
0 Primary payer payments (see instructions)		0		9
00 Subtotal (line 8 minus line 9)		0		10
00 Deductibles billed to program patients (exclude amounts applica	able to physician	0		11
professional services)	1 5			
00 Subtotal (line 10 minus line 11)		0		12
00 Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	0		13
for physician professional services)				
00 80% of Part B costs (line 12 x 80%)		0		14
00 Subtotal (see instructions)		0		15
00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	<u>,</u>	0		16
50 Pioneer ACO demonstration payment adjustment (see instructions) 55 Rural community hospital demonstration project (§410A Demonstra				16
adjustment (see instructions)	atron) payment			
99 Demonstration payment adjustment amount before sequestration		0		16
00 Allowable bad debts (see instructions)		0		17
01 Adjusted reimbursable bad debts (see instructions)		0		17
00 Allowable bad debts for dual eligible beneficiaries (see instru	uctions)	0		18
00 Total (see instructions)		0		19
01 Sequestration adjustment (see instructions)		0		19
D2 Demonstration payment adjustment amount after sequestration)		0		19
03 Sequestration adjustment-PARHM pass-throughs				19
25 Sequestration for non-claims based amounts (see instructions)		0		19
00 Interim payments		0		20
01 Interim payments-PARHM 00 Tentative settlement (for contractor use only)		0		20
01 Tentative settlement (for contractor use only)		0		21
00 Balance due provider/program (line 19 minus lines 19.01, 19.02,	19 25 20 and 21)	0		22
01 Balance due provider/program-PARHM (see instructions)				22
00 Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2,	0		23
chapter 1, §115.2				
Rural Community Hospital Demonstration Project (§410A Demonstra				
.00 Is this the first year of the current 5-year demonstration peri	od under the 21st			200
Century Cures Act? Enter "Y" for yes or "N" for no.				_
Cost Reimbursement	(at D 1 Dt 11 line			1201
.00 Medicare swing-bed SNF inpatient routine service costs (from WH 66 (title XVIII hospital))	KSt. D-1, Pt. 11, 111e			201
.00 Medicare swing-bed SNF inpatient ancillary service costs (from	Wkst D-3 col 3 lin	he		202
200 (title XVIII swing-bed SNF))				
.00 Total (sum of lines 201 and 202)				203
.00 Medicare swing-bed SNF discharges (see instructions)				_204
Computation of Demonstration Target Amount Limitation (N/A in f	first year of the curre	ent 5-year demons	tration	
period)				
.00 Medicare swing-bed SNF target amount				205
.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 tir	, ,			_206
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse				
.00 Program reimbursement under the §410A Demonstration (see instru	-	1		207
.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, and 3)	Sor. I, Sum OF FITTES	·		208
.00 Adjustment to Medicare swing-bed SNF PPS payments (see instruct	tions)			209
. 00 Reserved for future use				210
Comparision of PPS versus Cost Reimbursement		. I		1
.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 20	0 plus line 210) (see			215

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Pre 5/27/2022 1:4	pared
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR	XIX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		819, 535		1.0
00	Medical and other services			0	2.0
00	Organ acquisition (certified transplant centers only)		0	_	3.0
00	Subtotal (sum of lines 1, 2 and 3)		819, 535	0	4.0
00	Inpatient primary payer payments		0	0	5.0
00	Outpatient primary payer payments		010 525	0	
00	Subtotal (line 4 less sum of lines 5 and 6)		819, 535	0	7.0
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges				-
00	Routine service charges		562, 640		8.0
00	Ancillary service charges		1, 034, 396	0	9.0
00	Organ acquisition charges, net of revenue		1, 034, 390	0	10.0
. 00	Incentive from target amount computation		0		11.0
. 00	Total reasonable charges (sum of lines 8 through 11)		1, 597, 036	0	
	CUSTOMARY CHARGES		1,0,1,000		
. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.0
	basi s	5			
. 00	Amounts that would have been realized from patients liable for	payment for services	on 0	0	14.
	a charge basis had such payment been made in accordance with 4	12 CFR §413.13(e)			
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	15.
. 00	Total customary charges (see instructions)		1, 597, 036	0	
. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	777, 501	0	17.
	line 4) (see instructions)				
. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds li	ne 0	0	18.
00	16) (see instructions)		0	0	10
0. 00 0. 00	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see instr	suctions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line 1		819, 535	0	
. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	21.
00	Other than outlier payments		0	0	22.
. 00	Outlier payments		0	0	
. 00	Program capital payments		0	Ū	24.
. 00	Capital exception payments (see instructions)		0		25.
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	27.
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28.
. 00	Titles V or XIX (sum of lines 21 and 27)		819, 535	0	29.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
. 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))	819, 535	0	31.
. 00	Deducti bl es		0	0	
. 00	Coinsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0		35.
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	819, 535	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		010 505	0	
. 00	Subtotal (line 36 ± line 37)		819, 535	0	
00	Direct graduate medical education payments (from Wkst. E-4)		010 505	_	39.
0.00	Total amount payable to the provider (sum of lines 38 and 39)		819, 535	0	
. 00	Interim payments Relance due provider (program (line 40 minus line 41)		803, 752	0	41.
. 00	Balance due provider/program (line 40 minus line 41)	aco with CMS Dub 15 3	15, 783	0	
. 00	Protested amounts (nonallowable cost report items) in accordar chapter 1, §115.2	ice with two Pub 15-2,	0	0	43.

	Financial Systems MEMORIAL HOSPIT. E SHEET (If you are nonproprietary and do not maintain	Provi der C		eriod: com 01/01/2021	u of Form CMS-2 Worksheet G	
und-t nl y)	ype accounting records, complete the General Fund column		Tc		Date/Time Pre	
		General Fund	Specific Purpose Fund	Endowment Fund	5/27/2022 1:4 Plant Fund	
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS	24 290 455		0	0	1 1
. 00 . 00	Cash on hand in banks Temporary investments	24, 389, 655		0	0	
. 00	Notes receivable		0	0	0	
. 00	Accounts receivable	75, 981, 732	0	0	0	4.
. 00	Other receivable	4, 228, 001	0	0	0	
00	Allowances for uncollectible notes and accounts receivable			0	0	
00 00	Inventory Prepaid expenses	1, 676, 143 1, 172, 203		0	0	
00	Other current assets	1, 172, 203	0	0	0	
0.00	Due from other funds	C	0	0	0	
1.00	Total current assets (sum of lines 1-10)	55, 487, 692	0	0	0	11
	FI XED_ASSETS	· · · · ·	т			ł.,
	Land	205, 783		0	0	
3.00	Land improvements Accumulated depreciation	838, 517 -519, 061	0	0	0	
	Buildings	71, 692, 889		0	0	
	Accumulated depreciation	-42, 528, 424		0	0	
	Leasehold improvements	C	0	0	0	17
	Accumulated depreciation	C	0	0	0	
	Fixed equipment	8, 229, 054		0	0	
	Accumulated depreciation	-4, 388, 434		0	0	
	Automobiles and trucks Accumulated depreciation	108, 602 -108, 602		0	0	
	Major movable equipment	46, 557, 149		0	0	
	Accumulated depreciation	-27, 923, 033		0	0	
6.00	Minor equipment depreciable	C	0	0	0	25
	Accumulated depreciation	C	0	0	0	
	HIT designated Assets	C	0	0	0	
	Accumulated depreciation Minor equipment-nondepreciable		0	0	0	
	Total fixed assets (sum of lines 12-29)	52, 164, 440		0	0	
	OTHER ASSETS			-	-	
	Investments	2, 100, 018	0	0	0	
	Deposits on Leases	C	0	0	0	
3.00	Due from owners/officers Other assets		0	0	0	
4.00 5.00	Total other assets (sum of lines 31-34)	13, 674, 910 15, 774, 928		0	0	
6.00	Total assets (sum of lines 11, 30, and 35)	123, 427, 060		0	0	
	CURRENT LI ABI LI TI ES				-	
7.00	Accounts payable	19, 326, 875	0	0	0	37
3.00	Salaries, wages, and fees payable	1, 876, 315		0	0	
9.00	Payroll taxes payable			0	0	
	Notes and Loans payable (short term) Deferred income	1, 867, 000	0	0	0	
	Accel erated payments		0	0	0	41
	Due to other funds		0	0	0	
4.00	Other current liabilities	1, 939, 091	0	0	0	44
5.00	Total current liabilities (sum of lines 37 thru 44)	25, 009, 281	0	0	0	45
,	LONG TERM LIABILITIES					l
5.00	Mortgage payable Notes payable		0	0	0	
7.00 8.00	Unsecured Loans	5, 284, 485	0	0	0	
9.00	Other long term liabilities	20, 992, 999	0	0	0	
	Total long term liabilities (sum of lines 46 thru 49)	26, 277, 484		0	0	
. 00	Total liabilities (sum of lines 45 and 50)	51, 286, 765	0	0	0	51
	CAPITAL ACCOUNTS	I	1			
	General fund balance	72, 140, 295				52
3.00 1.00	Specific purpose fund Donor created - endowment fund balance - restricted		0	0		53
5.00	Donor created - endowment fund balance - restricted			0		55
b. 00	Governing body created - endowment fund balance			0		56
7.00	Plant fund balance - invested in plant				0	
3.00	Plant fund balance - reserve for plant improvement,				0	58
0 00	replacement, and expansion	70 4/2 2	_	_	-	
9.00 0.00	Total fund balances (sum of lines 52 thru 58)	72, 140, 295		0	0	
	Total liabilities and fund balances (sum of lines 51 and	123, 427, 060	y U	0	0	60

Health Financial Systems N STATEMENT OF CHANGES IN FUND BALANCES	IEMORIAL HOSPITAL	Provider CC	CN: 15-0072	Period: From 01/01/2021 To 12/31/2021	u of Form CMS- Worksheet G- Date/Time Pr	1
	General	Fund	Speci al	Purpose Fund	5/27/2022 1: Endowment Fund	47 pm
	1.00	2.00	3.00	4.00	5.00	
<pre>1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify) 5.00 6.00 7.00 8.00 9.00 10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance</pre>		2.00 72,908,927 -768,632 72,140,295 0 72,140,295 0 72,140,295	3. UU			 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
	6.00	7.00	8.00			
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 29)3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments) (specify)5.006.007.008.009.009.00	0			0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
9.00 Total additions (sum of line 4-9) 10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 14.00 15.00 16.00 17.00 10.00	0 0	0 0 0 0 0 0		0		9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
 18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18) 	0 0			0 0		18.00 19.00

Heal th	Financial Systems MEMORIAL HOSPITAL	LOGANSPORT		In Lie	u of Form CMS-2	2552-10
STATE	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-0072	Period: From 01/01/2021 To 12/31/2021		pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES General Inpatient Routine Services					-
1.00	Hospi tal		9, 929, 9	70	9, 929, 979	1.00
2.00	SUBPROVIDER - IPF		7, 727, 7		7,727,717	2.00
3.00	SUBPROVI DER – I RF					3.00
4.00	SUBPROVIDER					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)		9, 929, 9	/9	9, 929, 979	10.00
11 00	Intensive Care Type Inpatient Hospital Services		1 ()7 //	24	1 ()7 404	11 00
11.00 12.00	CORONARY CARE UNIT		1, 627, 40	J4	1, 627, 404	11.00
12.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	1, 627, 40	04	1, 627, 404	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11, 557, 3		11, 557, 383	17.00
18.00	Ancillary services		34, 695, 3			18.00
19.00	Outpatient services		3, 700, 7			
20.00	EXPRESS MEDICAL CENTER			0 0	0	20.00
20.01	FAMILY HEALTH CARE			0 0		
21.00 22.00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY			0 0	0	21.00 22.00
22.00	AMBULANCE SERVICES			0 0	0	
23.00	CMHC			0	0	23.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE					26.00
27.00	NONREIMBURSABLE		200, 20	11, 870, 444	12, 070, 708	27.00
27.01	PRO FEES		2, 817, 10	02 14, 137, 553	16, 954, 655	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	52, 970, 8	70 210, 776, 541	263, 747, 411	28.00
	G-3, line 1)					
~~ ~~	PART II - OPERATING EXPENSES			107 440 440		
29.00 30.00	Operating expenses (per Wkst. A, column 3, line 200)			107, 448, 113 0		29.00
30.00	ADD (SPECI FY)			0		30.00
31.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		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) Total operating expenses (sum of lines 29 and 36 minus line 4	2) (transfer		107 449 112		42.00
43.00	to Wkst. G-3, line 4)	z) (ti ansi er		107, 448, 113		43.00
			I	I	I	I

		TAL LOGANSPORT		u of Form CMS-2	
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet G-3 Date/Time Pre 5/27/2022 1:4	pared:
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,	Line 28)		263, 747, 411	1.00
2.00	Less contractual allowances and discounts on patients' ac			163, 673, 884	2.00
3.00	Net patient revenues (line 1 minus line 2)			100, 073, 527	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, I	ine 43)		107, 448, 113	
5.00	Net income from service to patients (line 3 minus line 4)	,		-7, 374, 586	
	OTHER I NCOME				
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 communica	ition services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
	J			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00				0	
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to oth	er than patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts			0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	5			0	20.00
	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00 24.00	Governmental appropriations OTHER REVENUE			0 2, 507, 957	23.00
	INVESTMENT INCOME			2, 507, 957 520, 898	
	LOSS ON SALE OF EQUIPMENT			187, 460	
24.02	OTHER NON-OPERATING REVENUE			187,400	24.02
	COVID-19 PHE Funding			3, 389, 639	
	Total other income (sum of lines 6-24)			6, 605, 954	
	Total (line 5 plus line 25)			-768, 632	
27.00	OTHER EXPENSES (SPECIFY)			-700,032	27.00
	Total other expenses (sum of line 27 and subscripts)			0	28.00
20.00	Net income (or loss) for the period (line 26 minus line 2	20)		-768, 632	

ALCULATION OF CAPITAL PAYMENT	Provi der CCN: 15-0072	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Pre 5/27/2022 1:4	
	Title XVIII	Hospi tal	PPS	y piii
			1.00	
PART I - FULLY PROSPECTIVE METHOD				
CAPI TAL FEDERAL AMOUNT				
00 Capital DRG other than outlier			253, 654	1.
01 Model 4 BPCI Capital DRG other than outlier			0	
00 Capital DRG outlier payments			24, 397	
01 Model 4 BPCI Capital DRG outlier payments			0	
00 Total inpatient days divided by number of days in the co	ost reporting period (see ins	structions)	14.76	
00 Number of interns & residents (see instructions)			0.00	
00 Indirect medical education percentage (see instructions)			0.00	
00 Indirect medical education adjustment (multiply line 5 b 1.01) (see instructions)			0	
00 Percentage of SSI recipient patient days to Medicare Par 30) (see instructions)	't A patient days (Worksheet	E, part A line	0.00	7.
00 Percentage of Medicaid patient days to total days (see i	nstructions)		0.00	
00 Sum of lines 7 and 8			0.00	
0.00 Allowable disproportionate share percentage (see instruc	tions)		0.00	
. 00 Disproportionate share adjustment (see instructions)			0	1
.00 Total prospective capital payments (see instructions)			278, 051	12.
			1.00	
PART II - PAYMENT UNDER REASONABLE COST			1.00	
00 Program inpatient routine capital cost (see instructions	<u>ز</u> ز		0	1 1.
00 Program inpatient ancillary capital cost (see instruction	ons)		0	2.
00 Total inpatient program capital cost (line 1 plus line 2	2)		0	3.
00 Capital cost payment factor (see instructions)			0	4.
00 Total inpatient program capital cost (line 3 x line 4)			0	5.
			1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
00 Program inpatient capital costs (see instructions)			0	
00 Program inpatient capital costs for extraordinary circum			0	1 -
00 Net program inpatient capital costs (line 1 minus line 2	<u>'</u>)		0	
00 Applicable exception percentage (see instructions)			0.00	
00 Capital cost for comparison to payments (line 3 x line 4			0	-
00 Percentage adjustment for extraordinary circumstances (s			0.00	
Adjustment to capital minimum payment level for extraorc	inary circumstances (line 2	x iine 6)	0	
00 Capital minimum payment level (line 5 plus line 7)	applicable)		0	
00 Current year capital payments (from Part I, line 12, as 0.00 Current year comparison of capital minimum payment level			0	1
.00 Carryover of accumulated capital minimum payment level c			0	
	al navments (line 10 plus li	ne 11)	0	12.
Worksheet L, Part III, line 14)	ar payments tille to plus II.		0	
.00 Net comparison of capital minimum payment level to capit			0	
.00 Net comparison of capital minimum payment level to capit .00 Current year exception payment (if line 12 is positive,	enter the amount on this lin		0	11
 Net comparison of capital minimum payment level to capit Current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level of 	enter the amount on this lin		0	14.
 2.00 Net comparison of capital minimum payment level to capit 3.00 Current year exception payment (if line 12 is positive, 4.00 Carryover of accumulated capital minimum payment level of (if line 12 is negative, enter the amount on this line) 	enter the amount on this lin over capital payment for the		-	
 2.00 Net comparison of capital minimum payment level to capit 3.00 Current year exception payment (if line 12 is positive, 4.00 Carryover of accumulated capital minimum payment level of 	enter the amount on this lin over capital payment for the ee instructions)		0	15

		EMORIAL HOSPITA					u of Form CMS-2	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-0072		eriod:	Worksheet M-1	
			Component	CCN: 15-8561	Fr To	com 01/01/2021 0 12/31/2021	Date/Time Pre 5/27/2022 1:4	
						RHC I	Cost	
		Compensation	Other Costs	Total (col.	1	Recl assi fi cat	Recl assi fi ed	
				+ col. 2)		i ons	Trial Balance	
							(col. 3 +	
							col. 4)	
		1.00	2.00	3.00		4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	0		0	0		1.00
2.00	Physician Assistant	0	0		0	0	°,	2.00
3.00	Nurse Practitioner	1	0		1	0	1	3.00
4.00	Visiting Nurse	0	0		0	0	0	4.00
5.00	Other Nurse	0	0		0	0	0	5.00
6.00	Clinical Psychologist	0	0		0	0	0	6.00
7.00	Clinical Social Worker	0	0		0	0	0	7.00
8.00	Laboratory Techni ci an	0	0		0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0		0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1	0		1	0	1	10.00
11.00	Physician Services Under Agreement	0	0		0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0	0	0	12.00
	Other Costs Under Agreement	0	0		0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	0	14.00
	Medical Supplies	0	0		0	0	0	15.00
	Transportation (Health Care Staff)	0	0		0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0	0	0	17.00
	Professional Liability Insurance	0	0		0	0	0	18.00
19.00	Other Health Care Costs	0	0		0	0	0	19.00
	Allowable GME Costs							20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of	1	0		1	0	1	22.00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES			1				
23.00	Pharmacy	0	0		0	0	-	23.00
24.00	Dental	0	0		0	0	-	24.00
25.00	Optometry	0	0		0	0	0	25.00
	Tel eheal th	0	0		0	0	0	25.01
25.02	Chronic Care Management	0	0		0	0	0	25.02
26.00	All other nonreimbursable costs	0	0		0	0	0	26.00
27.00	Nonallowable GME costs							27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	0	28.00
	through 27)							
00.00	FACILITY OVERHEAD				0		2	00.00
	Facility Costs	0	0		0	0		29.00
30.00	Administrative Costs	0	0		0	0	-	30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	0		U	0	0	31.00
22.00	30) Tatal facility costs (our of lines 22, 20		~		-	~		22.00
32.00	Total facility costs (sum of lines 22, 28	1	0		I	0	1	32.00
	and 31)			I				I

		EMORIAL HOSPIT				u of Form CMS	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-0072	Period: From 01/01/2021	Worksheet M-	1
			Component	CCN: 15-8561	To 12/31/2021	Date/Time Pr 5/27/2022 1:	
					RHC I	Cost	47 pili
		Adjustments	Net Expenses			0031	
		.,	for				
			Allocation				
			(col. 5 +				
			col. 6)	-			
		6.00	7.00				
	FACILITY HEALTH CARE STAFF COSTS			1			1 1 00
1.00 2.00	Physician Physician Assistant	0	-	1			1.00
2.00 3.00	Nurse Practitioner	0	1				3.00
4.00	Visiting Nurse	0					4.00
5.00	Other Nurse	0	c c				5.00
5.00	Clinical Psychologist	0					6.00
7.00	Clinical Social Worker	0	C C				7.00
3.00	Laboratory Techni ci an	0	C				8.00
9.00	Other Facility Health Care Staff Costs	0					9.0
0.00	Subtotal (sum of lines 1 through 9)	0	1	•			10.0
1.00	Physician Services Under Agreement	0	C				11.0
2.00	Physician Supervision Under Agreement	0	C				12.0
3.00	Other Costs Under Agreement	0	C				13.0
4.00	Subtotal (sum of lines 11 through 13)	0	C				14.0
15.00	Medical Supplies	0	C				15.0
6.00	Transportation (Health Care Staff)	0	C				16.0
17.00	Depreciation-Medical Equipment	0	-	1			17.0
18.00	Professional Liability Insurance	0	C				18.0
19.00	Other Health Care Costs	0	C				19.0
20.00	Allowable GME Costs						20.0
21.00	Subtotal (sum of lines 15 through 20)	0	C				21.0
22.00	Total Cost of Health Care Services (sum of	0	1				22.0
	lines 10, 14, and 21)						-
23.00	COSTS OTHER THAN RHC/FQHC SERVICES	0	C				23.0
23.00	Pharmacy Dental	0		•			23.0
4.00 5.00	Optometry	0					24.0
5.01	Tel eheal th	0	C C				25.0
5.02	Chronic Care Management	0	C	1			25.0
26.00	All other nonreimbursable costs	0	C				26.0
7.00	Nonallowable GME costs	-	-				27.0
8.00	Total Nonreimbursable Costs (sum of lines 23	0	C				28.0
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0					29.0
30.00	Administrative Costs	0	C				30.0
1. 00	Total Facility Overhead (sum of lines 29 and	0	C				31.0
	30)						
32.00	Total facility costs (sum of lines 22, 28	0	1				32.0
	and 31)						

		EMORIAL HOSPITA					u of Form CMS-2	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-0072		eriod:	Worksheet M-1	
			Component	CCN: 15-8563	Fr To	rom 01/01/2021 0 12/31/2021	Date/Time Pre 5/27/2022 1:4	
						RHC II	Cost	
		Compensati on	Other Costs	Total (col.	1	Recl assi fi cat	Recl assi fi ed	
				+ col. 2)		i ons	Trial Balance	
							(col. 3 +	
							col. 4)	
		1.00	2.00	3.00		4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	0		0	0	0	1.00
2.00	Physician Assistant	0	0		0	0	0	2.00
3.00	Nurse Practitioner	1	0		1	0	1	3.00
4.00	Visiting Nurse	0	0		0	0	0	4.00
5.00	Other Nurse	0	0		0	0	0	5.00
6.00	Clinical Psychologist	0	0		0	0	0	6.00
7.00	Clinical Social Worker	0	0		0	0	0	7.00
8.00	Laboratory Techni ci an	o	0		0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0		0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1	0		1	0	1	10.00
11.00	Physician Services Under Agreement	0	0		0	0	0	11.00
	Physician Supervision Under Agreement	0	0		0	0	0	12.00
	Other Costs Under Agreement	0	0		0	0	0	13.00
	Subtotal (sum of lines 11 through 13)	0	0		0	0	0	14.00
	Medical Supplies	0	0		0	0	0	15.00
	Transportation (Health Care Staff)	0	0		0	0	0	16.00
	Depreciation-Medical Equipment	0	0		0	0	0	17.00
	Professional Liability Insurance	0	0		0	0	0	18.00
	Other Health Care Costs	0	0		0	0	0	19.00
	Allowable GME Costs	0	0		U	0	0	20.00
		0	0		0	0	0	
	Subtotal (sum of lines 15 through 20)	0	0		0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of	1	0		1	0	1	22.00
	l i nes 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0		0	0	0	23.00
	Dental	0	0		0	0	-	23.00
24.00	Optometry	0	0		0	0	0	24.00
	Tel eheal th	0	0		0	0	0	25.00
		0	0		0	0	0	
25.02	Chronic Care Management	0	0		0	0	-	25.02
	All other nonreimbursable costs	0	0		0	0	0	26.00
27.00	Nonallowable GME costs				-			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	0	28.00
	through 27)							
20.00	FACILITY OVERHEAD	0		1	0	0	2	20.00
	Facility Costs	0	0		0	0		29.00
30.00	Administrative Costs	0	0		0	0	-	30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	0		υ	0	0	31.00
00.00	30)		-		_	_	-	00.07
32.00	Total facility costs (sum of lines 22, 28 and 31)	1	0		1	0	1	32.00
				1				1

Heal th	Financial Systems M	EMORIAL HOSPIT	AL LOGANSPORT		In Lieu	u of Form CMS-	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CO	CN: 15-0072	Peri od:	Worksheet M-	1
			Component (CCN: 15-8563	From 01/01/2021 To 12/31/2021	Date/Time Pre	
					RHC II	5/27/2022 1:4 Cost	47 pili
		Adjustments	Net Expenses			0031	
		naj astinonto	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6.00	7.00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	0				1.00
2.00	Physician Assistant	0					2.00
3.00	Nurse Practitioner	0	1				3.00
4.00	Visiting Nurse	0	0				4.00
5.00	Other Nurse	0	0				5.00
6.00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	0	0				7.00
8.00	Laboratory Techni ci an	0	0				8.00
9.00	Other Facility Health Care Staff Costs	0	0				9.00
10.00 11.00	Subtotal (sum of lines 1 through 9) Physician Services Under Agreement	0	0				10.00
12.00		0	0				12.00
	Physician Supervision Under Agreement Other Costs Under Agreement	0	0				12.00
13.00	Subtotal (sum of lines 11 through 13)	0	0				13.00
14.00	Medical Supplies	0	0				15.00
16.00		0	0				16.00
17.00	Depreciation-Medical Equipment	0	0				17.00
18.00	Professional Liability Insurance	0	0				18.00
	Other Health Care Costs	0	0				19.00
20.00	Allowable GME Costs	0	Ŭ				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0				21.00
22.00	Total Cost of Health Care Services (sum of	0	1				22.00
	lines 10, 14, and 21)	-					
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0				23.00
24.00	Dental	0	0				24.00
25.00	Optometry	0	0				25.00
25.01	Tel eheal th	0	0				25.01
25.02	Chronic Care Management	0	0				25.02
26.00	All other nonreimbursable costs	0	0				26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.00
	through 27)						
	FACILITY OVERHEAD	-					
29.00	Facility Costs	0					29.00
30.00	Administrative Costs	0	0				30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	0				31.00
22.00	30) Tatal facility acots (our of lines 22, 20	~					22.00
32.00	Total facility costs (sum of lines 22, 28	0	'				32.00
	and 31)						1